UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF MISSOURI
SOUTHEASTERN DIVISION

	§	**Chapter 11**
In re:	§	
	§	**Case No. 20-43597-399**
BRIGGS & STRATTON CORPORATION, *et al.*,	§	
	§	**(Joint Administration Requested)**
	§	
Debtors.[1]	§	Hearing Date: TBD
	§	Hearing Time: TBD
	§	Hearing Location: TBD

MOTION OF DEBTORS FOR ORDER (I) CONFIRMING INAPPLICABILITY OF SECTION 1114 OF THE BANKRUPTCY CODE; (II) IN THE ALTERNATIVE, APPROVING DEBTORS' PREPETITION TERMINATION OF RETIREE BENEFITS PURSUANT TO SECTION 1114(L) OF THE BANKRUPTCY CODE; AND (III) GRANTING RELATED RELIEF

Briggs & Stratton Corporation and its debtor affiliates in the above-captioned chapter 11 cases, as debtors and debtors in possession (collectively, the "**Debtors**"), respectfully represent as follows in support of this motion (the "**Retiree Benefits Motion**" or the "**Motion**"):

Preliminary Statement

1. On the date hereof (the "**Petition Date**"), the Debtors each commenced with this Court a voluntary case under title 11 of the United States Code (the "**Bankruptcy Code**"). The Debtors are authorized to continue to operate their business and manage their properties as debtors in possession pursuant to sections 1107(a) and 1108 of the Bankruptcy Code. No trustee, examiner, or statutory committee of creditors has been appointed in these chapter 11 cases. The Debtors have also filed a motion requesting joint administration of their chapter 11 cases pursuant to Rule 1015(b) of the Federal Rules of Bankruptcy Procedure (the "**Bankruptcy Rules**") and

[1] The Debtors in these chapter 11 cases, along with the last four digits of each Debtor's federal tax identification number are: Briggs & Stratton Corporation (2330), Billy Goat Industries, Inc. (4442), Allmand Bros., Inc. (4710), Briggs & Stratton International, Inc. (9957), and Briggs & Stratton Tech, LLC (2102). The address of the Debtors' corporate headquarters is 12301 West Wirth Street, Wauwatosa, Wisconsin 53222.

Rule 1015(b) of the Local Rules of Bankruptcy Procedure for the Eastern District of Missouri (the "**Local Rules**").

2. The Debtors, combined with their non-Debtor affiliates (collectively, the "**Company**"), are the world's largest producer of gasoline engines for outdoor power equipment and a leading designer, manufacturer and marketer of power generation, pressure washer, lawn and garden, turf care and job site products. The Company's products are marketed and serviced in more than 100 countries on six continents through 40,000 authorized dealers and service organizations. Additional information regarding the Debtors' business and capital structure and the circumstances leading to the commencement of these chapter 11 cases is set forth in the *Declaration of Jeffrey Ficks, Financial Advisor of Briggs & Stratton Corporation, in Support of the Debtors' Chapter 11 Petitions and First Day Relief*, sworn to on the date hereof (the "**Ficks Declaration**"),[2] which has been filed with the Court contemporaneously herewith and is incorporated by reference herein.

3. Until recently, the Debtors maintained various benefits, including medical, dental, vision, and prescription drug benefits, health savings accounts, life insurance, and accidental death and dismemberment insurance (collectively, the "**Retiree Health and Welfare Benefits**") for eligible retired employees ("**Eligible Retirees**"). The Stalking Horse Bidder (as defined in the Ficks Declaration) was unwilling to assume the Retiree Health and Welfare Benefits. As such, given the Debtors' limited cash resources and ongoing sale process, which will be followed by a chapter 11 plan of liquidation and dissolution, the Debtors determined, in their business judgment, that they could not justify maintaining the Retiree Health and Welfare Benefits

[2] Capitalized terms used but not otherwise defined herein shall have the meanings ascribed to such terms in the Ficks Declaration. All dollar ($) references in this Motion are to the U.S. dollar, unless stated otherwise.

and paying the premiums and costs associated with the underlying insurance policies, which total approximately $650,000 each month and which have a total unfunded status of approximately $50 million. *See* Lehr Declaration, Exhibit C, at 2.

4. As a result, on July 19, 2020, the Board of Directors of the Company (the "**Board of Directors**") exercised the Company's right to terminate the Group Insurance Plan for Retirees of Briggs & Stratton Corporation, Plan Number 502 (the "**Retiree Group Insurance Plan**"), which Plan provides for and governs all Retiree Health and Welfare Benefits.[3] To implement the termination in a way that minimizes disruption to Eligible Retirees, coverage will not cease until August 31, 2020. The Board of Directors' determination was one of many difficult decisions that the Debtors have had to make in recent months.

5. The explicit language of the Plan Document for the Retiree Group Insurance Plan (the "**Plan Document**"), which governs all Retiree Health and Welfare Benefits, reserves to the Debtors the unilateral right to terminate or modify benefits available thereunder. *See* Lehr Declaration, Exhibit A, at 8. The Plan Document's reservation of the Company's right to terminate the Retiree Group Insurance Plan renders section 1114 of title 11 of the Bankruptcy Code inapplicable under prevailing case law. Moreover, because the Debtors terminated the Retiree Group Insurance Plan prepetition, section 1114 does not apply as a prepetition termination is not a modification of retiree benefits by a *debtor*.

6. In the alternative, if this Court were to determine that section 1114 of the Bankruptcy Code applies, the balance of the equities warranted termination of the Retiree Group Insurance Plan pursuant to section 1114(l) of the Bankruptcy Code. In addition, the appointment

[3] Since January 1, 2017, all Retiree Health and Welfare Benefits have been governed by a single plan, the Retiree Group Insurance Plan.

of an official retiree committee is unwarranted and would serve no practical purpose, because the Debtors lack the financial wherewithal to make a reasonable proposal to the Eligible Retirees.

7. The Debtors filed this Motion and are providing notice hereof to all Eligible Retirees, along with a copy of one of the letters attached as Exhibit D to the Lehr Declaration, to (i) inform them of the Debtors' actions and (ii) provide them their day in Court. In addition, because of the Debtors' limited financial resources, it is important to avoid delay that might result from uncertainty regarding the applicability of section 1114 of the Bankruptcy Code and the treatment of Retiree Health and Welfare Benefits under any chapter 11 plan. Any such delay would increase administrative costs and impact the recovery available to unsecured creditors.

8. Consequently, this Court should approve the Debtors' prepetition termination of the Retiree Group Insurance Plan either as a proper exercise of the Company's contractual right or because the balance of the equities weigh in favor of termination.

Jurisdiction

9. The Court has jurisdiction to consider this matter pursuant to 28 U.S.C. §§ 157 and 1334. This is a core proceeding pursuant to 28 U.S.C. § 157(b). Venue is proper before the Court pursuant to 28 U.S.C. §§ 1408 and 1409.

Relief Requested

10. By this Motion, the Debtors seek entry of an order (the "**Proposed Order**"), confirming that section 1114 of the Bankruptcy Code is inapplicable because the Company properly exercised its contractual right to unilaterally terminate the Retiree Group Insurance Plan prepetition.

11. In the alternative, if the Court determines that section 1114 of the Bankruptcy Code applies, the Court should find that the balance of the equities warranted the

prepetition termination of the Retiree Group Insurance Plan pursuant to section 1114(l) of the Bankruptcy Code.

The Briggs & Stratton Retiree Group Insurance Plan

12. Prior to termination of the Retiree Group Insurance Plan, health coverage was provided to approximately 450 Eligible Retirees, and life insurance coverage was provided to approximately 4,000 Eligible Retirees.[4] For most Eligible Retirees, health coverage was provided only for the lesser of 10 years or until the Eligible Retiree reached the age of 65.

13. Retirees are Eligible Retirees if they meet certain criteria, which varies depending on factors such as date of birth, date of hire, years of service, whether the Retiree was part of a union, whether the Retiree was an employee of Briggs and Stratton Power Products Group, LLC ("**PPG**") or Briggs and Stratton Corporation ("**B&S**"), and whether the Retiree was previously employed by Simplicity Manufacturing, Inc. ("**Simplicity**") before being employed by the Debtors. However, while specific eligibility criteria may vary based on the foregoing, all Retiree Health and Welfare Benefits are provided under and subject to the Plan Document.

14. Some of the Eligible Retirees were represented by a union during employment. The Debtors' Milwaukee locations were represented by the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial, and Service Workers International Union, with which the Company bargained to impasse following the 2017 expiration of the collective bargaining agreement and did not reach a new agreement. In the past, the Debtors have had other employees covered by additional collective bargaining agreements at other locations,

[4] In addition, there are approximately 244 active Employees currently eligible for retiree health coverage and 257 active Employees currently eligible for retiree life insurance coverage, but who have not yet retired.

but all of those locations are now closed and the collective bargaining agreements expired. There are no active collective bargaining agreements governing the Retiree Health and Welfare Benefits.

15. Generally, Eligible Retirees continued with the same medical, dental and vision benefits as active Employees, but the costs of coverage varied. Most of the Retiree Health and Welfare Benefits required Eligible Retirees to make contributions, which were deducted from the Retirees' pension checks and/or billed monthly from the Retirement Health and Welfare Benefits administrator, bSwift LLC. The level of contributions Eligible Retirees were required to make to their Health and Welfare Benefits depended on factors such as each Eligible Retiree's hire date, her or his retirement date, the type of coverage the Eligible Retiree elected, and her or his length of employment with the Debtors.

16. Under the Retiree Group Insurance Plan, the Company operated various "Programs" to provide each category of benefits to Eligible Retirees, including Medical coverage through United Healthcare (Wisconsin), Prescription Drugs through Express Scripts, Dental through Delta Dental, Vision through Delta Vision, as well as Health Clinic options, Health Savings and Reimbursements Accounts, Health Advocacy, and Retiree Health Consulting.

17. Retiree Medical Program. The Debtors offered Eligible Retirees medical care and prescription drug coverage (the "**Retiree Medical Program**"), which was self-funded by the Debtors and administered by United Healthcare and Express Scripts, as applicable. Under the Retiree Medical Program, the Debtors paid up to a maximum of $12,000 per year in medical claims for Eligible Retiree-only coverage, or $24,000 per year in medical claims for coverage of an Eligible Retiree and spouse.

18. Retiree Dental Program. The Debtors offered Eligible Retirees dental coverage (the "**Retiree Dental Program**"), which was a self-funded program administered by Delta Dental.

19. As self-funded plans, the Debtors funded all medical and dental claims submitted to the applicable benefits provider on account of services rendered to participants ("**Retiree Health Benefit Claims**") as such claims were processed by the benefit providers. The Debtors funded Retiree Health Benefit Claims on a weekly basis. The Debtors also paid fees for the administrative services provided by the benefit providers

20. Retiree Vision Program. The Debtors offered Eligible Retirees voluntary vision coverage (the "**Retiree Vision Program**") through Delta Vision, which was administered by EyeMed Vision Care. The Retiree Vision Plan was fully insured, and most Retirees paid 100% of premiums.

21. Health Savings Accounts & Health Reimbursement Accounts. Some Eligible Retirees had the option to maintain a Health Savings Account ("**HSA**") or Health Reimbursement Account ("**HRA**"), depending on which of the Debtors' medical program options the Retiree participated in as an active Employee. The Debtors did not contribute to HSAs or HRAs after retirement or pay administrative fees for Retiree HSAs.

22. Health Clinic & Retiree Health Advocacy. The Debtors provided Eligible Retirees and their covered dependents with health advocacy services administered by DirectPath. The Debtors paid DirectPath approximately $500 per month, to maintain this program. The Debtors also offered Eligible Retirees access to the Debtors' Health Clinics, which were included in the fees the Debtors paid to the Health Clinic Managers for active Employees.

23. Retiree Health Consulting. The Debtors provided Eligible Retirees with retirement and Medicare education, planning, and consulting services administered by National Benefits Consulting, Inc. ("**NCBI**").

24. The Debtors also maintained life insurance and in some cases, Accidental Death & Dismemberment insurance, for Eligible Retirees (the "**Retirement Life Insurance Program**"), which was fully insured by Prudential. Approximately 4,000 Eligible Retirees participated in the program. Over ninety percent of those Eligible Retirees were entitled to life insurance benefits of only $8,000 or less.

25. Under the Retirement Life Insurance Program, the Debtors provided varying levels of coverage to Eligible Retirees, based on each Eligible Retiree's status as a salaried, hourly, and/or union employee when the Eligible Retiree was employed by the Debtors. The coverage provided to Eligible Retirees was also determined by the location where the Eligible Retirees worked and whether the Eligible Retirees were previously employed by Simplicity.

26. The Debtors paid 100% of premiums under the Retirement Life Insurance Program, totaling approximately $100,000 a month.

27. Eligible Retirees could also elect Supplement Life and Accidental Death & Dismemberment insurance, for which the Eligible Retirees paid 100% of premiums.

Termination of the Retiree Group Insurance Plan

28. To maintain the Retiree Health and Welfare Benefits, the Debtors would have been required to continue monthly costs of approximately $650,000 for more than a decade. Lehr Declaration ¶ 4. The Debtors determined that, given the financial circumstances of their estates, they could no longer justify paying the monthly costs associated with the Retiree Health and Welfare Benefits.

29. The Plan Document for the Retiree Group Insurance Plan expressly reserves the right of the Debtors to unilaterally amend or terminate the Retiree Group Insurance Plan at any time without notice. Specifically, the Plan Document provides that, "in addition to the amendment or termination rights granted to the Company under the Programs comprising the Plan, the Company has reserved the sole right to alter, amend or terminate this Plan and/or any or all Programs, in whole or in part, as to any or all Participants, including active or retired Employees or both, at any time it determines to be appropriate, without notice." Lehr Declaration, Exhibit A, at 8.

30. The Briggs & Stratton Corporation 2020 Benefits Guide (the "**Benefits Guide**") reiterates the Company's right to terminate all benefits provided under the Retiree Group Insurance Plan as per the Plan Document. Lehr Declaration, Exhibit B. Specifically, the final page of the Benefits Guide states that the Company "reserves the right to amend or end any of its benefits, in whole or in part, at any time, with respect to any and all classes of employees, including retirees." The Company distributes the Benefits Guide annually to all employees and retirees, most recently in November 2019. Lehr Declaration ¶ 6.

31. On July 19, 2020, the Board of Directors approved the termination of the Retiree Group Insurance Plan. To implement the termination in a way that minimizes disruption to the Eligible Retirees and enables them to obtain substitute coverage, coverage will not cease until August 31, 2020. The Debtors are providing notice to all Eligible Retirees of the termination of the Retiree Group Insurance Plan and of this Motion. Lehr Declaration, Exhibit D. In this regard, Eligible Retirees also will be provided information regarding the opportunity to elect to continue their health coverage under the Consolidated Omnibus Budget Reconciliation Act ("**COBRA**") at their own cost after August 31, 2020, so as to avoid any interruption in health

coverage, and information regarding how to convert their life insurance policies into individual policies.

Section 1114 Does Not Apply to the
Prepetition Termination of the Retiree Group Insurance Plan

32. Under prevailing case law, the debtor is not subject to the requirements of section 1114 if the debtor maintained the unilateral right to modify the benefit plan in prepetition documents granting the benefits. *See In re Doskocil Cos.*, 130 B.R. 870, 877 (Bankr. D. Kan. 1991) (ruling that Section 1114 did not apply to employer's adjustments to retiree health benefit plan whose description unambiguously allowed amendment, modification, or termination of benefits); *In re Delphi Corp*., 2009 WL 637315, at *6 (Bankr. S.D.N.Y. Mar. 10, 2009) ("[T]he debtors' interpretation of Section 1114 is the correct one, and . . . if, in fact, the debtors have the unilateral right to modify a health or welfare plan, that modifiable plan is the plan that is to be maintained under Section 1114(e), with the debtors' pre-bankruptcy rights not being abrogated by the requirements of Section 1114.").

33. A minority of courts have disagreed with this approach. *See In re Farmland*, 294 B.R. 903 (Bankr. W.D. Mo. 2003); *In re Visteon Corp.*, 612 F.3d 210 (3d Cir. 2010). However, their view is contrary to the broader consensus among the courts that "section 1114 does not trump any agreement between a company and its employee that gives the company the right to amend or terminate a welfare plan." *In re Chemtura Corp.*, 2011 WL 1344573, at *6 (Bankr. S.D.N.Y. Apr. 8, 2011) (citation omitted). Thus, section 1114 applies only where the employer and its employees or retirees have not agreed that the benefits are terminable by the company, and thus retirees may not be on notice that their benefits are terminable.

34. Furthermore, the plain language of section 1114 restricts an employer's right to "modify" retiree benefits, but it does not restrict the debtor's right to terminate the plan

where that right is expressly reserved in the plan. *See In re N. Am. Royalties, Inc.*, 276 B.R. 860, 866 (Bankr. E.D. Tenn. 2002) ("Section 1114 limits the debtor's contractual right, if any, to modify retiree benefits without consulting the retirees. It says nothing about whether the debtor can exercise a power reserved in the contract to terminate it . . . . Despite § 1114, the debtor can terminate the contract as allowed by its terms.").

35. Outside the bankruptcy context, the Eighth Circuit has "repeatedly held that an unambiguous reservation-of-rights provision is sufficient without more to defeat a claim that retirement welfare plan benefits are vested." *Stearns v. NCR Corp*., 297 F.3d 706, 712 (8th Cir. 2002). The Eighth Circuit also has found that the use of predictive language—for example, "[t]he Company fully intends to continue this Plan indefinitely"—"does not indicate finality" and, therefore, is not indicative of vesting. *Hughes v. 3M Retiree Med. Plan*, 281 F.3d 786, 792 (8th Cir. 2002).

36. Here, as set forth above, the Company expressly reserved its right to terminate benefits unilaterally by including in the Plan Document the statement that "the Company has reserved the sole right to alter, amend or terminate this Plan and/or any or all Programs, in whole or in part, as to any or all Participants, including active or retired Employees." Lehr Declaration, Exhibit A, at 8. Thus, the Retiree Group Insurance Plan was terminable by the Company.

37. Moreover, the Board of Directors terminated the Retiree Group Insurance Plan prior to the filing of this action and, therefore, section 1114 of the Bankruptcy Code does not apply. Section 1114(e) of the Bankruptcy Code prohibits a *debtor* from modifying retiree benefits absent either a court order modifying the retiree benefits or an agreement between the debtor and the authorized representative of the recipients of the retiree benefits permitting such modification.

Section 1114(e) does not apply to a termination of benefits prior to the filing of bankruptcy, because such a termination is not a modification of retiree benefits by a *debtor*. *See In re Anchor Glass Container Corp.*, 342 B.R. 878, 881 (Bankr. M.D. Fla. 2005) (finding that a debtor that had terminated retiree benefits shortly before filing the bankruptcy was not subject to § 1114(e) because "section 1114(e) is not applicable to a pre-petition modification of retiree benefits").

The Balance of the Equities Warranted
Termination of the Retiree Group Insurance Plan

38. In the alternative, if the Court were to determine that section 1114 does apply to the Retiree Group Insurance Plan notwithstanding the Company's unilateral termination rights, the Court should find that termination was nevertheless effective under section 1114(l) of the Bankruptcy Code.

39. Under section 1114(l), "[i]f the debtor, during the 180-day period ending on the date of the filing of the petition—(1) modified retiree benefits; and (2) was insolvent on the date such benefits were modified" then the court shall only reinstate those benefits if the court does not find that "the balance of the equities clearly favors such modification." *See* 11 U.S.C.A. § 1114(l). Therefore, even if section 1114 were applicable, the Court here should assess only whether "the balance of the equities clearly favors" the Company's prepetition modification of retiree benefits.

40. As set forth in the Ficks Declaration, the Debtors have limited liquidity and are expected to dissolve after selling substantially all of their assets and confirming a plan of liquidation. Although the Debtors are hopeful for a robust auction that would provide a meaningful recovery for unsecured creditors, the purchase price for the assets set forth in the Stalking Horse Agreement (as defined in the Ficks Declaration) (currently a cash purchase price of approximately $550 million, subject to adjustment) is unlikely to be sufficient to provide a substantial recovery

for such creditors, let alone sufficient to make payments under the Retiree Group Insurance Plan into perpetuity (as noted, estimated at approximately $50 million in today's dollars). The termination of the Retiree Group Insurance Plan, therefore, represented the only logical option under the circumstances.

41. Most courts follow the six-factor test outlined by the United States Court of Appeals for the Second Circuit in the context of section 1113 when evaluating the balance of the equities under sections 1113 and 1114, several of which do not apply in the 1114 context:

a. The likelihood and consequence of liquidation if rejection is not permitted;

b. The likely reduction in the creditors' claims if the bargaining agreement remains in force;

c. The likelihood and consequences of a strike if the bargaining agreement is voided;

d. The possibility and likely effect of any employee claims for breach of contract if rejection is approved;

e. The cost-spreading abilities of the various parties, taking into account the number of employees covered by the bargaining agreement and the manner in which various employees' wages and benefits compare with those of others in the industry; and

f. The good or bad faith of the parties in dealing with the debtor's financial dilemma.

Truck Drivers Local 807, Intern. Broth. Of Teamsters, Chauffeurs, Warehousemen & Helpers of America v. Carey Transp. Inc., 816 F.2d 82 (2d. Cir. 1987).

42. "[T]he primary question in a balancing test is the effect the rejection of the agreement will have on the debtor's prospects for reorganization." *In re Northwest Airlines Corp.*, 346 B.R. 307, 329 (Bankr. S.D.N.Y. 2006) (citation omitted).

43. Here, reinstatement of the Retiree Group Insurance Plan will make it more difficult, if not impossible, for the Debtors to develop and confirm a chapter 11 plan, as it is uncertain at best whether the Debtors will have over $50 million in remaining assets after payment of secured, administrative, and priority creditors. Therefore, if the Debtors are forced to continue to provide benefits under the Retiree Group Insurance Plan, it could also lead to a conversion of the Debtors' cases to cases under chapter 7, which would reduce distributions to the Debtors' creditors. Such an outcome is not in the best interests of the Debtors' estates and their creditors. "In considering the totality of the impact of the Debtors' financial problems on all of its constituencies," the termination of the Retiree Group Insurance Plan is necessary and fair. *See In re Ormet Corp.*, 324 B.R. 655, 661 (Bankr. S.D. Ohio 2005).

44. A balancing of the equities analysis assumes that the Debtors had several options before them. They do not. Given that the Debtors will be liquidating following a sale of substantially all of their assets, there will no entity going forward, and no cash resources available, to continue the Retiree Group Insurance Plan. As it stands, the Debtors' general unsecured creditors will likely receive distributions representing only a small fraction of their claims. The Debtors, therefore, had no choice but to terminate the Retiree Group Insurance Plan in an effort to conserve their cash resources to avoid the possibility of administrative insolvency. *See In re Mission Coal Co., LLC*, 2019 WL 1024933, at *33 (Bankr. N.D. Ala. Mar. 1, 2019) (finding the balance of the equities favored rejection of the collective bargaining agreements where "the

recoveries of all parties in these chapter 11 cases, including unsecured creditors, administrative creditors, and the Debtors' secured creditors, are at significant risk").

45. Finally, any funds to provide Eligible Retirees with a meaningful recovery, assuming such funds were even available after the asset sale, would necessarily come directly out of the recovery to other general unsecured creditors. As those unsecured creditors are already expected to receive cents on the dollar, equity would not be served by taking those cents and giving them to the Eligible Retirees.

46. In considering the equities, the Debtors are already paying the costs associated with the Retiree Health and Welfare Benefits in full through August 31, 2020, which the Board of Directors decided to do instead of terminating all benefits immediately (which it could have done), to provide Eligible Retirees with notice and an opportunity to secure alternate coverage. The Debtors intend to work with Eligible Retirees to answer their questions and help them transition to alternative providers. Unfortunately, the Debtors simply do not have the financial means to pay the Eligible Retirees or continue their benefits in perpetuity.

The Appointment of a Retiree Committee Would Be Futile

47. Finally, only "upon a motion by any party in interest, and after notice and a hearing," should the Court consider appointing a retiree committee under section 1114(d) of the Bankruptcy Code.

48. The circumstances of the Debtors' cases, including their strained financial position and the fact that the Debtors will be liquidating following the sale of substantially all of their assets, render a retiree committee under section 1114 inappropriate. *See In re Ionosphere Clubs, Inc.*, 134 B.R. 515, 522 (Bankr. S.D.N.Y. 1991) (finding that the "consistent premise underlying § 1114 is that a reorganization is in progress.").

49. Under the analogous section 1113 standard addressing "identical wording" to that in section 1114, the Eighth Circuit BAP interpreted "necessary to permit the reorganization of the debtor" to mean "necessary to accommodate confirmation of a Chapter 11 plan," and further stated that a debtor selling its assets "should not be forced into Chapter 7 in order to preserve its assets for equitable distribution to all creditors." *In re Family Snacks, Inc.*, 257 B.R. 884, 894-98 (B.A.P. 8th Cir. 2001); *see also In re U.S. Truck Co. Holdings*, 2000 Bankr. LEXIS 1376, at *28 (Bankr. E.D. Mich. Sept. 29, 2000) ("[A]pplying § 1113 to a liquidating Chapter 11 . . . is somewhat problematic because many of the § 1113 requirements and the case law interpreting them focus on or presuppose efforts to rehabilitate an ongoing business [but] . . . [t]hese standards must necessarily be construed, if possible, in a way that gives them meaning in this liquidation setting."); *In re Chicago Constr. Specialties, Inc.*, 510 B.R. 205, 216–18 (Bankr. N.D. Ill. 2014) (noting that "the majority of cases dealing with section 1113 are of the nonliquidating variety, . . . [and] the majority of opinions addressing section 1113 address it in the context of a debtor's reorganization," but that, in a liquidation, the factors for section 1113(c) relief "must be applied contextually, rather than strictly" with "the impending liquidation of the Debtor firmly in mind").

50. Here, the Debtors are selling substantially all of their assets. Any remaining assets will be liquidated, and the proceeds will be distributed to the Debtors' stakeholders in accordance with their respective priorities. Thus, it is not feasible for the Debtors to interact meaningfully with a retiree committee in the way anticipated by the statutory language. The Debtors anticipate a distribution to general unsecured creditors of no more than cents on the dollar unless their asset sale yields substantially higher offers than the consideration being provided in the Stalking Horse Agreement. Any funds to pay a retiree committee will impact that already meager distribution, as would any payments made to continue to provide the Retiree Health and

Welfare Benefits. The only feasible proposal to make to a retiree committee would be the elimination of all benefits under the Retiree Group Insurance Plan, which is exactly the action the Board of Directors has already taken. Consequently, the appointment of a retiree committee would merely waste the limited assets of the Debtors.

51. Furthermore, given the Debtors' limited resources, appointing a retiree committee and granting retiree claims for the period prior to a court-approved modification the status of administrative expense claims under section 1114(e)(1) will place further strain on the Debtors' ability to confirm a plan. The Debtors are in critical need of conserving cash. Congress could not have intended for a debtor's general unsecured creditors to bear the expense of a futile application of Section 1114 and the appointment of a retiree committee. *See In re AMR Corp.*, 477 B.R. 384, 450 (Bankr. S.D.N.Y. 2012) (finding that "[f]rom the viewpoint of the other creditors, rejection [of the collective bargaining agreement under § 1113] is preferable" given the treatment of potential damages claims for unpaid benefits as administrative expenses) (citation omitted).

52. In the instant cases, where the Debtors are working quickly towards a sale of substantially all of the Debtors' assets, where the anticipated recoveries for unsecured creditors are minimal, and where the Debtors have a need to move expeditiously to the chapter 11 plan process to preserve any recovery for unsecured creditors, the appointment and funding of a retiree committee is not appropriate.

Reservation of Rights

53. Nothing contained herein is intended to be or shall be deemed as (i) an admission as to the validity of any claim against the Debtors, (ii) a waiver or limitation of the Debtors' or any party in interest's rights to dispute the amount of, basis for, or validity of any

claim, (iii) a waiver of the Debtors' rights under the Bankruptcy Code or any other applicable nonbankruptcy law, (iv) an agreement or obligation to pay any claims, (v) a waiver of any claims or causes of action which may exist against any creditor or interest holder, or (vi) an approval, assumption, adoption, or rejection of any agreement, contract, lease, program, or policy under section 365 of the Bankruptcy Code. Likewise, if the Court grants the relief sought herein, any payment made pursuant to the Court's order is not intended to be and should not be construed as an admission to the validity of any claim or a waiver of the Debtors' rights to dispute such claim subsequently.

Notice

54. Notice of this Motion will be provided to (i) the Office of the United States Trustee for the Eastern District of Missouri; (ii) the holders of the 30 largest unsecured claims against the Debtors on a consolidated basis; (iii) Latham & Watkins LLP (Attn: Peter P. Knight, Esq. and Jonathan C. Gordon, Esq.), as counsel to JPMorgan Chase Bank, N.A., as the administrative agent and collateral agent under the ABL Credit Facility and DIP Facility; (iv) Pryor Cashman LLP (Attn: Seth H. Lieberman, Esq. and David W. Smith, Esq.), as counsel to Wilmington Trust, N.A., as successor indenture trustee under the Unsecured Notes; (v) the Internal Revenue Service; (vi) the United States Attorney's Office for the Eastern District of Missouri; (vii) the Securities and Exchange Commission; (viii) the Banks; (ix) the Eligible Retirees; (x) the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial, and Service Workers International Union, on behalf of its Local 2-232 AFL-CIO, CLC, and (xi) any other party that has requested notice pursuant to Bankruptcy Rule 2002 (collectively, the "**Notice Parties**"). Notice of this Motion and any order entered hereon will be served in accordance with Local Rule 9013-3(A)(1).

No Previous Request

55. No previous request for the relief sought herein has been made by the Debtors to this or any other court.

Conclusion

56. For all of the foregoing reasons, the Court should enter the Proposed Order and confirm that section 1114 of the Bankruptcy Code is inapplicable because the Company properly exercised its contractual right to unilaterally terminate the Retiree Group Insurance Plan prepetition.

57. In the alternative, if the Court determines that section 1114 of the Bankruptcy Code applies, the Court should find that the balance of the equities warranted termination of the Retiree Group Insurance Plan pursuant to section 1114(l) of the Bankruptcy Code.

Dated: July 20, 2020
St. Louis, Missouri

Respectfully submitted,

CARMODY MACDONALD P.C.

/s/ Robert E. Eggman

Robert E. Eggmann, #37374MO
Christopher J. Lawhorn, #45713MO
Thomas H. Riske, #61838MO
120 S. Central Avenue, Suite 1800
St. Louis, Missouri 63105
Telephone: (314) 854-8600
Facsimile: (314) 854-8660
Email: ree@carmodymacdonald.com
cjl@carmodymacdonald.com
thr@carmodymacdonald.com

Proposed Local Counsel to the Debtors and Debtors in Possession

-and-

WEIL, GOTSHAL & MANGES LLP
Ronit J. Berkovich (*pro hac vice* pending)
Debora A. Hoehne (*pro hac vice* pending)
Martha E. Martir (*pro hac vice* pending)
767 Fifth Avenue
New York, New York 10153
Telephone: (212) 310-8000
Facsimile: (212) 310-8007
Email: Ronit.Berkovich@weil.com
Debora.Hoehne@weil.com
Martha.Martir@weil.com

Proposed Counsel to the Debtors and Debtors in Possession

UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF MISSOURI
SOUTHEASTERN DIVISION

	§	**Chapter 11**
In re:	§	
	§	**Case No. 20-43597-399**
BRIGGS & STRATTON CORPORATION, *et al.*,	§	
	§	**(Joint Administration Requested)**
	§	
Debtors.[1]	§	

DECLARATION OF RACHELE LEHR IN SUPPORT OF THE DEBTORS' MOTION FOR ORDER (I) CONFIRMING INAPPLICABILITY OF SECTION 1114 OF THE BANKRUPTCY CODE; (II) IN THE ALTERNATIVE, APPROVING DEBTORS' PREPETITION TERMINATION OF RETIREE BENEFITS PURSUANT TO SECTION 1114(L) OF THE BANKRUPTCY CODE; AND (III) GRANTING RELATED RELIEF

I, Rachele Lehr, make this declaration (the "**Declaration**") under 28 U.S.C. § 1746:

1. I am the Senior Vice President Corporate Systems and Human Capital. I was elected to my current position effective July 1, 2020. I previously served as the Vice President Human Resources (an executive officer position) from September 2018 through June 2020. Prior to that, I served as Vice President Human Resources from July 2015 through September 2018, as Human Resources Senior Director from March 2015 through June 2015, as Human Resources Director from June 2013 through February 2015, and as Controller from April 2010 through May 2013.

2. Except as otherwise indicated herein, this Declaration is based upon my personal knowledge, my review of relevant documents, information provided to me by employees of the Debtors or the Debtors' legal and financial advisors, or my opinion based upon

[1] The Debtors in these chapter 11 cases, along with the last four digits of each Debtor's federal tax identification number are: Briggs & Stratton Corporation (2330), Billy Goat Industries, Inc. (4442), Allmand Bros., Inc. (4710), Briggs & Stratton International, Inc. (9957), and Briggs & Stratton Tech, LLC (2102). The address of the Debtors' corporate headquarters is 12301 West Wirth Street, Wauwatosa, Wisconsin 53222.

my experience, knowledge, and information concerning the Debtors' operations. If called upon to testify, I would testify competently to the facts set forth in this Declaration.

3. This Declaration is submitted in support of the Retiree Benefits Motion. I am authorized to submit this Declaration on behalf of the Debtors.

4. Until recently, the Debtors maintained various benefits, including medical, dental, vision, and prescription drug benefits, health savings accounts, life insurance, and accidental death and dismemberment insurance (collectively, the "**Retiree Health and Welfare Benefits**") for eligible retired employees ("**Eligible Retirees**"). The monthly cost to the Company associated with the Retiree Health and Welfare Benefits was approximately $650,000.

5. The Group Insurance Plan for Retirees of Briggs & Stratton Corporation, Plan Number 502 (the "**Retiree Group Insurance Plan**") provides for and governs all Retiree Health and Welfare Benefits. A true and accurate copy of the Plan Document for the Retiree Group Insurance Plan is attached hereto as **Exhibit A**. This document is made available to all Eligible Retirees upon request.

6. A summary of the Retiree Health and Welfare Benefits is provided to all retirees annually. The most recent summary, the Briggs & Stratton Corporation 2020 Benefits Guide (the "**Benefits Guide**"), is attached hereto as **Exhibit B**. The Benefits Guide was distributed to all employees and retirees in November 2019.

7. Each year, Mercer LLC provides an Actuarial Valuation Report that estimates the liabilities and costs associated with the Retiree Group Insurance Plan. A true and accurate copy of the Actuarial Valuation Report as of June 30, 2020 is attached hereto as **Exhibit C**.

8. The Debtors are providing notice to all Eligible Retirees of the termination of the Retiree Group Insurance Plan in the form of one of the letters attached hereto as **Exhibit D**. The form of the letter each Eligible Retiree depended on whether the Eligible Retiree also participated in the Non-Qualified Retirement Plan.

9. I declare under penalty of perjury that, to the best of my knowledge and after reasonable inquiry, the foregoing is true and correct.

Executed this 20th day of July, 2020

/s/ *Rachele Lehr*
Rachele Lehr
on Behalf of the Debtors and Debtors-in-Possession

EXHIBIT A

PLAN DOCUMENT

FOR THE

GROUP INSURANCE PLAN FOR RETIREES OF

BRIGGS & STRATTON CORPORATION

Effective as of January 1, 2010
Amended and Restated as of January 1, 2020

Plan Number 502

PLAN DOCUMENT

FOR THE

GROUP INSURANCE PLAN FOR RETIREES OF

BRIGGS & STRATTON CORPORATION

TABLE OF CONTENTS

I. GENERAL PROVISIONS AND DEFINITIONS 1
1.1 Definitions 1
1.2 Purpose 2
1.3 Construction 2
II. TERMS OF THE PLAN 3
2.1 Retiree Eligibility 3
2.2 Spouse and Dependent Eligibility 3
2.3 Insuring and Funding Benefits 3
2.4 Benefits and Termination of Rights to Benefits 3
2.5 Procedures for the Submission and Review of Claims 3
2.6 Inspection of Documents 6
2.7 Continuation Coverage under COBRA 6
2.8 Qualified Medical Child Support Orders 6
2.9 FMLA Leaves 6
2.10 USERRA Compliance 6
2.11 GINA Compliance 7
2.12 Rebates, Refunds and Other Proceeds 7
2.13 HRA Opt Out 7
III. ADMINISTRATION 7
3.1 Plan Administrator 7
3.2 Duties and Powers of the Plan Administrator 7
3.3 Representations 8
3.4 Indemnity 8
3.5 Expenses 8
3.6 Discretionary Authority 8
IV. AMENDMENT OR TERMINATION 8
4.1 Reserved Rights to Amend or Terminate 8
V. PARTICIPANT RIGHTS AND RESPONSIBILITIES AND LIMITATIONS THEREOF 9
5.1 No Assignment 9
5.2 Subrogation and Reimbursement 9
5.3 Rights to Receive and Release Necessary Information 9

5.4 Notice of Address 10
5.5 No Vesting of Benefits 10
5.6 Waiver and Estoppel 10
5.7 Effect on Other Benefit Plans 10
VI. GOVERNING TERMS AND APPLICABLE LAW 10
6.1 Severability 10
6.2 Conflicts of Terms 10
6.3 Controlling Law 10
VII. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION 10
7.1 Protected Health Information 10
7.2 Permitted Uses and Disclosures of PHI 10
7.3 Certification: Plan Sponsor's Use of Protected Health Information 12
7.4 Summary Health Information 13
SCHEDULE A PARTICIPATING EMPLOYERS 14
SCHEDULE B PROGRAMS OFFERED AS OF JANUARY 1, 2020 15

PLAN DOCUMENT

FOR THE

GROUP INSURANCE PLAN FOR RETIREES OF

BRIGGS & STRATTON CORPORATION

The Plan is established effective as of January 1, 2010 to provide medical, dental and vision benefits to eligible retirees of Briggs & Stratton Corporation. Prior to 2010, eligible retirees received medical, dental and/or vision benefits under the Group Insurance Plan for Briggs & Stratton Corporation (Plan 501). The Company amended Plan 501 effective as of January 1, 2010 to exclude all former employees and retirees from coverage, other than former employees who are eligible for COBRA continuation coverage. As of January 1, 2010, the Group Insurance Plan of Briggs & Stratton Corporation and the programs thereunder will be the sole source of medical, dental and/or vision benefits for active employees of the Company.

I. GENERAL PROVISIONS AND DEFINITIONS

1.1 Definitions. The following terms shall have the meanings described below unless the context clearly indicates to the contrary or unless defined otherwise in a particular Program:

(a) **Code** means the Internal Revenue Code of 1986, as amended from time to time.

(b) **Company** means Briggs & Stratton Corporation, or any successor(s) thereto.

(c) **Effective Date.** This Plan is effective as of January 1, 2010.

(d) **Employee** means any individual classified by the Company as a common-law employee of the Company or of any Participating Employer, or as otherwise defined in any applicable Program.

(e) **ERISA** means the Employee Retirement Income Security Act of 1974, as amended.

(f) **FMLA** means the Family and Medical Leave Act of 1993, as amended from time to time.

(g) **LTD Participant** means an individual who is receiving benefits under a Long Term Disability Program of the Company.

(h) **Participant** means any Eligible Retiree (as defined in Section 2.1) who elects to participate in a Program or who is automatically covered by a Program (and shall include any Eligible Retiree's dependent or other person who derives his or her eligibility for a Program solely through such Eligible Retiree and becomes covered by such Program), in accordance with the terms and conditions established for that Program, and who has not for any reason become ineligible to participate further in that Program. An Eligible Retiree shall be a Participant in this Plan if and only if such Eligible Retiree is participating in one or more Programs.

(i) **Participating Employer** means the Company or any other entity which is aggregated with the Company under Code Sections 414(b), (c), (m) or (o) and that, with the approval of the Company, has adopted, sponsors or maintains on behalf of its own Eligible Retirees, one or more of the Programs which comprise the Plan. "Participating Employer" includes any successor(s) to a Participating Employer. All Participating Employers are listed in **Schedule A.**

(j) **Plan** means the "Group Insurance Plan for Retirees of Briggs & Stratton Corporation" as may be amended from time to time. The terms of the Plan shall be set forth in this Plan Document and in the various Programs described herein. Any reference to the Plan shall include the provisions in both the Plan Document and the Programs. (However, for purposes of the reporting and

disclosure requirements of ERISA and/or the Code, this Plan may constitute separate plans, each of which may be separately filed and have a different Plan Year.)

(k) **Plan Administrator** or **Administrator** means the Company or such other entity, person or persons as may be designated by the Company with respect to any particular Program.

(l) **Plan Document** means this Plan Document for the Group Insurance Plan for Retirees of Briggs & Stratton Corporation which includes the provisions described herein regarding the operation of the Plan and each of the Programs and which, together with the Programs, constitute the official documents of the Plan.

(m) **Plan Year** means the calendar year (except as otherwise may be specified in an individual Program).

(n) **PPACA** means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, and as further amended

(o) **Program(s)** means any of the written arrangements incorporated under this Plan that are offered by the Company or a Participating Employer and shall include any and all medical, dental and vision benefits that the Company or a Participating Employer offers to its Retirees or LTD Participants. Each Program under the Plan is identified in **Schedule B**. This Plan contains one or more Programs that would be treated as "employee welfare benefit plans" under Section 3(1) of ERISA. Once a Participating Employer has adopted this Plan, it is within the discretion of that Participating Employer, with the consent of the Company, to designate the Programs the Participating Employer shall offer to its Employees through this Plan. This Plan may also contain one or more arrangements which constitute a "cafeteria plan" under Code Section 125; provided, however, that such arrangement shall not be treated as subject to the requirements of ERISA solely be reason of the arrangement's inclusion in this Plan.

(p) **Retiree** means a former Employee of the Company.

(q) **USERRA** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

1.2 Purpose. The Company sponsors various Programs for the exclusive benefit of Participants. It is intended that all health, dental and vision benefits that the Company provides to Retirees and LTD Participants be provided under this Plan and that no health, dental or vision benefits that the Company provides to active employees be provided under this Plan. Except to the extent that the Company chooses to treat a Program as a separate plan for purposes of reporting and disclosure under ERISA and/or the Code, as described in Section 1.1(j), all of the Programs are part of this same Plan and shall be treated as a single plan.

The Company has established this Plan to provide certain uniform rules and policies among all of the Programs. The terms of this Plan Document and the written document(s) describing each of the Programs shall, until amendment or termination, constitute the official Plan documents as to each such Program, as required by Section 402 of ERISA. In the event of a conflict between this document and the terms of any Program document regarding eligibility of Employees for participation under the Plan or a Program, this document shall govern.

To the extent that the assets of any such Programs are held in any related trust fund maintained under Section 501(c)(9) of the Code, such assets shall be held for the exclusive purposes of providing benefits to the Participants and their beneficiaries of such Programs and for defraying reasonable expenses in administering such Programs, as provided in the terms of any such trust.

1.3 Construction. When words are used herein in the singular form, they shall be construed as though they were also used in the plural form in all cases where they would so apply. Headings of sections and subsections of this Plan are inserted for convenience or reference, are not part of this Plan and are not to be considered in the construction hereof. The words "hereof," "herein," "hereunder," and other similar compounds of the word "here" shall mean and refer to the entire Plan, and not to any particular provision or section. The masculine gender, where

appearing in the Plan, shall be deemed to include the feminine or common genders, unless the context clearly indicates to the contrary.

II. TERMS OF THE PLAN

2.1 Retiree Eligibility. An "Eligible Retiree" with respect to this Plan shall be any Retiree or LTD Participant who is eligible to participate in and receive benefits under one or more Programs. Active Employees are not eligible to participate in this Plan or any Program.

An Eligible Retiree's eligibility to receive benefits under this Plan shall be determined by and limited to his or her eligibility to receive benefits under the terms and conditions of each applicable Program, and an Eligible Retiree may be able to participate in one Program but not another, consistent with the terms of each Program.

This Plan is intended to provide all health, dental and vision benefits that the Company offers to Retirees and LTD Participants and only the benefits that the Company offers to such individuals. To the extent that any Program provides that an active employee is eligible to participate, the terms of this Plan document shall govern.

2.2 Spouse and Dependent Eligibility. The definition of "spouse" and "dependent" and the eligibility of any "spouse" or "dependent" to participate in any Program is set forth in such Program. Notwithstanding the foregoing, the term "spouse" shall include an Employee's same-sex spouse.

2.3 Insuring and Funding Benefits. Funding for this Plan shall consist of an aggregation of the funding methods for all Programs, which may include contributions by the Company, Participating Employers and Participants, as determined by the Company. The Company shall have the right to insure any benefits under this Plan or to establish any fund or trust for the holding of contributions or payment of benefits under this Plan, either as mandated by law or as the Company deems advisable. In addition, the Company shall have the right to alter, modify or terminate any method or methods used to fund the payment of benefits under this Plan, including, but not limited to, any trust or insurance policy.

If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the insurance carrier. To the extent funds are transferred to or accumulated in a trust (including a trust maintained under Section 501(c)(9) of the Code) to provide any benefit, that benefit will be payable from the assets of such trust. Neither the Company nor any Participating Employer shall have any further responsibility to pay such benefit.

If any benefit is funded all or in part by Participant contributions, the Company will determine and periodically communicate the Participant's share of the cost of the benefits provided through each Program, and it may change that determination at any time.

Each Participating Employer shall, upon demand from the Company, reimburse the Company for the Participating Employer's appropriate share of any insurance premiums, Plan funding, or administrative costs necessary to provide benefits under this Plan.

2.4 Benefits and Termination of Rights to Benefits. The benefits available under this Plan shall consist of an aggregation of the medical, dental and vision benefits available under each Program, including all terms, conditions, limitations and exclusions with respect to each Program's benefits.

A Participant's right to benefits under this Plan shall consist of and be limited to his or her right to benefits under each Program in which he or she is a Participant. Any termination or cessation of a Participant's rights or coverage under a Program shall be considered a termination or cessation of those same rights under this Plan. This Plan provides for no benefits to any Participant other than those benefits provided for under each Program as applicable to such Participant.

2.5

Procedures for the Submission and Review of Claims.

(a) The procedure to be followed for submitting claims under this Plan shall correspond to the claims procedure for the applicable Program under which the claim is being submitted. Claims under a Program for which no claims procedure is established shall be submitted on a form approved by the Plan Administrator or its designee, which shall be delivered to the Plan Administrator or the Plan Administrator's designee and accompanied by such substantiation (such as receipts, records of treatment, Participant certifications, etc.) that the Plan Administrator or its designee considers necessary and reasonable under the circumstances.

(b) The procedure to be followed for reviewing claims under this Plan shall correspond to the claims review procedure or other appeals or grievance procedure for the applicable Program under which the claim or grievance was originally submitted. The claims review procedure under this Section 2.5(b) shall only apply to claims under a Program for which no claims, grievance, appeals or other similar review procedure has been otherwise established. Unless the Plan Administrator or Plan Administrator's designee (such as an insurance carrier or third-party administrator) publishes a different procedure for reviewing claims under such a Program, the claims review procedure for that Program shall be as follows:

(i) If the Plan Administrator or its designee denies the validity of the claim in full or in part, the claimant will be notified of its decision in writing. Such writing shall be in a form designed to be understood by the claimant and will contain:

(A) The specific reason or reasons for the denial;

(B) A specific reference to pertinent Plan provisions on which the denial is based;

(C) A description of any additional material or information necessary for such claimant to perfect the claim and an explanation of why such material or information is necessary; and

(D) Information as to the steps to be taken if the claimant wishes to appeal the decision, including a statement of the claimant's right to bring an action under Section 502(a) of ERISA following a denial upon appeal.

Such notification will be given by the Plan Administrator or its designee within 90 days after the claim is received by the Plan Administrator (or within 180 days if the Administrator or its designee determines special circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given to the claimant within the initial 90 day period).

(ii) A claimant who wishes to have his claim reviewed on appeal must, within 60 days from the date on which a claimant receives a written notice of a denied claim, file with the Plan Administrator or its designee a written appeal of the decision, together with any additional materials or information the claimant would like to have considered. The timely filing of such a request for review is necessary to preserve any legal recourse which may be available to the claimant. In connection with an appeal, the claimant (or his authorized representative) may review pertinent documents and may submit evidence and arguments in writing to the Plan Administrator or its designee.

The Plan Administrator or its designee shall decide the questions presented by the appeal by taking into consideration all documents and information submitted, without regard to whether such information was submitted or considered in the initial claim determination. The Plan Administrator or its designee will notify the claimant in writing of its decision on the appeal. Such notification will be in a form designed to be understood by the claimant and, if a denial, will contain the specific reason or reasons for the denial and a specific reference to pertinent Plan provisions on which the decision is based, and a

statement that the claimant is entitled to receive reasonable access to and copies of all documents and other information relevant to the claim. Such notification will be given by the Plan Administrator or its designee within 60 days after the complete appeal is received (or within 120 days if the Plan Administrator or its designee determines special circumstances require an extension of time for considering the appeal, and if written notice of such extension and circumstances is given to the claimant within the initial 60 day period).

(iii) No action may be brought by any person challenging a denial of benefits until after the claim review procedures have been exhausted. If challenged in court, a claim decision made by the Plan Administrator or its designee shall not be subject to an initial redetermination of the claim, but to review only and shall not be overturned unless proven to be arbitrary and capricious based upon the evidence considered by the Plan Administrator or its designee at the time of the determination.

(iv) Notwithstanding subsections (i), (ii) and (iii) above, if this Section 2.5(b) applies to a Program which provides disability benefits or which is a group health plan and is subject to ERISA, then the additional requirements set forth in applicable DOL regulations shall apply to claims and claims appeals under such Program.

(c) For claims involving urgent care, the following will apply:

(i) Urgent care claims are claims that require notification or approval prior to receiving medical care and a delay in the care:

(A) Could seriously jeopardize your life or health or your ability to regain maximum function; or

(B) In the opinion of a physician with knowledge of your medical condition, could cause severe pain.

(ii) If a Participant files an urgent care claim in accordance with the Plan's procedures and include all needed information, the Plan Administrator or its designee will notify the Participant of the determination, whether adverse or not, as soon as possible, but not later than 72 hours after receipt of the urgent claim.

(iii) If a Participant fails to follow the Plan's procedures for claims submission, the Plan Administrator or its designee will notify the Participant of the improper filing and how to correct it within 24 hours of receipt of the improper claim. This notification will be oral, in the interest of time. If a Participant fails to provide all the information required to decide his or her urgent claim, the Plan Administrator or its designee will notify the Participant of the additional information needed within 24 hours after it received the claim. The Participant will then have 48 hours to provide the requested information.

(iv) The Plan Administrator or its designee will be notified of the determination on your claim no more than 48 hours after the earlier of:

(A) The Plan Administrator's or its designee's receipt of the requested information; or

(B) The end of the 48 hours given to the Participant to provide the requested information.

(v) A denial of an urgent care claim will include the information listed above for post-service claim denials. Notifications regarding urgent care claim determinations may be oral, in which case written or electronic confirmation will follow within three days.

2.6 Inspection of Documents. This Plan document, the Programs, and any relevant insurance contracts shall be available for inspection during normal business hours at the human resources office of the Company or other reasonable location designated by the Plan Administrator. Participants shall have the right to obtain copies of such documents from the Plan Administrator, and the Plan Administrator shall have the authority to charge a reasonable fee for their duplication or retrieval.

2.7 Continuation Coverage under COBRA. All persons whose health benefits under a Program subject to Code Section 4980B would otherwise terminate due to a qualifying event described in Code Section 4980B may have rights to continuation coverage at their own expense. To the extent that the law or applicable regulations require continuation coverage under any Program covered under this Plan:

(a) Any Participant who becomes eligible for continuation coverage shall be notified of such eligibility within the period of time that is the maximum allowed by law;

(b) All periods of coverage and election periods shall be for the minimum required by law; and

(c) Premiums shall be chargeable at the maximum rate allowed by law.

(d) Any notice required to be provided by a covered person shall be provided within the minimum time period allowed by law. Failure to timely provide such notice shall negate the right to continuation coverage under the applicable Program.

The provisions of this Section 2.7 shall supplement, but are not intended to contradict, the provisions of any Program related to continuation coverage. In the event of any conflict or inconsistency, the provisions regarding continuation coverage set forth in any separate Program shall be controlling.

2.8 Qualified Medical Child Support Orders.

(a) With respect to any Program to which Section 609 of ERISA applies, the Plan Administrator will enroll for coverage under this Plan an alternate recipient who is the subject of a medical child support order if the Plan Administrator determines that such order is a "Qualified Medical Child Support Order" ("QMCSO") to the extent necessary to comply with Section 609 of ERISA. The Plan Administrator may impose any conditions, limitations or requirements on such coverage as it determines, to the extent such conditions, limitations or requirements are not inconsistent with Section 609 of ERISA or other applicable law.

(b) As soon as possible after receiving a medical child support order, the Plan Administrator shall (1) notify the Participant and each alternate recipient covered by the order (at the address included in the order) in writing of the receipt of such order and the Plan's procedures for determining whether the order qualifies as a QMCSO, and (2) make an administrative determination as to whether the order is a QMCSO and notify the Participant and each affected alternate recipient of such determination. To give effect to this requirement, the Plan Administrator shall establish reasonable, written procedures for determining the qualified status of a medical child support order (which shall be incorporated herein), and permit any alternate recipient to designate a representative for receipt of copies of notices that are sent to the alternate recipient with respect to the order.

2.9 FMLA Leaves. The Plan Administrator may establish policies and procedures necessary to maintain the Plan's compliance with the Family Medical Leave Act of 1993, as amended. Such policies may be set forth in the applicable Program or otherwise.

2.10 USERRA Compliance. Each Program offered under the Plan shall comply with the provisions of USERRA, to the extent applicable to such Program. The Plan Administrator may establish policies and procedures necessary to maintain such Program's compliance. Such policies may be set forth in the applicable Program or otherwise.

2.11 GINA Compliance. In accordance with Title I of the Genetic Information Nondiscrimination Act of 2008, in no event shall the Plan or any of its insurers discriminate against any Participant on the basis of genetic information with respect to eligibility, premiums, or contributions.

2.12 Rebates, Refunds and Other Proceeds. In some situations, a rebate may be paid by an insurance company which provides coverage under the Plan, a refund may be paid by a service provider to a Program pursuant to an agreement with the Company, and/or other payments or return of excess premiums may be made by insurance companies or Program service providers to the Company. Such a rebate could include, but is not limited to, a Medical Loss Ratio rebate under PPACA. Except as specifically and unambiguously provided in a Program document, or as otherwise required by applicable law, the Company, in its sole discretion, may consider any such payment to be an asset of the Company, not the Plan, and may, but is not required to, use such payment to benefit any Eligible Employee, Participant or beneficiary under the Plan.

2.13 HRA Opt Out. A Participant may opt out of coverage under a Program that constitutes or includes a health reimbursement arrangement as described in IRS Notice 2013-54 by opting out of the group health plan coverage with which such health reimbursement arrangement is integrated and otherwise in accordance with the rules governing any such Program.

III. ADMINISTRATION

3.1 Plan Administrator. The Company shall be the Plan Administrator of this Plan (unless it appoints one or more persons in that position), and, to the extent a Program does not name a plan administrator, of each of the Programs. All references to the "Plan Administrator" in this Article III shall be deemed to refer both to the Company and to any other person or entity named or acting as Plan Administrator under any Program. The provisions of this Article III shall supplement any provisions regarding Plan administration set forth in any separate Program, but shall not contradict the same. In the event of any conflict or inconsistency, the provisions regarding Plan administration set forth in any separate Program shall be controlling. The Plan Administrator shall administer this Plan and the Programs and shall be a "named fiduciary" for this Plan and the Programs which are subject to ERISA. Nothing herein shall restrict the Company's right to remove itself and appoint some other person or entity as Plan Administrator at any time.

The Plan Administrator shall have control of the day-to-day administration of this Plan and the Programs, and no Company Employee shall receive any additional compensation from the assets of any Program, except for reimbursement of out-of-pocket expenses properly incurred. If the Company appoints one or more persons as Plan Administrator, it shall have no duty or responsibility with respect to the administration of this Plan and the Programs other than the appointment or removal of the Plan Administrator.

3.2 Duties and Powers of the Plan Administrator. The Plan Administrator shall have full power and authority as may be necessary to direct the administration of the Plan and the Programs, including, but not by way of limitation, the following powers, responsibilities and authority with respect to the administration of this Plan and Programs:

(a) Complete discretionary authority to construe and interpret this Plan and the Programs including, without limitation, determining an Employee's eligibility to participate in and receive benefits under one or more Programs, correcting any defect, supplying and omitting and reconciling any inconsistency and finally resolving any and all claims;

(b) To prescribe uniform procedures to be followed by Eligible Retirees and Participants in making elections, filing claims, and any other administrative procedure necessary to properly administer any or all of the Programs;

(c) To prepare and distribute information explaining this Plan and the Programs to Eligible Retirees and Participants;

(d) To receive from the Company, Participating Employers, the Eligible Retirees and Participants such information as may be necessary or desirable for the proper administration of this Plan and the Programs;

(e) To employ such persons, including, but not limited to, actuaries, accountants, claims administrators, and counsel, as the Plan Administrator deems appropriate, to perform such duties as may from time to time be required either by administrative convenience or necessity or under ERISA, the Code, or applicable regulations and to render advice upon request with regard to any matters arising under this Plan or the Programs;

(f) To prepare and file any reports or returns with respect to this Plan and the Programs required under applicable law;

(g) To allocate responsibilities in writing (which may include fiduciary responsibilities) relating to the operation or administration of the Plan or any Program to any other person, persons or entity; and

(h) To take all other steps deemed necessary or appropriate to properly administer this Plan and the Programs in accordance with their terms and the requirements of applicable law.

3.3 Representations. The Plan Administrator and any person performing services for such Administrator shall be entitled to rely on representations made by the Company, Participating Employers, Participants, Retirees, former Employees, LTD Participants and beneficiaries with respect to age, marital status and other personal facts.

3.4 Indemnity. The Company and each Participating Employer shall jointly and severally indemnify and hold harmless (from its and their own corporate assets) and defend any Plan Administrator who is an Employee and each other Employee who acts as a representative, agent or delegate of the Company, the Plan Administrator, or a Participating Employer under this Plan or any Program, against any claim, action, liability, cost or expense (including reasonable counsel fees) asserted against him or her in connection with any action or failure to act regarding the Plan or any Program, except as and to the extent that any such claim may be based upon the individual's own willful misconduct. This indemnification shall be in addition to any other rights to which such individual may be entitled. Further, this indemnification shall not duplicate but may supplement any coverage available under any applicable insurance.

3.5 Expenses. Except as otherwise provided in this Plan or in any applicable Program, any properly allowable expenses and charges incurred in the administration and operation of the Plan or Program, including those of any outside administrator or other agents or professionals employed or retained pursuant hereto, will be paid by any Plan trust or account established for such purpose to the extent not paid by the Company or a Participating Employer in such Program. No compensation shall be paid by this Plan to any employee of the Company in connection with the administration of the Plan but such persons may be reimbursed for their reasonable expenses incurred in carrying out their duties, responsibilities and authority hereunder. No bond shall be required of the Plan Administrator, except as may be otherwise required by law.

3.6 Discretionary Authority. The Plan Administrator shall have full discretionary authority to interpret and construe the Plan, including this Plan Document and each Program, and its provisions and rules with regard to eligibility, benefit determination, general administrative matters, and all other provisions of the Plan and each Program. Benefits under each Program shall be paid only if the Plan Administrator decides, in its discretion, that the applicant is entitled to them. The Plan Administrator's decisions shall be binding on all Plan Participants and conclusive as to all questions of coverage and benefit entitlement under this Plan and each applicable Program.

IV. AMENDMENT OR TERMINATION

4.1 Reserved Rights to Amend or Terminate. This Plan and Programs are established with the intention of being maintained for an indefinite period of time. However, in addition to the amendment or termination rights granted to the Company under the Programs comprising the Plan, the Company has reserved the sole right to alter, amend or terminate this Plan and/or any or all Programs, in whole or in part, as to any or all Participants, including active or retired Employees or both, at any time it determines to be appropriate, without notice. Any action taken by the Company may be taken by action of the board of directors of the Company, the Vice President - Human Resources of the Company, or by any authorized officer or employee of the Company or other person or persons authorized by the board. Any such amendment must be in writing. In addition, a member of the Employee Benefits Department of the Company may update the Program list included on Schedule B each year.

The Company may transfer any Program from the Plan into a separate, unrelated plan or may add any additional Program or Programs to this Plan at any time. The Company may amend or substitute any set of Program terms without affecting other Plan or Program provisions. Termination of a Program (including termination of an insurance contract through which such benefits are provided) is not a termination of the Plan. Rather, it is an amendment to the Plan.

V. PARTICIPANT RIGHTS AND RESPONSIBILITIES AND LIMITATIONS THEREOF

5.1 No Assignment. Except as may otherwise be specifically provided in this Plan, the Programs, or applicable law, a Participant's rights, interests or benefits under this Plan or the Programs shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the Programs, and any such attempt shall be void.

5.2 Subrogation and Reimbursement. If, in the event of any injury, sickness or other illness for which a Participant will have a claim for benefits under this Plan or any Program, a Participant and/or other covered person acquires any right or action against a third party for such injury, sickness or other illness, then the Plan shall be entitled to reimbursement for such benefits from such third party up to 100% of the benefits paid by the Plan and the Plan is automatically subrogated to all such rights or claims of the Participant or other covered person. The Participant and/or other covered person shall cooperate fully with the Plan in the enforcement of the Plan's subrogation and reimbursement rights. In addition, the Participant and/or other person shall permit suit to be brought in the Participant's name under the direction of and at the expense of the Company if the Company so chooses. The Plan shall not be liable for a Participant's or other person's attorney's fees absent prior written approval from the Plan. The Plan Administrator may require the receipt of a signed and dated subrogation and reimbursement agreement from the Participant before advancing any monies.

The failure or refusal of a Participant (or other covered person or payee, as applicable) to fully cooperate with the Plan in the enforcement of the Plan's subrogation and reimbursement rights shall result in a forfeiture of all benefits payable to that Participant (or other covered person or payee), even if such benefits have already been paid, in which event the Company shall retain a right to recover paid benefits which are forfeited in such a manner.

The Company, on behalf of this Plan, shall have a first priority right to recover from and a lien against any payment, whether designated as a payment for medical benefits or any other type of damages, from the proceeds of any recovery, including but not limited to any settlement, award or judgment which results from a claim or lawsuit by or on behalf of a Participant and/or other person who received benefits under this Plan (even if such Participant and/or other covered person is not made whole). Notice of the Plan's claim shall be sufficient to establish this Plan's lien against the third party or insurance carrier. The Company shall be entitled to deduct the amount of the lien from any future claims payable to or on behalf of the Participant and/or other covered person or payee if the Participant and/or other covered person or payee fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to this Plan's subrogation and reimbursement rights.

In the event that the Plan obtains a recovery against a third party in excess of payments made to or on behalf of the Participant and reasonable out of pocket expenses of the recovery, then the Plan shall pay over to the Participant that excess amount recovered by the Plan.

In the event of any direct conflict between this Section 5.3 and the subrogation and reimbursement provisions in any Program, the subrogation and reimbursement provisions in the Program shall control. Otherwise, the provisions of this Section 5.3 shall apply and may supplement those contained in any Program.

5.3 Rights to Receive and Release Necessary Information. For the purpose of determining the applicability and implementation of the terms of this Plan or any Program, the Plan Administrator (or his or her delegate) may, without the consent of or notice to any person, release or obtain from any other organization or person any information with respect to any person which he or she deems to be necessary or desirable for these purposes. Any person claiming benefits under the Plan or any Program shall furnish to the Plan Administrator (or his or her delegate) any information requested to implement this Plan or the relevant Program.

5.4 Notice of Address. Each person entitled to benefits under one or more Programs must file with the Company or its designee, in writing, his or her mailing address and each change of mailing address. Any communication, statement or notice addressed to such person at such address shall be deemed sufficient for all purposes of this Plan and the Programs, and there shall be no obligation on the part of the Company, Participating Employers, the Plan Administrator (or his or her delegate), or any insurer to search for or to ascertain the location of such person.

5.5 No Vesting of Benefits. Nothing in the Plan, nor anything in any Program, shall be construed as creating any vested rights to benefits in favor of any Participant, Employee or other covered person.

5.6 Waiver and Estoppel. No term, condition, or provision of this Plan or any Program shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan or Program, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No Participant or other covered person other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purposes.

5.7 Effect on Other Benefit Plans. Amounts credited or paid under this Plan or any Program shall not be considered to be compensation for purposes of any Program hereunder or any qualified or nonqualified pension plan maintained by the Company or a Participating Employer unless expressly provided in such Program or qualified or nonqualified pension plan, as applicable. The treatment of amounts paid under this Plan or any Program for purposes of any other employee benefit plan maintained by the Company or a Participating Employer shall be determined under the provisions of the applicable employee benefit plan.

VI. GOVERNING TERMS AND APPLICABLE LAW

6.1 Severability. If any provision of this Plan or any Program is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

6.2 Conflicts of Terms. In the event of any conflict between the terms of this Plan Document and any insurance company contract or any Program, the insurance company contract or Program terms shall govern.

6.3 Controlling Law. This Plan shall be administered, construed, and enforced according to the federal law and the laws of the State of Wisconsin, to the extent not preempted by federal law.

VII. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

7.1 Protected Health Information. Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Department of Health and Human Services ("HHS") has issued regulations protecting the privacy of "individually identifiable health information." This information – referred to as "protected health information" or "PHI" – is any information that may identify, or may be used to identify, an individual person and relates in any way to his or her health or health care. The Programs in the Group Insurance Plan for Retirees of Briggs & Stratton Corporation which provide health benefits (including, but not limited to, any PPO, EPO Consumer Plus, prescription drug, dental, vision, health risk assessment, medical reimbursement account, EAP, medical flexible spending account, and any other health benefits subject to HIPAA), are referred to herein as the "Health Programs" and must comply with most of the requirements of the HIPAA privacy regulations. (Solely for purposes of HIPAA compliance, any other health program maintained by the Company and subject to HIPAA, shall be considered a Health Program hereunder and the provisions of this Article VII shall apply to such health program in the same manner as if it were a Program under the Plan.) The HIPAA privacy regulations limit the Health Programs' use and disclosure of PHI. The primary purpose of the provisions in this Article VII are to describe under what circumstances the Health Programs will disclose PHI to the "Plan Sponsor" (i.e., Briggs & Stratton Corporation) and how the Plan Sponsor will use or disclose PHI.

7.2 Permitted Uses and Disclosures of PHI. Upon the certification (described in Section 7.3 below) from the Plan Sponsor, the Health Programs may disclose PHI to the Plan Sponsor for purposes of plan administration

functions performed on behalf of the Health Programs. Specifically, the Health Programs will disclose PHI to the Plan Sponsor for purposes related to payment and health care operations.

(a) "Payment" includes activities undertaken by the Health Programs to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(i) Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);

(ii) Coordination of benefits;

(iii) Adjudication of health benefit claims (including appeals and other payment disputes);

(iv) Subrogation of health benefit claims;

(v) Establishing employee contributions;

(vi) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(vii) Billing, collection activities and related health care data processing;

(viii) Claims management and related health care data processing, including auditing payments, investigation and resolving payment disputes and responding to participant inquiries about payments;

(ix) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(x) Medical necessity reviews or reviews of appropriateness of care or justification of charges;

(xi) Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

(xii) Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed to a consumer reporting agencies for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or Health Program); and

(xiii) Reimbursement to the Health Program.

(b) "Health Care Operations" include, but are not limited to, the following activities:

(i) Quality assessment;

(ii) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(iii) Rating provider and Health Program performance, including accreditation, certification, licensing or credentialing activities;

(iv) Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

(v) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(vi) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Health Programs, including formulary development and administration, development or improvement of payment methods or coverage policies;

(vii) Business management and general administrative activities of the Health Programs, including, but not limited to:

(A) Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or

(B) Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

(viii) Resolution of internal grievances; and

(ix) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

7.3 Certification: Plan Sponsor's Use of Protected Health Information. The Health Programs are permitted to make disclosure of PHI to the Plan Sponsor because this Section 7.3 constitutes the Plan Sponsor's certification and agreement that it will conform to the following requirements:

(a) Not to use or further disclose PHI other than as necessary to administer the Health Programs or as required by law (the Programs administrative activities are limited to activities that would meet the definition of payment or health care operations as described above, but do not include modification, amendment or termination of the Programs or solicitation of bids from prospective insurers)

(b) To ensure that any agents, including subcontractors, to which Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to Plan Sponsor and agree to implement reasonable and appropriate security measures to protect the information;

(c) Not to use or disclose PHI for employment-related actions and decisions;

(d) Not to use or disclose PHI in connection with any other benefit or employee benefit plan sponsored by Plan Sponsor;

(e) To report to the group health plan any PHI use or disclosure inconsistent with HIPAA's requirements that Plan Sponsor becomes aware of, including but not limited to a security breach;

(f) To make PHI available to enrollees based upon HIPAA's access requirements;

(g) To make PHI available to enrollees for amendment, and to incorporate any such amendments as required by HIPAA;

(h) To make available the information required to provide an accounting of disclosures;

(i) To make available to HHS Plan Sponsor's internal practices, books and records relating to the use and disclosure of PHI received from the Health Programs to determine the Programs' compliance with HIPAA;

(j) If feasible, to return or destroy all PHI received from the Health Programs that Plan Sponsor still maintains in any form, and to destroy PHI copies when they are no longer needed for the disclosure purpose. If return or destruction is not feasible, Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction infeasible; and

(k) To implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the PHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Programs; and

(l) to ensure that an adequate separation between the Health Programs and Plan Sponsor are established and supported by reasonable and appropriate security measures. In connection with such separation, enrollees should know that:

(i) The employees or classes of employees who will have access to the PHI from the Health Programs are: the employee benefits director; group insurance and employee benefits department personnel; and benefit representatives located at divisional regional sites and subsidiary sites.

(ii) Access to and use of PHI by such individuals shall be limited to the plan administration functions that they perform. (Employment-related decisions are made independent of PHI). Should any of these individuals fail to comply with their obligations not to disclose PHI except in accordance with the HIPAA privacy standards, such individuals will be subject to discipline which may include dismissal.

7.4 Summary Health Information

(a) The HIPAA privacy rules also permit the Health Programs to disclose to the Plan Sponsor, and permit the Plan Sponsor to use, summary health information for the purpose of:

(i) Obtaining premium bids for providing health insurance coverage under the group Health Programs;

(ii) Modifying, amending or terminating the group Health Programs.

Summary health information is PHI that includes claims history, claims experience or the type of claims experienced by individuals in the group health plan and is "de-identified", except that zip code information may be included.

(b) The Health Programs may also use and disclose PHI with a covered individual's express written authorization or as required or permitted by law. Additionally, the Health Programs may disclose to the Plan Sponsor information on whether individuals have enrolled, disenrolled or are participating in the Health Programs.

(c) The Health Programs shall implement policies and procedures with respect to protected health information that are designed to comply with the standards, implementation specifications and other requirements of the HIPAA privacy rules. The Health Programs have designated Mr. Paul Prickett as the privacy official who is responsible for the development and implementation of the policies and procedures of the group Health Programs with respect to HIPAA compliance. Mr. Paul Prickett is also the person who is responsible for receiving any complaints from individuals covered by the health plan with respect to compliance with the HIPAA privacy rules and who will also be able to provide employees with further information about matters covered by a privacy notice employees will receive from the Plan. The Health Programs may change these designations from time to time.

SCHEDULE A

PARTICIPATING EMPLOYERS

Briggs & Stratton Corporation

SCHEDULE B

PROGRAMS OFFERED AS OF JANUARY 1, 2020 TO HOURLY EMPLOYEES WHO RETIRED FROM BRIGGS & STRATTON CORPORATION PRIOR TO AUGUST 1, 2006

Retiree benefits that were previously provided under the Group Insurance Plan of Briggs & Stratton Corporation and the Group Insurance Program for Retirees of Briggs & Stratton Power Products Group are provided under this Plan.

Medical Programs	High-Deductible PPO – UnitedHealthcare Standard PPO – UnitedHealthcare Milwaukee On-Site Clinic – Marathon Health Poplar Bluff On-Site Clinic – Marathon Health Murray Near-Site Clinic – HealthWorks (closed 01/31/2020) Statesboro Near-Site Clinic – Premise Health
Patient Resource Programs	DirectPath
Dental Programs	Delta Dental Basic Delta Dental Preferred
Vision Programs	Delta Vision Basic Delta Vision Preferred
Life Insurance Programs	Prudential – Basic Life Insurance Prudential – Basic AD&D Insurance

PROGRAMS OFFERED AS OF JANUARY 1, 2020 TO ALL SALARIED RETIREES AND HOURLY EMPLOYEES OF BRIGGS & STRATTON CORPORATION WHO RETIRED AUGUST 1, 2006 OR AFTER

Medical Programs	High-Deductible PPO w/HSA –UnitedHealthcare High-Deductible PPO w/HRA – UnitedHealthcare Milwaukee On-Site Clinic – Marathon Health Poplar Bluff On-Site Clinic – Marathon Health Murray Near-Site Clinic – HealthWorks Statesboro Near-Site Clinic – Premise Health
Patient Resources	DirectPath
Dental Programs	Delta Dental
Vision Programs	Delta Vision
Life Insurance Programs	Prudential – Basic Life Insurance Prudential – Basic AD&D Insurance

PROGRAMS OFFERED AS OF JANUARY 1, 2020 TO EMPLOYEES OF BRIGGS & STRATTON POWER PRODUCTS GROUP, LLC WHO RETIRED PRIOR TO JANUARY 1, 2014

Retiree benefits that were previously provided under the Group Insurance Plan for Retirees of Briggs & Stratton Power Products Group, LLC are provided under this Plan.

Medical Programs	High-Deductible PPO – UnitedHealthcare Standard PPO – UnitedHealthcare Basic – UnitedHealthcare Comprehensive $125/$250 – UnitedHealthcare Comprehensive $150/$300 – UnitedHealthcare Comprehensive $175/$350 – UnitedHealthcare Comprehensive $200/$400 – UnitedHealthcare Medigap Milwaukee On-Site Clinic – Marathon Health
Patient Resource Programs	DirectPath
Dental Programs	Delta Dental Basic Delta Dental Preferred
Vision Programs	Delta Vision Basic Delta Vision Preferred
Life Insurance Programs	Prudential – Basic Life Insurance

PROGRAMS OFFERED AS OF JANUARY 1, 2020 TO EMPLOYEES WHO RETIRED FROM BRIGGS & STRATTON POWER PRODUCTS GROUP, LLC DURING THE PERIOD BEGINNING JANUARY 1, 2014 AND ENDING DECEMBER 31, 2016 AND EMPLOYEES WHO WERE EMPLOYEES OF BRIGGS & STRATTON POWER PRODUCTS GROUP, LLC ON DECEMBER 31, 2016 AND RETIRED FROM BRIGGS & STRATTON CORPORATION AFTER DECEMBER 31, 2016

Medical Programs	High-Deductible PPO w/HSA – UnitedHealthcare High-Deductible PPO w/HRA – UnitedHealthcare Milwaukee On-Site Clinic – Marathon Health
Patient Resources	DirectPath
Dental Programs	Delta Dental
Vision Programs	Delta Vision
Life Insurance Programs	Prudential – Basic Life Insurance

PROGRAMS OFFERED AS OF JANUARY 1, 2020 TO EMPLOYEES WHO RETIRED FROM BRIGGS & STRATTON POWER PRODUCTS GROUP, LLC BEFORE JANUARY 1, 2014

Retiree benefits that were previously provided under the Group Insurance Plan for Retirees of Briggs & Stratton Power Products Group, LLC for employees worked at the McDonough, GA location are provided under this Plan.

Medical Programs	High-Deductible PPO – Anthem Standard PPO – Anthem AMA Medical Plus AMA Medical Preferred
Patient Resource Programs	Best Doctors
Dental Programs	Delta Dental Basic Delta Dental Preferred
Vision Programs	Delta Vision Basic Delta Vision Preferred

PROGRAMS OFFERED AS OF JANUARY 1, 2020 TO EMPLOYEES WHO RETIRED FROM BRIGGS & STRATTON POWER PRODUCTS GROUP, LLC DURING THE PERIOD BEGINNING JANUARY 1, 2014 AND ENDING DECEMBER 31, 2016 AND EMPLOYEES WHO WERE EMPLOYEES OF BRIGGS & STRATTON POWER PRODUCTS GROUP, LLC ON DECEMBER 31, 2016 AND RETIRED FROM BRIGGS & STRATTON CORPORATION AFTER DECEMBER 31, 2016

Retiree benefits that were previously provided under the Group Insurance Plan for Retirees of Briggs & Stratton Power Products Group, LLC for employees worked at the McDonough, GA location are provided under this Plan.

Medical Programs	High-Deductible PPO w/HSA – Anthem High-Deductible PPO w/HRA – Anthem AMA Medical Plus AMA Medical Preferred
Patient Resources	Best Doctors
Dental Programs	Delta Dental
Vision Program	Delta Vision

EXHIBIT B

BRIGGS & STRATTON CORPORATION

2020 BENEFITS GUIDE

THREE WAYS TO ENROLL:

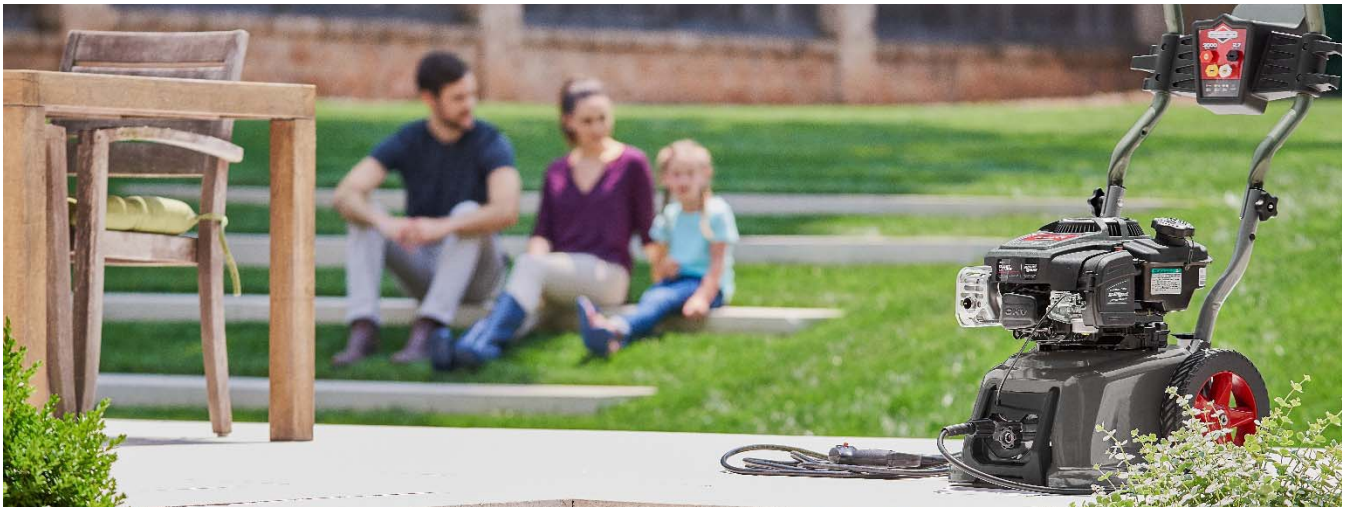
ONLINE: mylinks.basco.com – select *bswift* or basco.bswift.com

BSWIFT MOBILE APP: basco.bswift.com

BY PHONE: (877) 232–1083 for help or to ask questions

YOU.POWERED.

TABLE OF CONTENTS

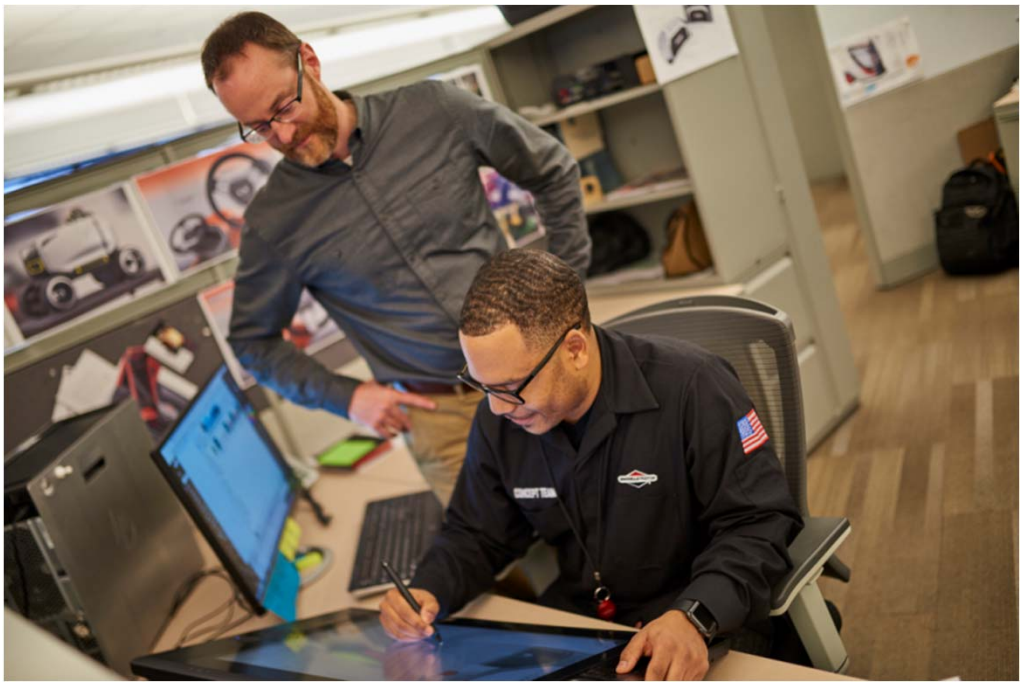


Overview	Welcome	4
	How to Enroll	5
	Resources for Enrollment & to Understand Your Benefits	6
	Eligibility	7
	Making Benefit Changes	8
Health Plan Benefits	Medical Plan Overview	9
	Additional Healthcare Resources	
	Briggs & Stratton Health Center Services	13
	Telemedicine/Virtual Visits	14
	Briggs & Stratton Wellness Program	15
	Weight Loss / Diabetes Prevention Programs	17
	Health Accounts	
	Health Savings Account (HSA)	18
	Health Reimbursement Account (HRA)	19
	Flexible Spending Accounts (FSA)	19
	Health Account Interactions with FSA	20
	Patient Advocacy & EAP Services	
	DirectPath/Cost & Quality and Rewards	21
	FEI Behavioral Health (EAP)	21
	Dental Plan Overview	22
	Vision Plan Overview	23
	Life and AD&D Insurance	24
Additional Resources	Who to Call	25
	Important Notices Regarding Your Benefit Plans	26

This Benefit Guide is a general overview of your health care benefits. Please review before you go online to make your benefit elections. Most benefits become effective on the 32nd day of employment.

Please note:

- bswift hosts Briggs & Stratton's enrollment system and provides enrollment assistance at **(877) 232-1083**
- **Enrollment window is open for up to 30 calendar days from your Hire Date**
- **Enroll online** through **mylinks.basco.com** (select bswift) or **basco.bswift.com**.
- **DirectPath** is available for benefit questions and education on the options – call **(866) 253-2273**



WHAT HAPPENS IF YOU DON'T ENROLL

By not taking any action, does not mean that you will be waived out of coverage. You are strongly encouraged to make an active choice based on your needs. If you don't make an active election within 30 days of your date of hire:

- **You will automatically be enrolled with single coverage under the High-Deductible plan with an HRA, single coverage under Delta Dental and no voluntary coverage.**
- You will receive company-paid Life and Accident Death & Dismemberment coverage, but no voluntary life insurance coverage.
- You will not be able to make Health Savings Account contributions until the next open enrollment period.
- You will not be able to set money aside in a Health Care or Dependent Care Flexible Spending Account (FSA) until the next open enrollment period.

HOW TO ENROLL

Briggs & Stratton partners with bswift to provide both the enrollment platform and a personal call center to assist you with:

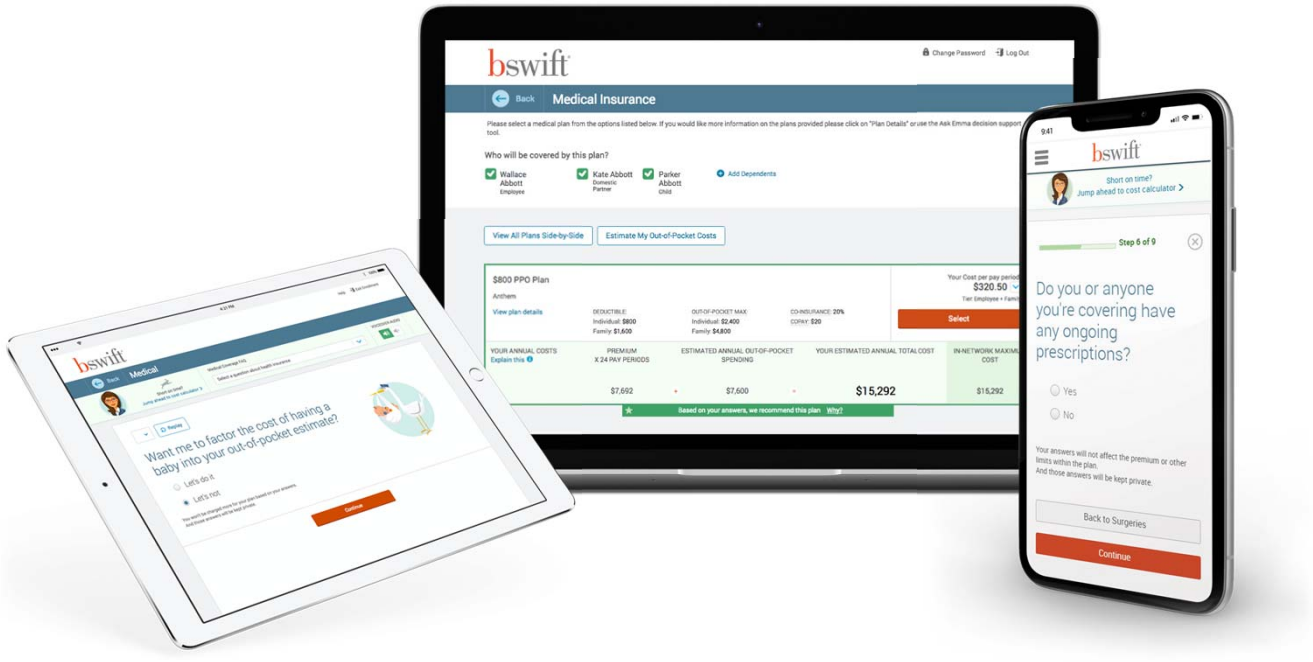
- Enrolling in benefits
- Assisting with family status changes (birth, divorce, etc.)
- Electing/changing your Health Savings Account payroll contributions
- Benefits library, including video presentations
- And much more

- **Online:**
  - mylinks.basco.com (click on bswift) or
  - basco.bswift.com (see log in instructions below)
- **Bswift Mobile App**
  - basco.bswift.com

    Username: BASCO + your employee ID number

    (example: BASCO**012345**; if your employee ID number is five digits, enter a preceding zero)

    Password: last 4 digits of your SSN (you will be prompted to change your password)
- **Phone:** (877) 232-1083
  - Representatives can assist you with your online enrollment and are available 7 am – 7 pm CST, Monday – Friday



BSWIFT

Your enrollment assistant: The bswift site is where you make your benefit elections annually and for life event changes, make changes to your HSA employee contributions, view your benefit coverages and access benefit plan documents and information.

bswift representatives are available from 7 am to 7 pm CST, Monday – Friday. You may contact bswift at (877) 232-1083 or via email at basco@bswift.com.

DIRECTPATH

Your personal benefits advocate: DirectPath representatives can help answer your questions about your benefits before you make your annual elections or life event changes or at any time you need help with a particular benefits. If you need help enrolling in benefits, they will transfer your call to bswift to complete your enrollment.

Representatives are available 7 am to 8 pm CST, Monday – Friday and 8 am to 1 pm CST on Saturday to assist you with questions about your benefits before you make your 2020 elections. You may contact a personal benefits advocate via phone at (866) 253-2273 or via email at advocate@directpathhealth.com.

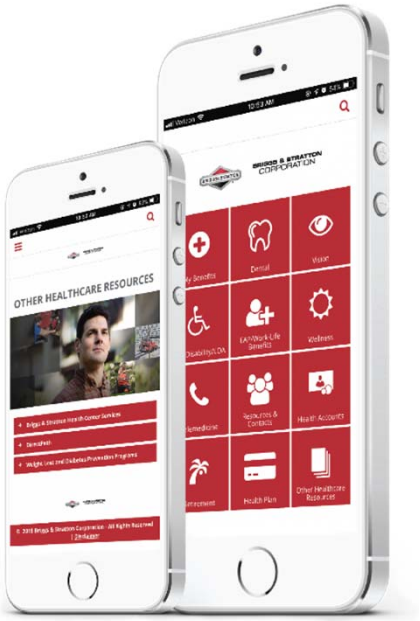
See page 20 for more things DirectPath can help you with in navigating your benefits.

MY BENEFITS APP

As a Briggs & Stratton employee, you have access to most employee benefit plan information and resources. You can access information from any smartphone, tablet or your computer.

Scan the QR Code or visit briggsstratton.mybenefitsapp.com

Add an icon to your smartphone for quick access



iPhone:

Tap the Share icon in Safari's lower menu bar

Tap the Add to home screen icon

Android:

Tap this Icon in the top right menu bar

Select: Add to Home screen

WHO IS ELIGIBLE FOR HEALTH CARE BENEFITS?

- Full-time hourly and salaried employees of Briggs & Stratton Corporation.
- Part-time employees regularly scheduled to work 30 or more hours per week. Refer to the enrollment website or your local Human Resources Department for more details.
- Legally married opposite-sex or same-sex spouse (refer to the About Spousal Coverage section below).
- Children through the month they turn 26. Our plan defines children as your biological, adopted, foster or stepchildren.
- Eligible children, who are disabled, as long as the child is declared disabled prior to reaching their 26th birthday and the request for extended coverage is submitted to bswift no later than 31 days after their 26th birthday.

Note: You can't be covered as both an employee and a dependent. Also, no one can be covered as a dependent of more than one employee and your dependent(s) cannot be covered unless you are covered.

DEPENDENT VERIFICATION

During the online enrollment process, you will be asked to acknowledge that any dependent(s) you newly enroll for coverage meets the above guidelines. Following enrollment, bswift will send you a request for appropriate documentation for your newly added dependent(s), such as a copy of a marriage certificate, birth certificate, adoption records, etc. If you are adding a newborn, you will need to provide a copy of the birth certificate. These documents can be uploaded to your Employee File in bswift.

ABOUT SPOUSAL COVERAGE – THE WORKING SPOUSE RULE

Our medical and dental plans require that working spouses elect coverage through their employer before they can be enrolled with secondary coverage under our plan, as long as their employer contributes to the cost of that coverage. The summary below describes when you can and cannot cover your spouse on our plans.

- If your spouse is eligible for medical insurance at his/her employer and **does not** elect that coverage as his/her primary coverage, then you **cannot** cover your spouse on the Briggs & Stratton plan.
- If your spouse is eligible for medical insurance at his or her employer and **does** elect that coverage as his/her primary coverage, then you **can** cover your spouse on the Briggs & Stratton plan as secondary coverage.
- If your spouse is eligible for medical insurance at his/her employer, but the employer **does not contribute** to the cost of the plan, then your spouse **can** be covered under the Briggs & Stratton plan as primary coverage.
- If you spouse is self-employed or not working, then your spouse can be covered under the Briggs & Stratton plan as primary coverage.

ONLY LIMITED CHANGES ARE ALLOWED DURING THE YEAR

Benefit decisions you make during the enrollment period, whether active or defaulted elections, will remain in effect for the entire calendar year unless you have a qualified life status event, such as:

- Marriage
- Divorce
- Birth or adoption of a child
- Change in dependent status (i.e. child is no longer a qualified dependent)
- Death of your spouse or child
- Changes in your spouse's employment status
- Loss or gain of coverage for you, your spouse or eligible dependent

Note: Eligibility for Children's Health Insurance Program (CHIP) – the employee or dependent must request coverage within 60 days of being terminated from Medicaid or CHIP coverage or within 60 days of being determined to be eligible for premium assistance.

MAKING CHANGES TO YOUR ELECTIONS

To change your benefit elections after a qualified life status event, you must make the change online or by phone within 30 days of the life event. Only election changes that are consistent with your life event will be allowed. Changing from a HSA medical plan to HRA medical plan or vice versa is not allowed during a life event change. Changes to your Health Savings Account contribution amounts can be made at any time during the year. Should you need assistance, contact bswift at (877) 232-1083.

Eligible employees have the opportunity to enroll in a medical plan linked to one of two health accounts chosen by you during the enrollment process. The plans are very similar to each other, with the exception of the individual deductible. Because the IRS has specific plan design requirements to ensure a plan is Health Savings Account Qualified, the HSA plans have been broken out into two options, based on who is covered under the plan: employee only coverage and employee plus (dependent) coverage.

For employees residing outside of Wisconsin, the medical and prescription drug plans are administered by **Anthem/IngenioRx**. Employees residing in Wisconsin, the plans are administered by **UnitedHealthCare/OptumRx**.

MEDICAL PLAN HIGHLIGHTS

Features of our health plan options:

- 100% coverage for preventive care services (in-network)
- No pre-existing condition limitations
- Annual deductible must be met before plan pays any costs towards non-preventive medical care AND prescription drugs
- Deductible and coinsurance paid by member are applied to both in-network and out-of-network limits
- Coverage is available for both in-network and out-of-network services
- Step therapy may be required for certain classifications of medication
- Referrals are not needed to see specialists
- 100% coverage for an annual **routine** vision exam (in-network only)
- Plans are linked to either a Health Savings Account (HSA) or Health Reimbursement Account (HRA)

HOW BRIGGS & STRATTON PLANS COORDINATE WITH OTHER COVERAGE

If you are covered by more than one group medical or dental plan, there are "coordination of benefits" (COB) rules that determine which plan is primary (pays benefits first), and which plan is secondary (pays benefits after the primary plan pays).

The Summary Plan Descriptions include details about how the Briggs & Stratton plans coordinate benefits with other plans if you are considering enrolling in multiple plans (such as Briggs & Stratton's plan and your spouse's employer's plan). You should review the "Effect of Benefits Under Other Plans" section to see which plan would be primary, then you can decide whether the level of benefits you would gain – if any – is worth the added cost.

If the Briggs & Stratton plan is **primary**, it simply pays benefits as described in the plan materials. If our plan is secondary, benefits are coordinated by following these steps:

1. Determine what benefit the Briggs & Stratton plan would pay if it were the primary plan (the normal benefit).
2. Subtract any benefit amount paid by the primary plan.
3. The Briggs & Stratton plan pays the difference between steps 1 and 2, if any.

	EXAMPLES BASED ON A $100 MEDICAL BILL		EXAMPLE 1	EXAMPLE 2
How Briggs & Stratton Plans Coordinate Benefits When They Are Secondary	Normal Benefit Paid B&S Plan…		$90	$80
	Normal Benefit Paid Primary Plan…		$80	$90
	After Coordination of Benefits…	B&S Pays…	$10	$0
		You Pay…	$10	$10

MEDICAL PLAN COVERAGE	High-Deductible PPO with HRA	High-Deductible PPO with HSA	
Health Account Type	Health Reimbursement Account (HRA)	Health Savings Account (HSA)	
Coverage Tier	All Levels of Coverage	Employee Only	Employee Plus (dependents)
Annual Deductible (In/Out of Network)	**In-Network –** $1,850 Single/ $3,700 Family **Out-of-Network –** $6,000 Single/ $12,000 Family	**In-Network –** $1,850 Single **Out-of-Network –** $6,000 Single	**In-Network –** $2,800 Single/ $3,700 Family **Out-of-Network –** $6,000 Single/ $12,000 Family
Annual Out-of-Pocket Maximum (In/Out of Network) (includes Deductible)	**In-Network –** $5,500 Single/ $11,000 Family **Out-of-Network –** $11,000 Single/ $22,000 Family	**In-Network –** $5,500 Single **Out-of-Network –** $11,000 Single	**In-Network –** $5,500 Single/ $11,000 Family **Out-of-Network –** $11,000 Single/ $22,000 Family
Lifetime Maximum	Unlimited		
Preventive Care (In/Out of Network)	100% / Not Covered		
Office Services (In/Out of Network)	10% Coinsurance after Deductible / 40% Coinsurance after Deductible		
Maternity Services (In/Out of Network)	10% Coinsurance after Deductible / 40% Coinsurance after Deductible		
Inpatient Services (In/Out of Network)	10% Coinsurance after Deductible / 40% Coinsurance after Deductible		
Outpatient Facility Services (In/Out of Network)	10% Coinsurance after Deductible / 40% Coinsurance after Deductible		
Durable Medical Equipment (In/Out of Network)	10% Coinsurance after Deductible / 40% Coinsurance after Deductible		
Home Care (In/Out of Network)	10% Coinsurance after Deductible / 40% Coinsurance after Deductible		
Hospice (In/Out of Network)	10% Coinsurance after Deductible / 40% Coinsurance after Deductible		
Emergency Care in ER (In/Out of Network) (waived if admitted)	10% Coinsurance after Deductible / 10% Coinsurance after Deductible Note: If care is determined to be non-emergency in nature, member will pay 50% coinsurance after deductible for both in-network and out-of-network providers		
Urgent Care Facility (In/Out of Network)	10% Coinsurance after Deductible / 40% Coinsurance after Deductible		
Ambulance (In/Out of Network)	10% Coinsurance after Deductible / 10% Coinsurance after Deductible Medical necessity applies; see Summary Plan Description for details		
Outpatient Therapy Visits – Physical / Occupational / Speech (In/Out of Network)	10% Coinsurance after Deductible / 40% Coinsurance after Deductible Visit limits apply; see Summary Plan Description for details		
Chiropractic Services (In/Out of Network)	10% Coinsurance after Deductible / 40% Coinsurance after Deductible		
Inpatient & Outpatient Mental Health (In/Out of Network)	10% Coinsurance after Deductible / 40% Coinsurance after Deductible		
Inpatient & Outpatient Substance Abuse (In/Out of Network)	10% Coinsurance after Deductible / 40% Coinsurance after Deductible		

PLAN ADMINISTRATOR	ANTHEM / INGENIO RX
Preventive Medications/Prescriptions*	Payable at 100%, no deductible. To determine if your medication is considered as a preventive care medication, visit the bswift enrollment website or log onto the www.anthem.com website.
Retail 30-day supply (Network)	Deductible applies first, then Tier 1: 20% coinsurance Tier 2: 30% coinsurance Tier 3: 40% coinsurance Tier 4: 25% coinsurance to a maximum of $100 per prescription per month
Mail Order or Retail 90-day supply (Network)	Deductible applies first, then Tier 1: 10% coinsurance Tier 2: 20% coinsurance Tier 3: 30% coinsurance Tier 4: 25% coinsurance to a maximum of $100 per prescription per month
Tier Description	Tier 1: Generic Tier 2: Preferred Brand Drugs Tier 3: Non-Preferred Brand Drugs Tier 4: Specialty Drugs

PLAN ADMINISTRATOR	UNITEDHEALTHCARE / OPTUM RX
Preventive Medications/Prescriptions*	Payable at 100%, no deductible. To determine if your medication is considered as a preventive care medication, visit the bswift enrollment website or log onto the www.myuhc.com website.
Retail 30-day supply (Network)	Deductible applies first, then Tier 1: 20% coinsurance Tier 2: 30% coinsurance Tier 3: 40% coinsurance Specialty: 25% coinsurance to a maximum of $100 per prescription per month
Mail Order or Retail 90-day supply (Network)	Deductible applies first, then Tier 1: 10% coinsurance Tier 2: 20% coinsurance Tier 3: 30% coinsurance Specialty: 25% coinsurance to a maximum of $100 per prescription per month
Tier Description	Tier 1: Lowest coinsurance expense Tier 2: Middle coinsurance expense – Consider a Tier 2 drug if no Tier 1 is available to treat your condition Tier 3: Highest coinsurance drug – usually more costly with some alternative drugs available in Tiers 1 or 2. Specialty Drugs fall within Tiers 1, 2 and 3

*To determine if your medication is considered preventive, visit the enrollment website or log onto the vendor websites listed above and on page 25.

SUMMARY OF BENEFITS & COVERAGE

By law, Briggs & Stratton is required to provide all eligible employees a document called a Summary of Benefits & Coverage (SBC), which describes our medical plan features in a consistent format that can be used to compare our plans to other medical plans. The SBCs are available on the enrollment website.

During the enrollment process, you will be asked if you have a PCP overseeing your care. Why are we asking? We know that you're young (OK, youngish) and healthy and have a thousand things to do. So why would you want to complicate your already hectic life with one more thing like finding a PCP and making an appointment? Consider the advantages of having one:

- **Live Longer** – Research shows that people who have a PCP actually live longer.
- **One-Stop Shopping** – A PCP knows how to deal with everything from helping you through a bout of the flu to back pain and digestion issues, to uncovering serious illnesses like cancer and heart disease.
- **Someone Who Knows All About You** – Over time, your doctor will get to know you as a person, not just your body. You'll build trust and be able to talk about anything that's bothering you physically and emotionally.
- **Coordination of Care** – Your PCP is the point person who helps you navigate the healthcare jungle.
- **Keeps You Healthy** – Your PCP isn't just interested in you when you are sick. He or she wants to partner with you on a wellness and prevention plan, too.
- **Routine Screenings** – Your PCP will do or arrange for screenings such as mammograms, colonoscopies, blood pressure, glucose, cholesterol and more. It's important to note that many serious illnesses are found during routine physicals.
- **Time Savings** – If you establish yourself with a PCP, it's easier to get in for an appointment.

A PCP is essential to help you navigate to good health and stay healthy; preventing disease by identifying risk factors; coordinating and managing chronic disease care for longevity and a better quality of life. So, if you don't have one, now is the time to get one!

Source: Mywheaton.org

BRIGGS & STRATTON HEALTH CENTER SERVICES

In addition to Briggs & Stratton's medical plan offerings, some locations have access to an on-site or near-site clinic. These health clinics are conveniently located and provide a variety of healthcare services similar to other healthcare providers but at a lower out-of-pocket cost than what you'd pay elsewhere.

Because the IRS regulates the HSA plan design, the fees charged by the Briggs & Stratton health clinics are different for HSA vs HRA plan participants.

If you waive our medical coverage, you are still able to use the clinics for your healthcare needs and the amount you pay is the same as the HRA fees. Expenses you incur at the clinics are submitted to your health insurance plan and the amount due will be based on whether your deductible and out-of-pocket maximums have been satisfied.

And since we pointed out why it's important to have a primary care provider, you can use the health center for your (and your family's) primary health care needs.

HIGH-DEDUCTIBLE PPO WITH THE HRA OR WAIVED MEDICAL PLAN	
VISIT TYPE	**YOU PAY**
Preventive Visit	$0
Non-Preventive Visit	Non-Preventive Exam: $5 Lab work (including blood draw): $0
Physical Therapist	$0
Pre-packaged Medications * *	Preventive medication per script: $0 Non-preventive med per script: $5

HIGH-DEDUCTIBLE PPO WITH THE HSA	
VISIT TYPE	**YOU PAY**
Preventive Visit	$0
Non-Preventive Visit	Non-Preventive Exam: $45 Lab work (including blood draw): $12
Physical Therapist	$35
Pre-packaged Medications * *	Preventive medication per script: $0 Non-preventive med per script: $5

**** Pre-packaged medications may be dispensed during an office visit, may require payment upfront and are limited to a select list of medications.***

Briggs & Stratton's On-Site and Near-Site Clinics are managed by:

Marathon health For life.

Milwaukee & Poplar Bluff

Premise Health™ Keep your edge.

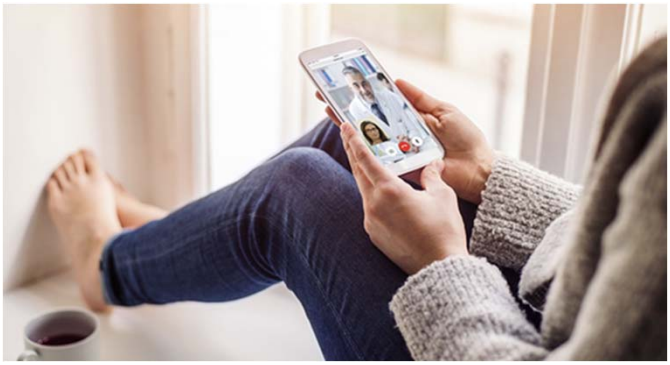
Statesboro

ADDITIONAL HEALTHCARE RESOURCES

VIRTUAL HEALTH CARE SERVICES

Why leave home when you're feeling sick? Now the doctor can come to you. Through **Anthem's Live HealthOnline** and **UHC's Virtual Visit,** doctors are available 24 hours a day, seven days a week, 365 days a year to address your minor health concerns including:

- Fever
- Sore throat
- Cough and colds
- Flu
- Urinary tract infections
- Sinusitis
- Allergies



To learn more and register today:

- Anthem members should visit livehealthonline.com
- UHC members should visit myuhc.com

HIGH QUALITY, COST EFFICIENT HEALTH CARE PROVIDERS

Studies show that people who actively engage with their primary health care providers in their health care decisions have fewer hospitalizations, fewer emergency visits, higher utilization of preventive care and overall lower medical costs. Both Anthem and UHC have tools and resources available to help you choose high quality, cost-efficient providers for you and your family members.

Anthem's Blue Distinction Total Care program is designed to help doctors do what they do best – take care of you and your family members. With Blue Distinction Total Care, doctors are paid for the quality of care, not just for the number of patients they see. That means they can take more time to listen to you to give you the personalized care that helps you get the care you need. Blue Distinction Total Care providers focus on:

- Helping patients stay healthy through preventive care and wellness programs
- Supporting patients in making better healthcare decisions
- Coordinating patients' care across the healthcare spectrum
- Expanding access to primary care through extended office hours and follow-up calls
- Reducing or eliminating unnecessary emergency room visits

Anthem BlueDistinction Total Care

UHC's Premium Designation Program evaluates physicians in various specialties using evidence-based medicine and national standardized measures to help you locate quality and cost-efficient providers. By choosing a doctor who meets these measures for quality and local benchmarks for cost efficiency, you can take an active part in helping to achieve better health outcomes while improving your experience and reducing costs.

To find a Premium Care Physician, go to myuhc.com and look for the blue hearts:

Premium Care Physician

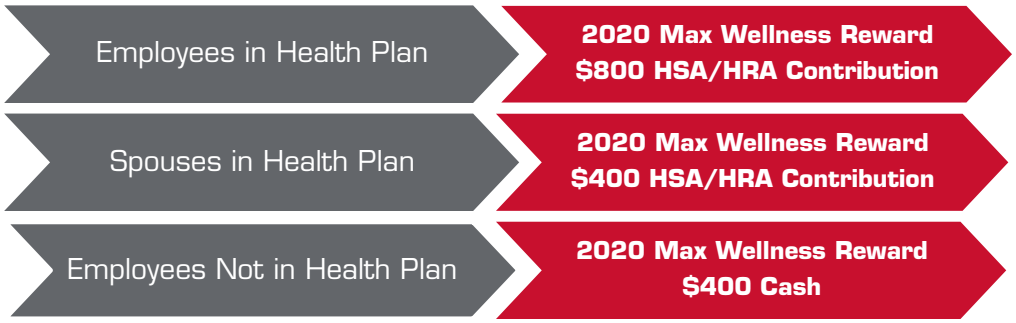
The physician meets the criteria for providing quality and cost-efficient care.

UnitedHealthcare

Briggs & Stratton's Wellness Program goes beyond simply knowing your personal health numbers. The program emphasizes the importance of having these numbers within healthy ranges. At the same time, it recognizes that change doesn't always happen overnight - but even small steps can have a positive impact on our overall health and well-being.

PROGRAM HIGHLIGHTS

- ✓ Focus on improving or maintaining your health numbers
- ✓ Earn points for your biometric screening values and other wellness activities
- ✓ Increased reward maximum – in recognition of the increased commitment from you



HOW THE PROGRAM WORKS

Benefits eligible employees and their spouses covered by the Briggs & Stratton health plan can earn points for:

- Completing a biometric health screening
- Your biometric screening results (see chart below)
- Being Tobacco-Free (or complete the 6-week online smoking (tobacco) cessation course by 10/31/20)
- Completing the Marathon Health Questionnaire (MHQ)
- Having your annual preventive health exam with your healthcare provider
- Receiving your flu shot
- 1 point = $1 Wellness Reward (up to noted maximums)

Note: Employees must complete a biometric screening in order to receive rewards (including spouse rewards).

Payout of Rewards earned under the 2020 Wellness Program:

- Rewards deposited into your HRA account will be available on January 1, 2021
- Rewards deposited into your HSA account will be available on your first paycheck of the year
- Rewards for employees who waived medical coverage will be paid out by the last payroll in January 2021

2020 Wellness Program

- Runs from November 16, 2019 through October 31, 2020
- All paperwork must be submitted by November 15, 2020

TO GET STARTED AND LEARN MORE

Log on to the **Marathon eHealth Portal** at my.marathon-health.com or contact a Marathon Health Wellness Coordinator at (802) 846-4675 or wellness@marathon-health.com.

Biometric Health Screening (REQUIRED)	Wellness Points
Employee **must** complete a fasting biometric screening to receive rewards (including spouse rewards). Can be completed at on-site event, on-site clinic, or through your healthcare provider. Form submission is only required for screenings completed by your healthcare provider.	50

Tobacco Free/User Status	Wellness Points
Completion of **Tobacco Free Statement** or **6 week Tobacco Cessation Online Workshop** on the Marathon eHealth Portal. Note: the Tobacco Free Statement can be completed at the onsite screening event or self reported online.	200

Biometric Values		Wellness Points
Healthy Value Range	• **Total Cholesterol/HDL ratio**: Males <5.1 or Females <4.5 • **Blood Pressure**: <120/80 mmHG • **BMI**: 18.5 - 24.9 **or** waist circumference <35 inches (females) or <40 inches (males) • **Fasting Blood Glucose**: < 100 mg/dL	150 points each
Moderate Value Range*	• **Total Cholesterol/HDL ratio**: Males 5.1 - 9.5 or Females 4.5 - 6.9 or 5% reduction of 2019 Triglyceride/HDL ratio value or Total Cholesterol/HDL ratio value • **Blood Pressure**:120 – 139 mmHG SBP and 80 – 89 mmHG **or** 5% reduction of 2019 value • **BMI**: 25-29.9 **or** 5% reduction of 2019 value • **Fasting Blood Glucose**: 100 – 125 mg/dL **or** 5% reduction of 2019 value	75 points each

*If results are outside of recommended ranges, employees may still earn points by actively working with their healthcare provider to address specific areas of concern and submitting a completed *Healthcare Provider Validation Form* to Marathon Health. Forms are available on Marathon eHealth Portal or at **mylinks.basco.com** (bswift) or **basco.bswift.com** and must be received no later than 11/15/20.

Wellness Activities	Wellness Points
Online Health Assessment • Complete either the Marathon Health History and Risk Assessment (HHRA), Health Risk Assessment (HRA) Annual Update or Marathon Health Questionnaire (MHQ) on the Marathon eHealth Portal **(my.marathon-health.com)** by 10/31/20.	50
Preventive Health Exam • Complete between 11/16/19 – 10/31/20. Health plan members receive credit based on preventive health claims filed; if you are not on the health plan, a completed *Healthcare Provider Validation Form* must be submitted to Marathon Health no later than 11/15/20.	125
Complete an Age / Gender Appropriate Screening or Exam • Complete between 11/16/19 – 10/31/20. Health plan members receive credit based on respective screening/exam claims filed; if you are not on the health plan, a *Healthcare Provider Validation Form* must be submitted to Marathon Health by 11/15/20. • Examples of routine screenings include a mammogram, colonoscopy, dental cleaning (points awarded for 1 cleaning per year), vision exam and preventive skin check.	50 pts each up to 100 max
Flu Shot • Complete between 11/16/19 – 10/31/20 at either an on-site event or with your healthcare provider. Onsite event flu shots will be credited based on participation reports. The *Healthcare Provider Validation Form* will be required if a flu shot is received through another source and must be submitted to Marathon Health no later than 11/15/20.	50
Health Coaching • Complete in-person or telephonic coaching sessions with a Marathon Health clinician, health coach or registered dietician between 11/16/19 – 10/31/20. Sessions must be started by October 1st.	25 per session up to 100
Financial Wellness Activity • Complete a Money Checkup in your Fidelity account at **NetBenefits.com/MoneyCheckup** by 10/31/20. Planning & Guidance tool available at **NetBenefits.Fidelity.com/planningcenter.** (Note: rewards will be posted to your wellness account on a quarterly basis)	50
Complete a Marathon Health Online Workshop • Visit the eHealth Portal (**my.marathon-health.com**) for available topics. Complete by 10/31/20.	25 up to 50 max

*If your results are outside of recommended ranges, you may still earn points by working with your healthcare provider to address your specific concern(s) and submitting a completed Healthcare Provider Validation Form to Marathon-Health.

WEIGHT LOSS/DIABETES PREVENTION PROGRAMS

Briggs & Stratton has partnered with Anthem, UnitedHealthcare (UHC) and our on-site/near-site clinics to offer weight loss/diabetes prevention programs at **no cost** to employees enrolled on a Briggs & Stratton medical plan.

- **Anthem** - Members within the Anthem service area can enroll in a program administered by **Solera Health:**
  - A year-long program that can help you lose weight, adopt healthy habits and significantly reduce your risk of developing diabetes that is available at no cost to members who qualify.
  - Choose from an array of national and local programs that include weekly lessons, a small group for support~~,~~ and tools like a wireless scale or activity tracker.
- **UHC** - Members within the UHC service area can enroll in a program administered by **Real Appeal**:
  - A year-long weight loss and maintenance program with a holistic approach that addresses diet, exercise, behaviors and willingness to change
  - Receive a Success Kit that includes gadgets to kick-start your weight loss and keep you going strong
  - 24/7 online support an mobile app featuring food, activity, weight and goal trackers
- **Marathon Health -**
  - Employees and spouses in Milwaukee and Poplar Bluff, contact your **Marathon Health** team to learn more about weight management and diabetes care management options.
  - Employees and spouses from other locations (outside Milwaukee and Poplar Bluff), access the **Marathon Health** team telephonically by calling the Milwaukee Health Center at 414.885.3601.
- **Statesboro Clinic managed by Premise Health** –
  - Employees and their covered spouses are able to enroll in the **TOP program** to manage chronic conditions, such as diabetes, high blood pressure and high cholesterol. The goal is for patients to learn everything they can about their chronic conditions and medications. The clinic staff partners with patients on lifestyle changes, diet and exercise and monitor progress toward a healthier you.

Be on the lookout for additional information regarding these programs and how to join!

Marathon health For life.

Premise Health™ Keep your edge.

SOLERA4ME

real appeal

When electing a Briggs & Stratton medical plan, you will be required to select a plan that is linked to one of two different health accounts – a **Health Savings Account (HSA)** or a **Health Reimbursement Account (HRA)**. The health accounts are in place to help you manage and pay for medical, dental or vision expenses that you are responsible for paying. However, the accounts have different eligibility rules, whether or not you can contribute to the health account, how they interact with a healthcare flexible spending account, how much you are charged for services at an onsite or near site clinic and more. Most importantly, the Briggs & Stratton Wellness Program rewards that you earn are deposited into one of these accounts.

HEALTH SAVINGS ACCOUNT (HSA)

If you enroll in the High-Deductible PPO plan with HSA, you are eligible to contribute to a Health Savings Account. This is your own personal savings account where you can put money aside to use to pay for eligible medical, pharmacy, dental and vision expenses. This includes costs that apply to your deductible and coinsurance maximum.

NOTE: You are **not** eligible to deposit money in an HSA, if you are enrolled in Medicare or any other health plan.

COMPANY CONTRIBUTIONS TO YOUR HSA

If you earn Wellness Program rewards during 2020, the Company will deposit your rewards into your HSA account with the first payroll of 2021.

YOUR CONTRIBUTIONS AND LIMITS

You may also elect to make additional contributions on a pre-tax basis to your HSA. Below are the 2020 IRS limits, (which include both the Company's and your contribution amounts):

- **Single Coverage (Employee Only):** $3,550
- **Plus):** $7,100
- **If you are age Family Coverage (Employee 55 or older**, you can contribute up to an additional $1,000 over the limits noted above.
- **If you are age 65 or over**, your ability to contribute to an HSA may be limited if/when you enroll in Medicare Part A or B. Make sure to review the rules located on the optumbank.com site.

HOW TO SET UP YOUR HSA

We partner with Optum Bank to provide a no-fee HSA account. During the enrollment process, you will authorize bswift to set up a bank account on your behalf at Optum Bank. If you are newly setting up an account, you will receive a Welcome Kit and debit card shortly after your account has been opened.

NOTE: In accordance with the US Patriot Act, there may be certain situations where Optum Bank may need to request additional documentation from you to open your account. Until this information is provided, Optum Bank will be unable to open your account. Make sure to respond promptly to their request.

- **If you elect to participate,** the account will be set up for you based on your election. You can elect to make pre-tax contributions of your own or opt to contribute $0 and just receive the Wellness Program Reward contributions. You can always make changes to your pre-tax contributions throughout the year.
- **If you elect not to establish an HSA,** you will not receive the Wellness Program Reward contributions. If you elect to establish an account mid-year, your Wellness Program Reward contributions will begin at that time.
- **If you are already an Optum Bank HSA account holder and wish to keep your HSA account,** you will still need to elect your HSA account, even if you are not contributing at this time. A new account number will not be created.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

A Health Reimbursement Account (HRA) is another type of health account that is company-funded with Wellness Program Rewards. Unlike other health savings accounts, only the Company can put money into your HRA and the account is owned by the Company. You may pay for qualified medical, pharmacy, dental and vision expenses with funds from your HRA up to the balance available in your account. Any unused funds at the end of the year may be rolled over to be used in the following years.

COMPANY CONTRIBUTIONS TO YOUR HRA

If you earn Wellness Program rewards during 2020, the Company will deposit your rewards into your HRA account as of January 1, 2021.

HOW TO SET UP YOUR HRA

We've partnered with PayFlex to provide a no-fee Health Reimbursement Account for plan years beginning 1/1/2020. If you enroll in the High-Deductible PPO plan with HRA **and** you earned rewards through the Wellness Program, your HRA will be set up automatically for you. First time enrollees will receive a pre-paid benefits card to access the funds in your account to pay for eligible medical, pharmacy, dental and vision expenses. This includes out-of-pocket costs, such as deductible and coinsurance. You may also pay for the expenses with other funds and then file a claim online for reimbursement. More information will be provided with your debit card and is available online on the enrollment website.

You will receive a debit card, the PayFlex Card, to begin accessing the funds available in your PayFlex account.

WHAT HAPPENS TO MY HRA IF I SWITCH TO THE MEDICAL PLAN WITH THE HSA?

If you choose to switch to the High-Deductible PPO with HSA plan in a future year, your access to the funds in your HRA account will be converted to a Limited Purpose HRA. This allows you access to the funds in your HRA to use for dental and vision expenses. Any funds left over at the end of a calendar year will roll over to the next year, into either your HRA or Limited Purpose HRA. Wellness rewards will be loaded into your HRA when you enroll again in the High-Deductible plan with HRA.

FLEXIBLE SPENDING ACCOUNTS (FSA)

We've partnered with PayFlex to provide you with two types of Flexible Spending Accounts (FSAs). FSAs are designed to help you save money when you contribute pre-tax dollars from your paycheck to help pay for eligible health care or dependent care expenses.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)

You can use funds in this account to pay for or reimburse yourself for qualified medical, pharmacy, dental and vision expenses that you and your dependents may incur. Your full annual election will be available to you with your first payroll contribution in 2020. **The 2020 IRS limit for an HCFSA is $2,750.**

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA)

You can use funds in this account to pay for or reimburse yourself for eligible day care expenses for your children or elderly family members while you work. **The 2020 IRS limit for a DCFSA is $5,000 (or $2,500 if married filing separately).**

IMPORTANT RULE TO REMEMBER

Plan your annual contribution amount carefully as these plans have a "use it or lose it" clause. This means that any FSA balance not used by the end of the calendar year will be forfeited, as required by law.

For additional information regarding Flexible Spending Accounts, visit the bswift website library or the payflex.com website.

If you elect the medical plan with the HSA, you can choose to contribute to an HCFSA, but it will be a Limited Purpose Health Care Flexible Spending Account (LPHCFSA) which comes with some limitations. You cannot use your LPHCFSA funds for medical expenses until your medical plan deductible is met. After your deductible is met, then you may use LPHCFSA funds for medical expenses.

Since you can use your HSA or LPHCFSA funds for dental and vision expenses at any time, why would you want both an HSA and an HCFSA?

Example 1: If you have predictable dental and/or vision expenses and you'd like access to your full FSA election early in the year.

Example 2: You may want to contribute the maximum amount to your HSA and don't want to use it unless you have medical expenses and you know you have predictable dental and/or vision expenses that you'd rather first use your HCFSA dollars.

HCFSA AND HEALTH REIMBURSEMENT ACCOUNT (HRA)

If you elect the medical plan with the HRA and choose to contribute to a Health Care Flexible Spending Account (HCFSA), you don't have the same limitations as the HSA plan does. The funds will be linked to the same pre-paid benefit card for your HRA, but the funds will be handled separately:

- Both the HRA and HCFSA contributions will be loaded onto your pre-paid benefit card.
- HCFSA funds will be used first, since you would lose that money if it isn't used by year-end.
- Once HCFSA funds are exhausted, HRA funds will be used.
- Only unused HRA funds will roll over to the next year. Any HCFSA left in the account at year-end will be forfeited, so plan carefully.

Since you can use your HRA and HCFSA for eligible expenses, why would you want both a HRA and a HCFSA? Since the HRA is an Employer-only funded account, contributing to a HCFSA is how you would set aside money pre-tax to help pay for your healthcare expenses.

HEALTH ACCOUNT COMPARISON

Wondering which health account options are best for you? Below is a quick summary of the differences:

ACCOUNT FEATURE:	HEALTH SAVINGS ACCOUNT (HSA)	HEALTH REIMBURSEMENT ACCOUNT (HRA)	HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)
You may contribute pre-tax contributions	Yes	No	Yes
Briggs & Stratton wellness rewards will be deposited into the account	Yes	Yes	No
Maximum Annual Contribution	$3,550/Individual $7,100/Family (wellness rewards and your contributions combined)	N/A	$2,700 per taxpayer
Investment account options to earn tax-free interest and dividends	Yes	N/A	N/A
Unused balances will carry over in the next year	Yes	Yes	No
Portability (you can take it with you if you leave)	Yes (Briggs & Stratton's sponsorship will end and you may be responsible to pay maintenance fees)	No (Only if you elect COBRA and you continue to make after-tax contributions or you elect retiree medical, if eligible)	No (Only if you elect COBRA and you continue to make after-tax contributions)

PATIENT ADVOCACY & TRANSPARENCY

DirectPath is a free and confidential resource designed to help you navigate the health care system with medical, dental and vision benefits, as well as FSA, HRA and HSA participation. In addition to the Member Advocacy service described on page 6, DirectPath can help you be a better consumer of healthcare.

- **Member Advocacy** - From scheduling appointments to seeking referrals for second opinions, DirectPath can:
  - Help you choose a health plan and explain how your Briggs & Stratton benefits work
  - Assist with medical and prescription drug claim questions and resolution, plus assist with appeals
  - Locate in-network providers and schedule appointments
  - Provide clinical specialists to act as the liaison between you, your providers and the insurance carriers
    - Assist with understanding your diagnosis, as well as helping you make informed cost-effective decisions about your treatment, health & wellness

- **Transparency Tools** – Help you be a better health care consumer
  Call DirectPath in advance of scheduling any elective test or procedure. Your Advocate will develop and deliver to you a comprehensive Transparency Report, comparing the cost and quality of three providers, giving you the information you need to make an informed decision.
- Active employees (& their covered dependents) are eligible to earn a percentage of the cost savings up to $500 when they choose a lower cost provider and submit their Explanation of Benefits to DirectPath within 6 months of the original Transparency Report request. Rewards are paid to employees by Briggs & Stratton as taxable income. Learn more by contacting DirectPath at (866) 253-2273.

ELIGIBILITY: You and your covered dependents

DirectPath®
To Reduce Health Care Costs

EMPLOYEE ASSISTANCE PROGRAM (EAP) AND WORK-LIFE SERVICES

Briggs & Stratton's EAP & Work-Life Services program is a confidential, voluntary program provided at no cost to you and is administered by FEI Behavioral Health.

The EAP offers you and your immediate family members support and direction with personal or job-related matters, such as, but not limited to:

- Relationship or family conflicts, parenting concerns
- Grief caused by a loved one's death
- Anxiety, depression, confusion or stress
- Drug and alcohol issues
- Conflicts at work
- Low self-esteem or insecurity

The EAP gives you access to a network of highly trained, professional therapists. EAP providers handle short-term issues that can usually be resolved in a few sessions without the use of your medical plan benefits. If your situation requires more frequent or ongoing counseling services, the EAP will help determine the best treatment plan and assist in coordinating care with your health plan.

Work-Life Services provide unlimited assistance designed for family care and personal needs which span the life cycle, such as:

- Child or elder care consultations and referrals
- Adoption consultation and referrals
- Legal or financial referrals
- Education and financial aid research

Be sure to check out the FEI website at www.feibh.com/briggs (username: briggs) & explore the many resources available. Call FEI at (888) 274-4476, 24/7/365 for assistance.

ELIGIBILITY: You and your immediate family members

fei workforce resilience

Regular dental exams can help you and your dentist detect problems in the early stages when treatment is simpler and costs are lower. Keeping your teeth and gums clean and healthy will prevent most tooth decay and periodontal disease, and is an important part of maintaining your physical health.

Briggs & Stratton's comprehensive dental plan is administered by **Delta Dental** and features two routine preventive check-ups per person per year covered at 100%, not subject to the annual limit.

PLAN HIGHLIGHTS

ANNUAL DEDUCTIBLE & MAXIMUM BENEFITS	
Annual Deductible	$25 Individual / $75 Family
Annual Maximum Benefits	$1,500
Lifetime Orthodontic Maximum Benefits	$1,500

PLAN FEATURES / MEMBER RESPONSIBILITY	
Preventive – includes two preventive check-ups (exams, x-rays and cleanings) per person per year	0%, no deductible
Basic Restorative (e.g. fillings, root canals, etc.)	20%, after deductible
Major Restorative (e.g. crowns, bridgework, etc.)	50%, after deductible
Orthodontics (e.g. braces)	50%, after deductible

EVIDENCE-BASED INTEGRATED CARE PLAN (EBICP)

If you or your family member is enrolled in the plan and have one of the medical conditions listed below, you may be eligible for additional dental cleanings and/or topical fluoride applications. These services are covered as described above. Please note that the periodontal cleanings are **not** considered preventative and are covered under the Basic Restorative benefit of your plan. **For more information, contact Delta Dental.**

- High risk cardiac conditions
- Suppressed immune systems
- Kidney Failure or Dialysis
- Cancer Therapy
- Diabetes
- Pregnancy
- Periodontal Disease

PROVIDER NETWORK

You may use any provider you wish, but your cost is lower if you use a Delta Dental network provider. Delta Dental provides two preferred networks of dentists from which to choose:

- **Delta Dental PPO Dentists** – provides the deepest discounts for your dental services. Because they have a contract with Delta Dental to accept reduced fees for the dental procedures provided, they will not bill you for the balance. You will still be responsible for paying any deductible, coinsurance and fees for procedures not covered or that exceed the annual or lifetime maximum benefit. Any payment made by Delta Dental is paid directly to your dentist.
- **Delta Dental Premier Dentists** - these providers have agreed not to charge you any amount that exceeds the fees agreed upon, with the exception of deductibles, coinsurance and fees for procedures not covered or that exceed the annual or lifetime maximum benefit. Any payment made by Delta Dental is paid directly to your dentist.
- **Non-contracted dentists** – although seeking treatment from a Delta Dental PPO or Delta Dental Premier dentist will reduce your out-of-pocket costs, you may choose to have services rendered by a non-contracted dentist. In addition to deductibles, coinsurance and fees for procedures not covered under the plan, **you will be responsible to pay the full billed charges for services performed and payment from Delta Dental will be sent directly to you.** If there are charges that exceed the maximum plan allowance (MPA), the dentist is not obligated to reduce your bill and you will be responsible to pay these charges.

If you are a medical plan participant, you are also eligible for an annual preventive vision exam under your medical plan. As long as you use your medical plan provider's network and the provider bills the vision exam as a routine exam, the exam will be covered in full.

If you are interested in additional vision coverage or waive our medical insurance, the **DeltaVision Preferred** plan may be a good fit for you. DeltaVision offers a voluntary vision plan administered by **EyeMed Vision Care**, one of the nation's leading vision providers. This plan includes coverage for important preventive eye care, eyewear and discounts on laser vision correction. Since this is a voluntary plan, the total premium cost is paid by you on a pre-tax basis.

DELTAVISION PREFERRED			
PLAN FEATURE	FREQUENCY	MEMBER PAYS IN-NETWORK (EYEMED PROVIDER)	MEMBER PAYS OUT-OF-NETWORK (NON-EYEMED PROVIDER)
Eye Exam	Once every 12 months (to the day)	Member pays $0	$35 allowance, then member pays balance
Eyeglasses – Frames	Frames covered every 24 months	$130 allowance, then member pays 80%	$65 allowance, then member pays balance
Eyeglasses – Standard Plastic Lenses*	Lenses covered every 12 months**	Member pays $0	Single vision - $25 allowance, Bifocal - $45 allowance, or Trifocal - $55 allowance, then member pays balance
Contact Lenses*	Lenses covered every 12 months**	$150 allowance, then member pays 85%	$96 allowance, then member pays balance
Contact Lens Fit and Follow-up (standard contact lenses)	Once every 12 months (to the day)	Member pays $0	$40 allowance, then member pays balance
Corrective Surgery (i.e. Lasik)	See your provider for details	Member pays 85% of retail or 95% of promotional cost	Member pays 100% (no discounts)

*Basic Lenses paid in full by the plan if purchased at an in-network provider. Additional discounted charges may apply for add-ons, such as anti-reflective coating, progressive lenses and scratch resistant coatings. A 20% discount applies to items not covered by the Plan at network providers, may not be combined with any other discounts or promotional offers and does not apply to EyeMed provider's professional services, or contact lenses. Retail prices may vary by location. Members also receive a 40% discount on complete eyeglass purchases and a 15% discount on conventional contact lenses once the funded benefit has been used.

Lenses **or contact lenses are covered every 12 months, not both.

PROVIDER NETWORK

Briggs & Stratton's vision plan is supported by the EyeMed Vision Care provider network. The network includes private practice optometrists, ophthalmologists, and opticians, as well as many leading optical retailers, including all LensCrafters locations nationwide.

For the most up-to-date listing of EyeMed providers in your area, visit EyeMed's website at www.eyemedvisioncare.com and use the Provider Locator service to locate providers in the Access network. You can also contact your current eye care professional and ask if he/she is a member of the EyeMed network.

THINGS TO CONSIDER BEFORE MAKING YOUR ELECTION

- Consider the annual cost of this plan plus the available discounts and/or putting money aside in a Health Savings Account or Health Care Flexible Spending Account.
- If you have a medical condition billed along with a routine vision exam, a portion of the exam may not be paid in full when using your medical plan routine vision benefit.
- Discounts are available for frames/lenses through EyeMed vs. sales offered through your local vision provider.

Life insurance is an important part of your financial security, especially if others depend on you for support. Accidental Death & Dismemberment insurance is designed to provide a benefit in the event of accidental death or dismemberment.

BASIC EMPLOYEE LIFE AND AD&D INSURANCE

As a benefits eligible employee, you are eligible for company-paid basic Life and Accidental Death & Dismemberment (AD&D) insurance coverage.

- If you are a salaried employee at any location or are an hourly employee working at Sherrill, Milwaukee, Holdrege or Lee's Summit locations, you have coverage in the amount of 2 times your base annual salary (your salary at hire) up to a limit of $500,000 **or** you may choose a lower volume of $50,000 to avoid the imputed income applied to volumes above $50,000.
- If you are an eligible hourly employee in Auburn, Poplar Bluff and Statesboro, you have coverage in the amount of $25,000.

This coverage doubles if you die as a result of an accident.

VOLUNTARY EMPLOYEE LIFE AND AD&D INSURANCE

You can elect additional Life and AD&D coverage for yourself above the basic coverage. This is known as Voluntary Life and AD&D insurance. Your premium cost is based on the amount of coverage, your age as of 12/31/20 and your smoker status.

If you are a salaried employee at any location or are an hourly employee working at Sherrill, Holdrege or Lee's Summit locations, you may elect one to three times your base salary (as of your hire date and every 9/1 thereafter), up to a limit of $500,000.

If you are an hourly employee at any another location, you may elect one of the following levels of coverage:

- $25,000; $50,000; $75,000; $100,000; or $125,000

VOLUNTARY DEPENDENT LIFE INSURANCE

You can also elect to provide life insurance coverage for your spouse and your dependent children up to age 26.

Voluntary dependent options are:

- Spouse: you can elect $10,000; $20,000; or $40,000 of coverage.
- Dependent Children: you can elect $5,000; $10,000; or $20,000 of coverage.

Note: Spousal coverage cannot be equal to more than half of your combined Basic and Supplemental (Voluntary) coverage amount. Dependent coverage cannot exceed 100% of employee coverage.

EVIDENCE OF INSURABILITY

Evidence of Insurability (EOI) is required for Employee life coverage of over $250,000.

In the future, EOI may be required for you or your spouse if you choose to increase your current coverage or enroll in coverage for the first time after waiving coverage in the past. After you've completed your enrollment, you will be taken to the life insurance website to respond to a few brief questions regarding your and/or your spouse's health. Coverage will be accepted immediately or pended. Our life insurance carrier will contact you for additional information, if needed. New coverage will not go into effect until Prudential has approved your request. You will be notified in writing as to whether coverage is approved or denied.

VOLUNTARY INSURANCE COSTS

To determine what your life insurance costs will be, log into the bswift enrollment website. The costs will be listed for each available benefit. Remember, too, that the costs are based on 5-year age bands, so it's always a good idea to review the costs annually.

DISABILITY COVERAGE

Disability coverage provides you with income protection in the event that you lose time on the job due to an injury or illness. Refer to the Employee Handbook or policy information located on the bswift website at mylinks.basco.com (select *bswift*).

PLAN	CONTACT	PHONE	WEBSITE
Benefit Advocacy & Education	DirectPath	(866) 253-2273	www.advocacy.directpathhealth.com/Briggs/ Mon-Fri: 7AM to 8PM CT Sat: 8AM to 1PM CT
Benefit Enrollment Assistance	bswift	877) 232-1083	mylinks.basco.com or www.basco.bswift.com 7AM to 7PM CT, Monday-Friday
COBRA	bswift	(877) 232-1083	www.basco.bswift.com
Dental	Delta Dental	(800) 236-3712	www.deltadentalwi.com
Employee Assistance Program (EAP) / Work-Life Services	FEI Behavioral Health	(888) 274-4476	www.feibh.com/briggs Username: briggs
Family Medical Leave (FMLA)	Prudential	(877) 367-7781	www.prudential.com/mybenefits
Flexible Spending Accounts (FSA)	PayFlex	(855) 516-8593	www.payflex.com
Health Reimbursement Account (HRA)	PayFlex	(855) 516-8593	www.payflex.com
Health Savings Account (HSA)	Optum Bank	(844) 326-7967	www.optumbank.com
International Business Travel Assistance	International SOS	Refer to ID card or app.internationalsos.com	www.internationalsos.com Membership# 11BYCA090434
Life Insurance	Prudential	(800) 524-0542	www.prudential.com/mybenefits
Long Term Disability (LTD)	Prudential	(877) 367-7781	www.prudential.com/mybenefits
Medical – members residing outside of WI	Anthem (medical) IngenioRx (prescription drugs)	(800) 659-7902 (833) 224-9870	www.anthem.com www.anthem.com
Medical – Wisconsin residents	UnitedHealthcare (UHC)	(844) 634-1232	www.myuhc.com
Retirement Plans	Fidelity	(800) 835-5095	www.netbenefits.com
Short Term Disability (STD)	Prudential	(877) 367-7781	www.prudential.com/mybenefits
Vision	Delta Vision (EyeMed network)	(866) 723-0513	www.eyemedvisioncare.com
Wellness Program	Briggs & Stratton Wellness Program	(802) 846-4675	wellness@marathon-health.com
ON-SITE / NEAR SITE CLINICS BY LOCATION			
Milwaukee	Marathon Health	(414) 885-3601	my.marathon-health.com
Poplar Bluff	Marathon Health	(573) 598-8733	my.marathon-health.com
Statesboro	Premise Health	(800) 920-4185 x89	www.mypremisehealth.com

WOMEN'S HEALTH AND CANCER RIGHTS ACT ANNUAL NOTICE

In 1998, Congress passed the Women's Health and Cancer Rights Act. This federal law requires that group and individual health plans that cover mastectomy procedures must also provide coverage in a manner determined in consultation with the attending physician and patient for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications for all stages of mastectomy, including lymphedemas

The Briggs & Stratton health plan will continue to provide coverage for mastectomies and the above procedures and conditions if the procedures are provided by a licensed physician according to our plan provisions.

GROUP HEALTH PLAN PRIVACY OBLIGATIONS (HIPAA)

The Briggs & Stratton health plan is required by law to protect the privacy of individually identifiable health information about you that it creates and receives and to provide you with a notice of its legal duties and privacy practices. Protected health information (PHI) is information about you, including demographic data that may identify you, that relates to your past, present or future physical or mental health or condition and related healthcare services. When the plan uses or discloses your protected health information, it is required to abide by the terms of the notice (or other notice in effect at the time of the use or disclosure). A copy of the Notice of Privacy Practices is available to you on the benefits enrollment website.

COVERAGE EXTENSION OPTION UNDER COBRA

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). When you or a family member loses eligibility in the health, dental or vision plans or the healthcare flexible spending account due to one of the qualifying status events listed on page 5, you may elect to continue your coverage through COBRA. You will receive the applicable COBRA communication and election materials from our third party COBRA administrator, **bswift**, following the qualifying event. COBRA continuation coverage must be offered to each person who is a qualified beneficiary. A qualified beneficiary is someone who will lose coverage under the plan because of a qualifying event. Those who elect to continue coverage under COBRA are responsible for the cost of the coverage.

HEALTH CARE REFORM – HEALTH INSURANCE MARKETPLACE

The Affordable Care Active (ACA), or Health Care Reform, requires you to have minimum essential health care coverage. If you do not have minimum essential healthcare coverage you may be subject to tax penalties. There are various sources through which you may get health coverage: your employer; Medicare, Medicaid or other similar government programs if you qualify; and the Health Insurance Marketplace (also known as healthcare exchanges). Briggs & Stratton continues to offer group health coverage to you as a benefits eligible employee. It is important for you to understand that the coverage offered under the Briggs & Stratton health plan does meet the federal criteria for minimum value. Therefore, you will not qualify for the premium subsidy assistance within the insurance marketplace plans if you are eligible for a Briggs & Stratton Health Plan AND the required premium for employee-only coverage under the lowest cost health plan option does not exceed 9.86% (2019 rate) of your household income.

Below are contacts that may be best able to assist you with your questions about the Health Insurance Marketplace and the Briggs & Stratton Health Plan.

CONTACT	FOR INFORMATION ABOUT	PHONE/WEB/EMAIL	OPEN ENROLLMENT DATES
Federal Resources	Your Healthcare Reform Rights & Responsibilities	(800) 318-2596 healthcare.gov	11/1/19 – 12/15/19
bswift	Briggs & Stratton's Group Health Plan	(877) 232-1083 basco@bswift.com	10/14/19 – 10/29/19

Briggs & Stratton complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Briggs & Stratton does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Briggs & Stratton:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Ellen Vebber, Senior Manager Employee Benefits, at (414) 978-4179.

If you believe that Briggs & Stratton has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Mel Adkinson, EEO Coordinator for Affirmative Action, PO Box 702, Wauwatosa, WI 53201-0702, (phone) (414) 256-1019, (fax) (414) 259-5789, adkinson.mel@basco.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Mel Adkinson, EEO Coordinator for Affirmative Action, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (414) 978-4179

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (414) 978-4179。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (414) 978-4179.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (414) 978-4179 번으로 전화해 주십시오.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (414) 978-4179

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (414) 978-4179.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-978-4179 (414).

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 978-4179 (414).

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-(414) 978-4179।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (414) 978-4179.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (414) 978-4179.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (414) 978-4179

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں (414) 978-4179.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (414) 978-4179.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (414) 978-179.

PLEASE NOTE:

This Benefits Summary provides a general overview of the benefit plans offered by Briggs & Stratton Corporation. It does not include all the details, limits or exclusions. If there is any discrepancy between the information in the Benefits Summary and the actual plan documents, plan amendments or insurance contracts, those documents will govern in all cases. While Briggs & Stratton Corporation hopes to continue the benefit plans, it reserves the right to amend or end any of its benefits, in whole or in part, at any time, with respect to any and all classes of employees, including retirees.

BRIGGS & STRATTON CORPORATION
Post Office Box 702
Milwaukee, WI 53201 USA
(414) 259-5333

EXHIBIT C

MERCER

ASC 715 (US GAAP)

ACTUARIAL VALUATION REPORT AS OF JUNE 30, 2020

POSTRETIREMENT BENEFIT PLANS

BRIGGS & STRATTON CORPORATION

July 14, 2020

CONTENTS

1. REPORT HIGHLIGHTS 1
2. BASIS OF VALUATION 4
3. ACTUARIAL CERTIFICATION 5

APPENDIX A: DISCLOSURE INFORMATION

APPENDIX B: ESTIMATED NET PERIODIC BENEFIT COST INFORMATION

1
REPORT HIGHLIGHTS

Mercer has prepared this report for Briggs & Stratton Corporation to present actuarial estimates of liabilities as of June 30, 2020 and actuarial estimates of the net periodic benefit cost for the fiscal year ending June 30, 2021 for the following plans:

- Milwaukee Retiree Medical
- Milwaukee Retiree Life Insurance
- Power Products Group Retiree Medical
- Snapper Retiree Medical

to incorporate, as Briggs & Stratton Corporation deems appropriate, in its financial statements under US accounting standards.

All figures in this report are expressed in US dollars ($), unless otherwise stated.

Please see Section 3 of this report for further explanation as to the purposes and limitations of this report.

SUMMARY OF RESULTS

Below are highlights of the results as of June 30, 2020 compared to the corresponding figures as of June 30, 2019.

	FISCAL YEAR ENDING JUNE 30, 2020	FISCAL YEAR ENDING JUNE 30, 2019
Net periodic benefit cost	**4,894,389**	**4,867,367**
Benefit obligation	(50,635,929)	(53,999,180)
Fair value of assets	N/A	N/A
Funded status	**(50,635,929)**	**(53,999,180)**
Composite discount rate at year-end for all plans	2.75%	3.55%

The net periodic benefit cost for the fiscal year ending June 30, 2020 includes no charges/credits due to special events.

The estimated net periodic benefit cost for the fiscal year ending June 30, 2021, is $4,435,275.

Please note that the actual net periodic benefit cost for the fiscal year ending June 30, 2021 may be substantially different from the estimate and may be revised if liabilities are remeasured during the year due to a significant event and/or if cash flows are updated.

REVIEW OF RESULTS

The unfunded obligation decreased by $3.4 million between June 30, 2019 and June 30, 2020, due to:

- Claims and contributions were updated to reflect the most recent experience. The resulting gain decreased the unfunded obligation by approximately $0.3 million.
- The discount rate decreased by 80 basis points from 3.55% to 2.75%. This loss increased the unfunded obligation by approximately $3.4 million.
- The mortality assumption was updated from RP-2014 separate annuitant/non-annuitant generational tables back projected to 2006 using MP-2014 with future improvements using MP-2018 projection scale to PRI-2012 no collar mortality tables with separate tables for retirees and contingent annuitants with projection scale MP-2019. This gain decreased the unfunded obligation by approximately $0.1 million.
- Demographic experience contributed to a gain which decreased the unfunded obligation by approximately $1.2 million.
- Passage of time (service cost plus interest cost less expected benefit payments) contributed to a gain which decreased the unfunded obligation by approximately $5.2 million

Accumulated other comprehensive income (AOCI) changed from $(18.1) million at June 30, 2019 to $(16.9) million at June 30, 2020, due to:

- Amortization of unrecognized gains and losses and prior service cost increased the AOCI by approximately $3.0 million.
- Claims and contributions were updated to reflect the most recent experience. The resulting gain increased the AOCI by approximately $0.3 million.
- The discount rate decreased by 80 basis points from 3.55% to 2.75%. This loss decreased the AOCI by approximately $3.4 million.
- The mortality assumption was updated from RP-2014 separate annuitant/non-annuitant generational tables back projected to 2006 using MP-2014 with future improvements using MP-2018 projection scale to PRI-2012 no collar mortality tables with separate tables for retirees and contingent annuitants with projection scale MP-2019. This gain increased the AOCI by approximately $0.1 million.
- Demographic experience contributed to a gain which increased the AOCI by approximately $1.2 million.

Details of the disclosure information are shown in Appendix A. Details of the expense calculation are shown in Appendix B. Please refer to the remainder of the report for more information about these summary numbers.

2
BASIS OF VALUATION

This report is based on the participant data, assumptions, methods and provisions summarized in the report titled Briggs & Stratton Postretirement Benefit Plans Data, Assumptions, Methods and Provisions as of *June 30, 2020* dated May 2020 and incorporated herein by Reference, except for the follow:

- The mortality assumption was updated from RP-2014 separate annuitant/non-annuitant generational tables back projected to 2006 using MP-2014 with future improvements using MMP-2018 projection scale to PRI-2012 no collar mortality tables with separate tables for retirees and contingent annuitants with projection scale MMP-2019.
    - Rationale: The plans are not expected to have mortality that is significantly different from that included in the Society of Actuary's study; accordingly, the most recently published mortality tables were selected. As discussed in Section 12.4 of RPEC's report, contingent survivor mortality was selected to only apply to existing survivors as of the measurement date. MMP-2019 is similar to SOA-published scales, but reflects a faster transition to ultimate improvement rates and uses lower ultimate improvement rates than the Society of Actuary's projection scale MP-2019, based on Mercer's analysis of the Society of Actuary's methods in projecting life expectancies. The plan does not have enough data to suggest that future mortality improvements would be significantly different from those projected; therefore, the most recent table was selected.

Authorized users of this report should contact Mercer to request a copy of the above report, if they do not already have the report, in order to understand all aspects of the calculations that are incorporated by reference.

We used financial data submitted by Briggs & Stratton as of the measurement date without further audit. Customarily, this information would not be verified by a plan's actuary. We have reviewed the information for internal consistency and general reasonableness.

3
ACTUARIAL CERTIFICATION

Mercer has prepared this report exclusively for Briggs & Stratton Corporation; subject to this limitation, Briggs & Stratton Corporation may direct that this report be provided to its auditors in connection with the audit of its financial statements. Mercer is not responsible for use of this report by any other party.

The only purpose of this report is to present actuarial estimates of liabilities as of June 30, 2020 and actuarial estimates of the net periodic benefit cost for the fiscal year ending June 30, 2021 for the following plans:

- Milwaukee Retiree Medical
- Milwaukee Retiree Life Insurance
- Power Products Group Retiree Medical
- Snapper Retiree Medical

for Briggs & Stratton Corporation to incorporate, as Briggs & Stratton Corporation deems appropriate, in its financial statements prepared under US accounting standards.

This report may not be used for any other purpose. Mercer is not responsible for the consequences of any unauthorized use. Its content may not be modified, incorporated into or used in other material, sold or otherwise provided, in whole or in part, to any other person or entity, without Mercer's permission.

This report was prepared in accordance with generally accepted actuarial principles and procedures. The actuarial assumptions were selected by Briggs & Stratton Corporation. Based on the information provided to us, we believe that the actuarial assumptions are reasonable for the purposes described in this report.

All parts of this report, including any documents incorporated by reference, are integral to understanding and explaining its contents; no part may be taken out of context, used, or relied upon without reference to the report as a whole.

Decisions about benefit changes, granting new benefits, investment policy, funding policy, benefit security, and/or benefit-related issues should not be made solely on the basis of this valuation, but only after careful consideration of alternative economic, financial, demographic, and societal factors, including financial scenarios that assume future sustained investment losses.

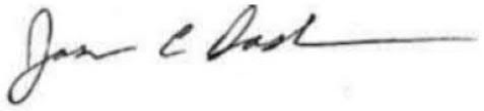
Briggs & Stratton Corporation is ultimately responsible for selecting the Plan's accounting policies, methods, and assumptions. This information is referenced or described in Section 2 of this report. Briggs & Stratton Corporation is solely responsible for communicating to Mercer any changes required to those policies, methods and assumptions.

This report is based on our understanding of applicable law and regulations as of the valuation date. Mercer is not an accountant or auditor and is not responsible for the interpretation of, or compliance with, accounting standards; citations to, and descriptions of accounting standards provided in this report are for reference purposes only. As you know, Mercer is not a law firm, and this analysis is not intended to be a legal opinion. You should consider securing the advice of legal counsel with respect to any legal matters related to this document and any attachments.

Briggs & Stratton Corporation should notify Mercer promptly after receipt of this valuation report if Briggs & Stratton Corporation disagrees with anything contained herein or is aware of any information that would affect the results of this report that has not been communicated to Mercer or incorporated therein. The valuation report will be deemed final and acceptable to Briggs and Stratton Corporation unless Briggs and Stratton Corporation promptly provides such notice to Mercer.

PROFESSIONAL QUALIFICATIONS

We are available to answer any questions on the material contained in this report, or to provide explanations or further details as may be appropriate. Collectively, the undersigned credentials actuaries meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained in this report. We are not aware of any direct or material indirect financial interest or relationship, including investments or other services that could create a conflict of interest, that would impair the objectivity of this work.



July 14, 2020

JASEN DASHNER, EA
(LONG-TERM ASPECT)

DATE

July 14, 2020

ROBERT HARRIS, ASA
(LONG-TERM ASPECT)

DATE

July 14, 2020

ALEC BRECKENRIDGE, FSA, MAAA
(HEALTHCARE ASPECT)

DATE

Mercer (US) Inc.
411 E Wisconsin Avenue, Suite 1300
Milwaukee, WI 53202
+1 414 223 4200

APPENDIX A

DISCLOSURE INFORMATION

PLAN NAME	MILWAUKEE RETIREE MEDICAL PLAN		RETIREE LIFE INSURANCE PLAN		RETIREE MEDICAL PLAN - PPG		RETIREE MEDICAL PLAN - SNAPPER		ALL PLANS	
COUNTRY	US		US		US		US			
FISCAL YEAR ENDING ON	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019
A. Change in benefit obligation										
1. Benefit obligation at beginning of year	$ 17,205,229	$ 23,478,545	$ 22,735,528	$ 21,627,183	$ 13,414,918	$ 13,008,614	$ 643,505	$ 685,867	$ 53,999,180	$ 58,800,209
2. Service cost	64,483	73,209	4,211	4,700	12,269	24,991	1,406	2,743	82,369	105,643
3. Interest cost	541,346	882,026	781,979	889,226	459,449	532,325	22,137	28,086	1,804,911	2,331,663
4. Employee contributions	1,798,438	1,854,698	-	-	111,878	299,243	31,390	58,266	1,941,706	2,212,207
5. Plan amendments	-	-	-	-	-	-	-	-	-	-
6. Plan curtailments	-	-	-	-	-	-	-	-	-	-
7. Plan settlements	-	-	-	-	-	-	-	-	-	-
8. Special termination benefits	-	-	-	-	-	-	-	-	-	-
9. a. Benefits paid from the plan	(6,922,221)	(8,526,133)	(967,588)	(1,109,277)	(1,033,276)	(1,041,618)	(84,197)	(138,084)	(9,007,282)	(10,815,112)
b. Direct benefit payments	-	-	-	-	-	-	-	-	-	-
10. Medicare subsidies received	-	-	-	-	-	-	-	-	-	-
11. Expenses paid	-	-	-	-	-	-	-	-	-	-
12. Taxes paid	-	-	-	-	-	-	-	-	-	-
13. Premiums paid	-	-	-	-	-	-	-	-	-	-
14. Net transfer in/(out) (including the effect of any business combinations/divestitures)	-	-	-	-	-	-	-	-	-	-
15. Plan combinations	-	-	-	-	-	-	-	-	-	-
16. Actuarial loss (gain)	(304,874)	(557,116)	1,659,734	1,323,696	476,458	591,363	(16,273)	6,627	1,815,045	1,364,570
17. Exchange rate changes	-	-	-	-	-	-	-	-	-	-
18. Benefit obligation at end of year	$ 12,382,401	$ 17,205,229	$ 24,213,864	$ 22,735,528	$ 13,441,696	$ 13,414,918	$ 597,968	$ 643,505	$ 50,635,929	$ 53,999,180

PLAN NAME	MILWAUKEE RETIREE MEDICAL PLAN		RETIREE LIFE INSURANCE PLAN		RETIREE MEDICAL PLAN - PPG		RETIREE MEDICAL PLAN - SNAPPER		ALL PLANS	
COUNTRY	US		US		US		US			
FISCAL YEAR ENDING ON	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019
B. Change in plan assets										
1. Fair value of plan assets at beginning of year	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2. Actual return on plan assets	-	-	-	-	-	-	-	-	-	-
3. a. Employer contributions to plan	5,123,783	6,671,435	967,588	1,109,277	921,398	742,375	52,807	79,818	7,065,576	8,602,905
b. Employer direct benefit payments	-	-	-	-	-	-	-	-	-	-
4. Employee contributions	1,798,438	1,854,698	-	-	111,878	299,243	31,390	58,266	1,941,706	2,212,207
5. Plan settlements	-	-	-	-	-	-	-	-	-	-
6. a. Benefits paid from the plan	(6,922,221)	(8,526,133)	(967,588)	(1,109,277)	(1,033,276)	(1,041,618)	(84,197)	(138,084)	(9,007,282)	(10,815,112)
b. Direct benefit payments	-	-	-	-	-	-	-	-	-	-
7. Medicare subsidies received	-	-	-	-	-	-	-	-	-	-
8. Expenses paid	-	-	-	-	-	-	-	-	-	-
9. Taxes paid	-	-	-	-	-	-	-	-	-	-
10. Premiums paid	-	-	-	-	-	-	-	-	-	-
11. Acquisitions / divestitures	-	-	-	-	-	-	-	-	-	-
12. Plan combinations	-	-	-	-	-	-	-	-	-	-
13. Adjustments	-	-	-	-	-	-	-	-	-	-
14. Exchange rate changes	-	-	-	-	-	-	-	-	-	-
15. Fair value of plan assets at end of year	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
C. Reconciliation of funded status										
1. Fair value of plan assets	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2. Benefit obligations	12,382,401	17,205,229	24,213,864	22,735,528	13,441,696	13,414,918	597,968	643,505	50,635,929	53,999,180
3. Funded status (plan assets less benefit obligations)	$ (12,382,401)	$ (17,205,229)	$ (24,213,864)	$ (22,735,528)	$ (13,441,696)	$ (13,414,918)	$ (597,968)	$ (643,505)	$ (50,635,929)	$ (53,999,180)
4. Contributions and distributions made by company from measurement date to fiscal year end	-	-	-	-	-	-	-	-	-	-
5. Net amount [asset (obligation)] recognized in statement of financial position	$ (12,382,401)	$ (17,205,229)	$ (24,213,864)	$ (22,735,528)	$ (13,441,696)	$ (13,414,918)	$ (597,968)	$ (643,505)	$ (50,635,929)	$ (53,999,180)

PLAN NAME	MILWAUKEE RETIREE MEDICAL PLAN		RETIREE LIFE INSURANCE PLAN		RETIREE MEDICAL PLAN - PPG		RETIREE MEDICAL PLAN - SNAPPER		ALL PLANS	
COUNTRY	US		US		US		US			
FISCAL YEAR ENDING ON	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019
D. Amounts recognized on the consolidated balance sheet position consists of										
1. Noncurrent assets	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2. Current liabilities	(2,704,000)	(4,257,000)	(1,456,000)	(1,425,000)	(981,000)	(997,000)	(41,000)	(43,000)	(5,182,000)	(6,722,000)
3. Noncurrent liabilities	(9,678,401)	(12,948,229)	(22,757,864)	(21,310,528)	(12,460,696)	(12,417,918)	(556,968)	(600,505)	(45,453,929)	(47,277,180)
4. Net amount [asset (obligation)] recognized in statement of financial position	$ (12,382,401)	$ (17,205,229)	$ (24,213,864)	$ (22,735,528)	$ (13,441,696)	$ (13,414,918)	$ (597,968)	$ (643,505)	$ (50,635,929)	$ (53,999,180)
E. Reconciliation of amounts recognized in statement of financial position										
1. Initial net asset(obligation)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2. Prior service credit (cost)	-	-	-	-	-	-	-	-	-	-
3. Net gain (loss)	(14,806,185)	(18,276,671)	(4,455,817)	(2,929,381)	2,135,630	2,882,427	198,877	204,066	(16,927,495)	(18,119,559)
4. Accumulated other comprehensive income (loss)	$ (14,806,185)	$ (18,276,671)	$ (4,455,817)	$ (2,929,381)	$ 2,135,630	$ 2,882,427	$ 198,877	$ 204,066	$ (16,927,495)	$ (18,119,559)
5. Accumulated contributions in excess of net periodic benefit cost	2,423,784	1,071,442	(19,758,047)	(19,806,147)	(15,577,326)	(16,297,345)	(796,845)	(847,571)	(33,708,434)	(35,879,621)
6. Net amount [surplus (deficit)] recognized in statement of financial position	$ (12,382,401)	$ (17,205,229)	$ (24,213,864)	$ (22,735,528)	$ (13,441,696)	$ (13,414,918)	$ (597,968)	$ (643,505)	$ (50,635,929)	$ (53,999,180)
F. Components of net periodic benefit cost										
1. Service cost	$ 64,483	$ 73,209	$ 4,211	$ 4,700	$ 12,269	$ 24,991	$ 1,406	$ 2,743	$ 82,369	$ 105,643
2. Interest cost	541,346	882,026	781,979	889,226	459,449	532,325	22,137	28,086	1,804,911	2,331,663
3. Expected return on plan assets	-	-	-	-	-	-	-	-	-	-
4. Amortization of initial net obligation (asset)	-	-	-	-	-	-	-	-	-	-
5. Amortization of prior service cost	-	(729,349)	-	-	-	-	-	-	-	(729,349)
6. Amortization of net (gain) loss	3,165,612	3,599,549	133,298	-	(270,339)	(419,484)	(21,462)	(20,655)	3,007,109	3,159,410
7. Curtailment (gain) / loss recognized	-	-	-	-	-	-	-	-	-	-
8. Settlement (gain) / loss recognized	-	-	-	-	-	-	-	-	-	-
9. Special termination benefit recognized	-	-	-	-	-	-	-	-	-	-
10. Net periodic benefit cost	$ 3,771,441	$ 3,825,435	$ 919,488	$ 893,926	$ 201,379	$ 137,832	$ 2,081	$ 10,174	$ 4,894,389	$ 4,867,367

PLAN NAME	MILWAUKEE RETIREE MEDICAL PLAN		RETIREE LIFE INSURANCE PLAN		RETIREE MEDICAL PLAN - PPG		RETIREE MEDICAL PLAN - SNAPPER		ALL PLANS	
COUNTRY	US		US		US		US			
FISCAL YEAR ENDING ON	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019
G. Changes recognized in other comprehensive income										
Changes in plan assets and benefit obligations recognized in other comprehensive income										
1. New prior service cost	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2. Net loss (gain) arising during the year (includes curtailment gains not recognized as a component of net period cost)	(304,874)	(557,116)	1,659,734	1,323,696	476,458	591,363	(16,273)	6,627	1,815,045	1,364,570
3. Effect of exchange rates on amounts included in AOCI	-	-	-	-	-	-	-	-	-	-
Amounts recognized as a component of net periodic benefit cost										
4. Amortization, settlement or curtailment recognition of net transition asset (obligation)	-	-	-	-	-	-	-	-	-	-
5. Amortization or curtailment recognition of prior service credit (cost)	-	729,349	-	-	-	-	-	-	-	729,349
6. Amortization or settlement recognition of net gain (loss)	(3,165,612)	(3,599,549)	(133,298)	-	270,339	419,484	21,462	20,655	(3,007,109)	(3,159,410)
7. Total recognized in other comprehensive loss (income)	$ (3,470,486)	$ (3,427,316)	$ 1,526,436	$ 1,323,696	$ 746,797	$ 1,010,847	$ 5,189	$ 27,282	$ (1,192,064)	$ (1,065,491)
8. Total recognized in net periodic benefit and other comprehensive loss (income)	$ 300,955	$ 398,119	$ 2,445,924	$ 2,217,622	$ 948,176	$ 1,148,679	$ 7,270	$ 37,456	$ 3,702,325	$ 3,801,876
Estimated amounts that will be amortized from accumulated other comprehensive income over the next fiscal year										
9. Initial net asset (obligation)	$ -		$ -		$ -		$ -		$ -	
10. Prior service credit (cost)	-		-		-		-		-	
11. Net gain (loss)	(2,752,119)		(440,353)		146,296		27,164		(3,019,012)	
12. Total estimated to be amortized from AOCI over the next fiscal year	$ (2,752,119)		$ (440,353)		$ 146,296		$ 27,164		$ (3,019,012)	

PLAN NAME	MILWAUKEE RETIREE MEDICAL PLAN		RETIREE LIFE INSURANCE PLAN		RETIREE MEDICAL PLAN - PPG		RETIREE MEDICAL PLAN - SNAPPER		ALL PLANS	
COUNTRY	US		US		US		US			
FISCAL YEAR ENDING ON	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019
H. Weighted-average assumptions to determine benefit obligations										
1. Effective discount rate	2.75%	3.55%	2.75%	3.55%	2.75%	3.55%	2.75%	3.55%	2.75%	3.55%
2. Rate of compensation increase	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	0.00%	0.00%
3. Measurement date	30-Jun-2020	30-Jun-2019	30-Jun-2020	30-Jun-2019	30-Jun-2020	30-Jun-2019	30-Jun-2020	30-Jun-2019	30-Jun-2020	30-Jun-2019
Additional information for post-retirement medical plans										
4. Assumed health care trend rate										
a. Immediate Trend Rate	5.42%	5.61%	Not applicable	Not applicable	5.42%	5.61%	Not applicable	Not applicable	5.42%	5.61%
b. Ultimate Trend Rate	4.50%	4.50%	Not applicable	Not applicable	4.50%	4.50%	Not applicable	Not applicable	4.50%	4.50%
c. Year that the rate reaches ultimate trend rate	2038	2038	Not applicable	Not applicable	2038	2038	Not applicable	Not applicable	2038	2038
I. Assumptions to determine net cost										
1. Discount rate	3.55%	4.25%	3.55%	4.25%	3.55%	4.25%	3.55%	4.25%	3.55%	4.25%
2. Expected return on assets	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
3. Rate of compensation increase	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
4. Basis used to determine overall expected long-term rate-of-return on assets assumption.										
Additional information for post-retirement medical plans										
5. Assumed health care trend rate										
a. Immediate Trend Rate	5.61%	5.96%	Not applicable	Not applicable	5.61%	5.96%	Not applicable	Not applicable	5.61%	5.96%
b. Ultimate Trend Rate	4.50%	4.50%	Not applicable	Not applicable	4.50%	4.50%	Not applicable	Not applicable	4.50%	4.50%
c. Year that the rate reaches ultimate trend rate	2038	2038	Not applicable	Not applicable	2038	2038	Not applicable	Not applicable	2038	2038

PLAN NAME	MILWAUKEE RETIREE MEDICAL PLAN		RETIREE LIFE INSURANCE PLAN		RETIREE MEDICAL PLAN - PPG		RETIREE MEDICAL PLAN - SNAPPER		ALL PLANS	
COUNTRY	US		US		US		US			
FISCAL YEAR ENDING ON	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019
J. Additional year-end information										
Required information for all defined benefit plans										
1. Accumulated benefit obligation	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Required disclosures for post-retirement medical plans										
2. Sensitivity to trend rate assumptions										
a. One percent increase in trend rate										
i. Effect on total service cost and interest cost components	13,080	24,755	-	-	16,235	16,419	-	-	29,315	41,174
ii. Effect on benefit obligation	221,007	328,456	-	-	427,626	462,028	-	-	648,633	790,484
b. One percent decrease in trend rate										
i. Effect on total service cost and interest cost components	(14,944)	(27,596)	-	-	(14,526)	(15,730)	-	(2,743)	(29,470)	(46,069)
ii. Effect on benefit obligation	(248,997)	(371,217)	-	-	(381,735)	(413,661)	-	-	(630,732)	(784,878)
3. Special Disclosure on the Impact of the Medicare Drug Act of 2003										
a. Reduction in APBO due to the federal subsidy	-	-	-	-	-	-	-	-	-	-
The effect of the federal subsidy by net periodic postretirement benefit cost component										
b. Service Cost	-	-	-	-	-	-	-	-	-	-
c. Interest Cost	-	-	-	-	-	-	-	-	-	-
d. Net amortization and deferral of actuarial (gain)/loss	-	-	-	-	-	-	-	-	-	-
e. Net periodic postretirement benefit cost	-	-	-	-	-	-	-	-	-	-
K. Additional year-end information for plans with accumulated benefit obligations in excess of plan assets										
1. Projected benefit obligation	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
2. Accumulated benefit obligation	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
3. Fair value of plan assets	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable

PLAN NAME	MILWAUKEE RETIREE MEDICAL PLAN		RETIREE LIFE INSURANCE PLAN		RETIREE MEDICAL PLAN - PPG		RETIREE MEDICAL PLAN - SNAPPER		ALL PLANS	
COUNTRY	US		US		US		US			
FISCAL YEAR ENDING ON	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019	JUN 30, 2020	JUN 30, 2019
L. Additional year-end information for plans with projected benefit obligations in excess of plan assets										
1. Projected benefit obligation	$ 12,382,401	$ 17,205,229	$ 24,213,864	$ 22,735,528	$ 13,441,696	$ 13,414,918	$ 597,968	$ 643,505	$ 50,635,929	$ 53,999,180
2. Fair value of plan assets	-	-	-	-	-	-	-	-	-	-
M. Cash flows										
1. Projected company contributions for following fiscal year	$ 2,704,000		$ 1,456,000		$ 947,000		$ 41,000		$ 5,148,000	
2. Expected benefit payments for FYE										
30-Jun-2021 :	2,704,000		1,456,000		981,000		41,000		5,182,000	
30-Jun-2022 :	2,253,000		1,459,000		955,000		41,000		4,708,000	
30-Jun-2023 :	1,867,000		1,458,000		937,000		40,000		4,302,000	
30-Jun-2024 :	1,458,000		1,453,000		922,000		40,000		3,873,000	
30-Jun-2025 :	985,000		1,444,000		906,000		37,000		3,372,000	
Next five years	2,584,000		6,972,000		4,154,000		179,000		13,889,000	
3. Expected Medicare subsidy receipts for FYE										
30-Jun-2021 :	-		-		34,000		-		34,000	
30-Jun-2022 :	-		-		37,000		-		37,000	
30-Jun-2023 :	-		-		38,000		-		38,000	
30-Jun-2024 :	-		-		39,000		-		39,000	
30-Jun-2025 :	-		-		40,000		-		40,000	
Next five years	-		-		221,000		-		221,000	

APPENDIX B

ESTIMATED NET PERIODIC BENEFIT COST

PLAN NAME	MILWAUKEE RETIREE MEDICAL PLAN		RETIREE LIFE INSURANCE PLAN		RETIREE MEDICAL PLAN- PPG		RETIREE MEDICAL PLAN-SNAPPER		ALL PLANS	
COUNTRY	US		US		US		US			
FISCAL YEAR ENDING ON	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020
A. Net Periodic Benefit Cost										
1. Service cost	$ 72,074	$ 64,483	$ 5,601	$ 4,211	$ 15,203	$ 12,269	$ 1,688	$ 1,406	$ 94,566	$ 82,369
2. Interest cost	303,333	541,346	645,854	781,979	356,630	459,449	15,880	22,137	1,321,697	1,804,911
3. Expected return on plan assets	-	-	-	-	-	-	-	-	-	-
4. Amortization of initial net obligation (asset)	-	-	-	-	-	-	-	-	-	-
5. Amortization of prior service cost	-	-	-	-	-	-	-	-	-	-
6. Amortization of net (gain) loss	2,752,119	3,165,612	440,353	133,298	(146,296)	(270,339)	(27,164)	(21,462)	3,019,012	3,007,109
7. Curtailment (gain) / loss recognized	-	-	-	-	-	-	-	-	-	-
8. Settlement (gain) / loss recognized	-	-	-	-	-	-	-	-	-	-
9. Special termination benefit recognized	-	-	-	-	-	-	-	-	-	-
10. Net periodic benefit cost	$ 3,127,526	$ 3,771,441	$ 1,091,808	$ 919,488	$ 225,537	$ 201,379	$ (9,596)	$ 2,081	$ 4,435,275	$ 4,894,389

PLAN NAME	MILWAUKEE RETIREE MEDICAL PLAN		RETIREE LIFE INSURANCE PLAN		RETIREE MEDICAL PLAN- PPG		RETIREE MEDICAL PLAN-SNAPPER		ALL PLANS	
COUNTRY	US		US		US		US			
FISCAL YEAR ENDING ON	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020
B. Additional Items For Net Periodic Benefit Cost Calculations										
1. Fair Value of Assets	-	-	-	-	-	-	-	-	-	-
2. Market-related value of assets	-	-	-	-	-	-	-	-	-	-
3. a. Expected expenses, taxes and insurance premiums	-	-	-	-	-	-	-	-	-	-
b. Weighted for timing	-	-	-	-	-	-	-	-	-	-
4. a. Expected benefits paid from plan assets	2,704,185	3,912,109	1,456,496	1,415,895	946,655	945,405	41,148	39,870	5,148,484	6,313,279
b. Weighted for timing	1,352,093	1,956,055	728,248	707,948	473,328	472,703	20,574	19,935	2,574,243	3,156,641
5. a. Expected benefits paid by company	-	-	-	-	-	-	-	-	-	-
b. Weighted for timing	-	-	-	-	-	-	-	-	-	-
6. a. Expected employer contributions to plan assets	-	-	-	-	-	-	-	-	-	-
b. Weighted for timing	-	-	-	-	-	-	-	-	-	-
7. a. Expected employee contributions	-	-	-	-	-	-	-	-	-	-
b. Weighted for timing	-	-	-	-	-	-	-	-	-	-
8. Average future years of service	4.93	5.23	4.62	4.92	5.41	5.70	5.12	6.51	Not applicable	Not applicable
9. Average future years of service to full eligibility	4.93	5.23	4.62	4.92	5.41	5.70	5.12	6.51	Not applicable	Not applicable

PLAN NAME	MILWAUKEE RETIREE MEDICAL PLAN		RETIREE LIFE INSURANCE PLAN		RETIREE MEDICAL PLAN- PPG		RETIREE MEDICAL PLAN-SNAPPER		ALL PLANS	
COUNTRY	US		US		US		US			
FISCAL YEAR ENDING ON	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020
C. Benefit Obligations and assets										
Funded Status										
1. Accumulated postretirement benefit obligation (APBO)										
a. Active participants	$ (12,382,401)	$ (17,205,229)	$ (24,213,864)	$ (22,735,528)	$ (13,441,696)	$ (13,414,918)	$ (597,968)	$ (643,505)	$ (50,635,929)	$ (53,999,180)
b. Inactive participants with deferred benefits	-	-	-	-	-	-	-	-	-	-
c. Inactive participants receiving benefits	-	-	-	-	-	-	-	-	-	-
d. Total (a. + b. + c.)	(12,382,401)	(17,205,229)	(24,213,864)	(22,735,528)	(13,441,696)	(13,414,918)	(597,968)	(643,505)	(50,635,929)	(53,999,180)
2. Fair value of plan assets	-	-	-	-	-	-	-	-	-	-
3. Funded status (1. + 2.)	$ (12,382,401)	$ (17,205,229)	$ (24,213,864)	$ (22,735,528)	$ (13,441,696)	$ (13,414,918)	$ (597,968)	$ (643,505)	$ (50,635,929)	$ (53,999,180)
Amounts to be reflected in future periods										
1. Transition obligation (asset)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2. Prior service cost (credit)	-	-	-	-	-	-	-	-	-	-
3. Net loss (gain)	14,806,185	18,276,671	4,455,817	2,929,381	(2,135,630)	(2,882,427)	(198,877)	(204,066)	16,927,495	18,119,559
4. Total not yet recognized in net periodic benefit cost (1. + 2. + 3.)	$ 14,806,185	$ 18,276,671	$ 4,455,817	$ 2,929,381	$ (2,135,630)	$ (2,882,427)	$ (198,877)	$ (204,066)	$ 16,927,495	$ 18,119,559
Cumulative employer contributions in excess of net periodic benefit cost	$ 2,423,784	$ 1,071,442	$ (19,758,047)	$ (19,806,147)	$ (15,577,326)	$ (16,297,345)	$ (796,845)	$ (847,571)	$ (33,708,434)	$ (35,879,621)

PLAN NAME	MILWAUKEE RETIREE MEDICAL PLAN		RETIREE LIFE INSURANCE PLAN		RETIREE MEDICAL PLAN- PPG		RETIREE MEDICAL PLAN-SNAPPER		ALL PLANS	
COUNTRY	US		US		US		US			
FISCAL YEAR ENDING ON	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020
D. Amortization amounts										
1. Transition obligation (asset)										
a. Net amount as of beginning of fiscal year	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
b. Years remaining	-	-	-	-	-	-	-	-	-	-
c. Annual amortization	-	-	-	-	-	-	-	-	-	-
2. Prior service cost (credit) - unrecognized base amounts shown as of beginning of fiscal year										
a. (i) Unrecognized prior service cost base 1										
(ii) Years remaining prior service cost base 1										
(iii) Amortization of prior service cost base 1										
b. (i) Unrecognized prior service cost base 2										
(ii) Years remaining prior service cost base 2										
(iii) Amortization of prior service cost base 2										
c. (i) Total unrecognized prior service cost	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
(ii) Total amortization of prior service cost	-	-	-	-	-	-	-	-	-	-
3. (Gain) loss										
a. Net amount as of beginning of fiscal year	$ 14,806,185	$ 18,276,671	$ 4,455,817	$ 2,929,381	$ (2,135,630)	$ (2,882,427)	$ (198,877)	$ (204,066)	$ 16,927,495	$ 18,119,559
b. Excess of fair value over market-related value	-	-	-	-	-	-	-	-	-	-
c. Net (gain) loss potentially subject to amortization (a. + b.)	14,806,185	18,276,671	4,455,817	2,929,381	(2,135,630)	(2,882,427)	(198,877)	(204,066)	16,927,495	18,119,559
d. Corridor	1,238,240	1,720,523	2,421,386	2,273,553	1,344,170	1,341,492	59,797	64,351	5,063,593	5,399,919
e. Amount subject to amortization (c. - d.)	13,567,945	16,556,148	2,034,431	655,828	(791,460)	(1,540,935)	(139,080)	(139,715)	14,671,836	15,531,326
f. Amortization period	4.93	5.23	4.62	4.92	5.41	5.70	5.12	6.51	Not applicable	Not applicable
g. Annual amortization	$ 2,752,119	$ 3,165,612	$ 440,353	$ 133,298	$ (146,296)	$ (270,339)	$ (27,164)	$ (21,462)	$ 3,019,012	$ 3,007,109

PLAN NAME	MILWAUKEE RETIREE MEDICAL PLAN		RETIREE LIFE INSURANCE PLAN		RETIREE MEDICAL PLAN- PPG		RETIREE MEDICAL PLAN-SNAPPER		ALL PLANS	
COUNTRY	US		US		US		US			
FISCAL YEAR ENDING ON	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020	JUN 30, 2021	JUN 30, 2020
E. Assumptions to determine net cost										
1. Discount rate	2.75%	3.55%	2.75%	3.55%	2.75%	3.55%	2.75%	3.55%	2.75%	3.55%
2. Expected return on assets	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
3. Rate of compensation increase	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
4. Assumed health care trend rate										
a. Immediate trend rate	5.42%	5.61%	Not applicable	Not applicable	5.42%	5.61%	Not applicable	Not applicable	5.42%	5.61%
b. Ultimate trend rate	4.50%	4.50%	Not applicable	Not applicable	4.50%	4.50%	Not applicable	Not applicable	4.50%	4.50%
c. Year that the rate reaches ultimate trend rate	2038	2038	Not applicable	Not applicable	2038	2038	Not applicable	Not applicable	2038	2038

MERCER
411 East Wisconsin Avenue, Suite 1300
Milwaukee, WI 53202
+1 414 223 4200
www.mercer.com

EXHIBIT D

BRIGGS & STRATTON CORPORATION

July 20, 2020

Dear Briggs & Stratton Retired Employee and/or Beneficiary,

Earlier today, Briggs & Stratton Corporation announced that we are pursuing a sale of the Company and have filed for Chapter 11 bankruptcy. Over the past several months, we have been working closely with our advisors to strengthen our financial position and improve financial flexibility. We explored multiple avenues and determined that this course of action is necessary and appropriate to ensure our business and financial success moving forward.

With this announcement comes a number of changes to retiree benefits as follows, some of which may or may not apply to you.

401(k) Plan

The Briggs & Stratton Consolidated Savings & Retirement Plan is a defined contribution tax-qualified plan funded with assets that are held in a separate trust outside of the Company, and would not be subject to creditor's claims through court-supervised proceedings. We do not anticipate any changes to the 401(k) plan or any payments provided through the plan as a result of the Chapter 11 filing. If you have questions regarding an active 401(k) plan, please contact Fidelity, at 800-835-5095.

Qualified Pension Plans

Beginning on July 20, 2020, the Briggs & Stratton Pension Plan and the Briggs & Stratton Cash Balance Retirement Plan (each, a "Plan" and collectively, the "Plans") are not permitted to pay a lump sum benefit to participants who elect to get a distribution of their benefits under the Plans, if the actuarial equivalent of such benefits exceeds $5,000. Federal law imposes this restriction because the Plan's funded level was less than 100% at the time of the bankruptcy filing. The restriction will no longer apply once the company emerges from bankruptcy or, if sooner, when the Plan's funded level reaches 100%.

Please understand that this is a temporary restriction and does not affect the amount of benefits that you have already earned under the Plan or your right to elect any other form of benefit under the Plan or to receive your pension payments.

We do not yet know whether the bankruptcy filing will have any other impact on pension benefits under the Plan and it may be a number of months until we do. In no event would pension plan assets be used to satisfy claims of the Company's creditors. By law, all pension plan assets would be used to provide benefits to Plan participants.

It is possible that the Pension Benefits Guaranty Corporation (PBGC), an agency of the U.S. Government, would take over the Plans in connection with the bankruptcy proceeding, and if that occurs, the PBGC would have the ability to modify benefits to the extent that Plan assets aren't sufficient to cover 100% of benefits if a participant's benefit exceeds PBGC maximum benefits levels. Whether a particular participant's benefits will be reduced depends on the participant's monthly benefit amount, regardless of whether the participant commenced benefits before or after the bankruptcy proceeding. You will receive notice of the resolution relating to your pension benefits once it is known.

If you are receiving an annuity pension payment from Western & Southern, the bankruptcy filing does not affect your payment.

BRIGGS & STRATTON CORPORATION

Retiree Health and Life Insurance

In situations such as this, difficult decisions have to be made. Pursuant to the Company's right under Section 4.1 of the Group Insurance Plan for Retirees of Briggs & Stratton Corporation (the "Plan"), the Board of Directors of the Company voted on July 19, 2020, to terminate the Plan. Your health and life insurance coverage will end on August 31, 2020. Any eligible claims incurred on or before August 31, 2020, will be covered by the Plan.

The Company has filed a motion with the Bankruptcy Court in the Eastern District of Missouri seeking confirmation of its termination of the Plan. You will receive a copy of that motion in a separate mailing.

This means retirees currently on the company's Retiree Health and Life Insurance plans will need to purchase their own coverage. In early September, affected participants will receive information from bswift regarding the opportunity to continue health insurance coverage at their own expense under COBRA (Consolidated Omnibus Budget Reconciliation Act), and information from Prudential regarding how to convert their life insurance policies to individual policies.

Additional Information and Questions

We understand that you likely have a number of questions. Answers to frequently asked questions and other important information can be found on our website, at www.bascoreorganization.com. Additional questions should be directed to our toll-free line (within US/Canada), at 1-866-544-7045 or our international number, at 781-575-2084. Pension and 401(k) questions should be directed to Fidelity, at 800-835-5095 or netbenefits.com.

We continue to be grateful for your dedication and years of service with the company.

Thank you,

Paul Prickett, Director-Compensation & Benefits

BRIGGS & STRATTON CORPORATION

July 20, 2020

Dear Briggs & Stratton Retired Employee and/or Beneficiary,

Earlier today, Briggs & Stratton Corporation announced that we are pursuing a sale of the company and have filed for Chapter 11 bankruptcy. Over the past several months, we have been working closely with our advisors to strengthen our financial position and improve financial flexibility. We explored multiple avenues and determined that this course of action is necessary and appropriate to ensure our business and financial success moving forward.

With this announcement comes a number of changes to retiree benefits as follows, some of which may or may not apply to you.

401(k) Plan

The Briggs & Stratton Consolidated Savings & Retirement Plan is a defined contribution tax-qualified plan and funded with assets that are held in a separate trust outside of the company and would not be subject to creditor's claims through court-supervised proceedings. We do not anticipate any changes to the 401(k) plan or any payments provided through the plan as a result of the Chapter 11 filing. If you have questions regarding an active 401(k) plan, please contact Fidelity, at 800-835-5095.

Qualified Pension Plans

Beginning on July 20, 2020, the Briggs & Stratton Pension Plan and the Briggs & Stratton Cash Balance Retirement Plan (each, a "Plan" and collectively, the "Plans") are not permitted to pay a lump sum benefit to participants who elect to get a distribution of their benefits under the Plans, if the actuarial equivalent of such benefits exceeds $5,000. Federal law imposes this restriction because the Plan's funded level was less than 100% at the time of the bankruptcy filing. The restriction will no longer apply once the company emerges from bankruptcy or, if sooner, when the Plan's funded level reaches 100%.

Please understand that this is a temporary restriction and does not affect the amount of benefits that you have already earned under the Plan or your right to elect any other form of benefit under the Plan or to receive your pension payments.

We do not yet know whether the bankruptcy filing will have any other impact on pension benefits under the Plan and it may be a number of months until we do. In no event would pension plan assets be used to satisfy claims of the Company's creditors. By law, all pension plan assets would be used to provide benefits to Plan participants.

It is possible that the Pension Benefits Guaranty Corporation (PBGC), an agency of the U.S. Government, would take over the Plans in connection with the bankruptcy proceeding, and if that occurs, the PBGC would have the ability to modify benefits to the extent that Plan assets aren't sufficient to cover 100% of benefits if a participant's benefit exceeds PBGC maximum benefits levels. Whether a particular participant's benefits will be reduced depends on the participant's monthly benefit amount, regardless of whether the participant commenced benefits before or after the bankruptcy proceeding. You will receive notice of the resolution relating to your pension benefits once it is known.

If you are receiving an annuity pension payment from Western & Southern, the bankruptcy filing does not affect your payment.

BRIGGS & STRATTON CORPORATION

Non-Qualified Retirement Plans

In situations such as this, difficult decisions have to be made. The Briggs & Stratton Supplemental Employee Retirement Plan (SERP), the Briggs & Stratton Supplemental Executive Retirement Plan (SERP-Ex) and Briggs & Stratton Key Employee Savings & Investment Plan (KESIP) are being terminated effective with the bankruptcy filing. Current and future distributions from these plans cease beginning with August 1, 2020 scheduled payments.

Retiree Health and Life Insurance

Also a difficult decision, pursuant to the Company's right under Section 4.1 of the Group Insurance Plan for Retirees of Briggs & Stratton Corporation (the "Plan"), the Board of Directors of the Company voted on July 19, 2020, to terminate the Plan. Your health and life insurance coverage will end on August 31, 2020. Any eligible claims incurred on or before August 31, 2020, will be covered by the Plan.

The Company has filed a motion with the Bankruptcy Court in the Eastern District of Missouri seeking confirmation of its termination of the Plan. You will receive a copy of that motion in a separate mailing.

This means retirees currently on the company's Retiree Health and Life Insurance plans will need to purchase their own coverage. In early September, affected participants will receive information from bswift regarding the opportunity to continue health insurance coverage at their own expense under COBRA (Consolidated Omnibus Budget Reconciliation Act), and information from Prudential regarding how to convert their life insurance policies to individual policies.

Additional Information and Questions

We understand that you likely have a number of questions. Answers to frequently asked questions and other important information can be found on our website, at www.bascoreorganization.com. Additional questions should be directed to our toll-free line (within US/Canada), at 1-866-544-7045 or our international number, at 781-575-2084. Pension questions should be directed to Fidelity, at 800-835-5095 or netbenefits.com.

We continue to be grateful for your dedication and years of service with the company.

Thank you,

Paul Prickett, Director-Compensation & Benefits