Your Scotts 2023 Retiree Medical Enrollment Guide

Pre-Medicare-Eligible

ScottsMiracle-Gro

Inside this Guide

Scotts is committed to providing medical coverage and valuable information to help you improve your health and well-being. Your 2023 Retiree Medical Enrollment Guide is divided into sections, each covering a specific benefit program or important information.

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What's the Deadline to Enroll or Make Changes?

For 2023 Benefits Open Enrollment, visit **livetotalhealth.com** by Wednesday, November 2, 2022, in order for changes to be effective January 1, 2023. You can also enroll by calling the Scotts Benefits Service Center at **1-888-918-5878** between 8 a.m. and 8 p.m. Eastern Time.

If you do not want to make changes, your 2022 coverage will continue for 2023 with 2023 premiums. Refer to your personalized enrollment worksheet for more details.

For new retirees, you must enroll by the deadline shown on your **personalized enrollment worksheet.**

2023 Benefits Highlights

Review this Guide to understand the medical plan options available to you and to ensure you make the right choices for you and your family. More information about the 2023 medical plan options is available on page 4.

How to Enroll

At **livetotalhealth.com** you can access, enroll in and manage your benefits. It makes it easy to learn about your medical plan options, choose the plan that is right for you and get answers to your questions. It also gives you access to tools to help you understand your choices and improve your health.

There are two ways you can enroll in benefits for 2023:

Enroll Online:

- Go to **livetotalhealth.com** and click on the *Enroll In / Change Benefits* button
- Click on the link in the main blue tile on the home page to enroll in your 2023 benefits

Note: You may also grant your spouse/domestic partner (DP) access to these tools and resources, but they cannot make changes to benefits. From the home page, select Profile (the icon in the upper-right corner) > Login & Recovery and update the Spouse/Domestic Partner Site Access section. You will then receive an email with additional information for your spouse/DP to complete the registration.

Enroll by phone:

You can also enroll by calling the Scotts Benefits Service Center at **1-888-918-5878**. Representatives are available to assist you Monday through Friday, from 8 a.m. to 8 p.m. Eastern Time during Open Enrollment, and Monday through Friday, 8 a.m. to 6 p.m. after Open Enrollment.

About Your Scotts Retiree Medical Options

Let's start with the medical options that are available to you as a pre-Medicare-eligible Scotts retiree. You can choose between two options:

- Basic PPO Plan
- Premium PPO Plan

Coverage Levels

All Scotts retiree medical plans offer two tiers of coverage:

- Single — one person covered
- Family — two or more covered

What's the Same Between the Two Plans?

Both PPO plans offer the same:

- Network of high-quality providers
- Covered services
- Preventive services covered at 100%
- Copay amounts

What's Different Between the Two Plans?

- The Basic PPO has lower premiums but higher costs when you receive care, with a higher deductible and coinsurance
- The Premium PPO has higher premiums but lower costs when you receive care

Copayments, Annual Deductibles, Coinsurance: *When Do They Apply?*

There are two ways you pay for a covered non-preventive service:

1. You pay a **copayment** (a flat fee), and then the plan covers the rest of the amount at 100%. **Examples of services:** in-network office visits or generic prescription drugs
2. You pay for covered services until you meet your **annual deductible**. Once you've satisfied the deductible, you pay a percentage of a covered service (**coinsurance**) until you reach the annual out-of-pocket maximum **Examples of services:** hospital services or surgeries

How Your Plans Compare

	Basic PPO Plan		Premium PPO Plan	
Services	**Your In-network Costs**	**Your Out-of-network Costs**	**Your In-network Costs**	**Your Out-of-network Costs**
Annual Deductible ▪ Individual ▪ Family	▪ $1,250 ▪ $2,500	▪ $3,000 ▪ $6,000	▪ $750 ▪ $1,500	▪ $1,500 ▪ $3,000
Annual Medical Out-of-pocket Maximum ▪ Individual ▪ Family	▪ $5,000 ▪ $10,000	▪ $10,000 ▪ $20,000	▪ $3,500 ▪ $7,000	▪ $7,000 ▪ $14,000
Physician Office Visits ▪ Primary Care Physician ▪ Specialist	▪ $30 copay ▪ $60 copay	▪ 40% after deductible ▪ 40% after deductible	▪ $30 copay ▪ $60 copay	▪ 30% after deductible ▪ 30% after deductible
Preventive Care ▪ Physical Exams ▪ Well-child care and immunizations ▪ Preventive Screenings (Pap tests, mammograms, PSA, colorectal exams, etc.)	▪ No charge ▪ No charge ▪ No charge	▪ 40% after deductible ▪ 40% after deductible ▪ 40% after deductible	▪ No charge ▪ No charge ▪ No charge	▪ 30% after deductible ▪ 30% after deductible ▪ 30% after deductible
Allergy Testing and Injection	▪ 20% after deductible	▪ 40% after deductible	▪ 10% after deductible	▪ 30% after deductible
Hospital Services ▪ Inpatient (IP) ▪ Outpatient (OP)	▪ 20% after deductible ▪ 20% after deductible	▪ 40% after deductible ▪ 40% after deductible	▪ 10% after deductible ▪ 10% after deductible	▪ 30% after deductible ▪ 30% after deductible
Outpatient Surgery (in doctor's office, surgery center, outpatient facility)	▪ 20% after deductible	▪ 40% after deductible	▪ 10% after deductible	▪ 30% after deductible

How Your Plans Compare (continued)

	Basic PPO Plan		Premium PPO Plan	
Services	**Your In-network Costs**	**Your Out-of-network Costs**	**Your In-network Costs**	**Your Out-of-network Costs**
Maternity Care ▪ Prenatal ▪ Postnatal ▪ Hospital delivery	▪ 1st visit: $30 copay 20% after deductible thereafter[1] ▪ Same as prenatal ▪ 20% after deductible	▪ 40% after deductible ▪ 40% after deductible ▪ 40% after deductible	▪ 1st visit: $30 copay 10% after deductible thereafter ▪ Same as prenatal ▪ 10% after deductible	▪ 30% after deductible ▪ 30% after deductible ▪ 30% after deductible
Emergency Room[1] (covered for emergency medical conditions only, as determined true emergencies)	▪ $150 copay plus 20% after deductible	▪ $150 copay plus 20% after deductible	▪ $150 copay plus 10% after deductible	▪ $150 copay plus 10% after deductible
Ambulance Service (when medically necessary)	▪ 20% after deductible	▪ 20% after deductible	▪ 10% after deductible	▪ 10% after deductible
Urgent Care	▪ $75 copay	▪ 40% after deductible	▪ $75 copay	▪ 30% after deductible
Diagnostic Services (X-ray/lab)	▪ 20% after deductible	▪ 40% after deductible	▪ 10% after deductible	▪ 30% after deductible
Short-term Rehabilitation Therapy (physical, speech or occupational therapy)	▪ $30 copay	▪ 40% after deductible	▪ $30 copay	▪ 30% after deductible
Spinal Manipulation and Chiropractic	▪ $30 copay	▪ 40% after deductible	▪ $30 copay	▪ 30% after deductible
Weight Loss Treatment (surgery for morbid obesity only)	▪ 20% after deductible	▪ Not covered	▪ 10% after deductible	▪ Not covered
TMJ Treatment	▪ Not covered	▪ Not covered	▪ Not covered	▪ Not covered

[1] Emergency room copays are waived if admitted within 24 hours.

How Your Plans Compare (continued)

	Basic PPO Plan		Premium PPO Plan	
Services	**Your In-network Costs**	**Your Out-of-network Costs**	**Your In-network Costs**	**Your Out-of-network Costs**
Accident-related Dental	▪ 20% after deductible	▪ 40% after deductible	▪ 10% after deductible	▪ 30% after deductible
Durable Medical Equipment and Prosthetics (including breast prosthetics)	▪ 20% after deductible	▪ 40% after deductible	▪ 10% after deductible	▪ 30% after deductible
Organ and Tissue Transplants Covered transplants: ▪ Standard transplants (kidney, pancreas, kidney/pancreas, liver, heart, lung, heart/lung, small bowel, and bone marrow or stem cell transplants for certain conditions)	▪ 20% after deductible ▪ Pre-cert required ▪ Travel & lodging covered for patient and one companion (up to plan limits)	▪ Not covered	▪ 10% after deductible ▪ Pre-cert required ▪ Travel & lodging covered for patient and one companion (up to plan limits)	▪ Not covered
Reproductive Services ▪ Fertility testing/ exams ▪ Advanced infertility treatment[2]	Comprehensive infertility treatment covered, (artificial insemination, GIFT, ZIFT, IVF, elective egg freezing) ▪ Lifetime maximum[2]: *Med:* $20,000 *Rx:* $10,000 ▪ 20% after deductible	Comprehensive infertility treatment covered, (artificial insemination, GIFT, ZIFT, IVF, elective egg freezing) ▪ Lifetime maximum[2]: *Med:* $20,000 *Rx:* $10,000 ▪ 40% after deductible	Comprehensive infertility treatment covered, (artificial insemination, GIFT, ZIFT, IVF, elective egg freezing) ▪ Lifetime maximum[2]: *Med:* $20,000 *Rx:* $10,000 ▪ 10% after deductible	Comprehensive infertility treatment covered, (artificial insemination, GIFT, ZIFT, IVF, elective egg freezing) ▪ Lifetime maximum[2]: *Med:* $20,000 *Rx:* $10,000 ▪ 30% after deductible
Sterilization	▪ Women's: No charge ▪ Men's: 20% after deductible	▪ Women's: 40% after deductible ▪ Men's: 40% after deductible	▪ Women's: No charge ▪ Men's: 10% after deductible	▪ Women's: 30% after deductible ▪ Men's: 30% after deductible

[2] Lifetime maximums are combined for in-network and out-of-network services.

How Your Plans Compare (continued)

	Basic PPO Plan		Premium PPO Plan	
Services	**Your In-network Costs**	**Your Out-of-network Costs**	**Your In-network Costs**	**Your Out-of-network Costs**
Skilled Nursing Facility Care (for convalescence from illness or injury)	▪ 20% after deductible	▪ 40% after deductible	▪ 10% after deductible	▪ 30% after deductible
Home Health Care (Note: Private Duty Nursing is covered only when rendered by a Home Health Care agency)	▪ 20% after deductible	▪ 40% after deductible	▪ 10% after deductible	▪ 30% after deductible
Hospice Care	▪ 20% after deductible	▪ 40% after deductible	▪ 10% after deductible	▪ 30% after deductible
Chemotherapy, Radiation Therapy, Dialysis Treatment	▪ 20% after deductible	▪ 40% after deductible	▪ 10% after deductible	▪ 30% after deductible
Mental Health and Substance Abuse ▪ Inpatient ▪ Outpatient	▪ 20% after deductible ▪ $30 copay	▪ 40% after deductible ▪ 40% after deductible	▪ 10% after deductible ▪ $30 copay	▪ 30% after deductible ▪ 30% after deductible

Looking for a Provider?

You can check which providers and facilities are in-network for your plan:

- From the enrollment home page, click on the “Health Tools” tile
- Then click “Get Help” that can be found next to the “Need help finding a Doctor?” option

You will be able to search providers by plan name, ZIP code, specialty area and more.

What If My Spouse/DP Is Medicare-eligible?

If you are not Medicare-eligible, but have a Medicare-eligible spouse/DP, this situation (and vice versa) is known as a "split family." Split families have different coverage options and two separate enrollment processes. This means, for example, that if your covered spouse/DP is Medicare-eligible and you are not, you will have different retiree health care benefits available to you and two different ways that you will need to enroll for coverage.

Pre-Medicare-eligible retirees and spouses/DPs will continue to be eligible for Scotts' two PPO medical plans and remain in the group plan until eligible for Medicare.

If you are a Medicare-eligible retiree or spouse/DP, enrollment for health care benefits will be through RightOpt. RightOpt Enrollment Advocates will provide personalized support to help with decisions during the Medicare enrollment period.

Terms to Know

Premium: the amount paid each month for your medical coverage.

Annual deductible: the amount you pay for some services before the plan begins to pay benefits. This does not apply to certain services such as in-network doctors' office visits, preventive care or prescription drugs.

Copayment (or copay): the flat amount you pay each time you receive certain in-network health care services or prescription drugs. This amount does not count toward your deductible.

Coinsurance: a percentage of a covered expense that you must pay after you satisfy the annual deductible.

Annual out-of-pocket maximum: the most you pay in deductibles, coinsurance and copayments during a calendar year.

Split family: a family in which some members are Medicare-eligible and some are not Medicare-eligible.

Make Sure Your Dependents Are Eligible

You can enroll your eligible spouse and dependents for coverage under a Scotts retiree medical plan. For benefits purposes, an eligible dependent includes:

- Your legally married spouse (as defined under federal law)
- Your domestic partner (who meets certain criteria and completes a domestic partner affidavit)
- Your eligible children up to age 26
- Your children for whom a court order for medical support (QMCSO) is issued
- Your eligible children of any age if they have a physical or mental disability that makes them dependent on you for support. The disability must have started before the child reached age 26

If you had an eligible dependent at the time you retired who you did not enroll, you can enroll him or her at a later date (one time only). If you want to add this dependent or delete a dependent who is no longer eligible, make this change by the deadline. **For 2023 Open Enrollment, the deadline is Wednesday, November 2, 2022. For new retirees, the deadline is provided on your personalized enrollment worksheet.** In addition, if you are already enrolled and have a new dependent as a result of marriage, birth, legal guardianship, adoption or placement for adoption, you are able to enroll your dependents. However, you must request enrollment within 31 days after the marriage or 60 days for birth, legal guardianship, adoption or placement for adoption.

It is your responsibility to understand the Company's definition of dependent eligibility and provide accurate information when enrolling for benefits. If you enroll dependents who are not eligible for Scotts benefit plans, you could be legally required to repay the Company any benefits you or your ineligible dependents received as a result of any intentional and material misrepresentations or inaccuracies.

Children are defined as your biological children, children under your legal guardianship, adopted children (including those placed for adoption), stepchildren, or grandchildren and foster children for whom you are a certified legal guardian.

Scotts Retiree Prescription Drug Coverage

When you enroll in a Scotts retiree medical plan, you automatically receive prescription drug coverage administered by CVS/caremark at no additional cost. Prescription drugs not on the CVS/caremark drug formulary (which is a list of preferred brand-name and generic medications) are also covered, but you will have to pay more.

If You Purchase:	Through a Retail Pharmacy (up to a 30-Day Supply) Your Costs Are:	Mail-Order Service (up to a 90–Day Supply) Your Costs Are:
Tier 1: Generic Drugs	$10 copayment	$25 copayment
Tier 2: Brand-name Drugs on Formulary	25% coinsurance ($20 min/$80 max)	25% coinsurance ($50 min/$200 max)
Tier 3: Brand-name Drugs not on Formulary	40% coinsurance ($40 min/$100 max)	40% coinsurance ($100 min/$250 max)

You have two convenient ways to get your prescriptions filled, and three drug copayment levels:

Two Convenient Ways to Fill Prescriptions

- **Filling prescriptions at the pharmacy:** You can fill your short-term prescriptions at participating network pharmacies, including most major chains. You pay the applicable copayment or coinsurance for up to a 30-day supply of your covered drug. (Remember: you pay less for generic drugs than for brand-name drugs)
- **Filling prescriptions through the mail:** If you take maintenance drugs (medication taken on a regular basis for chronic conditions such as high blood pressure, arthritis, diabetes or asthma), you can get up to a 90-day supply through the prescription drug mail-order service. In addition to the convenience of having your prescriptions mailed to you, it costs you less because you pay only one copayment or coinsurance amount for up to the 90-day supply. See page 12 for details

Things to Consider

- Always discuss your prescriptions with your doctor. If a generic drug is not an option, ask your doctor if more than one drug can treat your condition and if one is less expensive. Be sure the prescription drug is on CVS/caremark's formulary list to avoid a higher coinsurance cost
- If you take medication on a regular basis for a chronic condition, save money by ordering it through the mail-order service

Looking for a Network Pharmacy?

To locate a network pharmacy, visit **livetotalhealth.com** or call the Scotts Benefits Service Center at **1-888-918-5878.**

Mail–Order Prescription

The first time you use the mail-order service for a maintenance prescription drug, you need to:

1. Complete the Prescription Mail-Order Form included in your enrollment packet. Forms can also be found on **livetotalhealth.com**

2. Provide a prescription from your doctor. Even if your current prescription has refills remaining, you must obtain a new prescription from your doctor

3. Send a completed Prescription Mail-Order Form and a new prescription to:

Walgreens Pharmacy
Scotts Wellness Center
14210 Scottslawn Road
Marysville, OH 43041

4. Once you have placed this initial order, you have three ways to refill your prescription:

- Complete a Prescription Mail-Order Form and send it to the address above
- Call Walgreens at **1-877-2SCOTTS** (1-877-272-6887), Monday through Friday, 7:30 a.m. to 5:30 p.m. Eastern Time
- Go to **walgreens.com** (available 24 hours a day, seven days a week)

What if My Prescription Is Not on the Formulary?

If a medication is selected that is not on the formulary, you will be responsible for the applicable higher coinsurance amount. (Please talk with your doctor about prescribing a generic or a brand-name medication on the drug formulary.) Prescription drugs included in the formulary are typically less expensive and equally as effective as non-formulary drugs. Some medications may require prior authorization for medical necessity to be covered on the formulary.

Drug Coverage Management Programs

The plan utilizes coverage management programs to help control rising drug costs and provide you with the coverage you need. Coverage management determines how your prescription drug plan will cover certain medications. Each program is administered by CVS/caremark.

Some medications are not covered unless you receive pre-approval or prior authorization. Even if you are currently taking one of those medications when you join the Plan, you will still be required to satisfy the requirements below. Coverage management programs make use of three authorization processes — prior authorization, step therapy programs and quantity limits. Medications may fall under one or more programs.

Prior Authorization

Prior authorization requires that you obtain pre-approval through a coverage review. The review will determine whether your plan covers your prescribed medication based on a confidential, clinical review to determine whether coverage is appropriate. This review is based on clinical guidelines for best medical practices. Below are examples of common conditions/medications that may require pre-approval. (Please note that this list is not all inclusive.)

- ADHD
- Narcolepsy
- Anabolic Steroids
- Androgens (e.g., Androderm, Androgel, etc.)
- Topical Acne Medications (e.g., Retin-A, Differin, Tazorac)

Step Therapy and Generic Step Therapy

Step therapy requires you to try a lower-cost medication before a higher-cost medication to help lower your out-of-pocket prescription costs. Generic step therapy requires first-line therapy failure before second- and third-line therapies are covered. If your doctor deems the generic drug ineffective, your doctor must submit a request for prior authorization to receive approval for the brand-name drug to be covered.

Quantity Limitations

For some medications, your plan may cover a limited quantity within a specified period of time. A coverage review may be necessary to have additional quantities of these medications covered by your plan.

Medical Plan Premiums

The rates on your worksheet reflect your share of the cost of coverage, which depends on your years of service at retirement. If you receive a pension benefit, your premiums may be deducted from it.

If your pension benefit is not large enough to cover your premiums, you must send a check made out to **The Scotts Company LLC** and mail it to:

The Scotts Company LLC Pension
and Retiree Medical Service Center
ATTN: Barbara Couture
100 Salem Street: O3N
Smithfield, RI 02917

To avoid cancellation of your retiree medical coverage, you must mail your payment by the 5th of each month. For those sending in payments, you may pay your premiums monthly, quarterly, semi-annually or annually.

For more information about your premiums, contact the Scotts Benefits Service Center at **1-888-918-5878**.

Benefits Contacts

If you have questions or issues related to your 2023 benefits, call **1-888-918-5878**.

For information about your pension, direct billing inquiries or address changes, call The Scotts Company LLC Pension and Retiree Medical Service Center at **1-888-763-1453**.

For information or if you have questions about the Medicare-eligible plan, call RightOpt at **1-866-978-9402**.

Frequently Asked Questions

Will I receive a confirmation in the mail?
Yes, you will receive a confirmation statement in November.

I have an address change. Who do I contact?
For changes to your address, contact The Scotts Company LLC Pension and Retiree Medical Service Center at **1-888-763-1453**.

Who should I contact if I need to update my direct deposit or change my tax withholding status?
For questions about your direct deposit or tax withholding status, contact The Scotts Company LLC Pension and Retiree Medical Service Center at **1-888-763-1453**.

Who should I contact if I have questions about Medicare or Medicare enrollment?
For questions specifically related to Medicare or Medicare enrollment, please contact the Social Security Administration at **1-800-772-1213**.

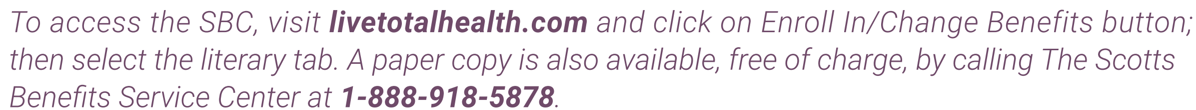
What happens if my spouse/DP or I turn age 65 during the year?
You and your spouse/DP may continue to receive coverage through the Scotts Retiree Medical Plan until each of you becomes Medicare-eligible. When you become Medicare-eligible, RightOpt will help you select coverage on the RightOpt retiree health insurance exchange marketplace. RightOpt will contact you three months before becoming Medicare-eligible with more details about how they will work with you. For example, if you become Medicare-eligible before your spouse/DP, you will transition to RightOpt. Your spouse/DP will stay on the Scotts Retiree Medical Plan until he or she becomes Medicare-eligible.

Do I have to follow the Step Therapy Program?
In order to receive coverage for second- and third-line therapies, you must follow the Step Therapy Program. This means you must try a lower cost medication before any higher cost medication and if it does not work, your doctor must submit a request for prior authorization to receive approval for any brand name drugs to be covered.

A Final Word

This Guide provides a summary of the benefits program Scotts makes available to eligible retirees (and, as applicable, their eligible dependents) as of January 1, 2023. The respective plan document will provide more information about these benefits. If there is ever a conflict between the information provided in this Guide and the plan document, the plan document will govern. Nothing in this Guide should be construed as a contract or offer to contract for employment for any specific time or under any particular terms and conditions. While it is the Company's intent to continue this program, we reserve the right to amend or terminate it at any time for any reason.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.



*To access the SBC, visit **livetotalhealth.com** and click on Enroll In/Change Benefits button; then select the literary tab. A paper copy is also available, free of charge, by calling The Scotts Benefits Service Center at **1-888-918-5878**.*