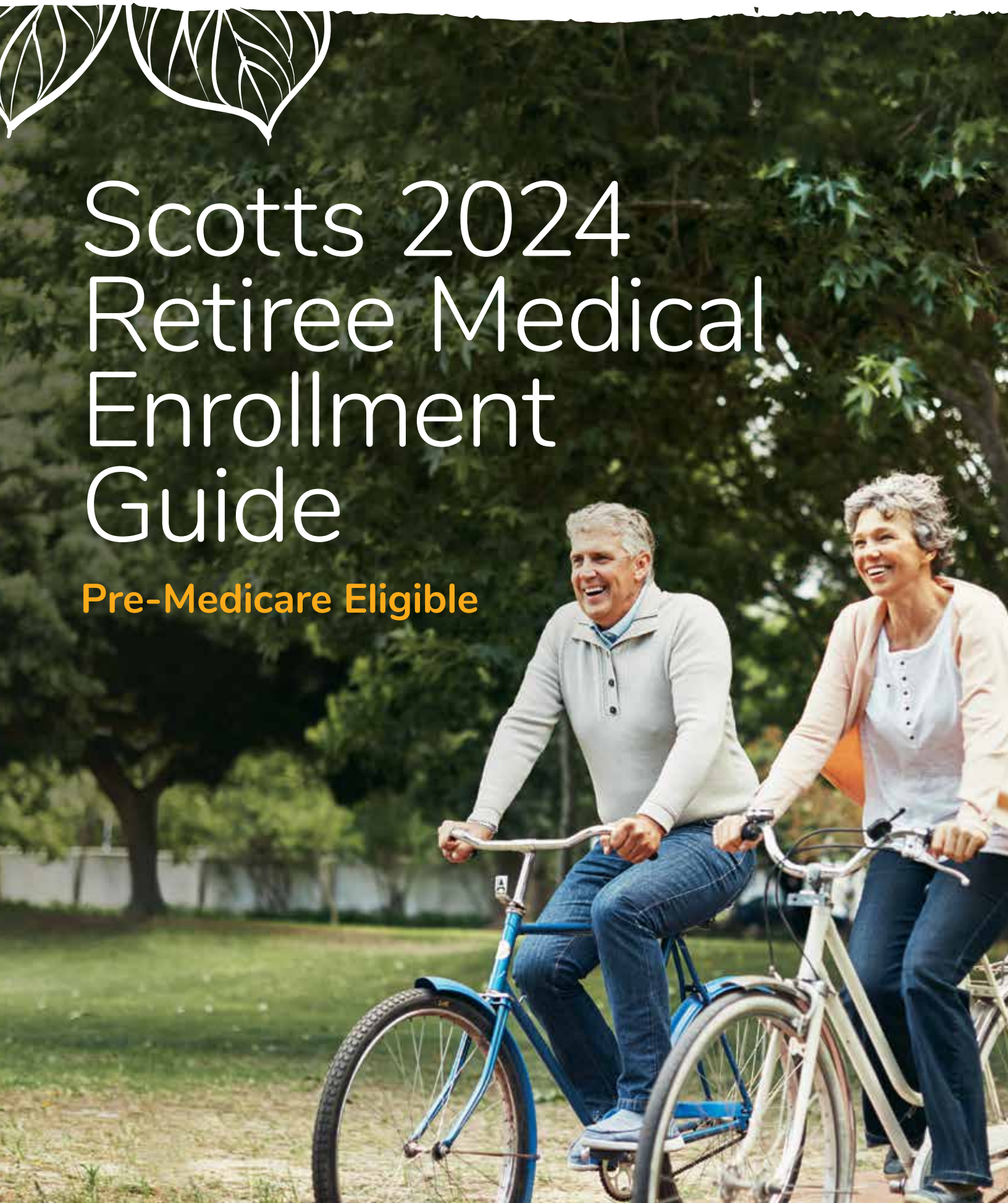
Scotts Miracle-Gro



Scotts 2024 Retiree Medical Enrollment Guide

Pre-Medicare Eligible

Inside This Guide

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.

What's the Deadline to Enroll or Make Changes?

Take action by November 1, 2023, if you have updates to your information or you want to make changes to your coverage. Changes will be effective January 1, 2024.

If you don't want to make changes, no action is required. Your 2023 coverage will continue for 2024 with 2024 premiums. Refer to your personalized enrollment worksheet for more details.

If you are a new retiree, you must enroll by the deadline shown on your personalized enrollment worksheet.

How to Enroll

There are two ways you can enroll:

1

Online

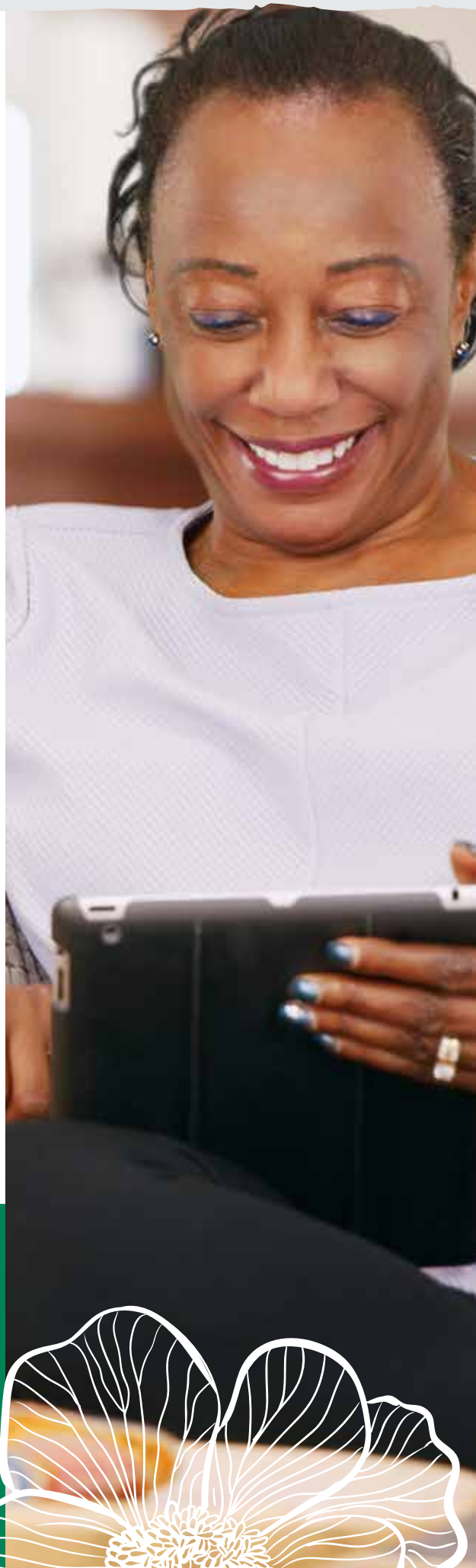
Go to **livetotalhealth.com** and click on the *Enroll In / Change Benefits* button.

Click on the link in the main teal tile on the homepage to enroll in your 2024 benefits.

2

By phone

Call the Scotts Benefits Service Center at **1-888-918-5878**, Monday–Friday from 8 a.m.–8 p.m. ET during Open Enrollment, and Monday–Friday from 8 a.m.–6 p.m. after Open Enrollment.



Managing Your Benefits

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

Scotts Retiree Medical Options

As a pre-Medicare-eligible Scotts retiree, you can choose between two plans:

- **Basic PPO Plan**
- **Premium PPO Plan**

Both 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

Both PPO plans also offer coverage for out-of-network care (but you save money when you stay in the network).

What's different between the two plans?

The **Basic PPO** has lower premiums but a higher deductible and coinsurance.

The **Premium PPO** has higher premiums but a lower deductible and coinsurance.

Understanding Copayments, Coinsurance, Deductibles, and Out-of-Pocket Maximums

When you seek medical care for covered services, what you pay depends on the service received. Remember, in-network preventive care is always no cost to you.

1

For some services, you pay the full cost until you meet your **annual deductible** — the amount you pay before the plan begins to pay benefits. Once you satisfy the deductible, you pay **coinsurance** (a percentage of the cost) until you reach the **annual out-of-pocket maximum**. The out-of-pocket maximum is most you pay in deductibles, coinsurance, and copayments during a calendar year.

Examples: hospital services and surgeries

2

For some services, you pay a **copayment** (a flat amount) then the plan covers the rest of the amount at 100%. Copayments or "copays" do not count toward your annual deductible.

Examples: in-network office visits, urgent care, and generic prescription drugs

Refer to the comparison charts on the following pages for details.

Medical Plan Comparison

Services	Basic PPO Plan		Premium PPO Plan	
	Your In-Network Costs	Your Out-of-Network Costs	Your In-Network Costs	Your Out-of-Network Costs
Annual Deductible				
• Individual	• $1,250	• $3,000	• $750	• $1,500
• Family	• $2,500	• $6,000	• $1,500	• $3,500
Annual Medical Out-of-Pocket Maximum				
• Individual	• $5,000	• $10,000	• $3,500	• $7,000
• Family	• $10,000	• $20,000	• $7,000	• $14,000
Physician Office Visits				
• Primary Care Physician	• $30 copay	• 40% after deductible	• $30 copay	• 30% after deductible
• Specialist	• $60 copay	• 40% after deductible	• $60 copay	• 30% after deductible
Preventive Care				
• Physical Exams	• No charge	• 40% after deductible	• No charge	• 30% after deductible
• Well-Child Care and Immunizations	• No charge	• 40% after deductible	• No charge	• 30% after deductible
• Preventive Screenings (Pap tests, mammograms, PSA, colorectal exams, etc.)	• No charge	• 40% after deductible	• No charge	• 30% after deductible
Allergy Testing and Injection	20% after deductible	40% after deductible	10% after deductible	30% after deductible
Hospital Services				
• Inpatient (IP)	• 20% after deductible	• 40% after deductible	• 10% after deductible	• 30% after deductible
• Outpatient (OP)	• 20% after deductible	• 40% after deductible	• 10% 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

Services	Basic PPO Plan		Premium PPO Plan	
	Your In-Network Costs	**Your Out-of-Network Costs**	**Your In-Network Costs**	**Your Out-of-Network Costs**
Maternity Care •Prenatal	•1st visit: $30 copy, 20% after deductible thereafter	•40% after deductible	•1st visit: $30 copy, 10% after deductible thereafter	•30% after deductible
•Postnatal	•Same as prenatal	•40% after deductible	•Same as prenatal	•30% after deductible
•Hospital Delivery	•20% after deductible	•40% after deductible	•10% 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

Medical Plan Comparison (Continued)

Services	Basic PPO Plan		Premium PPO Plan	
	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 (standard transplants covered: kidney, pancreas, kidney/pancreas, liver, heart, lung, heart/lung, small bowel or 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[1] **Med:** $20,000 **Rx:** $10,000 • 20% after deductible	Comprehensive infertility treatment covered (artificial insemination, GIFT, ZIFT, IVF, elective egg freezing). • Lifetime maximum[1] **Med:** $20,000 **Rx:** $10,000 • 40% after deductible	Comprehensive infertility treatment covered (artificial insemination, GIFT, ZIFT, IVF, elective egg freezing). • Lifetime maximum[1] **Med:** $20,000 **Rx:** $10,000 • 10% after deductible	Comprehensive infertility treatment covered (artificial insemination, GIFT, ZIFT, IVF, elective egg freezing). • Lifetime maximum[1] **Med:** $20,000 **Rx:** $10,000 • 30% after deductible
Sterilization • Women • Men	• No charge • 20% after deductible	• 40% after deductible • 40% after deductible	• No charge • 10% after deductible	• 30% after deductible • 30% after deductible

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

Services	Basic PPO Plan		Premium PPO Plan	
	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 homepage, click on the **Health Tools** tile.
- Then, click the **Get Help** button next to the **Need help finding a Doctor?** option.

You can search providers by plan name, ZIP code, specialty area, and more.

Dependent Eligibility

What if My Spouse/DP is Medicare Eligible?

If you are not Medicare eligible but have a Medicare eligible spouse/DP, this situation (or 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 **LIG Solutions**, a Gallagher company. LIG Solutions Health Insurance Advisors provide personalized support to help with decisions during the Medicare enrollment period.

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 them 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.

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.

Scotts Retiree Prescription Drug Coverage

When you enroll in a Scotts retiree medical plan, you automatically receive prescription drug coverage administered by CVS/Caremark.

If You Purchase:	**Through a Retail Pharmacy** (up to a 30-day supply)	**CVS/Caremark 90-Day Rx** (Rx delivery by mail or pharmacy pickup)
	Your Costs	**Your Costs**
Tier 1: Generic Drugs	$10 copayment	$25 copayment
Tier 2: Brand-Name Drugs on Formulary	25% coinsurance ($20 min/$100 max)	25% coinsurance ($50 min/$250 max)
Tier 3: Brand-Name Drugs not on Formulary	40% coinsurance ($40 min/$150 max)	40% coinsurance ($100 min/$375 max)

Specialty drugs: Benefits will be based on the drug classification listed above. Specialty drugs are limited to a 30-day supply and are dispensed exclusively through Caremark specialty pharmacy.

What if My Prescription Is Not on the Formulary?

A **formulary** is a list of preferred brand-name and generic medications.

If you need or choose a medication that is not on the CVS/Caremark drug formulary, they are covered, but 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.

Scotts Retiree Prescription Drug Coverage (Continued)

Two Ways to Get Your Prescriptions Filled

- **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. Remember, you pay less for generic drugs than for brand-name drugs.
- **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 overall for the 90-day supply.

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.

Save With 90-Day Supplies

When you fill medications you take regularly (like medication for asthma or high blood pressure) in 90-day supplies at a CVS Pharmacy® or through the CVS Caremark® Mail Service Pharmacy, you'll save money.

CVS Pharmacy

To transfer your prescription:

1. Visit **caremark.com/movemymeds**.
2. On the Move My Meds page, select which prescriptions you'd like to fill at your preferred CVS Pharmacy location.
3. A member of our pharmacy team may contact you if they have questions.

CVS Caremark Mail Service Pharmacy

To start receiving 90-day supplies through the mail, simply visit **caremark.com/mailservice**.

Looking for a Network Pharmacy?

Call Quantum Health at **1-877-324-3136**.

Drug Coverage Management Programs

Your 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 enroll in coverage, 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 that you 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 and Payments

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
900 Salem Street
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, semiannually, or annually.

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

Contacts

If you have questions or issues related to your 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**.

If you have questions about the Medicare-eligible plan, call LIG Solutions at **1-855-653-2364**.

Frequently Asked Questions

1

Will I receive a confirmation in the mail?

Yes, you will be mailed a confirmation statement in November.

2

Who should I contact if I have an address change?

For changes to your address, contact The Scotts Company LLC Pension and Retiree Medical Service Center at **1-888-763-1453**.

3

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**.

4

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**.

5

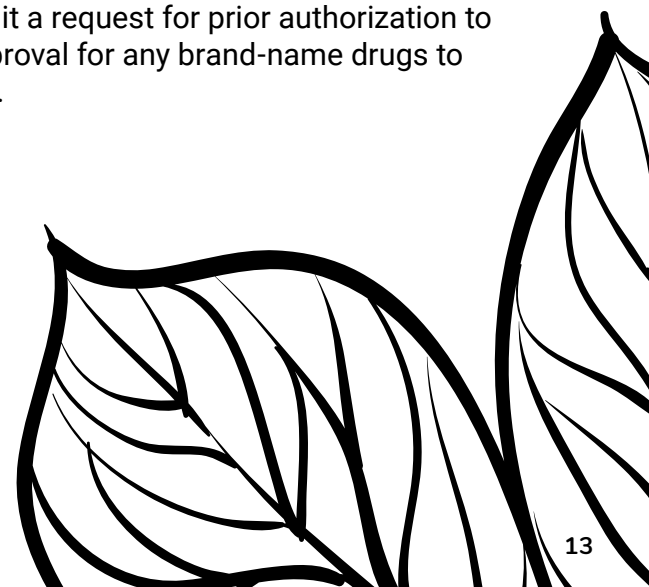
What happens if my spouse/DP or I turn age 65 during the year?

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, LIG Solutions will help you select coverage on the LIG Solutions retiree health insurance exchange marketplace. LIG Solutions 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 LIG Solutions. Your spouse/DP will stay on the Scotts Retiree Medical Plan until they become Medicare eligible.

6

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.



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, 2024. 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 the *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**.