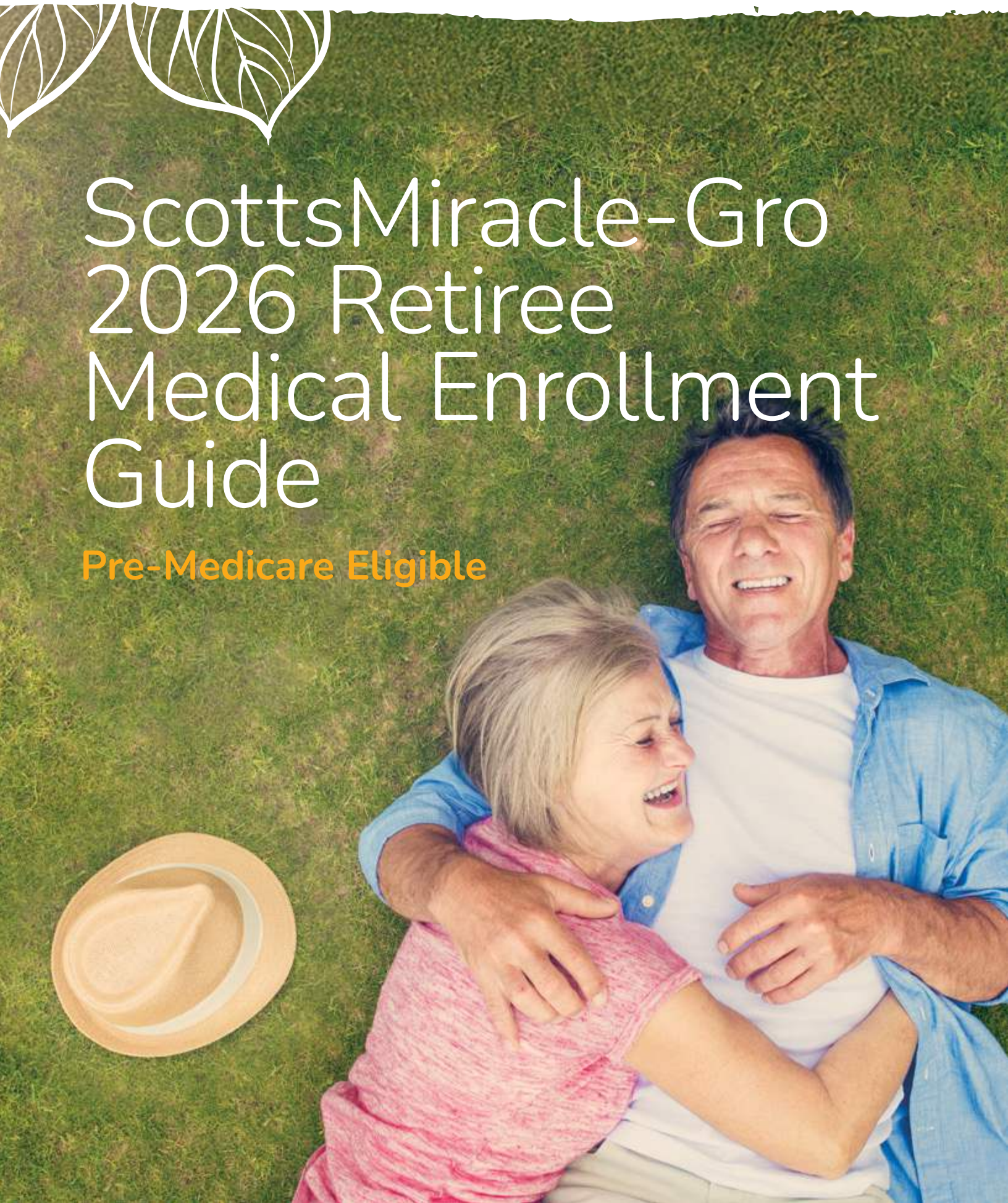
Scotts Miracle-Gro

ScottsMiracle-Gro 2026 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.

How to Enroll	2
ScottsMiracle-Gro Retiree Medical Options	3
Medical Plan Comparison	4
Dependent Eligibility	8
ScottsMiracle-Gro Retiree Prescription Drug Coverage	9
Medical Plan Premiums and Payments	12
Contacts	12
Frequently Asked Questions	13

What's the Deadline to Enroll or Make Changes?

Take action by November 5, 2025, if you have updates to your information or you want to make changes to your coverage. Changes will be effective January 1, 2026.

If you don't want to make changes, no action is required. Your 2025 coverage will continue for 2026 with 2026 premiums. Refer to this Guide and the cover letter for plan details and costs.

If you are currently enrolled in the Premium PPO Plan and don't make any changes during enrollment, you'll be automatically moved to the Anthem Traditional PPO Plan.

How to Enroll

There are two ways you can enroll:

1

Online

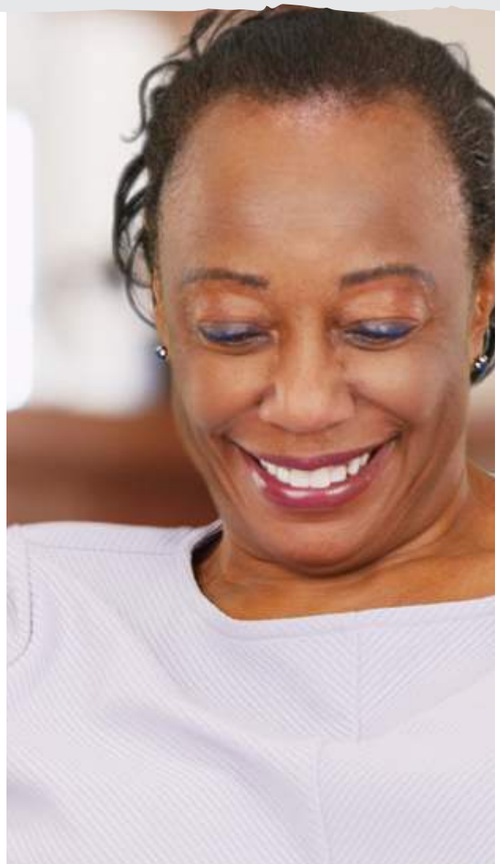
Go to **livetotalhealth.com** and click on the *Enroll In / Change Benefits* button.

Click on the link in the main teal tile on the homepage to enroll in your 2026 benefits.

2

By phone

Call the ScottsMiracle-Gro 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.

ScottsMiracle-Gro Retiree Medical Options

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

- **Anthem Traditional PPO Plan**
- New this year: **Surest Copay 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?

Copays for care: Both the **Anthem Traditional PPO Plan** and **Surest Copay Plan** offer copays for doctor visits, prescriptions and other certain services.

Preventive care: Both cover in-network preventive care at 100% (no copay or deductible).

Cost protection: Once you reach your out-of-pocket maximum, the plan pays 100% of eligible in-network expenses for the rest of the year.

What's different between the two plans?

Deductible: Anthem Traditional PPO Plan has a deductible for some services (like hospital care). Surest Copay Plan has **no deductible**.

Cost sharing: Anthem Traditional PPO Plan uses cost sharing after the deductible. Surest Copay Plan uses **copays only**, even for hospital care.

Upfront pricing: Surest Copay Plan shows what you'll pay before care and has no surprise bills.

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 the most you pay in deductibles, coinsurance and copayments during a calendar year.

Examples: hospital services and surgeries

2

For some services, you pay a **copay** (a flat amount) then the plan covers the rest of the amount at 100%. 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	Anthem Traditional PPO Your In-Network Costs	Surest Copay Plan Your In-Network Costs
Annual Deductible •Individual •Family	 •$1,250 •$2,500	 •$0 •$0
Annual Medical Out-of-Pocket Maximum •Individual •Family	 •$5,000 •$10,000	 •$5,500 •$11,000
Physician Office Visits •Primary Care Physician •Specialist	 •$30 copay •$60 copay	 •$25 to $130 copay •$25 to $130 copay
Preventive Care •Physical Exams •Well-Child Care and Immunizations •Preventive Screenings (Pap tests, mammograms, PSA, colorectal exams, etc.)	 •No charge •No charge •No charge	 •No charge •No charge •No charge
Allergy Testing and Injection	20% after deductible	$50 to $3,100
Hospital Services •Inpatient (IP) •Outpatient (OP)	 •20% after deductible •20% after deductible	 •$400 to $3,500 •$400 to $3,500
Outpatient Surgery (In doctor's office, surgery center, outpatient facility)	20% after deductible	$40 to $3,500

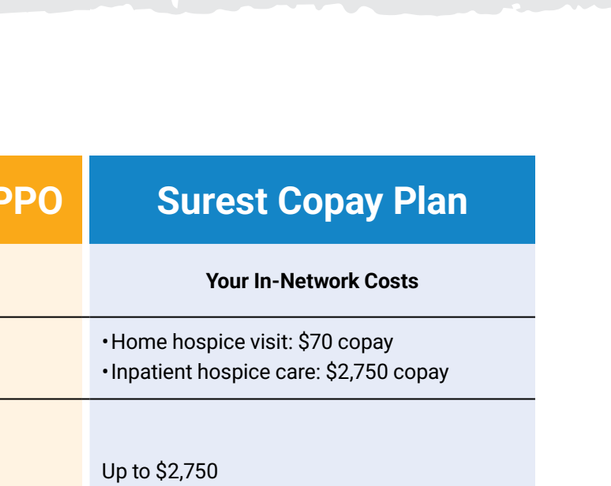
Services	Anthem Traditional PPO Your In-Network Costs	Surest Copay Plan Your In-Network Costs
Maternity Care •Prenatal •Postnatal •Hospital Delivery	 •1st visit: $30 copay, 20% after deductible thereafter •Same as prenatal •20% after deductible	 •No charge •No charge •$1,300 to $2,750
Emergency Room[1] (covered for emergency medical conditions only, as determined true emergencies)	$150 copay plus 20% after deductible	$900
Ambulance Service (when medically necessary)	20% after deductible	$500
Urgent Care	$75 copay	$80 copay
Diagnostic Services (X-ray/lab)	20% after deductible	No charge
Short-Term Rehabilitation Therapy (physical, speech or occupational therapy)	$30 copay	$15 to $130 copay 60 visit limit per person per plan year, not combined with other therapies
Spinal Manipulation and Chiropractic	$30 copay	$30 60 visit limit per person per plan year, not combined with other therapies
Weight Loss Treatment (surgery for morbid obesity only)	20% after deductible	Not covered
TMJ Treatment	Not covered	Not covered

[1] Emergency room copays are waived if admitted.

Medical Plan Comparison (Continued)

Services	Anthem Traditional PPO Your In-Network Costs	Surest Copay Plan Your In-Network Costs
Accident-Related Dental	20% after deductible	Up to $2,750
Durable Medical Equipment and Prosthetics (Including breast prosthetics)	20% after deductible	Up to $1,000
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-certification required • Travel and lodging covered for patient and one companion (up to plan limits)	• Pre-certification required • Up to $5,500
Sterilization • Women • Men	• No charge • 20% after deductible	Up to $5,500
Skilled Nursing Facility Care (for convalescence from illness or injury)	20% after deductible	$2,000 copay
Home Health Care (**Note:** Private duty nursing is covered only when rendered by a home health care agency)	20% after deductible	$70 copay
Hospice Care	20% after deductible	• Home hospice visit: $70 copay • Inpatient hospice care: $2,750 copay
Chemotherapy, Radiation Therapy, Dialysis Treatment	20% after deductible	Up to $2,750
Mental Health and Substance Abuse • Inpatient • Outpatient	• 20% after deductible • $30 copay	• $2,000 • Up to $130

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



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 two medical plans at ScottsMiracle-Gro 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 **Gallagher Alternative Health Solutions**. Gallagher 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/DP and dependents for coverage under a ScottsMiracle-Gro retiree medical plan. For benefits purposes, an eligible dependent includes:

- Your legally married spouse (as defined under federal law)
- Your same or opposite gender 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 after the 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 ScottsMiracle-Gro 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.

ScottsMiracle-Gro Retiree Prescription Drug Coverage

When you enroll in a ScottsMiracle-Gro 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	$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, it is 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 nonformulary drugs. Some medications may require prior authorization for medical necessity to be covered on the formulary.

ScottsMiracle-Gro 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.

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 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**.

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.

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 preapproval 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 preapproval 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 preapproval. (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 Pension
and Retiree Medical Service Center
ATTN: Barbara Couture
900 Salem Street, OTGW3
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 ScottsMiracle-Gro 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 Gallagher Alternative Health 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 ScottsMiracle-Gro Retiree Medical Plan until each of you becomes Medicare eligible. When you become Medicare eligible, Gallagher Alternative Health Solutions will help you select coverage on the Gallagher retiree health insurance exchange marketplace. Gallagher 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 Gallagher. Your spouse/DP will stay on the ScottsMiracle-Gro 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 ScottsMiracle-Gro makes available to eligible retirees (and, as applicable, their eligible dependents) as of January 1, 2026. 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**.