

**The Scotts Company
2026 Health Plan Disclosures
And Required Notifications**

PREPARED OCTOBER 2025

The Scotts Company

Summary of Employer and Group Health Plan Notices and Disclosures under the Patient Protection and Affordable Care Act

October 2025

The Scotts Company is required to provide the following disclosures to associates for the 2026 plan year (January 1 through December 31, 2026).

Questions

For more information on these disclosures, contact the Scotts Benefits Service Center at 888-918-5878 or on the *LiveTotal Health* page on The Garden from your work computer or at thegarden.myscotts.com.

The Scotts Company
Premium Assistance Under Medicaid and the Children’s Health Insurance Program
(CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health Insurance Premium Payment(HIPP)Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 / Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ARKANSAS – Medicaid	Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	

FLORIDA – Medicaid	Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp.index.html Phone: 1-877-357-3268	
GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chirpa Phone: 678-564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 / TTY: 711 Email: masspremassistance@accenture.com
	MINNESOTA – Medicaid
	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
INDIANA – Medicaid	MISSOURI – Medicaid
Health Insurance Premium Payment Program All other Medicaid Website: http://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone 1-800-403-0864 / Member Services 1-800-457-4584	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPProgram@mt.gov
	NEBRASKA – Medicaid
	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KANSAS – Medicaid	NEVADA – Medicaid
Website: https://www.Kancare.ks.gov/ Phone: 1-800-792-4884 / HIPP Phone: 1-800-967-4660	Medicaid Website: http://dhcfp.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIP.PPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 HIPP: 1-800-852-3345, ext 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
	NEW JERSEY – Medicaid and CHIP
	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Medicaid hotline: 1-888-342-6207 LaHipp: 1-855-618-5488	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s?language=en_US	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid	UTAH – Medicaid and CHIP
Website: http://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: http://health.utah.gov/chip
OKLAHOMA – Medicaid and CHIP	
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	
OREGON – Medicaid and CHIP	VERMONT– Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 Chip Website: www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 1-800-986-KIDS (5437)	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
	WASHINGTON – Medicaid
	Website: http://www.hca.wa.gov/ Phone: 1-800-562-3022
RHODE ISLAND – Medicaid and CHIP	WEST VIRGINIA – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://dhhr.wv.gov.bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP(1-855-699-8447)
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH DAKOTA - Medicaid	WYOMING – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269
TEXAS – Medicaid	
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493	

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

The Scotts Company
Women's Health and Cancer Rights Act (WHCRA) Enrollment and Annual Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductible and coinsurance apply:

Deductible:

HSA Advantage Plan -

In-network: \$1,750 single / \$3,500 family,

Out-of-network: \$4,500 single / \$9,000 family.

Surest Copay Plan –

In-network: \$0 single / \$0 family,

Out-of-network: \$0 single / \$0 family.

Traditional PPO Plan –

In-network: \$1,250 single / \$2,500 family,

Out-of-network: \$3,000 single / \$6,000 family.

Coinsurance:

HSA Advantage Plan – In-network: 80%, out-of-network: 60%

Surest Copay Plan – Copays start at \$25 for doctors visit, around \$80 for urgent care,

\$900 for emergency room, \$2,750 for inpatient hospitalization and up to \$3,500 for a major procedure.

Traditional PPO Plan – In-network: 80%, out-of-network: 60%,

If you would like more information on WHCRA benefits, call Scotts Benefits Service Center at 888-918-5878.

The Scotts Company LLC Total Family Protection Plan

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

(This Notice only Pertains to those Benefits under the Plan that are Covered under the Health Insurance Portability And Accountability Act of 1996.)

As we work every day to operate your health plan, protecting the confidentiality of your personal medical information has always been an important priority. The Scotts Company LLC Total Family Protection Plan (the “Plan”) has adopted policies to safeguard the privacy of your medical information and comply with federal law (specifically, the Health Insurance Portability and Accountability Act, known as “HIPAA”).

Note: “We” refers to The Scotts Company LLC Total Family Protection Plan. “You” or “yours” refers to the individual participants in the Plan. If you are covered by an insured health option under the Plan, you may have or will also receive a separate notice from your insurer or HMO.

This Notice explains:

- How your personal medical information may be used, and
- What rights you have regarding this information.

The Plan is required to provide you with this Notice regarding your rights and our policies and procedures regarding your individually identifiable health information (referred to in this Notice as “Protected Health Information” or “PHI”), and to abide by the terms of this Notice, as it may be updated from time to time. The Plan is also required to notify you following a breach of unsecured PHI.

Federal law requires that the Plan protect the privacy of your PHI, as it relates to your health, health care or payment for your healthcare.

By law, all of the carriers/administrators must adhere to strict privacy rules and have signed agreements with us agreeing to do so.

How The Plan May Use Your Information

In order to manage your health plans effectively, we are permitted by law to use and disclose your PHI in certain ways without your authorization:

For Treatment. So that you receive appropriate treatment and care, providers may use your PHI to coordinate or manage your health care services. The Plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to

provide your medical history as the result of an accident, the Plan may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment. To make sure that claims are paid accurately and you receive the correct benefits, we may use and disclose your PHI to determine Plan eligibility and responsibility for coverage and benefits. For example, we may use your information when we confer with other health plans to resolve a coordination of benefits issue. We may also use your PHI for utilization review activities.

For Health Care Operations. To ensure quality and efficient Plan operations, we may use your PHI in several ways, including plan administration, quality assessment and improvement, and vendor review. Your information could be used, for example, to assist in the evaluation of a vendor who supports us. We also may contact you with appointment reminders or to provide information about treatment alternatives or other health-related benefits and services available under the Plan.

We may also disclose your PHI to The Scotts Company (the Plan sponsor) in connection with these activities. If you are covered under an insured health plan or HMO, the insurer also may disclose PHI to the Plan sponsor in connection with payment, treatment or health care operations.

The Plan is prohibited from using or disclosing genetic information for underwriting purposes, and will not use or disclose any of your PHI which contains genetic information for underwriting purposes.

Other Permitted Uses and Disclosures

Federal regulations allow us to use and disclose your PHI, without your authorization, for several additional purposes, in accordance with law:

- To our Business Associates (vendors)
- Public health
- Reporting and notification of abuse, neglect or domestic violence
- Oversight activities of a health oversight agency
- Judicial and administrative proceedings
- Law enforcement
- Research, as long as certain privacy-related standards are satisfied
- To a coroner or medical examiner
- To organ, eye or tissue donation programs

- To avert a serious threat to health or safety
- Specialized government functions (e.g., military and veterans' activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations)
- Workers' compensation or similar programs established by law that provide benefits for work-related injuries or illness
- Other purposes required by law, provided that the use or disclosure is limited to the relevant requirements of such law.

In Special Situations...

We may disclose your PHI to a family member, relative, close personal friend, or any other person whom you identify, when that information is directly relevant to the person's involvement with your care or payment related to your care.

We also may use your PHI to notify a family member, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition, or death. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to agree to or object to this use or disclosure, we will do what in our judgment is in your best interest regarding such disclosure and will disclose only information that is directly relevant to the person's involvement with your health care.

Certain uses and disclosures of PHI require your authorization, such as any use or disclosure of psychotherapy notes, the use or disclosure of PHI for marketing purposes, and the sale of PHI.

Generally, the Plan may only use or disclose the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

The Plan also may be subject to state and local health information privacy laws that are more stringent than the federal requirements.

The Plan may disclose information to its vendors who agree in writing to protect the privacy of your information. The Plans do not disclose PHI to the Plan sponsor, your employer, except as permitted by law and the Plan rules.

We will make other uses and disclosures only after you authorize them in writing. You may revoke your authorization in writing at any time, except to the extent that we have already taken action in reliance on the authorization.

Your Rights Regarding PHI

You have the right to:

- Inspect and copy your PHI
- Amend or correct inaccurate information

- Receive a paper copy of this Notice, even if you agreed to receive it electronically
- Receive an accounting of certain disclosures of your information made by us
 - However, you are not entitled to an accounting of several types of disclosures including, but not limited to:
 - Disclosures made for payment, treatment or health care operations
 - Disclosures you authorized in writing
 - Disclosures made before April 14, 2003.
- You have the right to receive an accounting of disclosures of your PHI through an electronic health record by the Plan to carry out treatment, payment and health care operations during the three (3) years prior to your request. This right applies to:
 - For electronic health records acquired by the Plan as of January 1, 2009 – disclosures made on or after January 1, 2014, and
 - For electronic health records acquired by the Plan after January 1, 2009 – disclosures made after the later of January 1, 2011 or the date the Plans acquire the electronic health record.

Right to Request Restrictions

You may ask us to restrict how we use and disclose your PHI as we carry out payment, treatment, or health care operations. You may also ask us to restrict disclosures to your family members, relatives, friends, or other persons you identify who are involved in your care or payment for your care. However, we are not required to agree to these requests.

Notwithstanding our right to otherwise not agree to your request to restrict disclosures of your PHI, we will comply with the requested restriction if:

- Except as otherwise required by law, the disclosure is to a health plan for the purposes of carrying out payment or health care operations (and not for the purposes of carrying out treatment), and
- The PHI pertains solely to a health care item or service for which the health care provider has been paid out of pocket in full.

Right to Request Confidential Communications

You may request to receive your PHI by alternative means or at an alternative location if you reasonably believe that other disclosure could pose a danger to you. For example, you may only want to have information sent by mail or to an address other than your home. *For more information about exercising these rights, contact the office below.*

Complaints

If you believe that your privacy rights have been violated, or that the privacy or security of your unsecured PHI has been compromised, you may file a written complaint without fear of reprisal. Direct your complaint to the Plan Administrator at the address listed below under “Contacting

Us” or to the appropriate regional office of the Office of Civil Rights, U.S. Department of Health and Human Services or at their website at www.hhs.gov/ocr/privacy/hipaa/complaints/index.html. You will not be retaliated against for filing a complaint.

About This Notice

We are required by law to maintain the privacy of your PHI, to provide you with a copy of this Notice regarding our legal duties and privacy practices with respect to PHI, and to notify you following a breach of your unsecured PHI. We reserve the right to change the terms of this Notice and to make the new notice provisions effective for all PHI we maintain. If we change this Notice, you will receive a copy of the new Notice from the Plans. A copy of the current Notice will be posted in Scotts’ Benefits Department at all times.

Contacting Us

You may exercise the rights described in this Notice by contacting the Scotts office identified below, which will provide you with additional information. The contact is:

The Scotts Company
Benefits Department
Attn: HIPAA Privacy Officer
14111 Scottslawn Road
Marysville, OH 43041
Telephone: 937-644-0011

Effective date of notice: September 26, 2025

**Important Notice from The Scotts Company LLC
About Your Prescription Drug Coverage and Medicare
2026 Plan Year**

Please read this notice carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage with The Scotts Company LLC (the “Company”) and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- 2. The Scotts Company LLC has determined that the prescription drug coverage offered by the Scotts Company medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Scotts Company coverage will not be affected. The Scotts Company coverage will be treated as the primary coverage and Medicare will be secondary.

If you do decide to join a Medicare drug plan and drop your current Scotts Company coverage, be aware that you and your dependents will be able to get this coverage back if applicable.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with The Scotts Company and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

Starting with the end of the last month that you were eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

For more information about this notice or your current prescription drug coverage, please contact The Scotts Benefit Service Center at 888-918-5878.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Scott's medical plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: September 2025
Name of Entity/Sender: Scotts Benefit Service Center
Address: PO Box 5295
Cherry Hill, NJ 08034-5295
Phone Number: 888-918-5878

SUMMARY ANNUAL REPORT

The Scotts Company LLC Total Family Protection Plan

This is a summary of the annual report for The Scotts Company LLC Total Family Protection Plan (EIN: 31-1414921, Plan Number: 503) providing medical, dental, vision, prescription drug, life insurance, temporary disability, long-term disability, basic accidental death & dismemberment, voluntary accidental death & dismemberment, critical illness and accidental injury, group legal, severance, hospital indemnity, and business travel accident benefits for the year ended December 31, 2024. The annual report has been filed with the Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

The Scotts Company LLC (i.e., the plan sponsor) has committed itself to pay all of the medical, prescription drug, and temporary disability claims; some of the dental claims; and all of the severance benefits payable under the terms of the plan.

Insurance Information

The plan has contracts with Aetna Life Insurance Company, Prudential Insurance Company of America, Vision Service Plan, ARAG Insurance Company, Continental American Insurance Company, Kaiser Foundation Health Plan Inc., Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Kaiser Foundation Health Plan of the Northwest, First Reliance Standard Life Insurance Company, and Reliance Standard Life Insurance Company to pay all of the vision, life insurance, long-term disability, basic accidental death & dismemberment, voluntary accidental death & dismemberment, critical illness and accidental injury, group legal, hospital indemnity, and business travel accident benefit claims and some of the medical and dental benefit claims. The total premiums paid to insurance companies for the plan year ending December 31, 2024 were \$6,264,143.

Because the contract held with Vision Service Plan is a so-called experience-rated contract, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending December 31, 2024, the premiums paid under such experience-rated contracts were \$416,296 and the total of all benefit claims paid under this experience-rated contract during the plan year was \$344,433.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report or any part thereof, on request. Additional insurance information including commissions paid by insurance carriers is included with this full annual report. To obtain a copy of the full annual report or any part thereof, contact the Plan Administrator: Benefits Administrative Committee, 14111 Scottslawn Road, Marysville, Ohio 43041; phone (937) 644-0011. There may be a nominal charge to cover duplicating costs.

You also have the legally protected right to examine the annual report at the above-listed address and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department of Labor should be addressed to Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

**The Scotts Company Group Health Plan
GENERAL NOTICE OF
CONTINUATION COVERAGE RIGHTS UNDER COBRA**

Introduction

You are receiving this notice because you have recently become covered under one or more of the group health plan components of The Scotts Company LLC Total Family Protection Plan (the "Plan(s)"). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan under certain circumstances when coverage would otherwise end. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health plan benefits offered under The Scotts Company LLC Total Family Protection Plan (the medical, dental, vision, health care flexible spending account, employee assistance program, and Scotts wellness center components) and not to any other benefits offered under The Scotts Company LLC Total Family Protection Plan.

The right to COBRA continuation coverage was created by a federal law, The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- 1) Your hours of employment are reduced, or
- 2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 1) Your spouse dies;
- 2) Your spouse's hours of employment are reduced;
- 3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- 4) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- 5) You become divorced or legally separated from your spouse .

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

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

When is COBRA Coverage Available

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

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

The Scotts Company
Benefits Department
14111 Scottslawn Road
Marysville, OH 43041
Phone: 937-644-0011

You must also provide additional documentation such as a copy of the divorce decree or proof that a child is no longer a "dependent" under the Plan(s). You must also provide the Plan Administrator notice within 60 days if a second qualifying event occurs during your 18-month period of COBRA continuation coverage (see "Second Qualifying Event Extension of 18-month Period of Continuation Coverage"). Special notice rules apply if you or a covered dependent are disabled on the date of your qualifying event or becomes disabled within 60 days after electing COBRA continuation coverage (see "Disability Extension of 18-month Period of Continuation Coverage"),

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. Generally, if the qualifying event is termination of employment or reduction in hours of the employee, COBRA continuation coverage will last for up to 18 months from the date of the qualifying event or loss of coverage, whichever is later. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

When the qualifying event is the death of an employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months from the date of the qualifying event or loss of coverage, whichever is later.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). There are two ways in which this 18-month period of COBRA continuation coverage can be extended: (1) disability extension and (2) second qualifying event extension.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled (for Social Security disability purposes) and the Plan Administrator is notified of the Social Security's determination within 60 days of the later of (1) the date of the Social Security's determination, (2) the date on which the qualifying event occurs, or (3) the date on which you lose coverage under the Plan as a result of a qualifying event, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The Plan Administrator must receive the notification before the end of the 18-month period. If you apply to the Social Security Administration for disability benefits, they will notify you in writing of the determination. If you are an active employee, the written notification from the Social Security Administration must be sent to:

The Scotts Company
Benefits Department
14111 Scottslawn Road
Marysville, OH 43041
Phone: 937-644-0011

If you are receiving COBRA continuation coverage, you must send it to the COBRA administrator.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

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

Termination of COBRA Continuation Coverage

The law also provides that COBRA continuation coverage may end before the 18-, 29-, or 36-month periods for any of the following reasons:

- 1) Your employer no longer provides group health coverage to any of its employees;
- 2) The premium for continuation coverage is not paid on time;
- 3) A qualified beneficiary becomes covered under another group health plan, after the date of the qualified beneficiary's COBRA election, that does not contain any exclusion or limitation with respect to any pre-existing conditions such qualified beneficiary may have;
- 4) A qualified beneficiary becomes enrolled in Medicare (Part A, Part B, or both), after the date of the qualified beneficiary's COBRA election;
- 5) A qualified beneficiary extends coverage for up to 29 months due to a Social Security disability or a final determination has been made that the qualified beneficiary is no longer disabled.

If you are eligible for coverage under the health flexible spending account (the "health FSA"), you (or your spouse or dependent children) may elect to continue the health FSA coverage under COBRA but only if you have a positive account balance (i.e., year-to-date contributions exceed year-to-date claims) on the day before the qualifying event (taking into account all claims submitted on or before that date). If you are eligible for COBRA coverage under the health FSA, that coverage will continue only for the remainder of the Plan Year in which your qualifying event occurred.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. If you are determined ineligible for COBRA coverage, your Employer reserves the right to terminate it retroactively.

Under the law, you may have to pay all or part of the premium for your continuation coverage plus a 2% administrative fee. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

The Scotts Company
Benefits Department
14111 Scottslawn Road
Marysville, OH 43041
Phone: 937-644-0011

The Scotts Company
Health Insurance Marketplace Coverage Notice

The Affordable Care Act (also known as health care reform) expands health insurance in the U.S. to provide access to health care for more people. We are providing you with the attached notice about the Health Insurance Marketplaces (sometimes called Exchanges) established under the Affordable Care Act.

As you review the notice, you should know:

- The Affordable Care Act requires that Scotts (and most other employers) provide this information to all of our associates.
- Individuals are able to shop for and compare health insurance plans through the state-based, online Health Insurance Marketplace at www.HealthCare.gov.
- If you purchase health insurance through the Marketplace, you may qualify for a tax credit that lowers the premium you are required to pay for Marketplace insurance.

However, the Scotts health plan will meet the Affordable Care Act's minimum value standard during 2024. Therefore, if you are eligible for our plan, you will not qualify for the Marketplace premium discount unless the plan is considered unaffordable for you under the Affordable Care Act.

Attached please find additional information about the Marketplace and a list of things to consider if you are thinking about enrolling in coverage through the Marketplace.

If you have questions, contact the Scotts Benefits Service Center at 1-888-918-5878

New Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information

There is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings Through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹ However, if you actually enroll in an eligible employer-sponsored plan, you will not be eligible for a tax credit, even if the employer-sponsored plan does not meet the affordability or minimum value standards.

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description at livetotalhealth.com or contact the Scotts Benefits Service Center at 1-888-918-5878. The plan rates for your employer-sponsored coverage for 2026 will be available on your plan's website at livetotalhealth.com as of October 27, 2025.

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

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such cost

The Scotts Company
HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage or within 60 days after the birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact the Scotts Benefits Service Center at 1-888-918-5878.