IMPORTANT NOTICES

YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Briggs & Stratton 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 coveragein 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 currentcoverage 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 morecoverage for a higher monthly premium.
2. Briggs & Stratton has determined that the prescription drug coverage offeredby ExpressScripts (ESI) 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 through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) tojoin 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 Briggs & Strattoncoverage may be affected.
- If you do decide to join a Medicare drug plan and drop your Briggs & Strattoncoverage, be aware that you and your dependents may not be able to get this coverage back.

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 coverage with Briggs & Stratton 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 joina Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage, yourmonthly 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 credible 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 YOURCURRENT PRESCRIPTION DRUG COVERAGE

Contact the person listed below for further information. Note: You'll get this notice each year (before the next period you can join a Medicare drug plan), and if this coverage through Briggs & Stratton changes. You also may request a copy of this notice at any time.

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 contacteddirectly 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 backcover 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).***
Reminder: 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 whenyou 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: January 1, 2024
Name of Entity/Sender: Briggs & Stratton, LLC | Christine ReichardtAddress: 12301 W. Wirth Street | Wauwatosa WI 53222
Phone Number: ***414-259-5515***

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (JANET'SLAW)

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy (including lymphedema). These benefits are subject to applicable terms and conditions under your health plan,including copayments, deductible and coinsurance provisions. They are also subject to medical insurance limitations and exclusions. This notification is a requirement of the Act. Those enrolled are to be notified of the WHCRA's coverage requirements to participants at the time of enrollment and on a yearly basis.

The Women's Health and Cancer Rights Act (Women's Health Act) was signedinto law on October 21, 1998. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. The Women's Health Act amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

TELL US WHEN YOU'RE MEDICARE ELIGIBLE

Please notify your Human Resource Department when you or your dependents become eligible for Medicare. We are required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the health plan pays primary. You must also contact Medicare directly to notify them that you have health care coverage through an employer group. Privacy laws prohibit anyone other than the Medicare beneficiary, or their legal guardian, to update or change Medicare records. ***The toll free number to contactMedicare Coordination of Benefits Contractor is 1-800-999-1118.***

SUMMARY OF BENEFITS AND COVERAGE

In addition, health plans are required to provide members with a Summaryof Benefits and Coverage (SBC). The SBC is different from the standard summary in that it provides members with improved standardized informationdesigned to help better understand your coverage and compare the options available to you.

BRIGGS & STRATTON 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.

UNDERSTANDING YOUR HEALTH RECORD/ INFORMATION

Each time you visit a hospital, physician, dentist or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as ameans of communication among the many health professionals who contributeto your care.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy; better understand who, what, when, where and why others may access your health

information; and make more informeddecisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property ofthe health plan that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. Receive a copy of this Notice of Privacy Practices from us upon enrollmentor upon request.
2. Request restrictions on our uses and disclosures of your protected health information for treatment, payment and health care operations. We reservethe right not to agree to a given requested restriction.
3. Request to receive communications of protected health information inconfidence.
4. Inspect and obtain a copy of the protected health information contained in your medical or billing records and in any other of the organization's healthrecords used by us to make decisions about you.
5. Request an amendment to your protected health information. However, we may deny your request for an amendment, if we determine that the protectedhealth information or record that is the subject of the request:
   - Was not created by us, unless you provide a reasonable basis to believethat the originator of the protected health information is no longer available to act on the requested amendment;
   - Is not part of your medical or billing records;
   - Is not available for inspection as set forth above; or
   - Is accurate and complete.

   In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. Receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you, except for disclosures:
   - To carry out treatment, payment and health care operations as providedabove;
   - To persons involved in your care or for other notification purposes as provided by law;
   - To correctional institutions or law enforcement officials as provided by law;
   - For national security or intelligence purposes;
   - That occurred prior to the date of compliance with privacy standards (April14, 2003 or April 14, 2004 for small health plans):
   - Incidental to other permissible uses or disclosures;
   - That are part of a limited data set (does not contain protected healthinformation that directly identifies individuals);
   - Made to plan participant or covered person or their personal representatives;
   - For which a written authorization form from the plan participant or coveredperson has been received.
7. Revoke your authorization to use or disclose health information except to the extent that we have already taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization the right to contest a claim under the policy.
8. Receive notification if affected by a breach of unsecured PHI.

INFORMATION WE COLLECT ABOUT YOU

We collect the following categories of information about you from the following sources: 1) Information that we obtain directly from you, in conversations or on applications or other forms that you fill out. 2) Information that we obtain as a result of our transactions with you. 3) Information that we obtain from your medical records or from medical professionals. 4) Information that we obtain from other entities, such as health care providers or other insurance companies, in order to service your policy or carry out other insurance-related needs.

GENETIC INFORMATION

We will not use genetic or disclose genetic information or results from genetic services for underwriting purposes, such as:

- Rules for eligibility or benefits under the health plan;
- The determination of premium or contribution amounts under the health plan; and
- Other activities related to the creation, renewal or replacement of a contractof health insurance or health benefits.

COVERAGE EXTENSION OPTION UNDER COBRA

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

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a website that provides information about our services or benefits, the new notice will be posted on that website.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in the notice, except as noted herein.

OUR PRACTICE REGARDING CONFIDENTIALITY AND SECURITY

We restrict access to nonpublic personal information about you to those employees who need to know that information in order to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

OUR PRACTICE REGARDING CONFIDENTIALITY AND SECURITY FOR E-MAIL COMMUNICATION

If you choose to communicate with us via email, please be aware of the following due to the nature of email communication: (a) privacy and security of email messages are not guaranteed; (b) we are not responsible for loss due to technical failures; and (c) email communication should not be used foremergencies or time- and content-sensitive issues.

POTENTIAL IMPACT OF STATE LAW

In some circumstances, the privacy laws of a particular state, or other federallaws, provide individuals with greater privacy protections than those provided for in the HIPAA Privacy Regulations. In those instances, we are required to follow the more stringent state or federal laws, as they afford the individual greater privacy protections. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of Protected Health Information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing and reproductive rights.

NOTICE OF PRIVACY PRACTICES AVAILABILITY

You will be provided a hard copy for review at the time of enrollment (or by the Privacy compliance date for this health plan). Thereafter, you may obtaina copy upon request, and the notice will be maintained on the organization's website (if applicable website exists) for downloading.

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for thefollowing purposes:

- Treatment: We may use or disclose your health information without yourpermission for health care providers to provide you with treatment.

- Payment: We may use or disclose your health information without your permission to carry out activities relating to reimbursing you for the provision of health care, obtaining premiums, determining coverage and providing benefits under the policy of insurance that you are purchasing. Such functions may include reviewing health care services with respect to medicalnecessity,

coverage under the policy, appropriateness of care or justification of charges.

- To Carry Out Certain Operations Relating to Your Benefit Plan: We also mayuse or disclose your protected health information without your permission to carry out certain limited activities relating to your health insurance benefits, including reviewing the competence or qualifications of health careprofessionals, placing contracts for stop-loss insurance and conducting quality assessment activities.

- To Plan Sponsor: Your protected health information may be disclosed to the plan sponsor as necessary for the administration of this health benefit plan pursuant to the restrictions imposed on plan sponsors in the plan documents. These restrictions prevent the misuse of your information for other purposes.

- Health-Related Benefits and Services: We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your protected health information for the purpose of communicating to you about our healthinsurance products that could enhance or substitute for existing health plan coverage, and about health-related products and services that may add value to your existing health plan.

- Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

- Business Associates: There may be some services provided in our organization through contracts with Business Associates. An example might include a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the jobwe have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

- Limited Data Sets: We may use or disclose, under certain circumstances, limited amounts of your protected health information that is contained in limited data sets. These circumstances include public health, research andhealth care operations purposes.

- Organ and Tissue Donation: If you are an organ donor, we may releasemedical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

- Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- Health Oversight Activities: We may disclose protected health information tofederal or state agencies that oversee our activities.

- Law Enforcement: We may disclose protected health information as requiredby law or in response to a valid judge-ordered subpoena. For example, in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness or missing person; related to judicial oradministrative proceedings; or related to other law enforcement purposes.

- Military and Veterans: If you are a member of the armed forces, we mayrelease protected health information about you as required by military command authorities.

- Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request or other lawful process.

- Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

- Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- Coroners, Medical Examiners and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may benecessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

- Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

- Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person orthe public.

- Food and Drug Administration (FDA): As required by law, we may disclose tothe FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

For Purposes For Which We Have Obtained Your Written Permission: All otheruses or disclosures of your protected health information will be made only with your written permission, and any permission that you give us may be revoked by you at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our HIPAA Privacy Officer at the phone number or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer or with the Secretary of the Departmentof Health and Human Services. We will take no retaliatory action against you if you make such complaints. The contact information for both is included below:

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.,
Washington, D.C. 20201
Phone: 202-619-0257
Toll Free: 1-877-696-6775

Briggs & Stratton, LLC
Privacy Officer
12301 W. Wirth Street
Wauwatosa, WI 53222
Privacy@basco.com

HEALTH CARE REFORM – HEALTH INSURANCE MARKETPLACE

The Affordable Care Act (ACA) or healthcare reform requires you to have minimum essential health care coverage. If you do not have minimum essential health care coverage, you may be subject to tax penalties. There are various sources through which you may get health coverage -- your employer, Medicare, Medicaid or other similar government programs if you qualify; and the Health Insurance Marketplace (also known as healthcare exchanges).
Briggs & Stratton continues to offer group health coverage to you as a benefit- eligible employee. It is important for you to understand that the coverage offered under the Briggs & Stratton health plan does meet the federal criteriafor minimum value. Therefore, you will not qualify for the premium subsidy assistance within the insurance marketplace plans if you are eligible for a Briggs & Stratton Health Plan AND the required premium for employee-only coverage under the lowest cost health plan option does not exceed 8.39% (in 2024) of your household income.

The 2024 open enrollment period for health insurance coverage through the Marketplace runs from November 1, 2023 through January 15, 2024. Individuals must enroll or change plans prior to December 15, 2023 for coverage starting as early as January 1, 2024. After January 15,

2024, you can get coverage through the Marketplace for 2024 only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Briggs & Stratton benefits department. 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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Rewardsfor participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at (802) 846-4675 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

NEWBORN ACT DISCLOSURE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However,Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

If you are declining medical coverage under the Plan for yourself or your dependents (including your spouse) because of other medical insurance or group medical plan coverage, you may be able to enroll yourself and your dependents in the 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 30 days after your or your dependents' other medical 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 in the Plan's medical coverage. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.
In addition, you may be able to enroll yourself and your dependents in the Plan's medical coverage (1) if your or your dependent's coverage under a Medicaid plan or a State Children's Health Insurance Program ("CHIP") plan terminates due to loss of eligibility for such coverage, or (2) if you or your dependents become eligible for premium assistance with respect to the Plan's medical coverage under a Medicaid plan or a CHIP plan. However, you must request enrollment within 60 days after the date of termination of suchcoverage or the date you or your dependent is determined to be eligible for such assistance, whichever is applicable.

To request special enrollment or obtain more information, contact the Benefitsdepartment at benefit.questions@basco.com. If you are already enrolled in medical coverage for yourself, you may change your own medical coverage election in connection with enrolling a dependent child or spouse under the above special rules.

PATIENT PROTECTION DISCLOSURES

Certain medical options under the Plan may require the designation of a primary care provider. If a medical option requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in the applicable network and who is available to accept you or your eligible dependent. For information on how to select a primary care provider, and for a list of the participating primary care providers, please review the medical option's summary plan description or contact the enrollment administrator. For children, you may designate a pediatrician as the primary care provider.

If you are enrolled in the Plan, you do not need prior authorization in orderto obtain access to obstetrical or gynecological care from a health care professional in the applicable network and who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, review the medical option's summary plan description or contact the enrollment administrator.

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 eligiblefor 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 InsuranceMarketplace. 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 on page 39, 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 officeor 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 Medicaidor 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 states on page 39, you may be eligible for assistance paying your employer health plan premiums.

To see if any other states have added a premium assistance program sinceJuly 31, 2023, or for more information on special enrollment rights, contact either:

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

US Department of Health & Human Services
Centers for Medicare Medicaid Services
www.cms.hh.gov
(877) 267-2323 Menu Option 4, Ext 61565

The following list of states is current as of July 31, 2023. Contact your state for more information on eligibility.

ALABAMA – MEDICAID	FLORIDA – MEDICAID
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ALASKA – MEDICAID	**GEORGIA – MEDICAID**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	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-chipra Phone: (678) 564-1162, Press 2
ARKANSAS – MEDICAID	**INDIANA – MEDICAID**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
CALIFORNIA – MEDICAID	**IOWA – MEDICAID AND CHIP (Hawki)**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov	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
COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)	**PENNSYLVANIA – MEDICAID AND CHIP**
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 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 1-800-986-KIDS (5437)
VIRGINIA – MEDICAID AND CHIP	**NEW JERSEY – MEDICAID AND CHIP**
Website: https://coverva.dmas.virginia.gov/learn/premium-assitance/famis-select https://coverva.dmas/virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
KENTUCKY – MEDICAID	**MAINE – 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: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US 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
LOUISIANA – MEDICAID	**TEXAS – MEDICAID**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493
NEW YORK – MEDICAID	**NORTH DAKOTA – MEDICAID**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

MASSACHUSETTS – MEDICAID AND CHIP	OKLAHOMA – MEDICAID AND CHIP
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MINNESOTA – MEDICAID	**MONTANA – MEDICAID**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
MISSOURI – MEDICAID	**NEW HAMPSHIRE - MEDICAID**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
OREGON – MEDICAID	**RHODE ISLAND – MEDICAID AND CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEBRASKA – MEDICAID	**SOUTH CAROLINA – MEDICAID**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEVADA – MEDICAID	**WASHINGTON – MEDICAID**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH DAKOTA – MEDICAID	**NORTH CAROLINA – MEDICAID**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
WEST VIRGINIA – MEDICAID AND CHIP	**KANSAS – MEDICAID**
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)	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
UTAH – MEDICAID AND CHIP	**WISCONSIN – MEDICAID AND CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– MEDICAID	**WYOMING – MEDICAID**
Website: https://dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

SUMMARY ANNUAL REPORT – GROUP INSURANCE PLAN OF BRIGGS & STRATTON, LLC

This information summarizes the Form 5500 which is filed on an annual basis for each plan. If you are interested in receiving a copy of the full 5500 filing, please follow the instructions on the appropriate plan summary.

This is a summary of the annual report of the Group Insurance Plan of Briggs & Stratton, LLC (Employer Identification Number 85-2711260, Plan Number 501), for the plan year 01/01/2022 through 12/31/2022. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Briggs & Stratton, LLC has committed itself to pay certain medical and dental claims incurred under the terms of the plan.

Insurance Information

The plan has insurance contracts with Prudential Insurance Company of America, Wyssta Insurance Company Inc. and Starr Indemnity & Liability Company to pay certain life, accidental death & dismemberment, vision, temporary disability, long-term disability and business travel accident claims incurred under the terms of the plan. The total premiumspaid for the plan year ending 12/31/2022 were $1,798,167.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any partthereof, on request. The items listed below are included in that report:

- Insurance information, including sales commissions paid by insurancecarriers.

To obtain a copy of the full annual report, or any part thereof, write or call the plan administrator at 12301 W Wirth Street, Wauwatosa, WI 53222-2110 or phone number (414) 259-5333.

You also have the legally protected right to examine the annual report at the main office of the plan: 12301 W Wirth Street, Wauwatosa, WI 53222-2110, andat 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 should be addressed to: Public Disclosure Room, Room N-1513, 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.

YOUR RIGHTS & PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

- Emergency services: If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in- network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- **Certain services at an in-network hospital or ambulatory surgical center:** When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the U.S. Department of Health and Human Services at 1-877-696-6775. Visit https://www.hhs.gov/about/news/2021/07/01/hhs-announces-rule-to-protect-consumers-from-surprise-medical-bills.html for more information about your rights under federal law.

YOUR ERISA RIGHTS

As a participant in the Plan, You are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- Receive information about Plan Benefits.
- Examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents – including pertinent insurance contracts, collective bargaining agreements (if applicable), a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor, and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

You can continue health care coverage for Yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the Summary Plan Description and the Plan documents to understand the rules governing Your COBRA continuation coverage rights.

You have a right to a reduction or elimination of exclusionary periods of coverage for preexisting

conditions under the Plan, if You have creditable coverage from another plan. You should be provided a certificate of coverage, free of charge, from Your group health plan or health insurance issuer when You lose coverage under the plan, when You become entitled to elect COBRA continuation coverage, when Your COBRA continuation coverage ceases, if You request it before losing coverage of if You request it up to 24 months after losing coverage. Without evidence of creditable coverage, You may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after Your enrollment date in Your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate Your Plan, who are called "Fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your Employer, Your union or any other person may fire You or otherwise discriminate against You in any way to prevent You from obtaining a Plan benefit or exercising Your rights under ERISA.

If Your claim for a Plan benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules. See Section 9, Claims Procedures, for details.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of the plan document or the latest annual report from the Plan, and do not receive it within 30 days, You may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If You have a claim for Benefits, which is denied or ignored, in whole or in part, and You have exhausted the administrative remedies available under the Plan, You may file suit in a state or federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in a federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees; for example, if it finds Your claim is frivolous.

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW Washington, DC 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

MY BENEFITS APP

YOUR ACCESS TO BENEFITS INFORMATION - ANYWHERE, ANYTIME

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

Scan the QR Code or visit **briggsstratton.mybenefitsapp.com**

Add an icon to your smartphone for quick access – SCAN ME