2024 BENEFITS ENROLLMENT GUIDE

YOU.POWERED.™

BENEFITS – WE GOT YOU COVERED.

MYBASCOBENEFITS.COM

(877) 232-1083

Briggs & Stratton Benefits Service Center

Your resource for benefits

The Briggs & Stratton Benefits Service Center provides a team of dedicated professionals to assist you with understanding and enrolling in your benefits, as well as resolving claims issues and finding in-network providers.

- Connects you to all benefit vendors 24/7
- Talk to a call center representative Monday – Friday, 7 am – 7 pm CST
- Send a secure email via the myBascoBenefits.com benefits portal

- **Call when you have questions about:**
  - Eligibility for coverage
  - Changes in family status, adding or dropping dependents from coverage
  - Changes in work status (PT to FT) that may affect your benefits
  - Your benefit choices
  - The enrollment process

- **You can ask to be transferred to a health advocate *[or call (866) 799-2728 directly]* to discuss:**
  - Claims issues that you cannot resolve
  - Finding in-network providers
  - Education on our benefit offerings

- **Email the Briggs & Stratton Benefits Team at benefit.questions@basco.com to discuss**:
  - Your benefit-related payroll deductions

Connect Online. Briggs & Stratton has provided easy-to-use tools and resources to help you elect benefits that protect your health and well-being. Check out:

The Briggs & Stratton Benefits Portal — This benefits portal hosts documents, videos and resources that provide more detailed information about your choices. You may access the enrollment website in one of two ways:

Connect directly, at **myBascoBenefits.com** (You will need to register using your name, birthdate and employee ID number.)

New in 2024

Connect through Success Center — mylinks.basco.com **> Success Center > Benefits**

The Briggs & Stratton Benefits App (**https://briggsstratton.mybenefitsapp.com/**) — available anytime from work or home. View announcements, company events, detailed benefit information, links to provider directories and more.

TABLE OF CONTENTS

This document provides a general overview of the benefit plans offered by Briggs & Stratton. It does not include all of the details, limits or exclusions. If there is any discrepancy between the information in the benefit summary and the actual plan documents, plan amendments or insurance contracts, those will govern in all cases. Briggs & Stratton may amend, modify or terminate plan benefits and/or contributions, in whole or in part, at any time in its sole discretion. The plans do not constitute a contract between the employerand any covered person nor should they be considered as an inducement or condition of the employment of any employee. Nothing in the plans will give any employee the right to be retained in the service of the employer**.**

PICK THE BEST BENEFITS FOR YOU AND YOUR FAMILY

Briggs & Stratton strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of your benefits. This Benefits Guide highlights the benefit options available to you, and serves as a resource for making benefit election decisions that provide the best value to you and your family members.

Briggs & Stratton provides certain benefits — such as life insurance, disability coverage, paid time off and the Employee Assistance Program (EAP) — at no cost to you. You have the opportunity to choose from a variety of optional benefits for which you either share the cost with the Company or pay the entire amount.

WHAT BENEFITS ARE AVAILABLE TO ELECT?

- Medical
- Dental
- Vision
- Health Care Flexible Spending Account
- Dependent Daycare Flexible Spending Account
- Health Savings Account
- Long-Term Disability
- Voluntary Employee Life and AD&D Coverage
- Voluntary Life Insurance for your Spouse and/or Dependents
- Critical Illness, Accident and Hospital Indemnity

WHO IS ELIGIBLE?

If you're a Briggs & Stratton **full-time or part-time employee who works 30 or more hours per week,** you're eligible to enroll in the benefits outlined in this guide. In addition, the following family members are eligible for coverage:

- Legally married opposite-sex or same-sex spouse.
    - You cannot be covered as both an employee and a dependent.
    - Our medical plan requires that working spouses elect coverage through their employer before they can be enrolled with secondary coverage under our plan (see page 4).
- Eligible children through the month they turn 26 — your natural child, legally adopted child, child placed in your home for legal adoption, stepchild or a child for whom you have legal guardianship.
- Eligible children who are disabled as long as the child is declared disabled prior to reaching their 26th birthday and the request for extended coverage is submitted no later than 31 days after their 26th birthday.
- Dependent children cannot be covered by more than one employee.

WORKING SPOUSE PROVISION

We believe every employer should take primary responsibility for providing medical coverage to its own employees. When an employee's spouse enrolls in a Briggs & Stratton plan instead of his or her own employer's plan, the spouse's expenses shift to us. If a spouse has the choice of other coverage but declines it, we believe that adds a cost burden to our Plan.

This provision would not apply if your spouse:

- Is not employed,
- Is self-employed and spouse's business does not offer medical coverage to any employee or self-employed individual,
- Works part-time (even if eligible for coverage),
- Works full-time but is not eligible for coverage through his or her own employer,
- Has primary coverage through his or her own plan and enrolls in a Briggs & Stratton plan as secondary coverage, or
- Is employed by Briggs & Stratton.

Briggs & Stratton may require a spouse to certify that they are not eligible for medical coverage through their employer. Spouses who are found to be ineligible for coverage will be removed from the Plan.

DEPENDENT VERIFICATION

During the enrollment process, you will be asked to acknowledge that any dependent(s) you enroll for coverage meet the eligibility guidelines as shown on page 4.

Briggs & Stratton has contracted with Empyrean Benefit Solutions to conduct dependent eligibility verification. If you enroll your spouse and/or child(ren) in Briggs & Stratton's medical plan, you will be asked to provide documentation (birth certificate, adoption records, marriage license and/or tax records) to verify their eligibility.

Empyrean Benefit Solutions will mail you a list of what is needed to complete the verification process. Your dependents will not be eligible for coverage in 2024 if you do not respond or if you provide incomplete documentation.

Login to mybascobenefits.com to upload dependent verification documents. Or you may mail them to:

New in 2024

Briggs & Stratton Benefits Service Center
PO BOX 3288
Bellaire, TX 77402

YOUR ENROLLMENT ASSISTANT

If you have any questions, our Briggs & Stratton Benefits Service Center is here to help. Give us a call at 877-232-1083 from 7:00 AM to 7:00 PM CT, Monday through Friday.

WHEN CAN I ENROLL?

There are certain times throughout the year when benefit-eligible employees may enroll in health care and voluntary insurance benefits, or make changes to coverage. Once you make your elections, by law you cannot change your elections, unless you have a qualifying change in family status or until the next Annual Enrollment period, whichever comes first.

2024 Annual Enrollment *October 30th – November 15th, 2023*	**New Hires** *Within 30 days of your hire date*	**Qualified Life Events** *Within 30 days of the life event*
You have the opportunity to enroll in or make changes to your benefit elections during our annual enrollment period held in the fall of each year. The benefits you elect will become effective the following January 1. Watch for postcards, posters and email notices announcing the dates of enrollment. In general, your current benefits, with the exception of flexible spending accounts (Health Care FSA, Limited Purpose Health Care FSA or Dependent Daycare FSA), will roll over to the new plan year if you take no action. **To actively enroll in benefits and verify that your information is correct, go to mybascobenefits.com.**	New employees are eligible for most benefits on the 32nd day of employment. You have 30 days from your hire date to make your benefit elections. If you don't enroll within 30 calendar days, you will be enrolled in the default benefits: • Basic Life and AD&D coverage, • Disability benefits; and • Employee Assistance Program (EAP).	You may make changes in certain benefits if you have a Qualified Life Event. Examples of Qualified Life Events are: • Marriage, divorce or legal separation • Birth or adoption of a child • Change in child's dependent status • Death of a spouse, child or other qualified dependent • Change in employment status or a change in coverage under another employer-sponsored plan • Termination from Medicaid or CHIP Coverage (see page 38 for more information about CHIP) • Significant change in cost or coverage options To change your benefit elections after a Qualified Life Event, you must make the change within 30 days of the life event. Otherwise, it will not be accepted.

New in 2024

HOW TO ENROLL

Briggs & Stratton partners with Empyrean Benefit Solutions to provide both the benefits portal and a personal call center to assist you with benefits enrollment, making family status changes or electing or changing your HSA payroll contributions. The Briggs & Stratton benefits portal also houses a benefits library, including video presentations. Refer to the inside cover for enrollment details.

3 WAYS TO ENROLL

ONLINE

www.myBascoBenefits.com
or
mylinks.basco.com>Success Center>Benefits

MOBILE APP

www.myBascoBenefits.com

PHONE

877-232-1083

WHAT HAPPENS IF I DO NOT ENROLL?

NEW EMPLOYEES: If you do not enroll during the 30 day enrollment window, you will default to:

- No medical, dental or vision coverage
- Basic company-provided life and AD&D insurance *(your beneficiary information needs to be provided)*
- Employee Assistance Program (EAP)
- Company-provided disability benefits
- If you are at a location with an on-site clinic, you are eligible to use the clinic. However, when you receive treatment, you must provide a copy of your current medical insurance card.

ANNUAL ENROLLMENT: If you do not take any action, your current benefits and levels of coverage will roll over to the new plan year, without any Flexible Spending Accounts (Health Care and/or Dependent Daycare).

Flexible Spending Accounts require an annual election. The benefits that appear on your confirmation statement will be in effect on January 1 and you will not be able to make any coverage changes unless you experience a qualifying life event or until the next Annual Enrollment period, whichever comes first.

CONFIRMATION OF YOUR BENEFITS

After the enrollment window closes, you will receive a confirmation statement in the mail. Review the statement carefully. If a correction is needed, you must contact the Briggs & Stratton Benefits Service Center at (877) 232-1083 within 10 days of receipt of your confirmation statement. Changes cannot be made online.

Once your benefits are effective, your elections are locked until the next enrollment window as shown on page 5.

Exception: changes to your Health Savings Account contributions can be made at any time during the year.

HOW TO MAKE MID-YEAR CHANGES

- To change your benefit elections after a qualified life status event, you must make the change online or by phone **within 30 days of the life event**.
    - Written proof of the event, such as a birth certificate, should be provided within 30 days ***following*** the initial request. A newborn Social Security number may take longer than 30 days, but you should provide it as soon as it is available.
    - Only election changes that are consistent with your life event will be allowed.
- Changing from one medical plan type (PPO, HDHP HSA or EPO) to another is not allowed during a life event change.
- Changes to your HSA employee contributions can be made at any time during the year and will take effect with the next available pay period.
- If you need assistance making enrollment changes, contact the Briggs & Stratton Benefits Service Center at (877) 232-1083.

***Note about your retirement benefits*: Employees may change their contribution rate at any time by calling the Fidelity Benefits Service Center at (800) 835-5095 or by logging into www.netbenefits.com**

MEDICAL INSURANCE

We offer both PPO and EPO plans administered by Anthem BCBS.

2024 MEDICAL PLAN CHOICES

BENEFIT HIGHLIGHTS *(Per Calendar Year)*	PPO PLAN: ANTHEM NETWORK	PPO PLAN: OUT OF NETWORK *(Reasonable & Customary Apply)*
Deductible[1]	$1,500 Individual Not to exceed $3,000 Family	$6,000 Individual Not to exceed $12,000 Family
Coinsurance %	Plan pays 80% Member pays 20%	Plan pays 60% Member pays 40%
Coinsurance Maximum	$4,000 Individual Not to exceed $8,000 Family	$5,000 Individual Not to exceed $10,000 per family
Maximum Out of Pocket (Includes deductible and coinsurance)	$5,500 Individual Not to exceed $11,000 per Family	$11,000 Individual Not to exceed $22,000 per Family
MEDICAL SERVICES		
Routine Wellness Visits	Covered 100%	No Coverage
Preventive Care/Screening/Immunization	Covered 100%	No Coverage
Office Visits	$25 Copay	Covered 60% after Deductible
Specialist Visits	$60 Copay	Covered 60% after Deductible
Outpatient Behavioral Health	$25 Copay for office visit *All other charges - 80% after Deductible*	Covered 60% after Deductible
Lab Work *(Non-routine)*	Covered 80%, no Deductible	Covered 60% after Deductible
Telemedicine Visit *(24/7 Urgent Care via phone or computer)* *See page 9 for more information*	$25 Copay	N/A
Urgent Care	$50 Copay for office visit *All other charges – 80% after Deductible*	Covered 60% after Deductible
Emergency Room	Covered 80% after Deductible *(50% after deductible if non-emergent)*	Covered as in-network if emergency *(50% after deductible if non-emergent)*
Other Covered Medical Expenses	Covered 80% after Deductible	Covered 60% after Deductible

[1]Deductible/Coinsurance cross apply between PPO and Non-PPO limits.

ANTHEM NETWORKS:

- National PPO (BlueCard PPO) - https://www.anthem.com/find-care/?alphaprefix=901
- If you live in Wisconsin: WI Blue Preferred Network - https://www.anthem.com/find-care/?alphaprefix=107
- If you live in Georgia: Blue Open Access POS (Select Network) - https://www.anthem.com/find-care/?alphaprefix=108
- If you live in Poplar Bluff: Blue Access Choice (St. Louis) - https://www.anthem.com/find-care/?alphaprefix=103
- If you live in Lee's Summit: Preferred-Care Blue (KC) (Select Network) - https://www.anthem.com/find-care/?alphaprefix=102

WHAT IS THE DIFFERENCE BETWEEN EPO AND PPO?

- **EPO plan** — covers services performed solely by in-network providers. In exchange for lower plan premiums, members are required to receive medical care from the Anthem network *(see links above)*. With the exception of emergency services, there are no benefits for members who choose to receive services outside of the preferred provider network.

- **PPO plan** — has a network of providers, but also allows for the use of providers outside the plan's network. It is more flexible than an EPO, but is usually more expensive.

PPO PLAN WITH HSA / BASIC EPO PLAN

PPO PLAN WITH HSA: ANTHEM NETWORK	PPO PLAN WITH HSA: OUT OF NETWORK *(Reasonable & Customary Apply)*	BASIC EPO PLAN: ANTHEM NETWORK	BASIC EPO PLAN: OUT OF NETWORK *(Emergency Care Only)*
Employee Only $1,850 Individual / Employee Plus $3,200 Individual Not to exceed $3,700 per Family	$6,000 Individual Not to exceed $12,000 Family	$4,000 Not to exceed $8,000 Family	No Coverage
Plan pays 90% Member pays 10%	Plan pays 60% Member pays 40%	Plan pays 60% Member pays 40%	No Coverage
Employee Only Not to exceed $3,650 / Employee Plus Not to exceed $2,300 or $7,300 Family	$5,000 Individual Not to exceed $10,000 Family	$4,000 Individual Not to exceed $8,000 Family	No Coverage
$5,500 per member Not to exceed $11,000 per Family	$11,000 Individual Not to exceed $22,000 Family	$8,000 Individual Not to exceed $16,000 Family	No Coverage
Covered 100%	No Coverage	Covered 100%	No Coverage
Covered 100%	No Coverage	Covered 100%	No Coverage
Covered 90% after Deductible	Covered 60% after Deductible	$40 Copay	No Coverage
Covered 90% after Deductible	Covered 60% after Deductible	$60 Copay	No Coverage
Covered 90% after Deductible	Covered 60% after Deductible	$40 Copay for office visits *All other charges – 60% after Deductible*	No Coverage
Covered 90% after Deductible	Covered 60% after Deductible	Covered 80%, no Deductible	No Coverage
Covered 90% after Deductible	N/A	$40 Copay	No Coverage
Covered 90% after Deductible	Covered 60% after Deductible	$50 Copay for office visit *All other charges – 60% after Deductible*	No Coverage
Covered 90% after Deductible *(50% after Deductible if non-emergent)*	Covered 90% after Deductible *(50% after Deductible if non-emergent)*	Covered 60% after Deductible	No Coverage
Covered 90% after Deductible	Covered 60% after Deductible	Covered 60% after Deductible	No Coverage

YOUR PREMIUM COST FOR MEDICAL & PRESCRIPTION COVERAGE

Medical plan costs may vary by location, and the rate sheet is located on the benefits portal in the library. The rates will also appear online when you enroll for benefits.

IF YOU ARE THINKING, "I CAN'T AFFORD A HIGH DEDUCTIBLE..."

Remember preventive care is covered at 100%. If you receive a preventive exam, routine immunizations and other wellness screenings, the services will be covered in full.

Consider enrolling in the PPO or EPO plan; both have copays for office visits and prescription drugs rather than having to meet the deductible first.

Consider participating in the **Briggs & Stratton Wellness Program**. The Briggs & Stratton Wellness Program is designed to complement the benefits of the medical program. (See page 14)

Preventive prescription medications are covered at a lower copay and the deductible is waived. These include medications to treat: Asthma, COPD, Diabetes, High Cholesterol, Hypertension, Stroke/MI/DVT, Blood Clot Prevention, Osteoporosis, Prenatal Vitamins, Depression and Breast Cancer Prevention.

PHARMACY BENEFITS

Who is the administrator for the pharmacy benefits? Express Scripts (ESI) is our pharmacy benefit administrator. You will receive one insurance card that will have both your medical (Anthem) and prescription (ESI) information on it. Any deductible or coinsurance that you pay through Express Scripts will be sent to Anthem to apply to your medical plan deductible and coinsurance.

What is a formulary? A formulary is a list of generic and brand name prescription drugs covered under the health plan. The formulary is the same for all medical plans. However, how much you pay varies based on the medical plan you elect. To determine if your medication is considered a covered medication or if it will be considered as preventive, log onto the www.express-scripts.com website.

EXPRESS SCRIPTS NETWORK PHARMACY	PPO	PPO WITH HSA	BASIC EPO
Preventive Rx - Retail – 30 Day Supply Tier 1 – Generic Tier 2 – Preferred Brand Drugs Tier 3 – Non-Preferred Brand Mail Order or Retail – 90 Day Supply	No Deductible, you pay $5 Copay $10 Copay $10 Copay 3 X Retail Copay	No Deductible, you pay $5 Copay $10 Copay $10 Copay 3 X Retail Copay	No Deductible, you pay $5 Copay $10 Copay $10 Copay 3 X Retail Copay
Retail – 30 Day Supply Tier 1 – Generic Tier 2 – Preferred Brand Drugs Tier 3 – Non-Preferred Brand	No Deductible, you pay: $15 Copay $35 Copay $70 Copay	After your Deductible, you pay: 20% coinsurance 30% coinsurance 40% coinsurance	No Deductible, you pay: $15 Copay $35 Copay $70 Copay
Mail Order or Retail – 90 Day Supply Tier 1 – Generic Tier 2 – Preferred Brand Drugs Tier 3 – Non-Preferred Brand	No Deductible, you pay: $45 Copay $105 Copay $210 Copay	After your Deductible, you pay: 10% coinsurance 20% coinsurance 30% coinsurance	No Deductible, you pay: $45 Copay $105 Copay $210 Copay
Specialty Medication (30 day Maximum)	No Deductible, you pay: $250 Copay	After your Deductible, you pay 25% coinsurance to a maximum of $250 per prescription per month	No Deductible, you pay: $250 Copay

Note: Prescriptions are only covered through an Express Scripts network pharmacy.

CAN I CHOOSE NAME BRAND OVER GENERIC?

Many people believe that there is a significant difference between generic and name brand prescription drugs. However, generic drugs are only approved by the Food and Drug Administration (FDA) if they have the same active ingredient, strength, dosage form and route of administration as the name brand drug. The plan will cover generic medications. If you or your physician requests the name brand you will pay the difference.

INTRODUCING COPAY ASSISTANCE AND OUT OF POCKET PROTECTION TO MAKE SPECIALTY MEDICATIONS AFFORDABLE

Specialty medications are prescribed to patients with rare and complex medical conditions such as cancer, arthritis and multiple sclerosis. As a result, specialty medications are very expensive and patients often need help to afford them.

In order to assist our plan participants, Briggs & Stratton is rolling out two pharmacy programs that will make expensive specialty medications more affordable. When the participant is prescribed a specialty medication, Express Scripts will reach out to:

- Educate the participant about the medication,
- Help the participant enroll in the manufacturer's rebate program, and
- Reduce the pharmacy expense that would normally apply to the participant's deductible and out-of-pocket maximum.

TELEPHONIC/VIRTUAL HEALTH CARE SERVICES

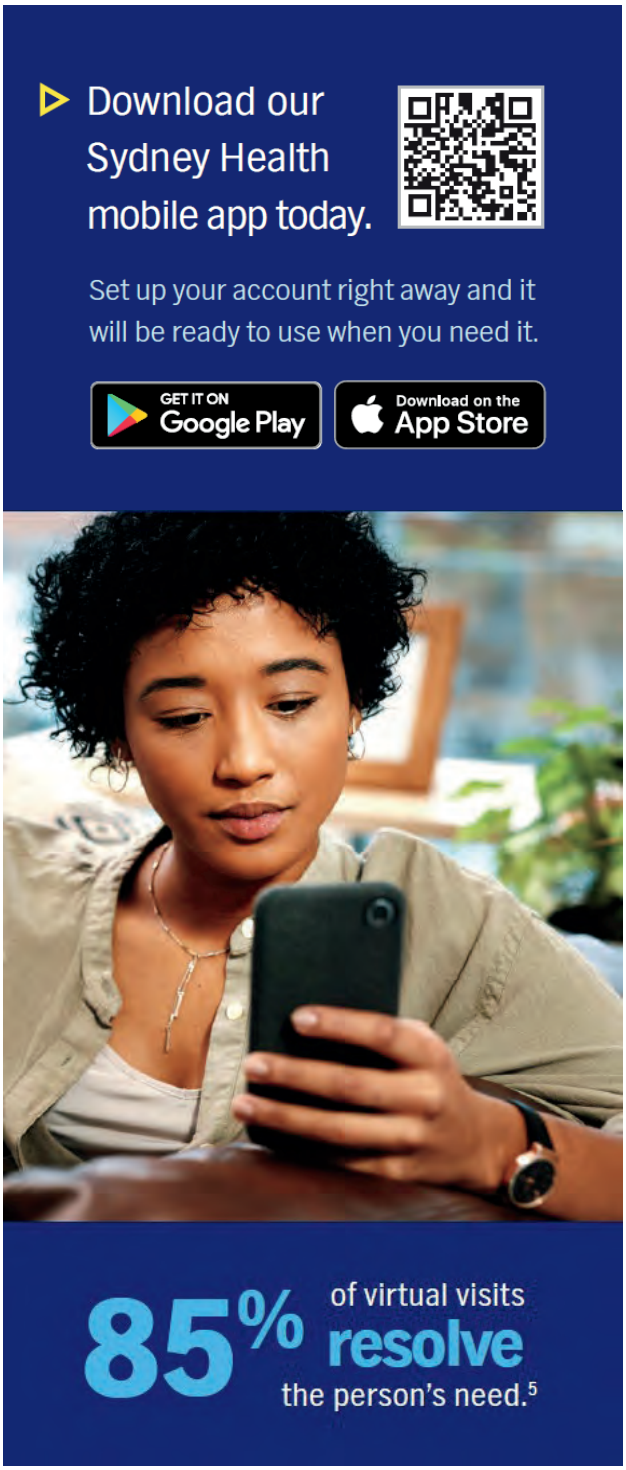
— AVAILABLE THROUGH THE MEDICAL PLAN

When you're not feeling well, you want to feel better fast. With LiveHealth Online, you don't need to make an appointment. Using LiveHealth Online, you can visit with a board-certified doctor, psychiatrist or licensed therapist through live video on your smartphone, tablet or computer with a webcam. It's an easy and convenient way to get the care you need.

Sign up by visiting livehealthonline.com or download the free Sydney Health app and sign up on your smartphone or tablet.

Through Anthem's LiveHealth Online, doctors are available 24 hours a day, seven days a week, 365 days ayear to address your minor health concerns, including:

- Fever
- Sore throat
- Cough and colds
- Flu
- Urinary tract infections
- Sinusitis
- Allergies
- Psychiatry & Psychology



CONSIDER A VIRTUAL PRIMARY CARE PHYSICIAN THROUGH LIVEHEALTH ONLINE

Visit with a doctor at your convenience.
Accessing the care you need, when you need it, matters. That's why our Sydney℠ Health mobile app connects you to a team of doctors ready to help you on your time.

Schedule a virtual primary care appointment.

- Routine care, including virtual annual preventive care (wellness) visit and prescription refills.
- Personalized care plans for chronic conditions, such as asthma or diabetes.

Assess your symptoms with the Symptom Checker.
When you're sick, you can use the Symptom Checker on Sydney Health to answer a few questions about how you're feeling. That information is run against millions of medical data points to provide care advice tailored to you.

Save money and time with virtual care.
Sydney Health brings care to you anywhere, anytime. The Symptom Checker is always free to use, while virtual primary care visits and on-demand urgent care through the app are available at low or no-additional cost.

New in 2024

COACHING PROGRAMS THROUGH ANTHEM'S LIVEHEALTH ONLINE

Briggs & Stratton has partnered with Anthem to offer coaching for eligible medical plan participants who have high blood pressure, are experiencing back and joint pain, are at risk for diabetes or need to lose weight.

The programs connect participants with a specially trained coach to give guidance, support and education. The coach will work collaboratively with a board-certified doctor in a manner designed to complement traditional medical care. These programs also promote medication management and pharmacy compliance.

Participants can schedule their own appointments (7 days a week) and can meet with their coach at home, at work or on the go.

As a reward for participating in the program, patients will benefit from reduced copays for medications and supplies related to their condition.

HEALTHY BLOOD PRESSURE

High blood pressure is especially dangerous because people can have it for years without knowing. In fact, 1 in 3 Americans have high blood pressure, and less than half have their condition under control. Medical research has shown that lowering blood pressure reduces cardiovascular risk by 20% - 25% for heart attack, 35%-40% for stroke and by 50% for heart failure.

Once the participant chooses his/her coach, the Healthy Blood Pressure program provides a web-connected blood pressure monitor. The program follows guidelines from the Centers for Disease Control and Prevention (CDC) to help you make small changes that can improve your health and decrease your risk over time.

HEALTHY BACK AND JOINT (Through SWORD)

Struggling with joint or muscle pain? Four out of 5 employees with chronic pain are not receiving expert-recommended non-surgical preventative care. Pain, muscle tightness, stiffness in the back and joints left untreated will continue to worsen as we get older. While there's no way to cure or reverse the disorder, there are tried-and-true ways to prevent it or keep it from getting worse. Doctors recommend a healthy diet, weight management and regular exercise. It may sound counterintuitive, but exercise strengthens the muscles around the joints to take the pressure off them.

Once you enroll, you are assigned a Doctor of Physical Therapy who will work with you to prevent and treat pain, help with recovery and more. You will get to select your own Physical Therapist, who will be with you throughout your program to answer questions and make sure you stay on track.

The Digital Therapist is accessible via the tablet that will be mailed to you. Our Digital Therapist uses motion sensor technology and artificial intelligence to guide exercises to completion and collects real-time feedback so your PT can adjust your next session accordingly. Get back to living a pain-free life!

HEALTHY WEIGHT

Nearly 40 percent of Americans 51 and older are overweight. Excess body fat increases the risk for high blood pressure, high blood sugar levels, high cholesterol and other chronic diseases.

Losing weight has many health benefits — and you don't need to lose that much weight to achieve them. Research shows that losing just 5% to 10% of your body weight may improve mental health and reduce your risk of cardiovascular disease and certain cancers. Losing weight also alleviates pressure on knees and joints, which can improve mobility.

LiveHealth Online creates an engaging experience where the participant and health coach can see real-time results with the use of connected scales. Start the journey to improve your health and live an active lifestyle.

PREVENTING DIABETES

Too much glucose in the blood for a long time can cause problems. High blood glucose, also called hyperglycemia, damages nerves and blood vessels. If not controlled, diabetes can lead to complications such as heart disease, stroke, kidney disease, blindness, nerve damage and amputations.

Participants in the diabetes program work with a coach to keep their blood sugar levels within a safe range to slow the progression of the disease and prevent other complications from developing. Once the participant chooses his/her coach, the program provides a web-connected scale.

OTHER COACHING RESOURCES

Briggs & Stratton has partnered with Marathon Health to provide health coaching and education resources for members with a variety of health concerns. Additionally, employees and dependents (even those not enrolled in a Briggs & Stratton medical plan) may participate in the tobacco cessation program.

Marathon Health

Coaching

- Diabetes
- Weight loss/Diet/Nutrition
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Low Back Pain
- Tobacco Cessation
- Stress Management
- Sleep Issues

Online Health Workshops

- Alcohol Abuse & Drug Addiction
- Arthritis
- Asthma
- Cardiovascular Disease
- COPD
- Depression
- Exercise
- And more... log on to my.marathon-health.com.

LET'S GET STARTED!

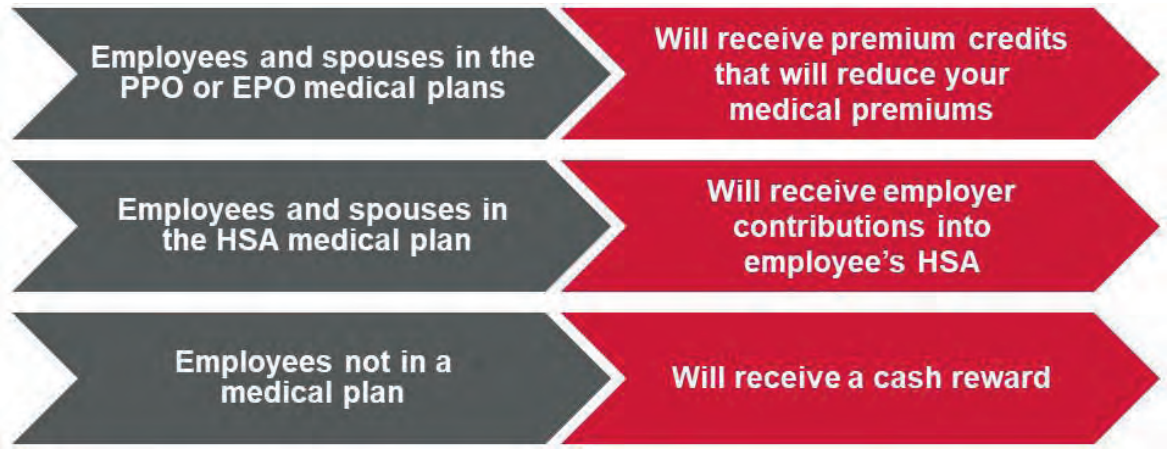
Schedule a health coaching visit and view your wellness program.
802-500-3276 | my.marathon-health.com

Briggs & Stratton Wellness Program

Briggs & Stratton is committed to providing you with the resources to promote physical, emotional and financial wellness. Whether you are just starting your wellness journey or are well on your way, Briggs & Stratton's Wellness Program is designed to support and motivate you every step of the way.

PROGRAM HIGHLIGHTS

- ✓ Focus on improving or maintaining your health numbers
- ✓ Earn points for your biometric screening values and other wellness activities



Payout of Rewards earned under the 2023 Wellness Program
(if you are still eligible for medical coverage in 2024):

- Rewards deposited into your HSA account will be available on your first paycheck of the year.
- Rewards in premium credits will be awarded in equal credits across all paychecks of the year.
- Rewards for employees who waived medical coverage will be paid out by the last payroll in January 2024.

2024 Wellness Program

- Runs from October 1, 2023 through September 30, 2024
- All paperwork must be submitted by September 30, 2024
- Earned rewards are paid in 2025

TO GET STARTED AND LEARN MORE

Log on to the **Marathon eHealth Portal** at my.marathon-health.com or contact a Marathon Health Wellness Coordinator at (802) 846-4675 or wellness@marathon-health.com. Full program details are available on the Wellness portal.

Consider participating in the Briggs & Stratton Wellness Program.

The Briggs & Stratton Wellness Program is designed to complement the benefits of the medical program. If you (and your covered spouse) participate in the program, Briggs & Stratton will provide employer contributions into your HSA or lower your medical premiums through premium credits, depending on the medical plan you have chosen. *(Scan the QR code for more information).*

HOW TO EARN WELLNESS REWARDS

Briggs & Stratton's Wellness Program goes beyond simply knowing your personal health numbers. The program emphasizes the importance of having these numbers within optimal ranges. At the same time, it recognizes that change doesn't always happen overnight – but even small steps can have a positive impact on our overall health and well-being.

2024 Wellness Program Eligibility

- All benefits-eligible employees employed prior to 9/30/2024.
- Covered spouses who are enrolled in a Briggs & Stratton medical plan.

There are two steps to qualify for Wellness Rewards. The rewards earned by the employee and spouse are independent. To receive the employee reward, the employee must earn 5 points. To receive the spouse reward, the eligible spouse must earn 5 points.

1. **Know your numbers!** The Briggs & Stratton Wellness Program **requires** participating employees and their covered spouses to complete a biometric screening.
   a. Schedule your screening between 10/1/2023 and 9/30/2024.
   b. Receive extra points if the results are within optimal range.

BIOMETRIC	VALUES (Earn up to 3 points)	POINTS
REQUIRED Biometric Screening	• Attend an on-site screening event; • Make an appointment at our on-site clinics; or • Visit your primary care physician or healthcare provider. Form submission is only required for screenings completed by your healthcare provider.	**1**
Optimal Value *3 out of 4*	• Total Cholesterol/HDL ratio: Males <5.1 or Females <4.5 • Blood Pressure: <120/80 mmHG • BMI: 18.5 - 24.9 or waist circumference <35 inches (females) or <40 inches (males) • Fasting Blood Glucose: <100 mg/dl	2
Moderate Value *3 out of 4*	• Total Cholesterol/HDL ratio: Males 5.1 - 9.5 or Females 4.5-6.9 • Blood Pressure: 120 - 139 mmHG SBP and 80-89 mmHG • BMI: 25 - 29.9 • Fasting Blood Glucose: 100 - 125 mg/dl	1

2. **Choose the wellness activities that are meaningful to you.** Employees and eligible spouses may pick from the list of wellness activities below to earn additional points.

ACTIVITY – *Login to: my.marathon-health.com*	POINTS
Tobacco Free/User Status • Complete the Online Tobacco Free Statement; or • Complete the 6-week Tobacco Cessation Online Workshop	2
Online Health Assessment	1
Preventative Health Exam	2
Age/Gender Appropriate Screening/Exam (choose 1) Includes: mammogram, dental exam, vision exam, pap smear, colonoscopy, prostate screening, skin check	1
Flu Shot (Influenza Vaccine) or COVID-19 Vaccine	1
Health Coaching (3 sessions): Complete in-person or telephonic coaching sessions with a Marathon Health clinician, health coach or participation in the LiveHealth Online coaching programs	2
Online Marathon Health Workshop: Visit the eHealth Portal (my.marathon-health.com) for available topics	1
Financial Wellness Activity: Complete Fidelity's Money Checkup or Planning – go to www.401k.com.	1
Participate in a community fitness event such as a 5K, triathlon or bike race.	1

DENTAL INSURANCE

Regular dental exams can help you and your dentist detect problems in the early stages when treatment is simpler and costs are lower. Keeping your teeth and gums clean and healthy will prevent most tooth decay and periodontal disease and is an important part of maintaining your physical health.

Briggs & Stratton's comprehensive dental plan is administered by Delta Dental and features two routine preventive check-ups per person per year covered at 100%, not subject to the annual limit.

BENEFITS HIGHLIGHTS	DELTA DENTAL PPO *or* DELTA DENTAL PREMIER NETWORK	OUT-OF-NETWORK *(Reasonable & Customary Apply)*
Deductible	$25 per member, $75 per family	
Annual Maximum	$1,500 per member	
Class I–Preventive *Exams, Cleanings, Fluoride[1], Sealants[2], Treatments and X-Rays (Bitewing Twice Every 12 months - Full Mouth Once Every 3 Years)*	Covered 100%, Deductible Waived *(diagnostic and preventive dental services are not applied to the individual annual maximum)*	Covered 100%, Deductible Waived
Class II–Basic Fillings *Periodontics, Root Canals, Emergency Exams and Simple Extractions*	Covered 80% after Deductible	Covered 80% after Deductible
Class III–Major *Crowns/Inlays/Onlays, Bridges and Dentures, Implants to Replace Missing Permanent Teeth*	Covered 50% after Deductible	Covered 50% after Deductible
Class IV–Orthodontic	Covered at 50%, up to $1,500 lifetime maximum per employee, spouse and dependent child to age 26	

[1,2] Age limitations apply

DELTA DENTAL NETWORK PROVIDERS

You may use any provider you wish, but your cost is lower if you use a Delta Dental network provider. Delta Dental provides two preferred networks of dentists from which to choose. Delta Dental pays network providers directly. For the most up-to-date listing of participating dentists in your area, go to https://www.deltadentalwi.com/s/find-a-provider.

- **Delta Dental PPO Dentists –** provides the deepest discounts for your dental services. You are responsible for paying any deductible, coinsurance and fees for procedures not covered or that exceed the plan maximums.
- **Delta Dental Premier Dentists –** These providers have agreed to not charge you for any amount that exceeds agreed-upon fees except for expenses you are responsible to pay, such as any deductible, coinsurance and fees for procedures not covered or that exceed the plan maximums.
- **Non-contracted dentists –** If you choose a dentist who is not contracted with Delta Dental, you will be responsible to pay the billed charges for services performed and payment from Delta Dental will be sent directly to you.

EVIDENCE-BASED INTEGRATED CARE PLAN (EBICP)

If you or your family member is enrolled in the plan and have one of the medical conditions listed below, you may be eligible for additional dental cleanings and/or topical fluoride applications. These services are covered as described as preventive.

Please note that the periodontal cleanings are not considered preventive and are covered under the Basic Restorative benefit of your plan. For more information, contact Delta Dental and advise them of your condition so that they can noteyour account accordingly.

- High risk cardiac conditions
- Suppressed immune systems
- Kidney Failure or Dialysis
- Cancer Therapy
- Diabetes
- Pregnancy
- Periodontal Disease

HOW DOES OUR DENTAL PLAN COORDINATE WITH OTHER INSURANCE COVERAGE?

If you are covered by more than one group medical plan, there are “coordination of benefits” (COB) rules that determine which plan is primary (pays benefits first), and which plan is secondary (pays benefits after the primary plan pays). Under our dental plan, our COB provision follows **the traditional rule**. It allows the beneficiary to receive up to 100% of the cost of the claim when you combine both the primary and secondary plans.

	EXAMPLES BASED ON A $900 BILL FOR A CROWN		EXAMPLE 1	EXAMPLE 2
Coordination of benefits when the Briggs & Stratton dental plan is the secondary payor.	Normal Benefits Paid B&S Plan		$450	$450
	Normal Benefits Paid by the Primary Plan		$300	$500
	After Coordination of Benefits	B&S Pays	$450	$400
		You Pay	$150	$0

YOUR COST FOR DENTAL COVERAGE

	PER PAYCHECK		ANNUAL CONTRIBUTIONS	
Coverage Tier	Hourly (52 periods)	Salaried (24 periods)	EMPLOYEE	EMPLOYER
Single	$1.68	$3.65	$87.57	$262.71
Employee + Spouse	$3.71	$8.03	$192.69	$578.07
Employee + Child(ren)	$3.37	$7.30	$175.20	$525.24
Family	$5.39	$11.67	$280.08	$840.84

VISION INSURANCE

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

If you are a medical plan participant, you are eligible for an annual preventive vision exam under your medical plan. As long as you use your medical plan provider's network and the provider bills the vision exam as routine, the exam will be covered in full.

VOLUNTARY VISION INSURANCE

If you are interested in additional vision coverage, or if you waive our medical insurance, the DeltaVision Preferred plan may be a good fit for you. DeltaVision offers a voluntary vision plan administered by EyeMed Vision Care, the industry's largest diverse network. This plan includes coverage for important preventive eye care, eyewear and discounts on laser vision correction. Since this is a voluntary plan, the total premium cost is paid by you ona pre-tax basis.

DELTAVISION PREFERRED			
PLAN FEATURE	FREQUENCY	MEMBER PAYS	
		EYEMED ACCESS NETWORK	OUT-OF-NETWORK (NON-EYEMED PROVIDER)
Eye Exam	Once every 12 months (to the day)	Payable in Full	$35 allowance, then member pays balance
Eyeglasses – Frames	Frames covered every 24 months	$130 allowance, then 20% off balance	$65 allowance, then member pays balance
Eyeglasses – Standard Plastic Lenses*	Lenses covered every 12 months**	Member pays $0	Single vision - $25 allowance, Bifocal - $40 allowance, or Trifocal - $55 allowance, then member pays balance
Contact Lenses*	Lenses covered every 12 months**	$150 allowance, then 15% off balance	$96 allowance, then member pays balance
Contact Lens Fit and Follow-up (standard contact lenses)	Once every 12 months (to the day)	Member pays $0	$40 allowance, then member pays balance
Corrective Surgery (i.e. Lasik)	See your provider for details	Member pays 85% of retail or 95% of promotional cost	Member pays 100% (no discounts)

*Basic Lenses paid in full by the plan if purchased at an in-network provider. Additional discounted charges may apply for add-ons, such as anti-reflective coating, progressive lenses and scratch-resistant coatings. A 20% discount applies to items not covered by the Plan at network providers, may not be combined with any other discounts or promotional offers and does not apply to EyeMed provider's professional services or contact lenses. Retail prices may vary by location. Members also receive a 40% discount on complete eyeglass purchases and a 15% discount on conventional contact lenses once the funded benefit has been used.

**Lenses or contact lenses are covered every 12 months, not both.

EYEMED PROVIDER NETWORK: ACCESS NETWORK

For the most up-to-date listing of EyeMed providers in your area, visit EyeMed's website at www.eyemedvisioncare.com and use the Provider Locator service to locate providers in the **ACCESS** network. You can also contact your current eye care professional and ask if they are a member of the EyeMed Access network.

THINGS TO CONSIDER BEFORE MAKING YOUR ELECTION

- Compare the annual cost of this plan plus the available discounts and/or putting money aside in a Health Savings Account or Health Care Flexible Spending Account.
- If you have a medical condition billed along with a routine vision exam, a portion of the exam may not be paid in full when using your medical plan routine vision benefit.
- Compare discounts available for frames/lenses through EyeMed vs. sales offered through your local vision provider.

YOUR COST FOR VISION COVERAGE

Coverage Tier	PER PAYCHECK		ANNUAL CONTRIBUTIONS
	Hourly (52 periods)	Salaried (24 periods)	EMPLOYEE
Single	$1.52	$3.29	$78.84
Employee + Spouse	$3.03	$6.57	$157.56
Employee + Child(ren)	$3.33	$7.23	$173.40
Family	$4.40	$9.54	$228.84

DISCOUNTS ON PRESCRIPTION SAFETY GLASSES

Safety-certified lenses and frames are much stronger than regular glasses. You may be eligible to get the right prescription safety glasses for your job with the EyeMed Safety Eyewear Program.

Participating providers include select Lenscrafters, Pearle Optical and Target Optical.

FLEXIBLE SPENDING ACCOUNTS

Briggs & Stratton offers an employer-sponsored flexible spending account (FSA) administered by Optum. Flexible Spending Accounts help you save money by reducing the amount of income tax you pay. Employees may deposit pre-tax money for health care or dependent daycare each Calendar Year (January 1– December 31) to offset eligible expenses. The accounts require two separate elections.

WHAT ARE THE BENEFITS OF AN FSA?

There are a variety of different benefits of using an FSA, including the following:

- **It helps you set aside money.** Allows you to put aside money tax-free that can be used for qualified medical, dental and vision expenses.
- **It's a tax-saver.** Since your taxable income is decreased by your contributions, you'll pay less in taxes.
- **It is flexible.** You can use your FSA funds at any time, even at the beginning of the year.

SCAN ME to learn more about the Flexible Spending Accounts

- *Videos*
- *Flyer/Brochures*
- *Online Tools & Resources*

IMPORTANT RULE TO REMEMBER: "Use it or lose it"

If you do not use all the funds in your account by the end of the calendar year, the funds will be forfeited, as required by law. You should only contribute the amount of money you expect to pay out-of-pocket that year.

ACCOUNT OPTIONS:

- **Health Care FSA (HCFSA)** Health Care FSAs allow you to contribute pre-tax dollars to pay for or reimburse yourself for qualified medical, pharmacy, dental and vision expenses that you and your dependents may incur. Your full annual election will be available to you with your first payroll contributionof the plan year. **You may contribute any amount between $260 and $3,050 in calendar year 2024.**
- **Limited Purpose Health Care FSA (LPFSA)** You are eligible for this account if you or your spouse is enrolled in a Health Savings Account (HSA). The Plan allows you to set aside additional money pre-tax for certain dental and vision expenses not covered by insurance. Once your medical deductible has been met, you may use your LP HCFSA for medical expenses. **You may contribute any amount between $260 and $3,050 in calendar year 2024.**
- **Dependent Daycare FSA (DCFSA)** Dependent Daycare FSAs allow you to save pre-tax dollars for qualified dependent daycare. These funds can be used to pay for or reimburse yourself for **eligible daycare expenses** for your children or elderly family members while you work. **In calendar year 2024, you may contribute any amount between $260 and $5,000 (or $2,500 if married and filing separately).**

FSA CASE STUDY

FSAs provide you with an important tax advantage that can help you pay for expenses on a pre-tax basis. Due to the personal tax savings you incur, your spendable income will increase. The example that follows illustrates how an FSA can save money.

Bob and Jane live in Texas and have a combined annual gross income of $45,000. They are married and file their income taxes jointly. Since Bob and Jane expect to spend $3,000 in eligible medical expenses in the next plan year, they decide to direct a total of $2,850 (the maximum allowed amount per individual, for that taxable year) into their FSAs. The table demonstrates their savings.

	WITHOUT FSA	WITH FSA
Gross income	$45,000	$45,000
FSA Contributions	$0	(-$2,850)
Gross income	$45,000	$42,150
Estimated taxes	(-$5,532)	(-$4,987)
After-tax earnings	$39,468	$37,163
Eligible out-of-pocket expenses	(-$3,000)	(-$150)
Remaining spendable income	$36,468	$37,013
Spendable income increases	—	$545

HEALTH SAVINGS ACCOUNTS

Health savings accounts (HSAs) are a great way to save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHPs). The funds may be used to pay for eligible medical, pharmacy, dental and vision expenses. This includes costs that apply to your deductible and coinsurance maximum. Please note, that if you are enrolled in Medicare or any other medical plan that is not HSA-qualified, you are not eligible to enroll in the HSA.

WHAT ARE THE BENEFITS OF AN HSA?

There are many benefits of using an HSA, including the following:

- **Save today. Spend whenever.** With an HSA, there's no "use it or lose it" rule. You decide whether to spend your money on health care expenses now or build your savings for expenses later. Any Wellness Rewards deposited into your HSA belong to you too.
- **Your savings grow tax-free.** Once your account has reached a threshold, you may be able to invest a portion of your HSA in mutual funds. Visit optumbank.com to learn more.
- **It is portable.** The money in your HSA is carried over from year to year and is yours to keep, even if you leave the company.
- **It is a tax-saver—**HSA contributions are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you'll pay less in taxes.

The maximum amount that you can contribute to an HSA in 2024 is:

- **$4,150 for individual coverage and**
- **$8,300 for "employee plus dependent(s)" coverage**
- **Employees age 55 or older may make an additional "catch-up" contribution of $1,000**

You may change your contribution amount at any time throughout the year as long as you don't exceed the annual maximum.

Note for Annual Enrollment: Your 2023 HSA contributions will "roll-over" to 2024. Make sure to review the contribution amount during Annual Enrollment, as mid-year changes will impact the amount defaulted for 2024.

HSA CASE STUDY

Justin is a healthy 28-year-old single man who contributes $1,000 each year to his HSA. His plan's annual deductible is $1,850 for individual coverage. Here is a look at the first two years of Justin's HSA plan, assuming the use of in-network providers. (This example only includes HSA contribution amounts and does not reflect any investment earnings.)

YEAR 1	
HSA Balance	$1,000
Total Expenses: – Prescription drugs: $150	(-$150)
HSA Rollover to Year 2	$850
Since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

YEAR 2	
HSA Balance	$1,850
Total Expenses: – Office visits: $100 – Prescription drugs: $200 – Preventative care services: $0 (covered by insurance)	(-$300)
HSA Rollover to Year 3	$1,550
Once again, since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

HOW TO SET UP YOUR HEALTH SAVINGS ACCOUNT

We've partnered with Optum to provide a no-fee HSA account. During the enrollment process, you will authorize us to set up a bank account on your behalf at Optum. Once you have passed the vetting process*, you will receive a Welcome Kit and debit card.

- **If you elect to participate,** the account will be set up for you based on your election. You can elect to make pre-tax contributions of your own or opt to contribute $0 and just receive the Wellness Program Reward contributions. You can always make changes to your pre-tax contributions throughout the year.
- **If you elect the HSA medical plan,** but choose not to establish an HSA, you will not receive the Wellness Program Reward contributions. If you elect to establish an account mid-year, your Wellness Program Reward contributions will begin at that time.
- **If you are already an Optum Bank HSA account holder and wish to keep your HSA account,** you will still need to elect your HSA account, even if you are not contributing at this time. A new account number will not be created if you notify Optum and request that they link your existing account with Briggs & Stratton, using our Group ID HB3767.

***Vetting requirements and providing additional documentation to Optum**

- In accordance with the US Patriot Act, Optum Bank performs a CIP (Customer Identification Program) screening on all HSA applicants. The US Patriot Act sets forth minimum requirements that a bank must adhere to when a customer opens a new account or obtains a product of service. In certain situations, the bank is required to obtain additional documentation to open the employee's account, such as a copy of a Social Security card or a valid photo ID with your address.
- If Optum does not receive the required information and cannot open an account, any employee contributions will be returned to the company and credited back to your paycheck as taxable income.

SCAN ME to learn more about the Health Savings Accounts

- *Videos*
- *Flyers / Brochures*
- *Online Tools & Resources*

HSA OR FSA

WHICH IS THE BEST ACCOUNT FOR ME?

Choosing benefits is a personal decision. These types of accounts can help you to save for health care expenses, but they do so in different ways. In choosing which option is best for you, you'll want to consider other factors such as those listed below.

ACCOUNT FEATURE	HEALTH SAVINGS ACCOUNT (HSA)	HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA)
You may contribute pre-tax contributions	Yes	Yes
Briggs & Stratton Wellness Rewards will be deposited into the account	Yes	No
Maximum Annual Contribution	$4,150/ Individual $8,300/ Family	$3,200 per taxpayer
Money in your account can earn tax-free interest and dividends	Yes	No
Unused balances will be carry over into the next year	Yes	No
Portability (you can take it with you)	Yes You will be responsible for maintenance fees if they apply.	No (Only if you elect COBRA and continue to make after-tax contributions)

SHORT-TERM DISABILITY

If you become temporarily disabled and unable to work, the loss of your income could make it difficult to manage your expenses. Disability benefits provide you with income protection in the event that you are unable to work due to an injury, illness or maternity leave. Briggs & Stratton provides this benefit at no cost to you, so you can focus on getting better and worry less about your bills.

- **Maximum benefit period -** Once approved, this benefit pays until the earlier of one-half the employee's length of service, or up to a maximum of 26 weeks, or until you are no longer disabled and able to return to work, as defined by the plan.
- **Elimination period -** the period of time between the onset of a disability, and the time you are eligible for benefits. In general, the elimination period could be up to seven calendar days.
- **How to apply -** Contact HR to report an absence or to receive a disability brochure and then call New York Life at (888) 842-4462 or log in to www.mynylgbs.com.

Refer to the Employee Handbook or policy information located on the benefits portal at mylinks.basco.com & select *Success Center>Benefits*. We have partnered with New York Life to provide our disability leave management. In the event that you need to report an absence or disability, make sure to notify your HR representative.

VOLUNTARY LONG-TERM DISABILITY

Long-term disability benefits begin if you have an illness or injury that prevents you from working for more than 26 weeks. It pays 60% of your monthly covered earnings. The maximum amount and duration of the benefit is based on your employment. You must be actively at work on the effective date of the insurance in order for the coverage to take effect. If you enroll in long-term disability when you are initially eligible, Evidence of insurability (EOI) is not needed. If waived initially, EOI would need to be completed for any future enrollments. Please see the EOI section on page 22 for more information.

Pre-existing Condition Limitation - Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, received medical treatment, care or services (including diagnostic measures), or for which a reasonable person would have consulted a physician during the 3 months just prior to the most recent effective date of insurance. Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured under this plan for at least 12 months after your most recent effective date of insurance.

LEAVE OF ABSENCE

Briggs & Stratton is committed to providing quality support and resources to our employees when they experience personal, family or medical needs that can require an employee to request time away from work.

Employees are required to request a leave of absence if they are going to miss three consecutive business days, or up to 10 intermittent days, due to one of the following situations:

- For incapacity due to pregnancy, prenatal medical care or child birth
- To care for the employee's child following the birth or placement for adoption or foster care
- To care for the employee's spouse, son, daughter or parent who has a serious health condition
- For a serious health condition (either work-related or non-work-related) that makes the employee unable to perform their job
- For military service, training or reserve duty

How to Request a Leave of Absence

- Call (888) 842-4462
- Log in to www.mynylgbs.com

Employees are required to notify their supervisor of:

- Missed work due to illness, injury or leave of absence
- Changes in work schedule, return to work or restrictions

The attendance policy will apply when employees fail to call New York Life or comply with call-in procedures.

BASIC LIFE & AD&D INSURANCE

Briggs & Stratton provides benefits-eligible employees with group term life and accidental death and dismemberment (AD&D) insurance through New York Life.

All employees have coverage in the amount of two times your annual base pay up to a maximum of $500,000. You may choose a lower amount of $50,000 to avoid imputed income taxes applied to coverage above $50,000. There is an age reduction with this plan. At age 65, the benefit reduces to 65% and at age 70, the benefit reduces to 50%.

Remember to designate your life insurance beneficiaries when first eligible and review them annually.

VOLUNTARY EMPLOYEE LIFE AND AD&D INSURANCE

While Briggs & Stratton offers basic term life insurance, some employees may want to purchase additional coverage. Life insurance can help you financially plan for the unexpected. Your loved ones can use these benefits to pay for expenses like mortgage or rent, tuition, car payment and even day-to-day expenses like utilities.

In your initial enrollment, you may purchase 1, 2 or 3 times your annual base pay (rounded to the next higher $1,000), up to a maximum of $500,000 without Evidence of Insurability (EOI). In following years, you may increase your coverage by one level each enrollment period without EOI. If waived initially, EOI will need to be completed for any future enrollments. Please see the EOI section on page 25 for more information.

There is an age reduction with this plan. At age 65, the benefit reduces to 65% and at age 70, the benefit reduces to 50%.

VOLUNTARY DEPENDENT LIFE INSURANCE

You can purchase coverage for your spouse and/or your dependent children up to age 26.Voluntary dependent options are:

- Spouse: you can elect $10,000; $20,000; $30,000; $40,000 or $50,000 of coverage, up to the lesser of $50,000 or 100% of employee's total life insurance amount
- Dependent Children: you can elect $5,000; $10,000; $15,000 or $20,000 of coverage

There is an age reduction with the spouse plan. At the spouse's age of 65, the benefit reduces to 65% and at the spouse's age of 70, the benefit reduces to 50%.

In your initial enrollment, you may elect up to $50,000 of life insurance for your spouse without the need to complete Evidence of Insurability (EOI) for your spouse. Once enrolled, in future year enrollment periods, you may increase spousal coverage by $10,000 each year, up to a maximum of $50,000, without EOI. If spousal coverage is waived initially, EOI would need to be completed by your spouse to elect $10,000 of coverage during the annual enrollment period. Once enrolled in the plan, spousal coverage may be increased by $10,000 each year up to a maximum of $50,000, without EOI. Please see the EOI section below for more information.

EVIDENCE OF INSURABILITY (EOI)

When Evidence of Insurability (EOI) is required, after you've completed your enrollment, you will be taken to the life insurance website to respond to a few brief questions regarding your health and/or your spouse's health. Coverage will be accepted immediately or pended. New York Life will contact you for additional information, if needed.

- New coverage will not go into effect until New York Life has approved your request. You will be notified in writing as to whether coverage is approved or denied.
- If you did not complete the online questions following enrollment, you still have another opportunity to complete the questions. Log onto the benefits portal and click on "View All Benefits" located at the bottom of the My Benefits section. A link to the New York Life website will appear under the requested life insurance benefits. If no response is received after 30 days, your coverage request will be closed and you will need to wait for the next annual enrollment or if you have a qualifying life status event.

YOUR COST FOR VOLUNTARY INSURANCE COVERAGE

With voluntary life insurance, you are responsible for paying the full cost of coverage through payroll deductions. Your premium cost is based on the amount of coverage and your age as of 12/31 of the plan year. Log into the Briggs & Stratton benefits portal to view the premiums.

CRITICAL ILLNESS

When a serious illness strikes, critical illness insurance through Cigna can provide financial support to help you through a difficult time. Critical illness plans pay a lump-sum cash benefit upon diagnosis of a covered condition which you can use in any way that meets your needs.

Employees can choose a benefit amount from $10,000 to $40,000 in $10,000 increments. Employees can cover their spouse and/or children as well at 50% of their employee elected amount. Rates are based on your age and the amount of coverage you elect. Please refer to the Briggs & Stratton benefits portal for detailed rate information.

To help prevent illness, this plan can also pay you an annual wellness benefit of $50 per covered person per calendar year if you or your covered dependents complete a covered health screening such as a physical exam, total cholesterol blood test, mammogram, lipid panel and more. Just call 800-754-3207 to speak with a dedicated customer service representative.

AM I GUARANTEED COVERAGE?

Eligible employees are guaranteed to receive the coverage without answering any health questions. There are no limitations for pre-existing conditions and this benefit is portable if you leave Briggs & Stratton. You must be actively at work on the effective date of the insurance in order for the coverage to take effect. Please note you can only drop this plan during the Annual Enrollment period or due to death or divorce.

The chart below illustrates covered conditions and the benefit amount that would be paid. Please refer to the full plan document for all details, limits and exclusions.

Cancer Conditions	Benefit Amount
Invasive Cancer	100%
Noninvasive Cancer	25%
Skin Cancer	$500 (1x per lifetime)
Vascular Conditions	**Benefit Amount**
Heart Attack, Stroke	100%
Coronary Artery Disease, Aortic & Cerebral Aneurysm, Advanced Heart Failure	25%
Nervous System Conditions	**Benefit Amount**
Advanced Stage Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Parkinson's Disease, Multiple Sclerosis, Mild Stage Alzheimer's Disease	100%
Huntington's Disease, Myasthenia Gravis	25%
Infectious Conditions	**Benefit Amount**
Bacterial Meningitis, Malaria, Tuberculosis, Necrotizing Fasciitis, Osteomyelitis, Severe Sepsis	25%
Other Specified Conditions	**Benefit Amount**
Benign Brain Tumor, Blindness, End-Stage Renal (Kidney) Disease, Major Organ Failure, Paralysis, Loss of Hearing, Loss of Speech	100%
Coma, Systemic Lupus, Systemic Sclerosis, Advanced Obesity, Crohn's Disease, Pulmonary Embolism	25%
Childhood Conditions	**Benefit Amount**
Cerebral Palsy, Cystic Fibrosis, Muscular Dystrophy, Poliomyelitis, Heart Wall Malformation, Sickle Cell	100%

ACCIDENT INSURANCE

You can't always avoid accidents but you can protect yourself from accident-related costs that can strain your budget. Accident coverage is a medical plan that provides employees and their families with a fixed cash benefit when you have a covered accident-related injury[1], like an ankle sprain or arm fracture.

As medical costs continue to rise, CIGNA's accident insurance provides a financial safety net that provides you with financial aid when you need it the most.

WHAT TYPES OF INJURIES ARE COVERED?

- Broken bones
- Burns
- Torn ligaments
- Cuts repaired by stitches
- Eye injuries
- Dislocations
- Concussions
- Emergency dental

WHAT TYPES OF TREATMENT ARE COVERED?

- Outpatient surgery
- Doctor's office visits
- Diagnostic lab & x-rays
- Ambulance
- Imaging (e.g. CT Scans, MRIs)
- Hospitalization
- Occupational Therapy
- Speech Therapy
- Chiropractic Visit
- Physical Therapy
- Urgent Care

HOW MUCH DOES THIS PLAN PAY?

The amount you receive depends on your injury and the treatment you receive, usually a set amount for specific covered injuries or care. In addition, the plan pays:

- $50 annual wellness benefit; call 800-754-3207 to speak with a dedicated customer service representative
- Sports Injury benefit that increases the reimbursement by 25%
- Accidental Death & Dismemberment (AD&D) benefit

HOW WILL I RECEIVE PAYMENT?

The benefit will be paid directly to you in one lump-sum payment. The benefit amounts will be paid regardless of the actual expenses incurred.

HOW CAN I USE THE MONEY?

You can use it any way you choose — for monthly bills, household expenses, co-pays, deductibles or other expenses your medical plan doesn't cover.

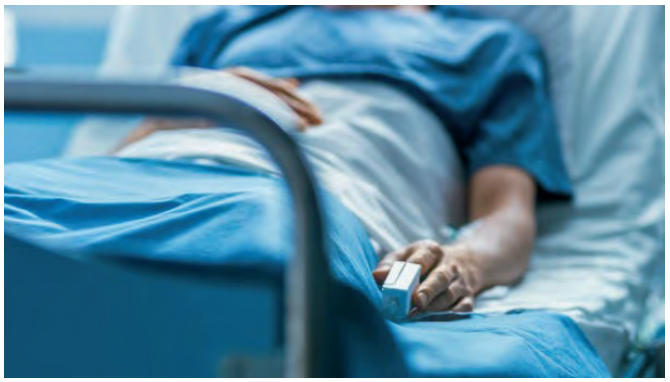
AM I GUARANTEED COVERAGE?

Eligible employees are guaranteed to receive the coverage without answering any health questions. There are no limitations for pre-existing conditions and this benefit is portable if you leave Briggs & Stratton. You must be actively at work on the effective date of the insurance in order for the coverage to take effect. Please note you can only drop this plan during the Annual Enrollment period or due to death or divorce.

Tier Level	Per Paycheck Hourly (52 periods)	Per Paycheck Salaried (24 periods)	Annual Contributions
Employee	$1.76	$3.81	$91.52
Employee + Spouse	$3.06	$6.63	$159.12
Employee + Child(ren)	$3.69	$8.00	$191.88
Family	$4.99	$10.81	$259.48

[1] *The plan provides 24 hour coverage for injuries on or off the job.*

HOSPITAL INDEMNITY



Medical bills can add up quickly after having to stay in the hospital. Cigna's hospital indemnity insurance can help ease the financial burden of a hospital stay as it pays a fixed cash benefit directly to you when you experience a covered hospital stay for events like an in-patient procedure or childbirth.

AM I GUARANTEED COVERAGE?

Eligible employees, spouses and children are guaranteed to receive the coverage without answering any health questions. There are no limitations for pre-existing conditions and this benefit is portable if you leave Briggs & Stratton. You must be actively at work on the effective date of the insurance in order for the coverage to take effect. Please note you can only drop this plan during the Annual Enrollment period or due to death or divorce.

EXAMPLES OF BENEFITS PAID WHEN YOU EXPERIENCE A COVERED IN-PATIENT HOSPITAL STAY:

- Hospital Admission (Non-ICU and ICU): $1,000
- Hospital Stay: $100 per day (limit of 30 days)
- Hospital ICU Stay: $200 per day (limit of 30 days)
- Newborn Nursery Care Admission: $500
- Newborn Nursery Care Stay: $100 per day (limit of 30 days)

EXAMPLES OF BENEFITS PAID WHEN YOU EXPERIENCE A COVERED MEDICAL FACILITY STAY:

- Skilled Nursing Facility Care: $50 per day (limit of 30 days lifetime maximum)
- Substance Abuse Facility Care: $50 per day (limit of 30 days lifetime maximum)
- Medical Illness and Nervous Disorder Facility: $50 per day (limit of 30 days lifetime maximum)

This plan also provides a $50 wellness benefit per covered person per calendar year if you or your covered dependents complete a covered health screening such as a physical exam, total cholesterol blood test, mammogram, lipid panel and more. Call 800-754-3207 to speak with a dedicated customer service representative.

Tier Level	Per Paycheck Hourly (52 periods)	Per Paycheck Salaried (24 periods)	Annual Contributions
Employee	$2.44	$5.29	$126.88
Employee + Spouse	$5.89	$12.76	$306.28
Employee + Child(ren)	$4.03	$8.73	$209.56
Family	$7.48	$16.21	$388.96

BRIGGS & STRATTON 401(K) RETIREMENT PLAN

The Briggs & Stratton, LLC., 401(k) Plan ("the Plan") offers you a convenient way to save for your future through a combination of your own contributions and company contributions which includes both Matching contributions ("Match") and a "non-elective" Basic contribution ("Basic"). When you contribute a portion of your eligible pay to the Plan, the company will contribute up to 4% as a Match. Regardless of whether or not you contribute to the Plan, the company will provide a Basic contribution of 3%.

We encourage all employees to take an active role in the Plan and to choose a contribution rate and investment options that are appropriate for your retirement goals.

PARTICIPATION & ELIGIBILITY

- All employees are eligible to participate after 45 days of active employment.
- Employees may make their deferral election after their first paycheck is processed.

CONTRIBUTIONS TO THE PLAN

- Employee contributions to the plan are payroll-deducted each pay period.
- Participants may elect to defer between 1% - 75% of their eligible compensation (Pre-tax and/or Roth), up to the IRS maximum. In 2023, the employee contribution limits are:
  - **$22,500** for employees under age 50
  - **$7,500** for employees aged 50 and older
- The Plan accepts qualified 401(k) rollovers from previous employers or individual retirement accounts (IRAs).
- **Employees may change their contribution rate at any time by calling the Fidelity Benefits Service Center at (800) 835-5095 or by logging into www.netbenefits.com.**

AUTOMATIC ENROLLMENT

- Employees who do not enroll in the plan after 35 days are automatically enrolled in the Plan at a pre-tax contribution rate of 3% of eligible pay. Employees may change that percentage at any time.
- The deferral will be effective once the eligibility requirements have been met.
- The default investment is the Fidelity Freedom Index Fund – Institutional Premium Class based on the employee's date of birth and corresponding retirement date (assuming age of 65). Target date funds are an asset mix of stocks, bonds and other investments that automatically become more conservative as the fund approaches its target retirement date and beyond. Principal invested is not guaranteed.

VESTING

Employees are automatically 100% vested in the company contributions (both Match and Basic) and any related investment earnings.

ACCOUNT INFORMATION

- Briggs & Stratton offers a variety of investment options so that employees can pick what fits their personal investment style and retirement goals.
- The plan offers both managed account or brokerage account investment options.
- Active employees may take a loan from their 401(k) account balance.
- Withdrawals are allowed only under certain guidelines, and are restricted.

EMPLOYEE ASSISTANCE PROGRAM (EAP) AND HEALTH ADVOCACY

Briggs & Stratton's EAP & Health Advocacy program is a confidential, voluntary program provided at no cost to you and is administered by Health Advocate.

The EAP offers you and your immediate family members support and direction 24/7 with personal or job-related matters, such as, but not limited to:

- Relationship or family conflicts, parenting concerns
- Grief caused by a loved one's death
- Anxiety, depression, confusion or stress
- Child or elder care consultations and referrals
- Adoption consultation & referrals
- Drug and alcohol issues
- Conflicts at work
- Low self-esteem or insecurity
- Legal or financial referrals
- Education and financial aid research

The EAP gives you access to a network of highly trained, professional therapists. EAP providers handle short-term issues that can usually be resolved in a few sessions without the use of your medical plan benefits. If your situation requires more frequent or ongoing counseling services, the EAP will help determine the best treatment plan and assist in coordinating care with your health plan.

The advocacy program through Health Advocate can help you with:

- Getting answers to your insurance and claims questions
- Resolving billing issues
- Making informed decisions about medical conditions and ensuring you get the care you need
- Locating resources and professionals to help you manage your health and feel happier and more productive
- The online concierge service helps take some of the "extras" off your plate. They can help with restaurant reservations, event planning, ticketing, travel research and booking and more.

Contact Health Advocate via:
Phone: (866) 799-2728
Email: answers@HealthAdvocate.com/members
Website: www.HealthAdvocate.com/Briggs

HealthAdvocate℠

BRIGGS & STRATTON HEALTH CARE CENTER SERVICES

In addition to Briggs & Stratton's medical plan offerings, some locations have access to an on-site clinic. These health clinics are conveniently located and provide a variety of health care services similar to other medical providers, but at a lower out-of-pocket cost than what you'd pay elsewhere.

If you waive our medical coverage, you are still able to use the clinics for your healthcare needs, and the amount you pay is the same as the copay for employees enrolled in the PPO or Basic EPO plans. Expenses you incur at the clinics are submitted to your health insurance plan and the amount due will be based on whether your deductible and out-of-pocket maximums have been satisfied.

SERVICE / VISIT TYPE	PPO, BASIC EPO & WAIVED MEDICAL COVERAGE	HIGH-DEDUCTIBLE PPO WITH HSA
Preventative Care	No Charge	No Charge
Blood Drawing and Laboratory	No Charge	$12
Primary Care and Urgent Care – per visit	$5	$45
Physical Therapy	No Charge	$35
Occupational Health	No Charge	No Charge
Preventative Prescriptions*	No Charge	No Charge
Non-Preventative Prescriptions*	$5	$5
Diabetic Nurse Educator	No Charge	No Charge
Dietitian	No Charge	No Charge
Wellness Coach	No Charge	No Charge
Business Travel Consultation & Related Services	No Charge	No Charge

**Pre-packaged medications may be dispensed during an office visit, may require payment upfront and are limited to a select list of medications.*

WHY ARE THE FEES HIGHER FOR HSA ACCOUNT HOLDERS?

When you enroll in the HSA option, you and the Company can contribute to your Health Savings Account as long as certain Internal Revenue Service (IRS) requirements are met. To make sure the HSA option continues to meet IRS requirements, we have developed a fee structure for non-preventive services and prescription drugs received through the health center. But, regardless of which medical plan you are enrolled in, all fees charged through the health center will be applied to your medical plan's out-of-pocket maximum.

Keep in mind that you still get more for your money at the health center. The amount you pay is significantly less than you'd pay for care from other outside providers. Plus, it's more convenient!

EMPLOYEE PERKS

EMPLOYEE PERKS PROGRAM

A one-stop shop for exclusive and convenient savings on products, services and experiences like electronics, theme parks, hotels, movie tickets, cards, groceries, special events and more. The perks program is cost-free, easy to enroll and includes national discounts. Visit https://basco.savings.workingadvantage.com/home and use passcode BRIGGS to start saving today.

ACTIVE & FIT DIRECT

Active & Fit Direct is a flexible, comprehensive, low-cost fitness program that gives you access to a membership starting at $28 per month (plus enrollment fee and any applicable taxes) at one of more than 16,000 fitness centers and studios in the nationwide Active & Fit Direct network. For additional information and to enroll, visit the Marathon Health website (my.marathon-health.com > Forms) or visit the Active & Fit Direct FAQ page (https://www.activeandfitdirect.com/FAQ/).

BUSINESS TRAVEL & ACCIDENT INSURANCE

If you are traveling on business, the company provides additional benefits, namely:

- Accidental Death & Dismemberment
- Out-of-Country travel medical insurance
- Medical evacuation and repatriation coverage
- ID Theft assistance
- Lost luggage locator service
- Auto rental coverage

TRAVEL ASSISTANCE

Travel Assistance is available to you through Zurich Travel Assist. When you are traveling and have an unexpected emergency, help is only a phone call away. All full-time employees and your covered dependents are eligible for this 24-hour, toll-free service (800-263-0261) that is designed to respond to most emergency medical care situations and many other emergencies you may have when you travel. It also offers pre-trip assistance before you travel and information on passport/visa requirements, inoculation requirements, foreign currency and weather.

COMPANY STORE

Purchase Company-branded materials such as apparel and promotional items.

SAFETY

- Safety shoe reimbursement
- Safety glasses

AND MORE...

- On-site flu shots
- Cell phone discounts
- Computer and Technology

FREQUENTLY ASKED QUESTIONS

Q: HOW DO OUR MEDICAL PLANS COORDINATE WITH OTHER INSURANCE COVERAGE?

A: If you are covered by more than one group medical plan, there are "coordination of benefits" (COB) rules that determine which plan is primary and which plan is secondary. Under our medical plans, we follow the **non-duplication COB rule** which means if the primary plan pays the same or more than what we would normally pay, our plan is not responsible for any additional benefits. Please see the Summary Plan Description for more information.

Q: WHAT MAKES ME INELIGIBLE FOR A HEALTH SAVINGS ACCOUNT (HSA)?

A: You are ineligible to contribute to an HSA if you are covered by any other health plan that is not a High Deductible Health Plan (HDHP), can be claimed as a dependent on another person's tax return or enrolled in any type of Medicare. When enrolling in Medicare after age 65, there is a six-month lookback period (but not before the month of reaching age 65), so a best practice is to stop contributing to your HSA six months before enrolling in Medicare to avoid penalties.

Q: WHAT HAPPENS TO MY HSA WHEN I DIE?

A: Upon death, ownership of your HSA is transferred to your beneficiary. If your beneficiary is your spouse, your spouse will have the option to transfer the funds into their own HSA if they have one, or request a check (taxes and penalties may apply if the funds are not used to pay or reimburse qualified medical expenses). If your beneficiary is someone other than your spouse, they will receive the funds via a check and it will be taxable. To update your beneficiary, log on to Optum Bank's website (https://www.optumbank.com/) or call Optum Bank at 844-326-7967 to request a paper beneficiary form.

Q: WHO IS RESPONSIBLE FOR DETERMINING WHETHER HSA DISTRIBUTIONS ARE USED EXCLUSIVELY FOR QUALIFIED MEDICAL EXPENSES?

A: As the HSA account holder, you must ensure that distributions are used for qualified medical expenses. Records of medical expenses should be maintained as evidence that distributions have been made for these purposes. You must also ensure that contributions to the HSA do not exceed the maximum limits.

Q: AFTER I ENROLL, WHAT ADDITIONAL FORMS MUST BE COMPLETED?

- **Voluntary Life Insurance**
  - If your election requires proof of good health (evidence of insurability), you will need to complete the online questionnaire on the New York Life website. The link is located on the benefits portal.
  - If you do not complete the questionnaire within 30 days of your election, your pending election will be removed. You will have an opportunity to elect coverage again during the next annual enrollment or if you have a qualified family status life event.
- **Health Savings Account**
  - If your address in the system is a PO Box, you will have to provide additional documentation to Optum in order to open a health savings account. You may also be contacted to provide additional documentation such as a copy of your Social Security card or a valid photo ID with your address in order to complete vetting requirements.

Q: WHERE DO I GO FOR ASSISTANCE WITH POST-65 HEALTH INSURANCE OPTIONS?

A: Navigating the post-65 health care journey can be confusing. A great resource is National Benefit Consultants, Inc. NBCI has licensed agents available to educate, answer questions and then provide group health insurance options, if you find an option you like. earn more by contacting NBCI at (800) 875-1505.

BENEFIT TERMINOLOGY

Below is a list of common terms used by the insurance plans. These are benefit terms that may or may not apply to your coverage. Please refer to your plan booklets for your specific plan information.

BENEFIT: A plan feature or the amount the medical plan will cover when paying for covered services.

BENEFIT PAY: For most employees, your benefit pay is your wages paid as of 12/31 plus your calendar year commissions. If you are a newly hired employee, your benefit pay is your annual base pay.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985 requires group health plans to provide employees and eligible family members the opportunity to continue health care coverage at their own expense when coverage would be lost under certain circumstances.

COINSURANCE: A cost sharing arrangement under an insured health plan under which a covered person pays a specified percentage of the cost of a specified service, such as 20%, of the cost of a medical procedure.

CO-PAYMENT (COPAY): A flat fee paid for certain office visits or when you obtain a prescription. For example, after paying a $15 copay, the medical plan pays for 100% of the cost of a prescription.

CREDITABLE COVERAGE: Under HIPAA, the period of an individual's coverage under a Group Health Plan, health insurance, Medicare or any one of several other specified health plans or health insurance sources that is not interrupted by a significant break in coverage (generally, a 63-day period).

CONVERSION: An optional provision that allows the insured to convert his or her terminated group plan to an individual plan (in most cases the benefit level and rates will change).

DEDUCTIBLE: The amount that a person must pay towards covered benefits before any benefits are payable from a health plan.

ELIMINATION PERIOD: Refers to the time period between the date of an injury and the date benefits are payable. In other words, the elimination period is a period of time an employee must be disabled beforebenefits are considered eligible to be paid.

FORMULARY: A list of prescription drugs covered by the plan, and the tier that each drug falls under (i.e. generic, brand name). The formulary is based on evaluations of efficacy, safety and cost-effectiveness of drugs.

GENERIC DRUG: A term used to describe an identical or bioequivalent medication to a brand name medication in dosage form, safety, strength, route of administration, quality, performance and intended use.

NETWORK PROVIDER: Physicians, hospitals, or other health care providers/facilities that contract with the insurance carrier to provide services to its members.

NON-NETWORK PROVIDER: Physicians, hospitals or other health care providers/facilities who DO NOT have a contract with the insurance carrier to provide services to its members. Depending on the plan, services provided by non-network providers may not be covered, or covered at a lower benefit.

OUT-OF-POCKET MAXIMUM: The maximum dollar amount you would pay in a given plan year before the plan begins to pay 100% of covered services.

PRE-CERTIFICATION: The process by which a patient is pre-approved for coverage of a specific medical procedure or prescription drug.

PREVENTIVE CARE: Services that are for prevention, such as routine physical exams and or some screenings. Services that treat active diseases or illnesses are not considered to be preventive.

PRIMARY CARE PHYSICIAN (PCP): Your primary care physician is your go-to provider for everything related to your health – from getting annual physicals to getting an immunization before flu season. Primary care physicians can also help ensure your long-term health and well-being. They track your overall health and look for potentially serious conditions. A PCP is generally any internal medicine, general practice, OBGYN, family practice physician or pediatrician.

WAITING PERIOD: The period that must pass before an employee or dependent is eligible to enroll (becomes covered) under the terms of the plan.

WORKING SPOUSE: A spouse who is employed full-time and whose employer offers medical insurance coverage.

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 informed decisions 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.

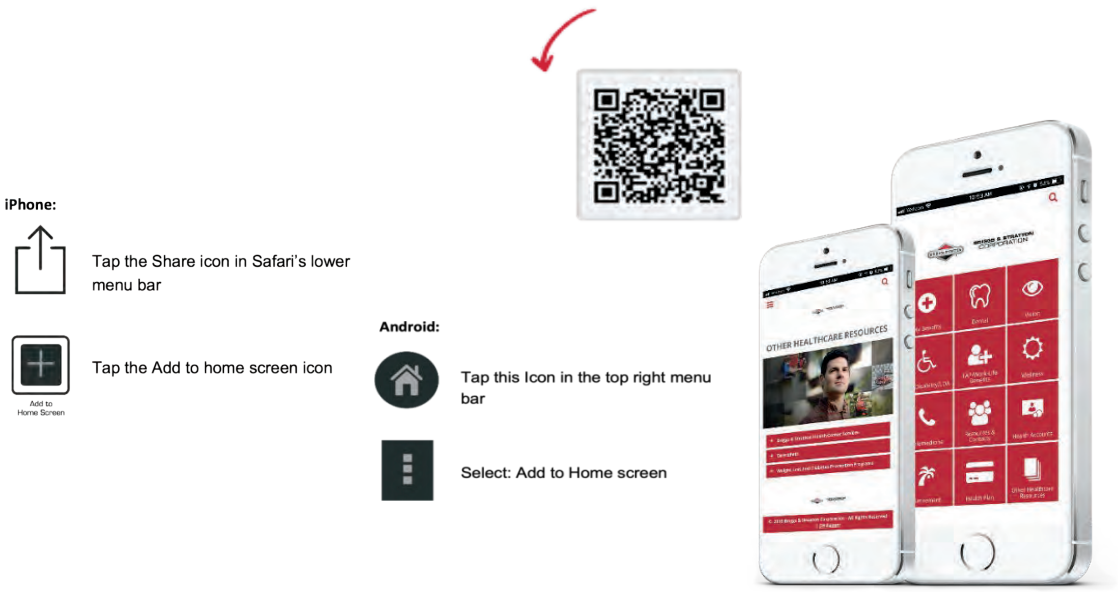
MY BENEFITS APP

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



WHO TO CALL

PLAN	CONTACT	PHONE	WEBSITE
Benefit Advocacy	Health Advocate	(866) 799-2728	www.HealthAdvocate.com/Briggs or email: answers@HealthAdvocate.com
Benefit Enrollment Assistance	Benefit Service Center	(877) 232-1083	mylinks.basco.com or www.mybascobenefits.com Monday-Friday, 7AM to 7PM CST
Business Travel Assistance	Zurich	800-263-0261 (In US or CAN) 416-977-0277 (anywhere else)	www.zurichtravelassist.com Policy: GTU4514578
COBRA	Benefits Service Center	(877) 232-1083	www.mybascobenefits.com
Dental	Delta Dental	(800) 236-3712	www.deltadentalwi.com
Disability - Long Term (LTD) Disability - Short Term (STD)	New York Life	(888) 842-4462	www.mynylgbs.com
Employee Assistance Program (EAP) / Work-Life Services	Health Advocate	(866) 799-2728	www.HealthAdvocate.com/Briggs or email: answers@HealthAdvocate.com
Family Medical Leave (FMLA)	New York Life	(888) 842-4462	www.mynylgbs.com
Flexible Spending Accounts (FSA)	Optum Bank	(844) 326-7967	www.optumbank.com
Health Reimbursement Account (HRA)	Optum Bank	(844) 326-7967	www.optumbank.com
Health Savings Account (HSA)	Optum Bank	(844) 326-7967	www.optumbank.com
Life Insurance	New York Life	(888) 842-4462	www.mynylgbs.com
Medical	Anthem (medical) ExpressScripts (prescriptions)	(800) 659-7902 (866) 773 4372	www.anthem.com www.express-scripts.com
Post-65 Medical Coverage	National Benefits Consultants	(800) 875-1505	www.nbci.biz
Retirement Plans	Fidelity	(800) 835-5095	www.netbenefits.com
Vision	DeltaVision (EyeMed ACCESS network)	(866) 723-0513	www.eyemedvisioncare.com
Voluntary Benefits (Accident, Critical Illness, Hospital Indemnity)	Cigna	(800) 754-3207	www.CignaSupplementalHealthPlans.com
Wellness Program	Briggs & Stratton WellnessProgram	(802) 846-4675	Email: wellness@marathon-health.com Website: my.marathon-health.com
ON-SITE CLINICS BY LOCATION			
Poplar Bluff	Marathon Health	(573) 598-8733	my.marathon-health.com
Sherrill / Munnsville	Marathon Anywhere		Marathon Health portal: marathon-health.com
Statesboro	Marathon Health	(912) 525-0520	my.marathon-health.com

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