

2026



Hormel Foods Family

EMPLOYEE BENEFITS

Handbook



PLANTERS



Health Care



DISABILITY & LIFE
Insurance



Retirement



Resources

Hormel Foods Corporation (the “company”) offers a competitive and comprehensive benefits program designed to assist you and your family with financial security and overall well-being.

The significant contributions made by the company toward your employee benefit package create a substantial portion of your overall total compensation package.

On average,
*employee
benefits*
make up

25%

of your
TOTAL
compensation

Use these CATEGORIES to navigate this booklet...



Health Care



ACCIDENT & LIFE
Insurance



Retirement



Resources

How to use this book:

This book is designed to help you understand the benefits available, enroll by the required deadlines and keep as a reference for future questions. Categories with corresponding icons are provided for easy navigation.

In addition to the information in this book, you can use the online education center HormelFoods.KnowMoreStressLess.com to learn more about your benefits or use the plan comparison calculator to compare and estimate your total out of pocket expenses and review all plan documents.

HormelFoods.KnowMoreStressLess.com



Register today

Register today using any device at
HormelFoods.KnowMoreStressLess.com
to learn more about your health care benefits.
You'll need your 9-digit Employee ID/Person Number.
It's on your pay stub.



Learn everything

Take this time to learn everything
you need to know about your Hormel
Foods benefits.



Compare Plans

Use the Plan Comparison Calculator
to input your total medical and prescription
expenses in order to better understand which
plan may work for you.

BENEFITS AT A GLANCE



BENEFIT	DESCRIPTION	WHO PAYS FOR BENEFIT?	MORE INFO
Your health plan	Medical coverage and Prescription drug coverage	You and Hormel Foods	Page 9
Flexible Spending Account (FSA)	Tax Advantaged Accounts	You	Page 14
Dental and Vision Plan	Dental and Vision Coverage	You and Hormel Foods	Page 16
Life Insurance	Basic Life	Hormel Foods	Page 20
	Optional Life	You	Page 20
Dependent Life Insurance	Basic Child Life	Hormel Foods	Page 22
	Optional Child Life	You	Page 22
	Optional Spouse Life	You	Page 22
Disability	Short-Term Disability	Hormel Foods	Page 23
401(k) Plan	Retirement Plan	You and Hormel Foods	Page 25

ADDITIONAL INFORMATION



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Dependents	Page 6
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Doctor On Demand	Page 30
Omada	Page 30
Employee Assistance Program – Inspired Health and Well-Being	Page 32
Financial and Personal Growth Resources	Page 33
Glossary of Terminology	Page 34
Cobra Notice	Page 36
Health Care Notices	Page 38

EMPLOYEE BENEFITS TOOLS & RESOURCES

RESOURCE	CONTACT INFO		DETAILS	APP
	 Horizon Solution Center (toll free) (866) 449-7712 Horizon Solution Center (internal direct extension) 7712 Fax (507) 437-9810 Email Address hresolutioncenter@hormel.com			
Oracle HCM	yoursource.hormel.com		Human resources, benefits	
ADP	myadp.com		Payroll	
Empower	(844)465-4455 empowermyretirement.com		401 (k) plan record keeper	
E*Trade	(800) 838-0908 etrade.com		Universal Stock Option Award and Employee Stock Purchase Plan	
Spring Health	(855) 629-0554 Hormel.SpringHealth.com		Work/life resource program	
MetLife	(800) 638-6420		Life/AD&D insurance	No App Available
Blue Cross Blue Shield of MN	(866) 537-7721 bluecrossmn.com/hormelfoods		Medical doctor, health and fitness	
Wex Health	(866) 451-3399 wexinc.com		Flexible Spending Account	
Delta Dental of MN	(800) 448-3815 deltadentalmn.org		Dental	
Doctor On Demand	doctorondemand.com/BCBSMN		Online doctor	
Hinge Health	(855) 902-2777 hingehealth.com/for/hormel		Back and joint pain program	
Omada	(888) 409-8687 go.omadahealth.com/Hormel		Diabetes management	
Prime Therapeutics	(855) 457-0002 myprime.com		Prescription drug	No App Available
Progyny	(833) 233-0871 progyny.com		Fertility benefits	
Alight	(855) 249-6318 Hormel.myleaveproservice.com		Leave management	
VSP	(800) 877-7195 vsp.com		Vision	

How to access Oracle

Much of your information is accessed and managed in Oracle. There are two ways you can access Oracle, online or through the mobile app.

New to Oracle?

Web based access	Mobile access
1. Visit yoursource.hormel.com 2. Click on Oracle Cloud  3. Follow instructions to log in below	1. Search "Oracle HCM Cloud" in your App Store or Google Play Store, download it and open it. 2. When you open the app, you might see a legal terms screen. Review and hit agree. 3. On the next screen, enter this address: ekkh.fa.us2.oraclecloud.com This initial log in is the only time you will have to enter this address. 4. You might get a pop up asking to allow notifications. It is recommended to choose Allow so you can be made aware of notifications in the system. 5. This will take you to the main log in page. Follow instructions to log in below.

First time logging in?

If you have a company email, click the company email button and sign in using your company email and login information.

If you do not have a company email, your username is your nine digit person number / employee ID. Your password will be what you had created. If you don't remember your password, contact your local HR office or call the Horizon Solution Center to add your email contact so a registration link can be emailed to you to register and set a password.

In Oracle, where do I enroll?

From the Home screen:

Click on Benefits



Then click on the button at the top center of this page.

Click the YELLOW button below to enroll in benefits.

Make Changes

What if I do not plan to enroll?

You should still log in to add beneficiaries for the basic (company provided) life insurance coverages. You can find a reference guide in Oracle under Help Desk / My Knowledge.

REMINDER:



Choose your benefits carefully, as the choices you make now will remain in effect for the entire calendar year unless you have a qualifying life event.



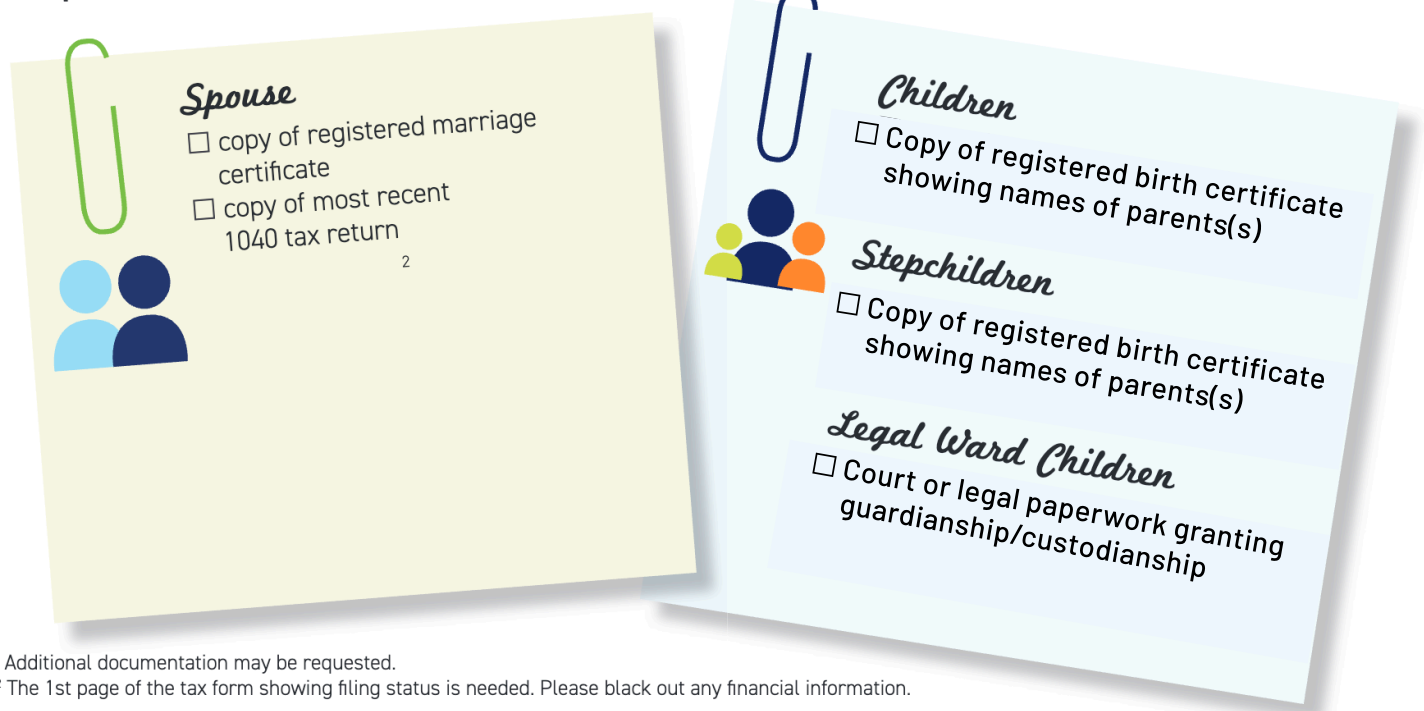
Dependent ELIGIBILITY

The following people are eligible for health care and life insurance coverage as a dependent:

- Spouse
- Children up to age 26
 - o Natural born children
 - o Stepchildren
 - o Legally adopted children
 - o Children in the process of adoption who have been placed in your home
 - o Legal ward
- Disabled children who meet certain requirements as stated in the Summary Plan Descriptions (health care coverage only)

You will need to **PROVIDE DOCUMENTATION** to verify your dependents' eligibility if adding them to medical or dental/vision coverage. ALL documentation must be provided no later than **30 days after eligibility**. If all documentation isn't received, your dependents will be removed from coverage and won't be able to be added back to coverage until Open Enrollment for 2027, or if you have a mid-year qualifying event.

Examples of documentation¹ include:



¹ Additional documentation may be requested.

² The 1st page of the tax form showing filing status is needed. Please black out any financial information.

How do I provide these documents to the Horizon Solution Center?

After logging into Oracle, from your Home screen, click on Me, then Benefits, and then Document Records. You'll attach either a scan or a picture of the document to upload. Please upload one document at a time.

If you're using the mobile app, click on Me, then Benefits, and then Document Records. The app allows you to take a picture of the document and upload. This is a secure method that does not save the image to your mobile device.

WHEN CAN I CHANGE MY BENEFITS?

After your initial enrollment, there are only certain times when you can make changes to your health care including medical, dental/vision, and life benefit elections.

Open Enrollment

You may change your benefit elections during this enrollment period. Open enrollment typically occurs each year in November. During this time, you will need to watch for communication materials sent to you regarding enrollment information, instructions and deadlines.

Mid-Year Election Changes

You may change your benefits coverage during the year if you have a permitted mid-year event. Examples of permitted mid-year events include:

- Marriage
- Divorce
- Birth or adoption
- Death of a dependent
- Gain or loss of other health coverage

Should you have a permitted mid-year event, you have

60 days from the date of the event to report the event and request changes to your coverage. You need to submit this request in Oracle under Me / Benefits / Report a Life Event and provide documentation for proof of the event within 30 days in order to update benefits. Any changes to your benefits will be effective when reported. The quick reference guide can be found in Oracle under Help Desk / My Knowledge.

When adding new dependents to coverage for a mid-year event, you have **30 days** to upload the necessary documents to verify dependents. Any unverified dependents will be removed after 30 days.

Flexible Spending Account (FSA) Changes

All FSA elections cannot be changed mid-year unless you have a qualifying life event.

Remember:



Be aware of your deadlines!

- *Mid-year election changes must be reported online within 60 days of the event.*
- *Open Enrollment materials will tell you when you are able to change your elections.*





Your

HEALTH CARE

Options





HEALTH PLAN INFORMATION

MEDICAL & PRESCRIPTION DRUG COVERAGE

Your health plan option features the Blue Cross Blue Shield (BCBS) network of providers. When you use these in-network providers, they agree to charge pre-negotiated, discounted fees for their services and submit claims directly to BCBS for processing.



Medical and Prescription Drug Cards

Blue Cross Blue Shield of Minnesota (medical) and Prime Therapeutics (prescription drug) are the claims administrators for your healthcare coverage. You will receive one card from Blue Cross Blue Shield that will be for both medical and prescription drug. You will receive a card for each of your verified dependents on coverage.

Due to timing of dependent verification, you may not receive all cards at once. It is important for you to provide necessary documentation, as referenced on page 6, for your dependents before they will be mailed their cards.

Weekly Employee Contributions

Your health plan contributions are based upon whether you have dependents, and by the plan you select.

Traditional Plan

The Traditional Plan Option is a low deductible health plan. Medical and prescription drug spending are separated under this plan. For the medical coverage, once the deductible has been met, co-insurance will apply until you've met your out-of-pocket maximum. Prescription drug coverage has immediate co-insurance. The co-insurance rate you pay depends upon the drug prescribed. You may contribute to a health care Flexible Spending Account (FSA).*

Want to learn more?

Visit HormelFoods.KnowMoreStressLess.com to view all your benefit information.



HormelFoods.KnowMoreStressLess.com



UNDERSTANDING YOUR OPTIONS

*In Network Plan Comparisons	BCBS PPO Plan					
Preventive Care	Covers 100% No Deductible					
Deductible						
 Single Deductible	\$850					
 Family Deductible	 +  = \$2,550** \$850 \$850 \$850					
Out of Pocket (OOP) Maximum						
 Single Medical OOP	\$4,250					
 Family Medical OOP	 +  = \$9,350** \$4,000 \$4,000					
 Single Drug OOP	\$2,750					
 Family Drug OOP	\$5,500					
Copay/Coinsurance						
 Prescription Drug	\$5 Minimum <table><tr><td>Generic you pay 10%</td><td>Brand you pay 20%</td><td>Non-Form you pay 35%</td></tr></table>			Generic you pay 10%	Brand you pay 20%	Non-Form you pay 35%
Generic you pay 10%	Brand you pay 20%	Non-Form you pay 35%				
 Emergency Room	After deductible + \$100 copay, plan pays 80% you pay 20%					
 Non-Preventive Services	After deductible, plan pays 80% you pay 20%					

Blue Cross Blue Shield's Online Portal

Once you've received your medical card from Blue Cross Blue Shield, you may then visit www.bluecrossmn.com/hor-melfoods to register and access the many tools available online.

Blue Cross Blue Shield's online portal provides many tools and resources for you to help you manage your health and health care. In addition to viewing your explanation of benefits for any claims processed and a summary of your claims activity, you'll also have access to online tools such as:

- Find a doctor
- Care Cost Estimator (ex. Estimating costs of procedures)
- Information on Preventive Care
- Interactive WebMD tool
- Quitting Tobacco Support

NOTES:

*Out of network care may have higher co-insurance and out-of-pocket maximums.

**Employee coverage and dependent coverage are calculated separately.

The employee must meet \$850 of the \$2,550 deductible and the remaining \$1,700 must be met by 2 or more dependents.

Dental and Vision Bundled Plan



Why should I enroll in the vision buy-up?

Enhancements under the buy-up plan include a vision exam and lenses/ frame (or contact lens in place of glasses) provided every calendar year instead of every 24 months. The frame allowance is greater at \$200 in network or \$70 out-of-network. And, lens enhancements covered in full are progressive lens and anti-reflective coating.



EXPLORE YOUR HEALTH CARE OPTIONS

Knowing your options can save you time and money.

FREE		Online Care Online access to doctors who can answer questions and provide a diagnosis for common health concerns. Visit www.DoctorOnDemand.com/bcbsmn
\$	 Retail Health Clinic	Retail Health Clinic Quick, convenient and affordable treatment for many common illnesses. These are typically located in retail stores, supermarkets, or pharmacies
\$\$	 Physician's Office	Physician's Office For a wide variety of services from routine checkups to immunizations during normal business hours.
\$\$\$	UC Urgent Care Center	Urgent Care Center Handles the same problems treated in a provider's office after normal business hours.
\$\$\$\$	ER Emergency Room	Emergency Room For the most serious or life-threatening conditions.

Preventive care at NO cost to you.

FREE

PREVENTIVE SERVICES INCLUDED IN YOUR HEALTH PLAN.



Lab Tests



Cancer Screenings



Vaccinations



Routine Visits



Pregnancy Care



Your health care plan is administered by Blue Cross Blue Shield of Minnesota. This comprehensive preferred provider organization (PPO) plan provides both medical and prescription drug coverage. After reaching your deductible, the plan will share costs until your out-of-pocket spending reaches the max and then the plan will cover 100%. There is no deductible for preventive and cancer screenings services. Your cost for prescription drugs will depend on what type of prescription is prescribed: generic, formulary brand or non-formulary brand. Copayments for the difference between the cost of a brand name product and its generic equivalent do not count toward the out-of-pocket maximum.

HOW YOU AND YOUR PLAN SHARE COSTS

Jane's Example

Jane's Employee Only Traditional Plan coverage

Jane's Plan Deductible: \$850

Co-Insurance: 20%

Out-Of-Pocket Max: \$4,250

Jan. 1st Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec. 31st

Beginning of Coverage Period

End of Coverage Period



Jane pays
100% Her plan pays
0%



Jane pays
20% Her plan pays
80%



Jane pays
0% Her plan pays
100%

Jane hasn't reached her \$850 deductible yet.	Jane reaches her \$850 deductible, co-insurance begins	Jane reaches her \$4,000 out-of-pocket max
The plan doesn't pay any of the costs.	Jane has seen her doctor several times and paid \$850 in total. The plan pays some of the costs for her next visit.	Jane has seen her doctor often and paid \$4,250 out of pocket in total. The plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: \$125 Jane pays: \$125 Her plan pays: \$0	Office visit costs: \$125 Jane pays: 20% of \$125 = \$25 Her plan pays: 80% of \$125 = \$100	Office visit costs: \$125 Jane pays: \$0 Her plan pays: \$125



TAX-ADVANTAGED ACCOUNTS

FLEXIBLE SPENDING ACCOUNTS

Health Care Flexible Spending Account

You can make contributions to the health care flexible spending account if you are enrolled in the Traditional Plan or waived healthcare.

- The contribution limit for the health care flexible spending account (FSA) for 2026 is \$3,300.
- You can rollover up to \$660 of any unused funds from your 2025 FSA.
- As a reminder, you must elect a contribution amount for 2027 to have funds rollover.

Dependent Care Flexible Spending Account

The contribution limit for the dependent care flexible spending account is \$5,000. This account does not allow for a rollover of any funds.

Why enroll in an FSA?



	WITH FSA	NO FSA
Annual Pay	\$35,000	\$35,000
Pre-tax FSA Contribution	-\$1,500	-\$0
Taxable Income	=\$33,500	=\$35,000
After-Tax Dollars Spent on Eligible Expenses	-\$0	-\$1,500
After-Tax Spendable Income	=\$26,138	=\$25,648
Tax Savings	\$490	\$0

Sample tax savings for a single taxpayer with no dependents. Actual savings will vary based on your individual tax situation. Consult a tax professional for more information.



FLEXIBLE SPENDING ACCOUNTS

A Flexible Spending Account (FSA) is a special account you put money into that you use to pay for certain out-of-pocket care costs. You don't pay taxes on this money. This means you'll save an amount equal to the taxes you would have paid on the money you set aside. For a list of eligible expenses, visit <https://www.wexinc.com/insights/benefits-toolkit/eligible-expenses/>

Health Care Flexible Spending Account (FSA)

You can make contributions to the health care flexible spending account (FSA) if you are enrolled in the Traditional Plan or waived healthcare.

- The contribution limit for the health care flexible spending account (FSA) for 2026 is \$3,300
- The funds in this account can be used for eligible medical, dental, vision, and prescription drug expenses for you and your eligible dependents.

Dependent Care Flexible Spending Account

You can contribute to this account no matter which healthcare plan you elect or even if waiving healthcare.

- The contribution limit for the dependent care flexible spending account is \$5,000.
- The funds in this account can be used for eligible daycare expenses for children under the age of 13 or elder care expenses.





HOW YOUR CLAIMS ARE PAID

When you see an in-network provider, you receive the highest level of benefits and the provider files claims for you. When you see an in-network provider for preventive care services, the plan pays 100 percent of eligible costs. If you see an out-of-network provider, you pay more for the cost of your care.

1. Your visit.

You may be required to pay a copay at the time of service, i.e. emergency room visit. Your member ID card indicates if a copay is required and the amount is listed in the copay field.

2. Your in-network provider submits your claim.

If you see an in-network provider, the provider submits your claim to Blue Cross Blue Shield. If you see an out-of-network provider, you may need to submit the claim yourself. Call Blue Cross Blue Shield at 1-866-537-7721 for assistance if you need to submit a claim.

3. Blue Cross Blue Shield typically processes your claim after receiving all the necessary paperwork from your provider.

4. You receive an Explanation of Health Care Benefits.

You will receive an Explanation of Health Care Benefits (EOB) in the mail. The EOB is not a bill, but shows what your responsibility should be. Your provider will send you a bill and the amount owed should match what is explained on the EOB.

Note: Each covered family member can see their own EOBs on their home page after they sign in at bluecrossmn.com/hormelfoods. EOB's for minors under the age of 12 can be viewed under the employee's sign in. Children over the age of 12 will need their own log in.

5. Provider bills typically arrive within two weeks after you receive your EOB.

6. Compare your EOB to your provider bill.

Make sure the amount on the bill matches what is listed on your EOB. If not, contact Blue Cross Blue Shield customer service for clarification.

7. Pay your provider.

You will need to pay your provider. You must pay with your personal funds or with available funds you may have in a health savings account or flexible spending account. Be sure to retain your EOB and any receipts. These are the best documents to provide to validate your expenses or to reimburse yourself from the FSA.

EXAMPLE

Jane visits her doctor.

Jane receives EOB showing:

- She has met her deductible.
- The plan will cover \$60 of the \$75 bill.

Jane receives her bill from the provider for \$15.

The EOB and bill match, so Jane pays the provider's \$15 bill.



This is a package plan providing both dental and vision coverage.



Dental & Vision FREQUENTLY ASKED QUESTIONS

1. **Who administers the coverage?**
Dental - Delta Dental of Minnesota
Vision - Vision Service Plan (VSP)
2. **Is there coverage for orthodontics?**
Yes, the plan pays for 50% of expenses up to a lifetime max. This is for children and adults.
3. **How can I find out which network my dentist is in?**
Either call your dentist or visit www.deltadentalmn.org.
4. **What do I do if I see an out of network dentist or optometrist?**
This depends upon the provider, but typically you must pay the provider and then submit documentation to Delta Dental or VSP for reimbursement.

Want to learn more?

Visit HormelFoods.KnowMoreStressLess.com to view all your benefit information.



HormelFoods.KnowMoreStressLess.com

DID YOU
KNOW?

WE ARE IN
THE TOP
5% OF PEER
COMPANIES
FOR DENTAL
COVERAGE!





DENTAL



Delta Dental of Minnesota is the claims administrator of the dental benefits. After you have satisfied the deductible, if any, the Dental Plan pays a percentage of the treatment cost, up to an annual plan maximum. Your costs depend on whether the provider is a Delta Dental PPO dentist, a Delta Dental Premier dentist or a nonparticipating dentist. If you see a nonparticipating dentist, your out-of-pocket expenses may increase.

	Delta PPO	Delta Premier	Nonparticipating ¹
DEDUCTIBLES & MAXIMUMS PER COVERED PERSON			
Deductible	\$0	\$75 individual \$150 family	\$75 individual \$150 family
Plan Annual Maximum Payment	\$3,000	\$2,500	\$2,500
TMJ Lifetime Maximum	\$1,500	\$1,500	\$1,500
Orthodontics Lifetime Maximum	\$3,000	\$2,500	\$2,500
AFTER DEDUCTIBLE YOU PAY			
Diagnostic & Preventive ²	10%	20%	20%
Basic Services	20%	20%	20%
Oral Surgery	20%	20%	20%
Endodontics	20%	20%	20%
Periodontics	20%	20%	20%
Major Restorative	20%	20%	20%
Prosthetic Repairs & Adjustments	20%	20%	20%
Prosthetics	20%	20%	20%
Orthodontics ²	50% Up to \$3,000	50% Up to \$2,500	50% Up to \$2,500

NOTES:

¹ You may be responsible for additional out-of-pocket expenses if charges are above the Table of Allowance amount.

² No deductible applies to this service.

How can I find an in-network dentist, oral surgeon, or orthodontist?

You can search for providers by visiting www.deltadentalmn.org. Don't be fooled, the website provides nationwide searching, not just Minnesota!

Vision Service Plan (VSP) is the claims administrator of the vision benefits. Your vision is an important part of your overall health. This plan provides benefits for a wide range of vision services and supplies. Conditions deemed medically necessary to see the eye doctor annually may be covered under the health care options. Please refer to the Medical and Prescription Drug Summary Plan description.

Benefit	Frequency	In-Network Coverage
VISION EXAMINATION		
WellVision Exam	24 months	• \$10 Copay
PRESCRIPTION GLASSES		
Frame	Every 24 months	• \$20 Copay • \$150 allowance for a wide selection of frames • \$170 allowance for featured frame brands • 20% savings on the amount over your allowance
Lenses	Every 24 months	• \$20 Copay • 100% Polycarbonate lenses for dependent children
Contact Lenses (Instead of Glasses)	24 months	• \$150 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)
LASER VISION CORRECTION		
Laser VisionCare Preferred Program	Once per lifetime	• \$200 allowance per eye for LASIK, Custom LASIK and PRK • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities
YOUR COVERAGE WITH OUT OF NETWORK PROVIDERS		
Exam up to \$40	Lined Bifocal Lenses up to \$89	Progressive Lenses up to \$100
Frame up to \$45	Lined Trifocal Lenses up to \$100	Contacts up to \$105
Single Vision Lenses up to \$60		

How can I find an in-network eye doctor?

You can search for providers by visiting www.vsp.com

Questions to ask:



Notes:

Lined area for notes on a yellow sticky note.

Things to remember:





Your

LIFE INSURANCE

benefits



THE IMPORTANCE OF LIFE INSURANCE

Why should I consider life insurance?

It's wise to purchase life insurance no matter your age or marital status, for a variety of reasons:



Funeral Costs

The average funeral costs more than \$7,000.



Debt

Ease the financial burden of your loved ones.



Replace Your Income

Provide your family with financial security for the future.



Children's College Fund

Ensure that the educational expenses for your children will be covered.

There are two forms of insurance benefits.



Basic

Provided by the company at no cost to you.



Optional

Offered to you to purchase for additional financial security.

Is Statement of Health (SOH) important to consider?

Statement of Health (SOH) is the application process in which you provide information on the condition of your health to be considered for insurance coverage.



New Hire

You are guaranteed approval of insurance when electing during your new hire enrollment.



Adding Insurance After New Hire Enrollment

You will need to provide Statement of Health (SOH) when electing coverage any time after your new hire enrollment. There is no guarantee of approval.



Increasing Insurance After New Hire Enrollment

You will maintain any amount you have already been approved for and you'll need to provide Statement of Health (SOH) when electing coverage any time after your new hire enrollment. There is no guarantee of approval.



LIFE INSURANCE

You are offered Basic coverage (company provided) and Optional coverage (Elected by you). Please refer to hormelfoods.knowmorestressless.com to see your offered coverages. Cost of coverage is available on the benefits enrollment site.

\$ OPTIONAL LIFE INSURANCE	
EMPLOYEE LIFE INSURANCE 	Choose as a flat dollar amount in the following options: (\$12,500, \$25,000, \$37,500, \$50,000, or \$75,000) - Your contributions are based on your age at the end of the next year and will increase as you get older - Statement of Health (SOH) is proof of good health. It is required for any increase.
CHILD LIFE INSURANCE 	You can elect up to \$5,000 - Covers children age 14 days to age 26 - Statement of Health (SOH) does not apply to child life insurance - It is important for you to list your eligible children on the benefits enrollment website so the company can provide this coverage to your eligible children
SPOUSE LIFE INSURANCE 	Life insurance for your spouse. \$10,000 to \$25,000 in \$5,000 increments. - Contributions are based on your spouse's age at the end of the next year and will increase as they get older. - Statement of Health (SOH) will be required on spouse for any future increases in coverage.



Adding or increasing coverage will be subject to Statement of Health (SOH). MetLife will mail you a health questionnaire to complete. Until MetLife determines approval or denial, the election will remain in a pending status.



DISABILITY COVERAGE

If you are unable to work due to injury or illness, disability benefits may continue a portion of your income during your absence from work.

SHORT-TERM is provided at no cost to the team member.

These are company provided benefits.



alight

Review your benefit features and plan documents for coverage and benefit eligibility.

Phone: 855-249-6318

8am-8pm ET

Hormel.MyLeaveProService.com

Questions to ask:



Notes:

Things to remember:





Your

RETIREMENT

benefits



Why Invest In Your 401(k) Plan NOW?



SAVINGS YEARS: Three Components of Success

1 TIME



2 AMOUNT YOU INVEST



3 INVESTMENT RETURNS



Annual Investment	Number of Years Saving (Age Range)	Total Invested	Potential at age 65
\$25/week (\$1,300/Year)	40 Years (ages 25-65)	\$52,000	\$382,859*
\$25/week (\$1,300/Year)	30 Years (ages 35-65)	\$39,000	\$162,825*
\$25/week (\$1,300/Year)	20 Years (ages 45-65)	\$26,000	\$64,221*

*Includes compound interest assuming an average annual return of 8% until age 65.

Make compound interest work for you.

The best way to ensure your future financial success is to start saving today.

You earn interest not only on the money you contribute, but also on the interest you have already earned.

Compound interest makes your money work hard for you, so start saving early to get the most from your investments!



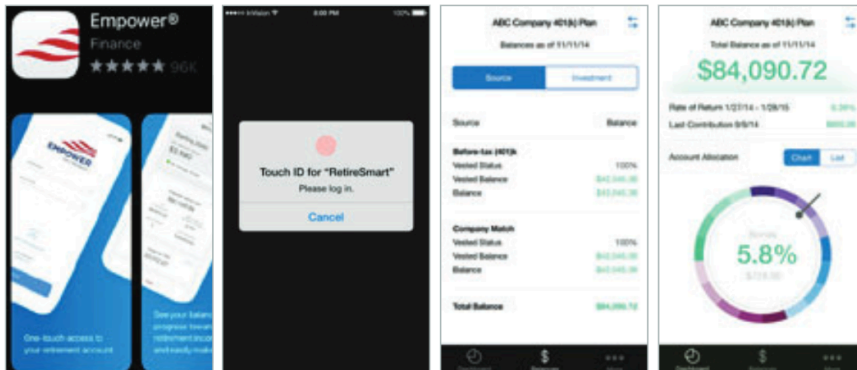
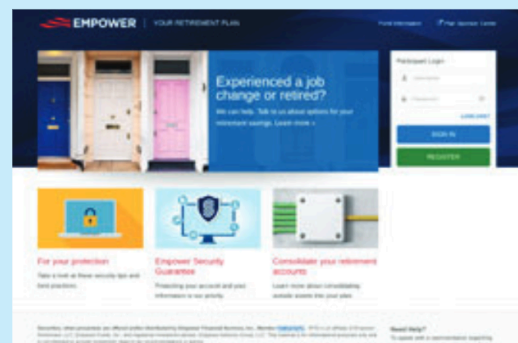
EMPOWER IS HERE TO HELP

By Telephone

- Telephone Services: **1-844-465-4455**
Customer Service Representatives
7 a.m. to 9 p.m. (CST) Monday to Friday
AND
8 a.m. to 4:30 p.m. (CST) on Saturdays



Participant Retirement Plan Website:
www.empowermyretirement.com



Empower Retirement mobile app lets you not only view your account information, but also change your contribution amount to save more!

Help keep your fees down by receiving your retirement communications online!

Lower Fees = More Money for your Retirement

1. Log into your account at **www.empowermyretirement.com**
2. On right side of screen, under "I want to..." click on "Update my communication preferences"
3. Click the "Edit" link for Plan Communication
4. Check the box for e-Delivery.
5. Enter your email address
6. Click "Save"

HOW DO YOU PICTURE RETIREMENT?

Questions to ask:

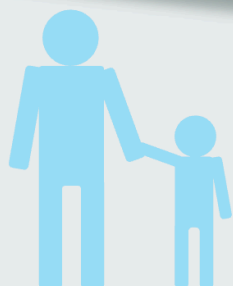


Notes:



Travel with your spouse, family, friends?

Things to remember:



Volunteer your time and skills to a worthy cause?

Enjoy retirement



Your

ADDITIONAL

benefits & resources





ADDITIONAL BLUE CROSS BLUE SHIELD BENEFITS

Telemedicine Services: Doctor On Demand on demand

You may wonder: Can a doctor really treat me without seeing me in person?

The answer: Absolutely!

Doctor Video Visits	Top Medical Issues Treated:		
	Cold & Flu	Stomach Issues	Prescription Refills*
	Allergies	Sore Throat	Travel Illness
	Skin & Eye Issues	Pediatric Issues	UTI & Yeast Infections

Doctor On Demand operates subject to state laws. Doctor On Demand offers medical care in all 50 states and the District of Columbia. Doctor On Demand offers behavioral health care in all states where behavioral health care is available to Doctor On Demand's patient population at large. Doctor On Demand is not intended to replace an annual, in-person visit with a primary care physician. *Doctor On Demand physicians do not prescribe Controlled Substances, and may elect not to treat or prescribe other medications based on what is clinically appropriate.

Doctor On Demand visits allow physicians and psychologists to provide focused care – without you having to leave your home. With video, they can look, listen, and engage with you to diagnose your issues and provide an effective treatment plan. The physicians at Doctor On Demand Professionals can treat a host of common illnesses quickly and effectively through a Video Visit. A front-facing camera is needed when using a tablet or smartphone.

Doctor On Demand is available free of charge to all team members and their dependents. Make sure you put in your BCBS number to get the discount. Please refer to www.doctorondemand.com/bcbsmn to see more information and all of the consultation costs.

The telemedicine services made available through Doctor On Demand are provided by licensed physicians practicing within a group of independently owned professional practices collectively known as "Doctor On Demand Professionals." These professional practices provide services via the Doctor On Demand telehealth platform.



omada

What is OMADA?

It's an online program that coordinates everything you need to adopt and maintain healthier habits. When you join, you get:

- A professional **health coach** to keep you on track.
- A wireless **smart scale** to monitor your progress.
- Weekly online **lessons**, fun games and quizzes to educate you.
- A peer **group** of participants to support you throughout the core 16-week program.

If you're eligible, Hormel Foods will cover the entire cost. To find out if you are eligible or for more information go to www.omadahealth.com/hormel.

Who is Eligible?

The program is available to those who meet both of the following:

- Employees and their adult family members who are eligible and enrolled in one of the Hormel Foods Plan Options through Blue Cross® and Blue Shield® of Minnesota.
- At risk for type 2 diabetes or heart disease



INSPIRED HEALTH AND WELLBEING

Inspired
Health

Nothing is more important than the health and well-being of our inspired people.



Hinge Health is here to help you conquer back and joint pain, recover from injuries, prepare for surgery, or stay healthy and pain-free. Hinge Health provides you with all the tools you need to get moving again from the comfort of your own home.

Here are some ways your treatment plan could be tailored to you:

- Get a personal care team, including a physical therapist and health coach
- Schedule personal physical therapy sessions as needed
- Receive wearable sensors that give live feedback on your form in the app
- COST: Provided by your health plan so there's no additional cost to you



You can join and participate in Weight Watchers for special monthly pricing!

OnlinePlus

Easily follow the plan step-by-step entirely online with digital and mobile tools including:

- Weight tracker, progress charts, restaurant guides and much more
- Available for men and women with tailored content that speaks directly to each audience

For more information, visit <https://wellness.weightwatchers.com/>

To be eligible for reimbursement, you must actively participate in the WW® program a minimum of one time each week for a total of four weeks per calendar month. Submit your request for reimbursement to wellness@hormel.com within 30 days of the completed calendar month of participation.



CARE

Supporting our team during life's challenges:
Crisis Assistance Relief Effort



Care Program

The Crisis Assistance Relief Effort Program (CARE Program) is designed to help team members and their families in emergency or hardship situations. This is entirely funded by employees for employees and their families. For information on making donations or submitting an application, contact your local HR or view on Pivot under Career and Total Rewards / Inspired Health / CARE Program.



Spring Health

Spring Health provides:

Personalized recommendations. Take a short online assessment and get care recommendations to support your immediate needs and long-term goals.

Wellness exercises. Moments is a library of self-guided exercises that can help you manage stress, calm anxiety, beat burnout, improve sleep, and be more mindful.

Dedicated guidance. Your Care Navigator can walk you through your care plan, help you find the right therapist, and provide support whenever you need it.

Medication management. If needed, 2 of your covered therapy sessions can be used for a medication management consultation with a doctor. Easily find a doctor and book online.

Company-sponsored therapy. Get support when it's convenient for you, either virtually or in person. Each member (age 6+) gets 8 free sessions per year.*

Coaching. Connect with a coach to help you reach goals related to personal development, health and wellness, relationships, or parenting. Each member (age 18+) gets 8 free sessions per year.

Diverse providers. Choose an experienced therapist you feel comfortable with. Browse recommendations or search by specialty, gender, ethnicity, or language.

Work-life services. Access expert guidance and resources to navigate legal or financial matters, child care, elder care, pet care, travel, household services, and more.

For more information, visit <https://benefits.springhealth.com/hormel/>

*Available to all team members and household dependents ages 6+.





FINANCIAL AND PERSONAL GROWTH RESOURCES



Employee Stock Purchase Plan

You may purchase Hormel Foods Corporation Common Stock at market value through systematic payroll deductions. This plan has been in effect since July 1, 1972, and is administered by Etrade.

As long as you are of legal age of majority in your state of residence, you're eligible to participate in this program. The minimum amount you may invest is \$10.00 per week. As an additional benefit, our company will pay all brokerage commissions associated with this purchase.

Details of the Plan are contained in the "Terms and Conditions", which can be found on Pivot or requested from the HR Solution Center.

To participate in the plan, visit etrade.com/enroll, and make your elections.



Inspired Pathways

Through the Inspired Pathways Scholarship, Hormel Foods will provide two-year community or technical college tuition to the dependent children of all benefits eligible U.S. team members.

Inspired Pathways has two parts:

1. The Hormel Inspired Pathways Scholarship offering children of Hormel Foods team members two years of tuition-free community and technical college.
2. A College Admission Guidance program created and led by former college admissions professionals.

For more information, visit <https://hormelinspiredpathways.com>



Workforce Edge

The purpose of Hormel Foods Tuition Reimbursement program is to financially assist eligible team members with pre-approved education courses that are career-related or are within specified areas beneficial to Hormel Foods. Hormel Foods partners with Workforce Edge, which has strategic relationships with educational institutions across the United States, to connect you with online degree and non-degree programs and tuition savings opportunities. Start using this program today to increase your skill-sets, amplify your talent and unlock your tuition reimbursement benefits.

To review the policy, visit Pivot and search for tuition reimbursement.



Adoption Reimbursement

To help those who are building a family, will reimburse up to \$10,000 towards eligible expenses per child, per household. Team members with at least one year of service are eligible for adoption benefits within 12 months of finalized adoptions. If both parents are eligible for adoption benefits through the Company, the maximum benefit applies jointly. Adoption expenses incurred during a team member's first year of employment are eligible, if the team member reaches one year of service before applying for reimbursement. Team members must be actively employed by the Company or on an authorized leave at the time of reimbursement. For more information, visit Pivot / Knowledge Resources / Policy Library and search for adoption assistance.



GLOSSARY

This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your [provider](#) charges more than the allowed amount, you may have to pay the difference. (See [Balance Billing](#).)

Balance Billing

When a [provider](#) bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A preferred provider may not balance bill you for covered services.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the [allowed amount](#) for the service. You pay co-insurance plus any [deductibles](#) you owe. For example, if the [health insurance](#) or plan's allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.

Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you pay for health care services your plan covers before your [health plan](#) begins to pay. For example, if your deductible is \$2000, your plan won't pay anything until you've met your \$2000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an [emergency medical condition](#) and treatment to keep the condition from getting worse.

Statement of Health

The proof of good health in order to be approved for coverage. [SOH](#) is required for some types of coverage. While applying for insurance, an applicant must confirm his or her physical fitness in writing, through a questionnaire or through a medical examination.

Excluded Services

Health care services that your [health insurance](#) or plan doesn't pay for or cover.

Imputed Income

In regards to health care coverage: If the employee's domestic partner is not considered a "tax dependent" per federal law, any health plan coverage provided to the domestic partner, must be included in the employee's gross income at the fair market value of the benefit and may impact the employee's taxable income and liability.

In regards to group term life insurance coverage: The cost or value of an employee's amount of life coverage above \$50,000 and some dependent life coverage may be considered taxable income. The value is determined by an IRS table.

In-network Co-insurance

The percent (for example, 20%) you pay of the [allowed amount](#) for covered health care services to providers who contract with your [health plan](#). In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment

A fixed amount (for example, \$15) you pay for covered health care services to [providers](#) who contract with your [health plan](#). In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network

The facilities, [providers](#) and suppliers your [health plan](#) has contracted with to provide health care services.

Non-Preferred Provider

A provider who doesn't have a contract with your [health plan](#) to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health plan has a "tiered" [network](#) and you must pay extra to see some providers.

Out-of-network Co-insurance

The percent (for example, 35%) you pay of the [allowed amount](#) for covered health care services to providers who do not contract with your [health plan](#). Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment

A fixed amount (for example, \$30) you pay for covered health care services from providers who do *not* contract with your **health plan**. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-pocket Maximum

The most you pay during a policy period (usually a year) before your **health plan** begins to pay 100% of the **allowed amount**. This limit never includes your contributions, **balance-billed** charges or health care your health plan doesn't cover. Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.

Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization

A decision by your health plan that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your health plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health plan will cover the cost.

Preferred Provider

A provider who has a contract with your health plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health plan has a "tiered" **network** and you must pay extra to see some providers. Your health plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health plan, but the discount may not be as great, and you may have to pay more.

Prescription Drug Coverage

A health plan that helps pay for **prescription drugs** and medications.

Prescription Drugs

Drugs and medications that by law require a prescription.

Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Vesting

"Vesting" in a retirement plan means ownership. This means that each employee will vest, or own, a certain percentage of their account in the plan each year. An employee who is 100% vested in his or her account balance owns 100% of it and the employer cannot forfeit, or take it back, for any reason.



COBRA NOTICE

Introduction

The Comprehensive Welfare Benefit Plan (the Plan), has two group health components – Medical and Dental. The Plan has three group health components – Medical, Dental and Health Flexible Spending Account (Health FSA). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA coverage.

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

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

What is COBRA coverage?

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

If you are an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- You become divorced from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce, and a divorce later occurs, then the divorce may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The child stops being eligible for coverage under the Plan as an eligible dependent.

When is COBRA Coverage Available?

The Plan will offer COBRA coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. Your employer must notify the Plan Administrator of the following qualifying events: end of employment, reduction of hours of employment or death of the employee.

For all other qualifying events (divorce of the employee and spouse or a child's losing eligibility for coverage as a dependent), you must notify the Plan Administrator in writing within 60 days after the qualifying event occurs. You must provide this written notice and supporting documentation to the Plan Administrator at the address listed at the end of this notice.

How is COBRA Coverage Provided?

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

How Long Does COBRA Coverage Last?

COBRA coverage under the Plan's Medical and Dental components is a temporary continuation of coverage

that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events (such as death of the employee, the employee's divorce or a child's losing eligibility as an eligible dependent), or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. COBRA coverage under the Health FSA component can last only until the end of the calendar year in which the qualifying event occurred.

There are two ways in which this 18-month period of COBRA coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled, and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA coverage and must last at least until the end of the 18-month period of COBRA coverage. To obtain this extended coverage, you must notify the Plan Administrator of Social Security's disability determination, and provide a copy of the determination, within 60 days of the date of the determination and 18 months of the qualifying event.

Second qualifying event extension of 18-month period of continuation coverage

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

Health FSA COBRA Coverage

COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply so any unused amounts will be forfeited

at the end of the calendar year, and COBRA coverage will terminate at the end of the calendar year.

Are There Other Coverage Options Besides COBRA Coverage?

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator listed below know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Hormel Foods Corporation

Attn: HR Solution Center

1 Hormel Place

Austin, MN 55912

Telephone: 1-866-449-7712 (toll free) or 1-507-437-5996

Fax: 1-507-437-9810



Annual Notices

Women's Health and Cancer Rights Act

Under the Federal Women's Health and Cancer Rights Act of 1998, you are entitled to the following services:

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

Services are provided in a manner determined in consultation with the physician and patient. Coverage is provided on the same basis as any other illness.

If you would like more information on WHCRA benefits, contact your health plan's claims administrator.

Special Enrollment Rights

If you have declined enrollment for yourself or your dependents (including your spouse) because of other health plan coverage, you may in the future be able to enroll yourself or your dependents in the health plan options, provided that you request enrollment within 60 days after the other coverage ends. In addition, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days after the event, if you experience any of the following events:

- Birth, adoption or placement for adoption,
- Marriage,
- You or your dependents lose Medicaid or Children's Health Insurance Program (CHIP) coverage due to no longer being eligible for such coverage, or
- You or your dependents become eligible for a state's premium assistance program under Medicaid or CHIP.

Please refer to your health care Summary Plan Description for details.

Confidentiality of Your Health Information Related to Your Health Care Program

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.

Use and Disclosure of Health Information

THIS NOTICE describes the medical information practices of the Group Health Plans of Hormel Foods Corporation and its subsidiaries and affiliated companies. The consolidated Plans are considered an Organized Health Care Arrangement under the

Health Insurance Portability and Accountability Act (HIPAA).

Health Plans are required by law to maintain the privacy of your Health Information and to provide you with this notice of their legal duties and privacy practices with respect to your Health Information and to notify you following a breach of unsecured Health Information. This notice is being issued to comply with the requirements of the Privacy Rules under the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rules").

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Make or Obtain Payment - The Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations - The Plan may use or disclose health information for its own operations to facilitate the administration of the Plan and as necessary to provide coverage and services to all of the Plan's participants. Health care operations include such activities as:

- Quality assessment and improvement activities;
- Activities designed to improve health or reduce health care costs;
- Clinical guideline and protocol development, case management and care coordination;
- Contacting health care providers and participants with information about treatment alternatives and other related functions;
- Health care professional competence or qualifications review and performance evaluation;
- Accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits. (The Plan may not, however, use or disclose any health information that is genetic information for underwriting purposes);
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs;
- Business planning and development including cost management and planning related analyses, formulary development, and retiree medical valuations;

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- Business management and general administrative activities of the Plan, including customer service and resolution of internal grievances.

For example, the Plan may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in employee service and grievance resolution activities.

For Treatment – The Plan may use or disclose your health information to health care providers (doctors, nurses, technicians, dentists, pharmacists, hospitals and other individuals who are involved in your care) in connection with your treatment. For example, your health information may be disclosed to your pharmacist who may request it to coordinate a pending prescription with prior prescriptions.

For Treatment Alternatives - The Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services - The Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

For Disclosure to the Plan Sponsor - The Plan may disclose your health information to the plan sponsor for plan administration functions performed by the plan sponsor on behalf of the Plan. In addition, the Plan may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from health insurers or modify, amend or terminate the plan. The Plan also may disclose to the plan sponsor information on whether you are participating in the Plan.

For Disclosure to Business Associates – The Plan may disclose your health information to third-party administrators, auditors, attorneys, consultants and the like (“business associates”) who will be hired to assist in operating and administering the Plan. The Plan’s business associates may use or disclose your health information to perform the services for which they have been hired. To protect your health information, each business associate must sign a contract limiting its ability to use and disclose health information and requiring it to implement appropriate safeguards.

For Communication with You and Your Family – Generally, Hormel Foods Corporation and its subsidiaries and affiliated companies will not discuss your health information with you or your family members without a specific signed authorization, unless it relates to basic eligibility or enrollment questions. Rather, inquiries from you or your family

members will be directed to the appropriate third-party administrator. Unless you object, the third-party administrator may disclose your health information to a family member, other relative, person authorized by law, or any other person you identify as involved in your care or the payment related to your care. Only health information relevant to that person’s involvement in your care or the payment related to your care will be disclosed. You can restrict this disclosure at any time, subject to certain limitations. If you are incapacitated or in the event of an emergency, the third-party administrator will exercise professional judgment to determine whether a disclosure of this type is in your best interest.

When Legally Required - The Plan will disclose your health information when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities - The Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings - As permitted or required by state law, the Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes - As permitted or required by state law, the Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the Event of a Serious Threat to Health or Safety - The Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

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For Specified Government Functions - In certain circumstances, federal regulations require the Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Worker's Compensation - The Plan may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

To Parents of Minors - The Plan, in most cases, will disclose health information of a minor child to a parent or guardian of that minor, subject to certain limitations imposed by State law.

Other Permitted Uses and Disclosures - The Plan may also disclose health information to prevent abuse, neglect or domestic violence; for the purpose of conducting research; to coroners, medical examiners or funeral directors; for purposes of organ donations and/or for public health activities.

Authorization to Use or Disclose Health Information

Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights With Respect to Your Health Information

You have the following rights regarding your health information that the Plan maintains:

Right to Request Restrictions - You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Plan's disclosure of your health information to someone involved in the payment of your care. However, the Plan is generally not required to agree to your request. If the Plan does agree to the request, but the Plan was not required to do so, the Plan will abide by your restriction unless the Plan needs to use your health information to provide emergency treatment. In addition, the Plan may generally elect to terminate the restriction at any time. In order to request a restriction, submit it in writing to

the Director of Employee Benefits at the address listed under Contact Person.

Right to Receive Confidential Communications - You have the right to request that the Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Director of Employee Benefits at the address listed under Contact Person. The Plan will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information - You have the right to inspect and copy your health information and in some cases you may have the right to receive the health information that you request in an electronic format. You may also choose to have such information transmitted directly to an entity or person you clearly designate. A request to inspect and copy records containing your health information must be made in writing to the Director of Employee Benefits at the address listed under Contact Person. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information - If you believe that your health information records are inaccurate or incomplete, you may request that the Plan amend the records. That request may be made as long as the information is maintained by the Plan. A request for an amendment of records must be made in writing to the Director of Employee Benefits at the address listed under Contact Person.

The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Plan, if the health information you are requesting to amend is not part of the Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Plan determines the records containing your health information are accurate and complete.

Right to an Accounting - You have the right to request a list of certain disclosures of your health information that the Plan is required to keep a record of under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. The request must be made in writing to the Director of Employee Benefits at the address listed under Contact Person.

Annual Notices

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 also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

Your current prescription drug coverage is provided through the health plan options, which includes medical and prescription drug coverage. You have the following options with regard to Medicare prescription drug coverage:

1. You can keep your current prescription drug coverage through the health plan options and choose not to enroll in a Medicare prescription drug plan;
2. You can enroll in a Medicare prescription drug plan and continue to have coverage through the health plan options. Your current coverage pays for other health care expenses, such as medical claims, and you will still be eligible to receive your medical and prescription drug benefits if you choose to enroll in a Medicare drug plan. If you enroll in a Medicare prescription drug plan and keep your current coverage, the Medicare Secondary Payer Rules will apply.
3. You can enroll in a Medicare prescription drug plan when you become eligible for Medicare and drop your coverage through the health plan options during open enrollment or through a mid-year election change when you become Medicare eligible. If you drop your coverage through the health plan options, you are dropping your coverage for medical and prescription drug coverage altogether. You will be eligible to enroll for coverage in the health plan options during the next annual open enrollment period.

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 the health plan options and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary

premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the Horizon Solution Center at 1-866-449-7712.

NOTE: You will receive this notice each year. You will also receive it before the next Medicare prescription drug plan enrollment period, and if your coverage through the health plan options changes. You may also request a copy of this notice at any time by calling the Horizon Solution Center.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Dated: October 1, 2021
 Sender: Hormel Foods Corporation
 Contact: Horizon Solution Center
 Address: 1 Hormel Place, Austin, MN 55912
 Telephone: 1-866-449-7712

Annual Notices

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these

programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: <http://myalhipp.com/>

Phone: 1-855-692-5447

ALASKA – 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>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>

Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program

Website: <http://dhcs.ca.gov/hipp>

Phone: 916-445-8322; Fax: 916-440-5676

Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

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

FLORIDA – Medicaid

Website:

<https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>

Phone: 1-877-357-3268

GEORGIA – Medicaid

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

INDIANA – Medicaid

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

IOWA – Medicaid and CHIP (Hawki)

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

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:

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<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>

Phone: 1-855-459-6328

Email: KIHIP.PPROGRAM@ky.gov

KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>

Phone: 1-877-524-4718

Kentucky Medicaid Website:

<https://chfs.ky.gov/agencies.dms>

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>

Phone: 1-800-862-4840

TTY: 711

Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp>

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website:

<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 573-751-2005

MONTANA – Medicaid

Website:

<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084

Email: HHSHIPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcfp.nv.gov>

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

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

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <http://www.hhs.nd.gov/healthcare>

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>

Phone: 1-888-365-3742

OREGON – Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website:

<https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>

Phone: 1-800-692-7462

CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)

CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>

Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>

Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: <http://dss.sd.gov>

Phone: 1-888-828-0059

TEXAS – Medicaid

Website:

<https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov/>

CHIP Website: <http://health.utah.gov/chip>

Phone: 1-877-543-7669

VERMONT– Medicaid

Website:

<https://dvha.vermont.gov/members/medicaid/hipp-program>

Phone: 1-800-250-8427

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VIRGINIA – Medicaid and CHIP

Website: <https://www.coverva.org/es/famis-select>
<https://www.coverva.org/es/hipp>
 Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>
 Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

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)

WISCONSIN – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
 Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
 Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 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
 1-866-444-EBSA (3272)

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

Paperwork Reduction Act Statement

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

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

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

This handbook is not a legal document, nor does it establish eligibility to participate in any benefit plan. If any information in this handbook conflicts in any way with the official plan document, the provisions of the plan document will govern. Please refer to your summary plan descriptions or life insurance certificates for additional information regarding your benefits.



Contact the HR Solution Center (toll free) at 1-866-449-7712
or email hresolutioncenter@hormel.com.

The customer service line is staffed Monday through Friday from 7:00 a.m. to 5 p.m. CT.