

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 11
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 22
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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Benefits Enrollment Process	Page 5
Dependents	Page 6
Changing Your Benefits	Page 7
Doctor On Demand	Page 30
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Employee Assistance Program – Inspired Health and Well-Being	Page 31
Financial and Personal Growth Resources	Page 33
Glossary of Terminology	Page 34
Cobra Notice	Page 36
Health Care Notices	Page 41

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 hrrsolutioncenter@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.



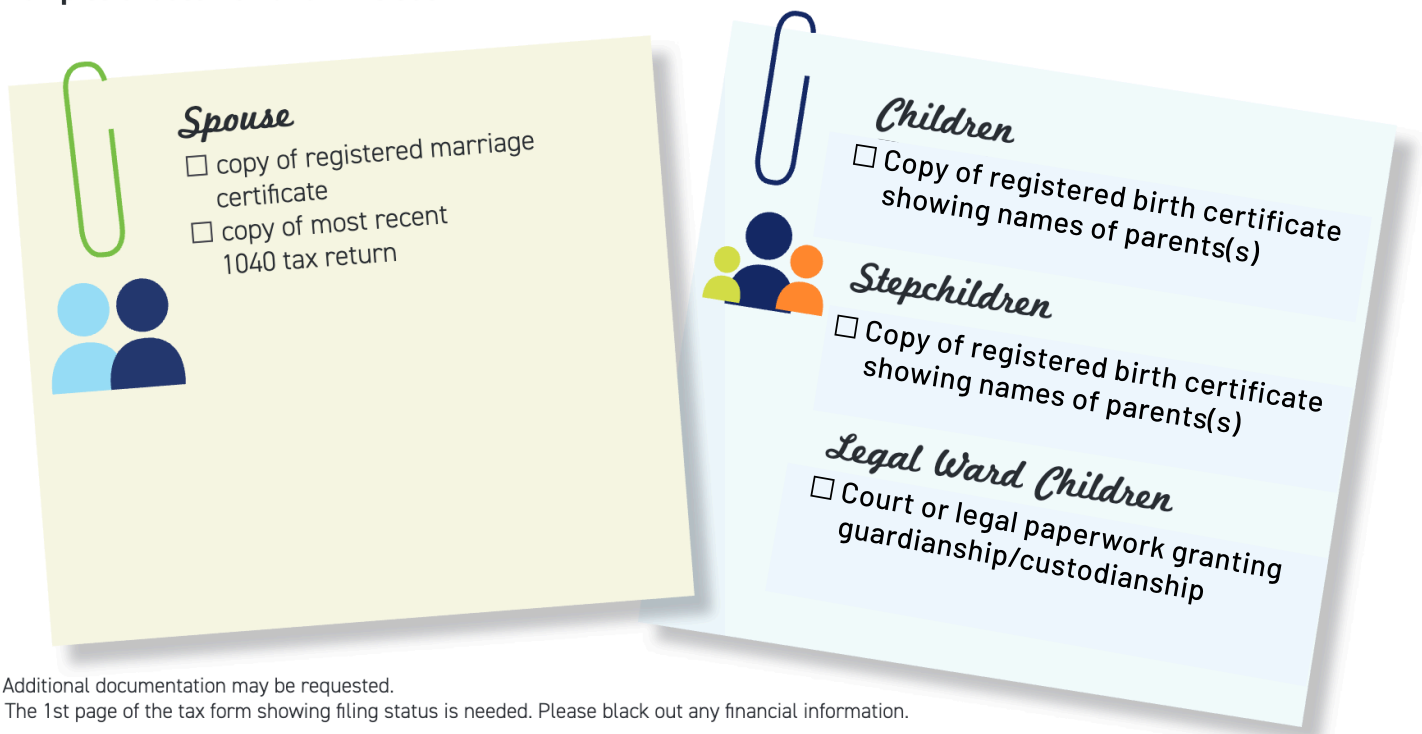
Dependent ELIGIBILITY

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?

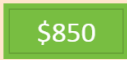
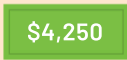
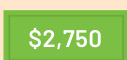
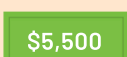
Visit HormelFoods.KnowMoreStressLess.com to view all your benefit information.



HormelFoods.KnowMoreStressLess.com



UNDERSTANDING YOUR OPTIONS

*In Network Plan Comparisons	BCBS PPO Plan					
Preventive Care	Covers 100% No Deductible					
Deductible						
 Single Deductible						
 Family Deductible						
Out of Pocket (OOP) Maximum						
 Single Medical OOP						
 Family Medical OOP						
 Single Drug OOP						
 Family Drug OOP						
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 +  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

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 \$4,250 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 2027 FSA.
- As a reminder, you must elect a contribution amount for 2026 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.



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



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 your benefit features to see your offered coverages. Cost of coverage is available on the benefits enrollment site.

OPTIONAL LIFE INSURANCE	
EMPLOYEE LIFE INSURANCE 	Choose as a times salary in the following options: 1/2 - 8 times your salary (this benefit will increase as your salary increases) • Maximum benefit is the lesser of 8x annual salary or \$1,000,000 • 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 election over \$350,000 when you are first eligible to elect coverage, or any future increase.
CHILD LIFE INSURANCE 	\$5,000, \$10,000, or \$20,000 • Covers children age 14 days to age 26 • 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/domestic partner. \$10,000 to \$100,000. • Contributions are based on your spouse's age at the end of the next year and will increase as they get older • SOH required over \$50,000 when first eligible. SOH will be required on spouse for any future increases in coverage.



Adding or increasing coverage will be subject to Statement of Health. 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!



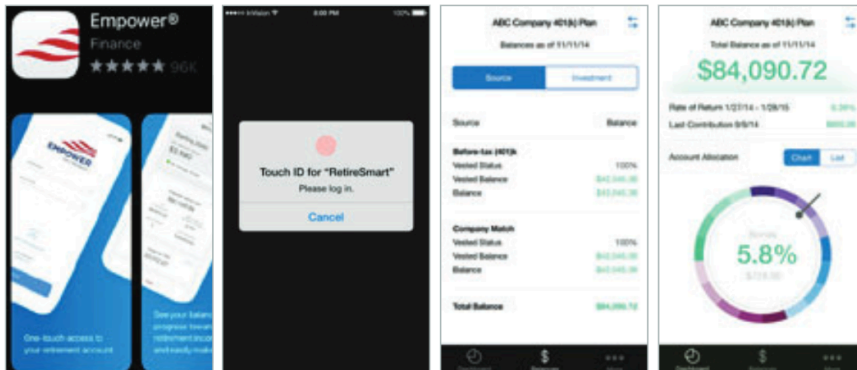
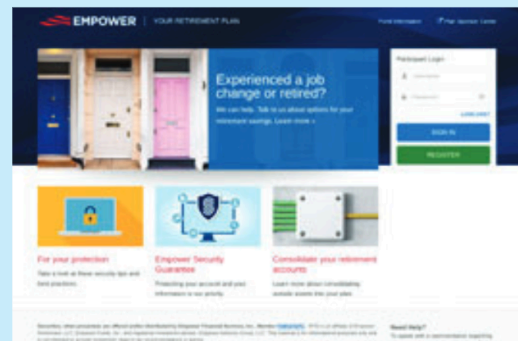
EMPOWER IS HERE TO HELP

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:

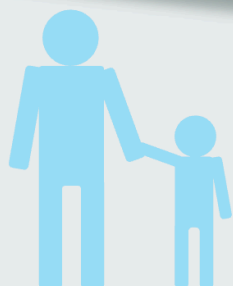


Notes:



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/horrel/>

*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.

Annual Notices

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 company's Health Care Program, 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 Program Summary Plan Description for details.

Important Notice About Creditable Prescription Drug Coverage and Medicare

PLEASE READ THIS NOTICE CAREFULLY and keep it for future reference.

This notice has information about your prescription drug coverage under the Health Care Program, which is a component of the Hormel Foods Corporation Comprehensive Welfare Benefit Plan, and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Hormel Foods Corporation, Plan Sponsor of the Health Care Program, has determined that prescription drug coverage offered by the Health Care Program 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 your current 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 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 Care Program, 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 Care Program 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 Care Program. If you enroll in a Medicare drug plan (Part D), you are not eligible to contribute to a Healthy Savings Account (HSA), if made available to you. Enrollment in Medicare may be retroactive for up to six months, and any HSA contributions made during that time may need to be corrected. Please consult with your tax advisor if you have contributed to an HSA and later enroll in Medicare. 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 Care Program during open enrollment or through a mid-year election change when you become Medicare eligible. If you drop your coverage through the Health Care Program, you are dropping your coverage for both medical and

Annual Notices

prescription drug coverage. You will be eligible to enroll in the Health Care Program 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 Care Program 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 Care Program 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, 2025
Sender: Hormel Foods Corporation
Contact: Horizon Solution Center
Address: 1 Hormel Place, Austin, MN 55912
Telephone: 1-866-449-7712

Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice of Availability

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Care Program, which is a component of the Comprehensive Welfare Benefit Plan (the "Plan"), is required to provide you with a HIPAA Notice of Privacy Practices ("Notice") at the time of your enrollment and at certain other times. In addition, the Health Care Program is required to periodically notify you of the availability of the Notice and provide you with information on how to obtain a copy of the Notice.

You may obtain a copy of the Notice at any time by accessing the Hormel Foods internal website at Pivot > Career & Total Rewards > Benefits > Health Care and scroll down to Documents. To request a paper copy of this notice, contact the Horizon Solution Center at 1-866-449-7712. This reminder pertains only to those health care benefits provided under the Health Care Program that are covered under HIPAA's privacy rules.

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.

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.