OPEN ENROLLMENT GUIDE

2027

EDUCATION TO HELP YOU MAKE THE DECISIONS RIGHT FOR YOU

Health Care

Disability & Life Insurance

Resources

Table of Contents

Hormel Foods is proud to support our employees' overall wellbeing with a variety of benefit options. This guide offers details on our 2027 offerings for you and your family. Contact the Horizon Solution Center department with any questions.

Scan for Your Plans!

Scan with your smartphone to access enrollment materials online anytime.

See page 41 for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to Hormel Foods Corporation. This Guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Welcome

Hormel Foods appreciates the hard work and dedication you bring to our team every day. To do our part, we are committed to keeping your benefits affordable and beneficial for you and your eligible family members.

Hormel Foods strives to provide benefits that:

- Meet your needs
- Are easy to understand and use
- Provide excellent value for affordable costs

To be your healthiest and help keep costs down, we ask that you take advantage of the provided wellness activities and preventive features.

This guide is designed to assist you and your family in making the best choices for your needs. It contains explanations of each benefit, contact information for benefits vendors, and costs you can expect for each benefit. Please review this guide in its entirety and keep as a resource throughout the year.

What's Changing This Year?

- Due to rising healthcare costs, you'll see a slight increase in medical premiums for 2027. You can help keep your costs down by participating in our wellness program, which offers a discount on weekly premiums. We are also increasing our annual contribution to Health Savings Accounts for those who elect that option.
- Our dental plan will be switching from Dental Company 1 to Dental Company 2. You will see lower deductions on your paycheck for dental insurance.
- We have expanded our additional benefits to now include access to pet insurance. Further details can be found in this guide.

Any Questions?

We're here to help. Contact Horizon Solution Center at 866-449-7712.

Coverage Timing

Here is a quick look at when coverage would end for various benefits if you leave the company or retire.

	COVERAGE ENDS ON THE LAST DAY OF EMPLOYMENT	COVERAGE ENDS ON THE LAST DAY OF THE MONTH OF THE QUALIFYING EVENT
EMPLOYEE ASSISTANCE PROGRAM	X	X
MEDICAL, DENTAL, VISION	X	X
FLEXIBLE SPENDING ACCOUNT (FSA)	X	X
VOLUNTARY ACCIDENT	X	X
VOLUNTARY CRITICAL ILLNESS	X	X
VOLUNTARY HOSPITAL INDEMNITY	X	X
BASIC AND VOLUNTARY AD&D	X	X
BASIC AND VOLUNTARY GROUP TERM LIFE	X	X
SHORT-TERM DISABILITY	X	X
LONG-TERM DISABILITY	X	X
VOLUNTARY WHOLE LIFE	X	X
401(K) SAVINGS PLAN	X	X
BUSINESS TRAVEL ACCIDENT	X	X
LEGAL PLAN	X	X

Note: If your coverage terminates, you may be eligible to continue medical, dental, vision, and Flexible Spending Account coverage under COBRA provisions.

Benefits FAQ

THIS YEAR'S OPEN ENROLLMENT PERIOD IS NOVEMBER 2 – NOVEMBER 16, 2026.

BENEFITS FAQs

What Do I Need to Do?

Make any election changes in Oracle by November 16, 2026. Please refer to page 4 for Oracle navigation instructions.

What if I want to continue my current health care coverage?

Your benefits election from 2026 will continue in 2027 except your flexible spending account or health savings account contribution. You will need to elect and enter your FSA or HSA contribution amount for 2027.

I might have funds in my FSA at the end of the year, can I use those funds next year?

If you will have unused funds at year end, you must re-enroll and elect to contribute to an FSA (minimum $52 annually) during Open Enrollment, in order to have any funds (up to $680) rollover to 2027.

Note: Dependent daycare flex spending does not allow for any rollover of funds.

What if I'm still waiting on my spouse's (domestic partner's) Social Security card or other documentation—should I wait to add them to my benefits?

No—you should still add your spouse/domestic partner during Open Enrollment, even if you don't have all their documentation yet. You can submit the required dependent information (like a birth certificate) later (deadline 12/16/2026), but the enrollment itself must happen during the Open Enrollment period. If you wait, you may not be able to add them until the next Open Enrollment or unless you experience a qualifying life event.

My spouse, who is also an employee, is going to carry the coverage in 2027. What do I need to do?

For company couples, if you're switching who will carry health care coverage, please notify the Horizon Solution Center (hrsolutioncenter@hormel.com) to help ease the dependent verification process.

When do my benefits start?

The benefits you elect during open enrollment will become effective Jan. 1, 2027. The effective date for life insurance may be later if Statement of Health (SOH) is required for adding or increasing life insurance.

When can I make changes during the year?

Choose your benefits carefully, as the choices you make now will remain in effect for the entire calendar year (January 1 - December 31, 2027).

You may only change your benefits coverage or enroll new dependents during the year if you have a qualified, permitted election change event, such as marriage, divorce, birth or adoption, etc.

Should you have a permitted election change, you have 60 days from the date of the event to make changes to your coverage or enroll a new dependent. These life events need to be submitted in Oracle under Benefits by selecting Report a Life Event. If you have questions or need assistance with this contact the Horizon Solution Center.

IMPORTANT INFORMATION

Please print, print to pdf, or screenshot your confirmation page.

NO confirmation statements will be mailed.

Questions? Please contact the Horizon Solution Center (toll free) at (866) 449-7712 or email hrsolutioncenter@hormel.com. Our customer service line will be staffed Monday through Friday from 7:00 a.m. to 5 p.m. CT.

Oracle

New to Oracle?

Web based Access

1. Visit yoursource.hormel.com
2. Click on Oracle Cloud
3. Follow instructions to log in below

Mobile access

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?

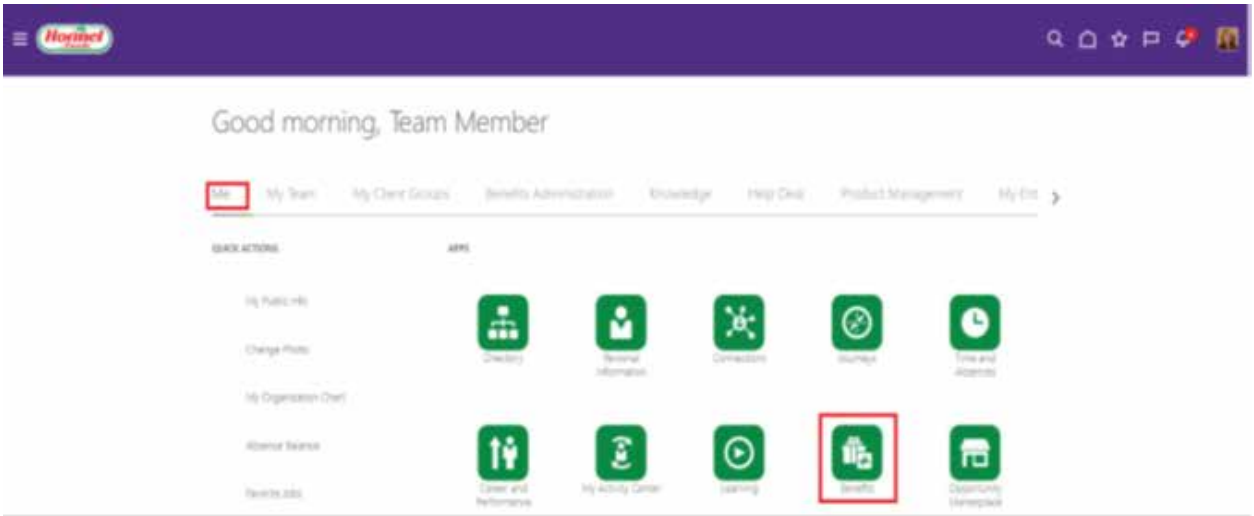
Your username is your nine digit / employee ID. Your password will be what you had created. If you don’t remember your password, contact your local HR office or call the Horizon Solution Center (866-449-7712) to add your email contact so a registration link can be emailed to you to register and set a password.

I’m logged into Oracle. Where do I go for open enrollment?

Please follow the instructions below and refer to the screenshots provided in each section.

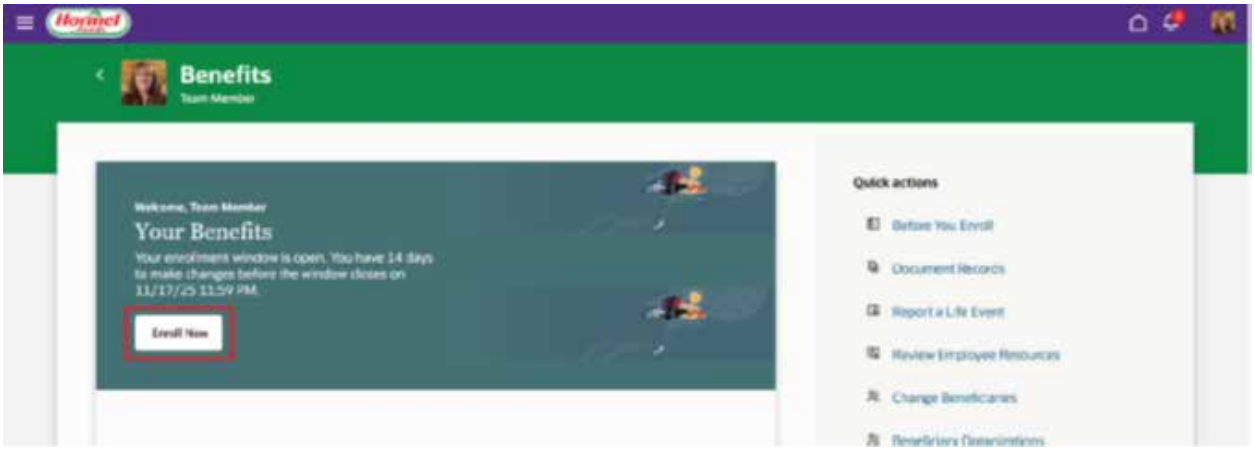
Access the Benefits Section

Navigate to the ‘Benefits’ section from the home screen.



Access Open Enrollment

Select ‘Enroll Now’.

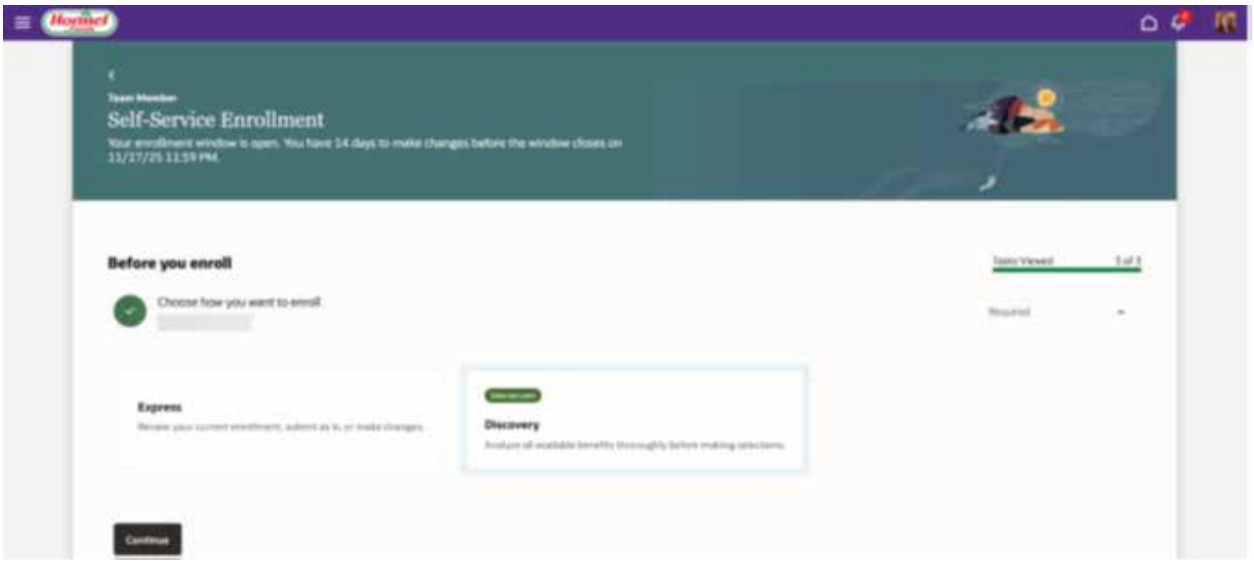


Choose Your Path

You have two options to choose from.

Discovery goes through each benefit individually. This will allow you to review each benefit individually and make changes as needed.

Express will allow you to review your current elections and then pick and choose which benefits you’d like to change or if no changes are needed you can simply submit your enrollments.



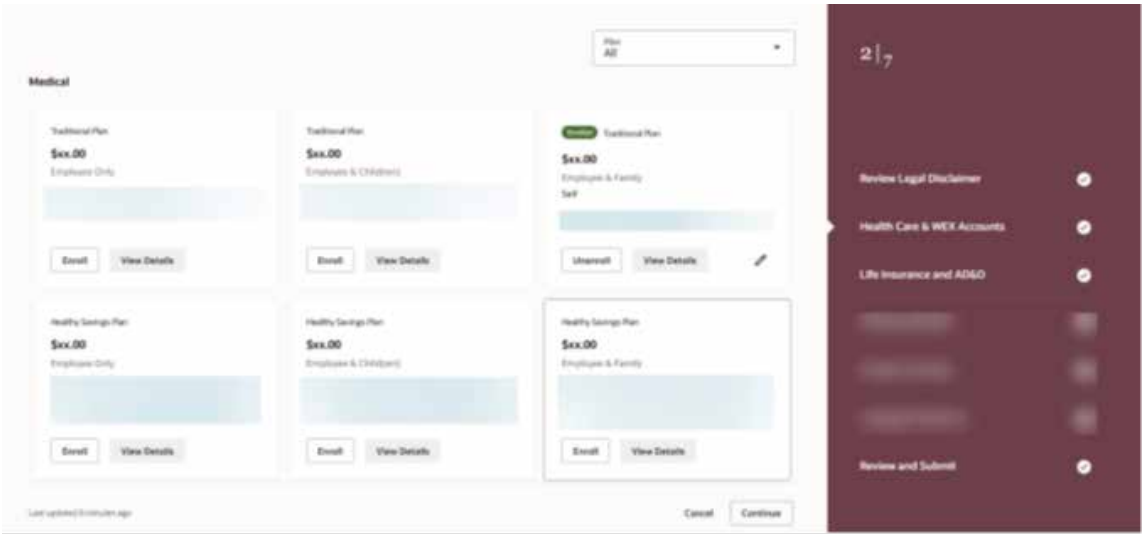
Add Your Dependents or Beneficiaries

Review your current contacts and add any new dependents or beneficiaries.

Enroll

Select 'Edit'

Select 'Enroll' under all the benefit offerings that you would like.



Confirm and Submit

After making your selections, review your choices and confirm that all information is correct. Submit your enrollment to finalize the process.

Step 5: Save Confirmation

Save, screenshot, or print the confirmation page for your records.

Need Help?

If you encounter any issues or have questions during the enrollment process, please contact the HR department for assistance or reach out to the Horizon Solution Center 866-449-7712.

Eligibility

Hormel Foods' benefits are designed to support your unique needs.

Eligibility

Coverage for Health Care and Life Insurance Benefits is available to you and your eligible dependents, which includes your spouse/domestic partner and children up to age 26.

Does My Child Qualify as a Dependent?

Children are eligible for the Medical and Prescription Drug Plan and Dental and Vision Plan up to age 26, regardless of student or marital status. You may also elect Child Life Insurance coverage for your children up to age 26.

Dependent Coverage Termination at Age 26

If your child is turning 26 during the calendar year, their healthcare coverage under your plan will continue through the end of the month in which they turn 26. This event qualifies as a life event, allowing them to enroll in a new health insurance plan through their own provider at that time. The following children are eligible for health care and life insurance coverage as a dependent:

- Your children
- Your domestic partner's children (only if your domestic partner is on coverage)
- Stepchildren
- Legally adopted children
- Legal ward (custodian)
- Children in the process of adoption who have been placed in your home
- Children for whom you are legally required to provide coverage by a Qualified Medical Child Support Order (QMCSO)
- For health care coverage only, disabled children who meet certain requirements as stated in the Summary Plan Descriptions for the Medical and Prescription Drug Plan and Dental and Vision Plan

Does my Domestic Partner Qualify as a Dependent?

If you meet the requirements listed below, your domestic partner is eligible for the Medical and Prescription Drug Plan and Dental and Vision Plan, and you may elect Domestic Partner Life Insurance. Your domestic partner is eligible for health care and life insurance coverage if you and your domestic partner meet the requirements of paragraph 1 or 2 below:

1. Your domestic partner is your registered domestic partner or civil union partner from a jurisdiction that recognizes domestic partnerships or civil unions

-OR-

2. You and your domestic partner meet all of the following requirements:
   - You and your domestic partner are same or opposite gender adults
   - You are both at least 18 years of age and are not married to or legally separated from anyone else and do not have other domestic partners
   - You are in a committed and mutually exclusive relationship of at least 12 months that is intended to be permanent
   - You have joint responsibility for welfare and financial obligations
   - You reside in the same principal residence and intend to do so permanently
   - You are not related by blood
   - You are each mentally competent

You will need to complete a Declaration of Domestic Partnership form and provide supporting documentation before coverage is approved for your domestic partner and your domestic partner's children. This form can be found in Oracle under Help Desk / My Knowledge.

You will be required to provide documentation to verify your dependent's eligibility. **Documentation is due by December 16, 2026.** Dependents will be removed from coverage if documentation is not provided by December 16, 2026.

Dependent Eligibility

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 **December 16, 2026**. 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 2028, or if you have a mid-year qualifying event.

Examples of documentation[1] include:

SPOUSE

- Copy of registered marriage certificate
- Copy of most recent 1040 tax return[2]

CHILDREN

- Copy of registered birth certificate showing names of parent(s)

STEPCHILDREN

- Copy of registered birth certificate showing names of parent(s)
- Copy of registered marriage certificate

LEGAL WARD CHILDREN

- Court or legal paperwork granting guardianship/ custodianship

[1]Additional documentation may be requested.

[2]The 1st page of the tax form showing filing status is needed if married for more than 2 years. Please black out any financial information.

How do I provide documents to verify my dependents?

After logging into Oracle, from your Home screen, click on Me, then quick actions "show more", 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 quick actions "show more", 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.

Deadlines to Submit Documentation:

You must submit all the necessary documentation to verify your dependents before **December 16, 2026**.

Any unverified dependents will be removed and are unable to be added back until the next open enrollment.

Note

This information is a summary only. For a complete description of dependent eligibility, refer to the plan's Summary Plan Description that can be found at HormelFoods.KnowMoreStressLess.com

Now's the Time to Enroll!

What Are Qualifying Life Events?

You can update your benefits when you start a new job or during Open Enrollment each year. But changes in your life called Qualifying Life Events (QLEs), as determined by the IRS, can allow you to enroll in health insurance or make changes outside of these times.

When a Qualifying Life Event occurs, you have 60 days from the date of the event to request changes to your coverage or enroll a new dependent. Your change in coverage must be consistent with your change in status. These life events need to be submitted in Oracle under Benefits by selecting Report a Life Event. If you have any questions or need assistance with this contact the Horizon Solution Center.

- A change in the number of dependents (through birth or adoption or if a child is no longer an eligible dependent)
- A change in your legal marital status (marriage, divorce, or legal separation)
- A change in a spouse/domestic partner's employment status (resulting in a loss or gain of coverage)

- Entitlement to Medicare or Medicaid
- Eligibility for coverage through the Marketplace (Healthcare.gov)
- Changes in address or location that may affect coverage
- Turning 26 and losing coverage through a parent's plan

- A change in employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility
- Death in the family (leading to change in dependents or loss of coverage)
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)

Reach out to Hormel Foods' Horizon Solution Center with questions regarding specific life events and your ability to request changes. Don't miss out on a chance to update your benefits!

Ready for Open Enrollment?

Hormel Foods covers a significant amount of your benefit costs. Your contributions for medical, dental, and vision benefits are deducted on a pre-tax basis, which reduces the amount you're required to pay taxes on. Employee contributions vary depending on the level of coverage you select — typically, the more coverage you have, the more you'll pay up-front for it.

Open Enrollment Action Items

Update your personal information.
Confirm your mailing address and phone number are up to date.

Double-check covered medications.
If you make any changes to your plan, consider how it affects your prescriptions (i.e., will their costs go up or down?).

Review available plans' deductibles.
Think you may have more medical needs than usual this year? You might want a lower deductible. If not, you could switch to a higher deductible plan and enjoy lower weekly premiums.

Consider your HSA or FSA.
An HSA or FSA can help cover healthcare costs, including dental and vision services and prescriptions. Adding one of these accounts to your benefits can help with your long-term financial goals.

Check your networks.
Receiving care by in-network providers often saves you money. Check for any plan changes to make sure your go-to providers and pharmacy are still your best bet.

Additional Health Benefits & Programs

HINGE HEALTH

With Hinge Health, you can get virtual physical therapy and more from real people who are dedicated to helping you feel your best. Employees and dependents 18+ currently enrolled in a Hormel medical plan are eligible.

SPECIALIZED CARE, PERSONALIZED FOR YOU

- A care plan designed for your everyday activities and long-term goals, including dedicated support for women's pelvic health
- Access exercise therapy sessions you can do in as little as 15 minutes – anytime, anywhere with the Hinge Health app
- Get 1-on-1 support from a physical therapist or health coach to tailor your sessions as needed and help you reach your goals
- Receive free wearable device to give life feedback through the app for those who qualify

To learn more and apply, scan the QR code or visit hinge.health/hormel.

Questions? Call (855) 902-2777

OMADA

Pending marketing materials.

PROGYNY

- For team members enrolled in a Hormel medical plan
- Fertility treatment and family-building services for every unique path to parenthood.
- Comprehensive consultations, IUI, IVF, preimplantation, and genetic testing
- One smart cycle is fully covered
- Donor tissue purchase (Egg and sperm tissue)
- Medications for fertility treatments through Progyny https://progyny.com/progyny-member-portal/

To learn more and activate your benefit, call: (866) 946-0675

How to Pick a Plan

You have two health plan options available to you so you can select the option that meets the needs of you and your family. The plan comparison chart in this booklet contains each health plan option's deductibles, and out-of-pocket maximums.

All health plan options feature 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. What plan is right for you? Consider any medical needs you foresee for the upcoming plan year, your overall health, and any medications you currently take.

TRADITIONAL PLAN

The Traditional Plan Option is a lower 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 prescribed drug. You may contribute to a health care Flexible Spending Account (FSA).*

*For more information about the health savings account, limited purpose flexible spending account, or the flexible spending account, please refer to your benefit feature.

HEALTHY SAVINGS PLAN

The Healthy Savings Plan Option is a high deductible health plan. You will pay 100% of medical and prescription costs until your deductible has been met. The deductible can be met with any combination of medical and prescription drug spending. Once the deductible has been met, then co-insurance will apply until you've met your out-of-pocket maximum. A Health Savings Account (HSA)* is available to you with this health plan. Additionally, you can contribute to a Limited Purpose Flexible Spending Account (LPFSA).*

*For more information about the health savings account, limited purpose flexible spending account, or the flexible spending account, please refer to your benefit feature.

Medical and Prescription Drug Cards

Blue Cross Blue Shield of Minnesota (medical) and Prime Therapeutics (prescription drug) are the claims administrators for your healthcare and prescription 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. (if electing for the first time or changing plans)

Weekly Employee Contributions

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

Want to learn more?

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

Medical Benefits

Medical benefits are provided through Blue Cross Blue Shield of MN. Consider the physician networks, premiums, and out-of-pocket costs for each plan when making a selection. Keep in mind, your choice is effective for the entire 2027 plan year unless you have a Qualifying Life Event.

How to Find a Provider

Visit bluecrossmn.com/hormelfoods or call Customer Care at 866-537-7721 for a list of Blue Cross Blue Shield of MN network providers.

Medical Plan Summary

This chart summarizes the 2027 medical coverage provided by Blue Cross Blue Shield of MN. All covered services are subject to medical necessity as determined by the plan. Please note that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	TRADITIONAL PLAN		HEALTHY SAVINGS PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE				
INDIVIDUAL	$850	$850	$2,500	$2,500
FAMILY	$1,700	$1,700	$$5,000	$5,000
COINSURANCE (EMPLOYEE PAYS)	20%%*	35%*	20%%*	35%%*
ANNUAL OUT-OF-POCKET MAXIMUM**				
INDIVIDUAL MEDICAL	$4,000	$7,500	$5,000	$7,600
FAMILY MEDICAL	$8,000	$15,000	$10,000	$9,000
INDIVIDUAL DRUG				
FAMILY DRUG				
COPAYS/COINSURANCE				
PREVENTIVE CARE	$0	35%	$0	35%
PRIMARY CARE	20%*	35%*	20%*	35%*
SPECIALIST SERVICES	20%*	35%*	20%*	35%*
DIAGNOSTIC CARE	20%*	35%*	20%*	35%*
MENTAL HEALTH - INPATIENT	20%*	35%*	20%*	35%*
MENTAL HEALTH - OUTPATIENT	20%	35%*	20%*	35%*
URGENT CARE	20%*	35%*	20%*	35%*
EMERGENCY ROOM	$300 + 20%*	$300 + 20%*	$300 + 20%*	$300 + 20%*

*After deductible
**All plans pay 100% once OOP is reached

For the XX plan(s), the individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will also be applied toward the "per family" deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the "per family" deductible amount. The same typically applies for the out-of-pocket maximum.

For the XX plan(s), each covered individual is not required to meet the individual deductible. The HDHP has an aggregate deductible, meaning the family deductible amount will include all combined eligible expenses that you and your covered dependents incur. The family deductible amount may be satisfied by one member or a combination of two or more members covered under your medical plan. The same typically applies for the out-of-pocket maximum.

Healthcare Cost Transparency

There are so many different providers and varying costs for healthcare services — how do you choose? Online services called healthcare cost transparency tools can help. Available through most health insurance carriers, these tools allow you to compare costs for services, from prescriptions to major surgeries, to make your choices simpler. Visit bluecrossmn.com/hormelfoods to learn more.

Note

Keep healthcare costs down by seeing the right provider for your situation.
See page 19 for more

Out-of-Pocket Costs

These are the types of payments you're responsible for:

Copay

The fixed amount you pay for healthcare services at the time you receive them.

Coinsurance

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.

Deductible

The amount you must pay for covered services before your insurance begins paying its portion/coinsurance.

Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

Preventive Care

Routine checkups and screenings are considered preventive, so they're often paid at 100% by your insurance. Some common covered services include:

Wellness visits, physicals, and standard immunizations

Screenings for blood pressure, cancer, cholesterol, depression, obesity, and diabetes

Pediatric screenings for hearing, vision, obesity, and developmental disorders

Anemia screenings, breastfeeding support, and pumps for pregnant and nursing women

Iron supplements (for infants at risk for anemia)

It's important to take advantage of these covered services. But remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. So, if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

What Vaccines Are Covered 100% Under Preventive Care?

Many vaccines are covered under preventive care when delivered by a doctor or provider in your plan's network. These include chickenpox, flu, and shingles. For a full list, visit www.healthcare.gov/preventive-care-adults.

Where to Go for Care

You're feeling sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new prescription, but the pharmacy is closed. Or you're on vacation and are under the weather. Instead of rushing to the emergency room or relying on questionable information from the internet, consider all of your site-of-care options.

Nurse Line

When to Use

You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.

Types of Care*

Answers to questions regarding:

- Symptoms
- Self-care/home treatments
- Medications and side effects
- When to seek care

Costs and Time Considerations**

- Usually available 24 hours a day, 7 days a week
- Typically free as part of your medical insurance

Telemedicine ($)

When to Use

You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

Types of Care*

- Cold & flu symptoms
- Bronchitis
- Urinary tract infection
- Sinus problems

Costs and Time Considerations**

- Usually a first-time consultation fee and a flat fee or copay for any visit thereafter
- Typically immediate access to care
- Prescriptions through telemedicine or virtual visits not allowed in all states

Primary Care Center ($)

When to Use

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

Types of Care*

- Routine checkups
- Immunizations
- Preventive services
- Managing your general health

Costs and Time Considerations**

- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Short wait time with scheduled appointment

*This is a sample list of services and may not be all inclusive.
**Costs and time information represent averages only and are not tied to a specific condition or treatment.

Urgent Care Center ($$)

When to Use

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

Types of Care*

- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns

Costs and Time Considerations**

- Copay and/or coinsurance usually higher than an office visit
- Walk-in patients welcome, but urgency determines order seen and wait time

Emergency Room ($$$)

When to Use

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

Types of Care*

- Heavy bleeding
- Chest pain
- Major burns
- Severe head injury

Costs and Time Considerations**

- Often requires a much higher copay and/or coinsurance
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first
- Ambulance charges, if applicable, will be separate and may not be in-network

*This is a sample list of services and may not be all inclusive.
**Costs and time information represent averages only and are not tied to a specific condition or treatment.

Do Your Homework

What may seem like an urgent care center might actually be a standalone ER. These facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

Virtual Medicine

When you're under the weather, there's no place like home, and if you're busy with work and family, scheduling an in-person doctor's appointment can be a pain. Virtual medicine is a convenient and easy way to connect with a doctor on your time.

Hormel Foods provides a virtual medicine benefit through Doctor On Demand for you and your dependents. Doctor On Demand offers on-demand access to board-certified doctors through online video, telephone, or secure email. General health issues can be addressed at home for a copay of $25 per consultation.

Doctor On Demand doctors can share information with your primary care physician with your consent. Please note that some states do not allow physicians to prescribe medications via telemedicine. For more information, visit doctorondemand.com/BCBSMN.

The first consultation is $5 and following visits are $25. For current users of Doctor On Demand, all visits that occur during the 2027 plan year are $25.

Doctor On Demand doctors can treat many medical conditions, including:

- Cold & flu
- Allergies
- Bronchitis
- Bladder infection/urinary tract infection
- Respiratory infection
- Pink eye
- Sore throat
- Stomachache
- Sinus problems

Access Virtual Visits

Visit doctorondemand.com/BCBSMN to request a virtual visit. After you register and request an appointment, you'll pay your portion of the service costs and enter a virtual waiting room. During your visit, you can talk to a doctor about your health concerns, symptoms, and treatment options.

Note

A virtual visit directly with your primary care physician (vs. Doctor On Demand) might also be an option — and typically costs the same as an office visit.

Pharmacy Benefits

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through Prime Therapeutics. You may find information on our benefits coverage and search for network pharmacies by logging on to myprime.com or by calling the Customer Care number on your ID card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Preferred, Non-Preferred, or Specialty Drugs.

	TRADITIONAL PLAN		HEALTHY SAVINGS PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
OUT-OF-POCKET MAXIMUM	$2,500	$5,000	Subject to medical deductible	
RETAIL RX (30-DAY SUPPLY)				
GENERIC	10% (min. $5)	10% (min. $5)	20%*	20%*
PREFERRED	20% (min. $5)	20% (min. $5)	20%*	20%*
NON-PREFERRED	35% (min. $5)	35% (min. $5)	20%*	20%*
SPECIALTY DRUGS	Refer to applicable prescription drug cost-sharing	Not covered	20%*	Not covered
MAIL ORDER RX (90-DAY SUPPLY)				
GENERIC	10% (min. $5)	10%	20%*	20%*
PREFERRED	20% (min. $5)	20%*	20%*	20%*
NON-PREFERRED	35% (min. $5)	35%*	20%*	20%*
SPECIALTY DRUGS	Refer to applicable prescription drug cost-sharing	Not covered	20%*	Not covered

*After deductible

Note

Apps and prescription discount programs such as GoodRx, Amazon Prime Rx Savings, Optum Perks, and Cost Plus Drug Company let you compare prices of prescription drugs and find possible discounts.

Generic Drugs

Want to save money on meds? Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety, and strength. Because they are the same medicine, generic drugs are just as effective as the brand names, and they are held to the same rigid FDA standards. But generic versions cost 80% to 85% less on average than the brand-name equivalent. To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

Lowering Medication Costs

How do prescription discount programs work? These discounts can't be combined with your benefit plan's coverage, so make sure to check the price against the cost of using your insurance's prescription drug benefit. Something else to consider: If you choose to use a discount card and are therefore not tapping into your insurance's prescription drug benefit, the cash amount you pay for the prescription may not count toward your deductible or out-of-pocket maximum under the benefit plan.

GoodRx is a web- and app-based platform that allows you to search for prescription drug coupons and compare pharmacy prices. The company claims a savings of up to 80% on generics. **Optum Perks** also provides coupons for medications and a searchable database for drug cost comparison at participating pharmacies near you. The Optum Perks member card, which can be used at more than 64,000 pharmacies, is free to use and requires no personal data. Another discount option is the **Amazon Prime Rx Savings** discount card, which is included with an Amazon Prime membership and is administered by Inside Rx. It provides discounts of up to 80% for generics and up to 40% for brand-name medication at participating pharmacies. **Cost Plus Drug Company** is a web-based pharmacy that claims to keep costs low by buying directly from the manufacturer. It currently only offers a certain selection of medications and accepts a handful of prescription insurance providers, but it may be worth checking the price difference between Cost Plus and your regular pharmacy.

Health Savings Account

Want funds handy to help cover out-of-pocket healthcare expenses? A Health Savings Account (HSA) with Wex is a personal healthcare bank account used to pay for qualified medical expenses. HSA contributions and withdrawals for qualified healthcare expenses are tax-free. You must be enrolled in the Healthy Savings Plan to participate.

Your HSA can be used for qualified expenses for you, your spouse/domestic partner, and/or tax dependent(s), even if they're not covered by your plan. If you are not currently enrolled in the Healthy Savings Plan but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

Wex will issue you a debit card with direct access to your account balance. Use your debit card to pay for qualified medical expenses — no need to submit receipts for reimbursement. Like a regular debit card, you must have a balance in your HSA account to use the card.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, PPE, over-the-counter medications, and more. Visit IRS Publication 502 on www.irs.gov for a complete list.

Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in an HSA-eligible High Deductible Health Plan.
- You are not covered by your spouse/domestic partner's or parent's non-HDHP.
- You do not or your spouse/domestic partner does not have a Healthcare Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

You Own Your HSA

Your HSA is a personal bank account that you own and manage. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change plans or jobs. There are no vesting requirements (you own all contributed HSA funds immediately) or forfeiture provisions (you keep all HSA funds whether you leave the company or retire).

How to Enroll

To enroll in Hormel Foods' HSA, you must elect the Healthy Savings Plan with Hormel Foods. Submit all HSA enrollment materials and choose the amount to contribute on a pre-tax basis. Hormel Foods will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

HSAs and Taxes

HSA contributions are made through payroll deduction on a pre-tax basis when you open an account with Wex. The money in your HSA (including interest and investment earnings, if any) grows tax-free. When the funds are used for qualified medical expenses, they are spent tax-free.*

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax. This is why it's important to know what medical expenses qualify for HSA use and to keep track of where you spend your HSA funds.

Note

Because HSA funds never expire, contributing your annual maximum to your HSA can help you save to pay for healthcare expenses tax-free after retirement.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2027, contributions (which include any employer contribution) are limited to the following:

2027 ANNUAL HSA FUNDING LIMITS	
EMPLOYEE	$4,500
FAMILY	$9,000
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

Hormel Foods provides an HSA employer contribution that will be deposited on a quarterly basis.

2027 ANNUAL EMPLOYER HSA CONTRIBUTION	
EMPLOYEE	$TBD
FAMILY	$TBD

HSA contributions over the IRS annual contribution limits ($4,500 for individual coverage and $9,000 for family coverage for 2027) are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you have two options:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed but won't have to pay a penalty tax.
- Leave the excess contributions in your HSA and pay 6% excise tax on them. Next year, consider contributing less than the annual limit to your HSA.

The Hormel Foods HSA is established with Wex. You may be able to roll over funds from another HSA. For more enrollment information, contact Horizon Solution Center or visit wexinc.com.

*State income taxes are also waived on HSA contributions in almost all states.

Flexible Spending Accounts

Take control of your spending! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses.

Healthcare Flexible Spending Account

With a Wex Healthcare FSA, you can contribute up to $3,400 annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them — no waiting for reimbursement.

Limited Use Flexible Spending Account

A Limited Use Flexible Spending Account (LUFSA) with Wex works with a Health Savings Account (HSA) and allows for reimbursement of eligible dental and vision expenses. The contribution limit is $3,400.

Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — even if you don't elect any other benefits. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is currently deposited in your account.

- With the Dependent Care FSA, you can set aside up to $7,500 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent daycare expenses that are necessary for you and your spouse/domestic partner to work or attend school full time. Eligible expenses include:

- In-home babysitting services (not provided by a dependent)
- Care of a preschool child by a licensed nursery or daycare provider
- Before- and after-school care
- Day camp
- In-house dependent daycare

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

Using the Account

Use your FSA debit card at doctor and dentist offices, pharmacies, and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you use the card at an ineligible location.

Submit a claim form along with the required documentation. Contact Wex with reimbursement questions. If you need to submit a receipt, Wex will notify you. Always save receipts for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges in case you need to prove an expense was eligible. Without proof an expense was valid, your card could be turned off and the expense deemed taxable.

General Rules

The IRS has the following rules for Healthcare and Dependent Care FSAs:

- Expenses must occur during the 2027 plan year.
- Funds cannot be transferred between FSAs.
- You are not permitted to claim the same expenses on both your federal income taxes and Dependent Care FSA.
- You must "use it or lose it" — any unused funds will be forfeited.
- Up to **$680** may be rolled over to the next plan year at the end of 2027 for Healthcare FSAs.
- You cannot change your FSA election in the middle of the plan year without a Qualifying Life Event.
- Terminated employees have ninety (90) days following termination to submit FSA claims for reimbursement.
- Those considered highly compensated employees (family gross earnings were $160,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more info.

Grace Period

- Our Company offers a rollover period for FSA spending. The deadline to complete 2026 is March 1, 2027. Any balances over the rollover limit will be forfeited.
- The rollover period applies to both the Dependent Care and Healthcare FSAs (Health Care, Dependent Care, and Limited Purpose).

Note

The Dependent Care FSA is not to be used for medical expenses, nor is it the same as electing medical coverage for dependents.

FSA vs HSA

FLEXIBLE SPENDING ACCOUNTS		HEALTH SAVINGS ACCOUNT
Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.	OWNERSHIP	You own your HSA. It is a savings account in your name, and you always have access to the funds, even if you change jobs.
You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You cannot be enrolled in both a Healthcare FSA and an HSA.	ELIGIBILITY & ENROLLMENT	You must be enrolled in a Qualified HDHP to contribute money to your HSA. You cannot be covered by a spouse/domestic partner's non-High Deductible plan or a spouse/domestic partner's FSA or enrolled in Medicare or TRICARE. You can change your contribution at any time during the Plan Year.
FSA contributions are tax-free via payroll deduction. Funds are spent tax-free when used for qualified expenses.	TAXATION	HSA contributions are tax-free; the account grows tax-free; and funds are spent tax-free on qualified expenses.
You can contribute up to $3,400 in 2027 to an FSA. This amount may be increased annually by the IRS.	CONTRIBUTIONS	Both you and your employer can contribute up to $4,500 in 2027 (up to $9,000 for families). Ages 55+ can make an annual $1,000 "catch-up" HSA contribution.
Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit receipts for reimbursement.	PAYMENT	Many HSAs include a debit card to pay for qualified expenses directly. Alternatively, you can save funds for future expenses or retirement.
Any unclaimed funds at the end of the year are forfeited. Exceptions might include an additional 2.5-month grace period for expenses to be incurred and reimbursed, or an allowed rollover amount.	ROLLOVER OR GRACE PERIOD	HSA funds roll over from year to year. The account is portable and may be used for future qualified expenses — even in retirement years.
Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, and vision care. A full list is available at www.irs.gov.	QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full list is available at www.irs.gov.
Dependent Care FSA (pre-tax dollars can be used for elder or child dependent care) and Limited Use FSA (used to pay for eligible dental and vision expenses).	OTHER TYPES	There is only one type of HSA.

Please refer to your summary plan description or plan certificate for your plan's specific FSA or HSA benefits.

Supplemental Health Benefits

Hormel Foods offers several ways to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and offered at discounted group rates.

Accident Coverage

Accident insurance through Voya provides you with a cushion to help cover expenses and living costs when you get hurt unexpectedly. This plan complements your health insurance by providing benefits to help cover direct or indirect costs that can arise with a serious or minor injury that occurs off the job. You may end up paying out of your own pocket for things like deductibles, copays, transportation, over-the-counter medicine, daycare or sitters, and extra help around the house. With accident insurance, the benefits you receive can help take care of these extra expenses and anything else that comes up.

Highlights

- You will receive a cash benefit for covered injuries and related services for accidents that occur outside of work.
- Benefits are paid on a schedule of benefits regardless of any other coverage you have, and you may spend it any way you choose.
- Accident coverage is especially helpful for families with young children and those who are active.

BRIEF SUMMARY OF BENEFITS	
INITIAL CARE (ER/UC/PCP)	$90
HOSPITAL ADMISSION/ CONFINEMENT	$1,250/$275
ICU ADMISSION/CONFINEMENT	$450
OPEN FRACTURES	$480-$6,720
OPEN DISLOCATIONS	$550-$7,700
AMBULANCE (AIR/GROUND)	$1,500/$360

*This list is a summary. Please refer to plan documents for a comprehensive list of covered benefits.

CLAIMS EXAMPLE	
John's daughter broke her wrist falling off her bike.	
EMERGENCY ROOM	$225
IMAGING	$275
BROKEN WRIST	$1,800
MEDICAL APPLIANCE	$200
FOLLOW-UP VISIT	$90
PHYSICAL THERAPY	$45
TOTAL BENEFIT PAYOUT:	**$2,635**

Critical Illness Coverage

No one knows what lies ahead on the road through life. Will you be diagnosed with cancer? Will you suffer a stroke or the complete loss of hearing? The signs pointing to a critical illness are not always clear and may not be preventable, but critical illness coverage helps offer financial protection in the event you are diagnosed. Critical illness insurance through Voya pays you cash to use in any way you need if you are diagnosed with a covered condition.

Highlights

- Critical illness provides you a lump-sum benefit upon diagnosis of a covered illness.
- You have the choice of $10,000, $20,000, or $30,000 in guaranteed issue coverage. Spouses can be covered at 50% and children at 50% of your elected amount. Child coverage will be included in the employee coverage.
- Rates are age-banded. Please refer to the benefit summary for a full rate table.
- Pre-existing conditions are waived!
- A $75 wellness benefit is payable each year for enrollees and their covered dependents for receiving a qualifying preventive screening.

PLAN BENEFITS*

	PERCENT OF BENEFIT AMOUNT PAYABLE	TOTAL MAXIMUM BENEFIT AMOUNT FOR COVERAGE
ALZHEIMER'S	100%	1 times the Benefit Amount
BENIGN BRAIN TUMOR	100%	No maximum Benefit Amount
CANCER	100%	No maximum Benefit Amount
COMA	100%	No maximum Benefit Amount
CORONARY ARTERY DISEASE (OR BYPASS - PUT UP TO %)	25%	No maximum Benefit Amount
HEART ATTACK	25%	No maximum Benefit Amount
LOSS OF HEARING/ SIGHT/SPEECH	100%	1 times the Benefit Amount
LOU GEHRIG'S DISEASE/ALS	100%	1 times the Benefit Amount
MAJOR ORGAN FAILURE (OR TRANSPLANT)	100%	No maximum Benefit Amount
PARALYSIS	100%	1 times the Benefit Amount
PARKINSON'S	100%	1 times the Benefit Amount
SKIN CANCER	10%	For Skin Cancer, the maximum is once per calendar year with a total maximum benefit amount of 10 times the Benefit Amount
STROKE	100%	No maximum Benefit Amount

*This list is a summary. Please refer to plan documents for a comprehensive list of covered benefits.

CLAIMS EXAMPLE

Tom elected $20,000 Critical Illness benefit and has a heart attack while the coverage is in place. He would receive a one-time cash payment of $20,000. Then, 6 months later, Tom experienced a stroke. He would receive another $20,000 payout.

TOTAL BENEFIT PAYOUT:	**$40,000**

Hospital Indemnity Coverage

You already know the importance of living well and staying well. But life is unpredictable — expenses associated with a hospital stay can be financially difficult if you are not prepared. Hospital indemnity insurance through Voya pays cash benefits directly to you if you have a covered stay in a hospital or critical care unit (ICU).

Highlights

- Hospital indemnity pays a cash benefit for hospital admissions due to a covered accident, illness, or pregnancy.
- Popular with those planning to have children, who are older or have conditions that subject them to a higher risk of hospitalization, and/or are covered by an HDHP.
- Pre-existing conditions are waived!
- Benefits are payable for both admissions and additional days spent in the hospital.

BRIEF SUMMARY OF BENEFITS*	
HOSPITAL ADMISSION	$1,100
HOSPITAL CONFINEMENT	$100 per day
MAXIMUM DAYS PAYABLE	60 days per confinement
HOSPITAL ICU ADMISSION	$1,100
HOSPITAL ICU CONFINEMENT	$200 per day
MAXIMUM DAYS PAYABLE	15 days per confinement

*This list is a summary. Please refer to plan documents for a comprehensive list of covered benefits.

CLAIMS EXAMPLE	
Maria is enrolled in Hospital Indemnity coverage. She is admitted to the hospital and stayed 3 days in confinement to deliver her healthy newborn.	
HOSPITAL ADMISSION	$1,100
HOSPITAL CONFINEMENT	$300
NEWBORN ADMISSION	$1,100
NEWBORN CONFINEMENT	$300
TOTAL BENEFIT PAYOUT:	**$2,800**

Note

You can submit claims to Voya at https://claimscenter.voya.com/static/claimscenter/.

Dental Benefits

Like brushing and flossing, visiting your dentist is an essential part of your oral health. Hormel Foods offers affordable plan options from Delta Dental of MN for routine care and beyond.

Stay in Network

After you have satisfied the deductible, if any, the Dental Plan pays the following percentages of the treatment cost, up to a maximum fee per procedure. The maximum fee allowed by Delta Dental is different for Delta Dental PPO™ dentists, Delta Dental Premier® dentists, and nonparticipating dentists. If you see a nonparticipating dentist, your out-of-pocket expenses may increase. If a Delta Dental PPO™ dentist provides dental services, the deductible will be waived and the payment percentages may increase, resulting in lower out-of-pocket costs. To find a network dentist, visit Delta Dental of MN at deltadentalmn.org.

Dental Premiums

Dental premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your premium.

Dental Plan Summary

This chart summarizes the dental coverage provided by Delta Dental of MN for 2027.

	DENTAL PLAN	
	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE		
INDIVIDUAL	$50	$50
FAMILY	$150	$150
ANNUAL MAXIMUM		
PER PERSON	$3,000	$3,000
COVERED SERVICES		
PREVENTIVE SERVICES Oral Exams, Routine Cleanings, Bitewing X-rays, Panoramic X-rays	100%	100%
BASIC SERVICES Full Mouth X-rays, Fillings, Oral Surgery, Simple Extractions	80%	80%
MAJOR SERVICES Oral Surgery, Complex Extractions, Denture Adjustments and Repairs, Root Canal Therapy, Periodontics, Crowns, Dentures, Bridges	80%	80%
ORTHODONTICS Dependent Child(ren) Only	50%	50%
ORTHODONTIC LIFETIME MAXIMUM	Delta Dental PPO Provider: 50%, up to $3,000 Delta Dental Premier: 50%, up to $2,500	50%, up to $2,500

Vision Benefits

Getting your eyes checked regularly is important even if you don't wear glasses or contacts. We provide quality vision care for you and your family through VSP.

Vision Premiums

Vision premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your premium.

Vision Plan Summary

This chart summarizes the vision coverage provided by VSP for 2027.

VISION

	IN-NETWORK	FREQUENCY
EXAMS		
COPAY	$10	Every other calendar year
LENSES		
SINGLE VISION	$20	Every other calendar year
BIFOCAL	$20	
TRIFOCAL	$20	
CONTACTS (IN LIEU OF LENSES AND FRAMES)		
ELECTIVE CONTACT LENSES	$150 allowance	Every other calendar year
FRAMES		
COPAY	$20	Every other calendar year
ALLOWANCE	$150	

Survivor Benefits

It's hard to think about, but it's important to have a plan in place to provide for your family if something were to happen to you. Survivor benefits provide financial protection for your loved ones in the event of an unexpected event.

Basic Life and Accidental Death & Dismemberment Insurance

Hormel Foods provides employees with Basic Life and Accidental Death and Dismemberment (AD&D) insurance as part of your basic coverage through MetLife, which guarantees that your spouse/domestic partner or other designated survivor(s) continue to receive benefits after death.

Your Basic Life and AD&D insurance benefit is one times your annual salary, up to $50,000. The Basic Child Life insurance benefit is $2,000 for your dependents age 14 days to 26 years old. If you are a full-time employee, you automatically receive Life and AD&D insurance even if you waive other coverage.

Naming a Beneficiary

Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life. You receive the benefit payment for a dependent's death under the MetLife insurance.

Name a primary and contingent beneficiary to make your intentions clear. Indicate their full name, address, Social Security number, relationship, date of birth, and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches age 18. Contact Horizon Solution Center or your own legal counsel with any questions.

Voluntary Life and AD&D Insurance

You may wish for extra coverage for more peace of mind. Eligible employees may purchase additional Voluntary Life and AD&D insurance. Premiums are paid through payroll deductions.

OPTIONAL LIFE INSURANCE

EMPLOYEE LIFE INSURANCE	**YOU CAN ELECT UP TO 8 TIMES YOUR SALARY, OR UP TO $1,000,000 WHICHEVER IS LESS.** » Below you will find a one time option to enroll in employee optional life insurance for 2027 with no health questions or Statement of Health (SOH). » If you are currently enrolled in optional employee life insurance you have the ability to increase your coverage by **one plan increment** (available options are 1x, 1.5x, 2x, 2.5x, 3x, 4x, 5x, 6x, 7x, 8x) up to $350,000 without going through Statement of Health (SOH). » If you currently waive your optional employee life insurance you will need to complete a Statement of Health (SOH) for any increase.
CHILD LIFE INSURANCE	**YOU CAN ELECT UP TO $20,000** » 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 my contact page in Oracle so the company can provide this coverage to your eligible children.
SPOUSE LIFE INSURANCE	**YOU CAN ELECT UP TO $100,000 OF COVERAGE.** » Below you will find one time options to enroll in spouse/domestic partner life insurance for 2027 with no health questions or Statement of Health (SOH). » If you are currently enrolled in spouse/domestic partner life insurance you have the ability to increase your coverage by one plan increment (up to $50,000) without going through Statement of Health (SOH). » If you currently waive your optional spouse life insurance your spouse will need to complete a Statement of Health (SOH) for any increase.

Mental Health

You visit your doctor when you're feeling sick, and you exercise and eat healthy to keep your body strong. But your mental health is just as important. What do you do to stay healthy mentally? Do you know where you can go when you need help? Whether you need assistance with work-life balance or anxiety, there are resources available to help you out.

Employee Assistance Program

We're here for you when you need help. Our Employee Assistance Program (EAP) helps you and your family manage your total health, including mental, emotional, and physical. And there's no cost to you — whether or not you're enrolled in a company-sponsored medical plan.

Through the EAP, you have access to mental health assistance and legal and financial help from professionals. You also have 24-hour access to helpful resources by phone and a designated number of face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with Hormel Foods. You may access information, benefits, educational materials, and more by phone at 855-629 0554 or online at benefits.springhealth.com/hormel.

The Program provides referrals to help with:

- Emotional health and wellbeing
- Alcohol or drug dependency
- Marriage or family problems
- Job pressures
- Stress, anxiety, depression
- Grief and loss
- Financial or legal advice

Mental Health and Your Medical Plan

When your covered EAP services run out, the medical plan covers behavioral and mental health services at 80% per visit. Coverage includes virtual therapy from Doctor On Demand. Via video or telephone, you can receive confidential 1-on-1 counseling from the privacy and convenience of your home. Your licensed virtual therapist may provide a diagnosis, treatment, and medication if needed. You can see the same therapist with each appointment and establish an ongoing relationship. See plan documents for specifics on coverage for inpatient and outpatient services. Your health plan coverage also includes the Doctor On Demand for an online option for behavioral health therapy. This tool provides access to providers for virtual visits through text or video. Call TBD or visit TBD for more information or to sign up.

The Big Five of Emotional Wellness

An important aspect of your overall wellbeing is emotional wellness — the ability to successfully adapt to changes and challenges as they arrive and handle life's stresses. These five actions have been shown to improve emotional wellness.

Practice mindfulness.

Practice deep breathing, take a walk, enjoy nature, and stay present in each moment.

Strengthen social connections.

Reach out to a friend or family member daily — even if it's just a call or text.

Get quality sleep.

Keep a consistent sleep schedule and limit electronic use before bed.

Improve your outlook.

Treat people with kindness, including yourself.

Deal with your stress in healthy ways.

Think positively, exercise regularly, and set priorities.

Other Mental Health Resources

No matter your problem, whether you're a manager or entry-level employee, don't be afraid to ask for help. There are resources available 24/7.

988 Suicide & Crisis Lifeline

Dial 988 to be connected with 24/7/365 emotional support.

Free, confidential crisis counseling, including appropriate follow-up services, is available no matter where you live in the United States.

Crisis Text Line

Text "HOME" to 741741

Send a text 24/7 to the Crisis Text Line to speak with a crisis counselor who can provide support and information. Standard text messaging rates may apply.

War Vet Call Center

Veterans and their families can call 877-WAR-VETS (877-927-8387) to talk about their military experience and/or readjustment to civilian life.

Call 911 if you or someone you know is in immediate danger or go to the nearest emergency room.

Note

According to the National Institute of Mental Health, it is estimated that more than one in five U.S. adults live with a mental illness.

Additional Benefits

Hormel Foods wants you to succeed in all aspects of life, so we offer a variety of additional benefits to make your day-to-day easier.

Pet Insurance

We know your pets are part of the family, and just like any other family member, our furry friends are bound to have some medical expenses from time to time. For the most part, these expenses come from standard checkups and immunizations, but the occasional unexpected illness or injury can rack up some significant bills when you least expect it. Pet insurance through Nationwide provides coverage for veterinary expenses related to accidents and illnesses, including X-rays, medications, vet visits, surgeries, and hospital stays. Policies are available for dogs, cats, birds, reptiles, and exotic pets. Optional wellness coverage is also available for dogs and cats, providing reimbursement for preventive care. To enroll or for additional information, visit petinsurance.com/hormelfoods or call 877-738-7874 for a fast, no obligation quote, today!

Prepaid Legal Coverage

MetLife offers low-cost access to attorneys for personal legal services. Payments are made conveniently through payroll deductions. It's like having your own attorney on retainer for a lot less. There are attorneys standing by to assist you with:

- Estate planning, wills, and trusts
- Real-estate matters
- Identity-theft defense
- Financial matters, such as debt-collection defense
- Traffic offenses
- Document review
- Family law, including adoption and name change
- Advice and consultation on personal legal matters
- Divorce

Working Advantage

TBD

Glossary

Balance Billing – When you are billed by a provider 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 $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount you pay for healthcare services received, as determined by your insurance plan.

Deductible – The amount you owe for healthcare services before your insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," so funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or rollover into the next plan year.

- **Healthcare FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.
- **Limited Use FSA –** Designed to complement a Health Savings Account, a Limited Use FSA allows for reimbursement of eligible dental and vision expenses.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Savings Account (HSA) – A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in a HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable if you change jobs.

High Deductible Health Plan (HDHP) – A plan option that provides choice, flexibility, and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, and all qualified employee-paid medical expenses count toward your deductible and out-of-pocket maximum.

Network – A group of physicians, hospitals, and healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network –** Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network –** Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage.

Out-of-Pocket Maximum – The most you pay during the plan year before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, out-of-network provider charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred, or specialty.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs –** Prescription medications used to treat complex, chronic, and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered. These medications are usually required to be filled at a specific pharmacy.
- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy –** The goal of a Step Therapy Program is to guide employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – 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 R&C amount is sometimes used to determine the allowed amount. Also known as the UCR (Usual, Customary, and Reasonable) amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, you are provided with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) – The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Required Notices

Important Notice From Hormel Foods Corporation About Your Prescription Drug Coverage and Medicare Under the Blue Cross Blue Shield of MN Traditional and Healthy Savings Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Hormel Foods Corporation and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. Hormel Foods Corporation has determined that the prescription drug coverage offered by the Blue Cross Blue Shield of MN Traditional and Healthy Savings plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Hormel Foods Corporation coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Hormel Foods Corporation 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 nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed at the end of these notices for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Hormel Foods Corporation changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2027
Name of Entity/Sender:	Hormel Foods Corporation
Contact—Position/Office:	Horizon Solution Center
Address:	1 Hormel Place Austin, MN 55912
Phone Number:	866-449-7712

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Horizon Solution Center at 866-449-7712.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Horizon Solution Center at 866-449-7712.

HIPAA Special Enrollment Rights

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

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 60 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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

To request special enrollment or obtain more information, contact Horizon Solution Center at 866-449-7712.

Illinois Essential Health Benefit (EHB) Listing

Employer Name: Hormel Foods Corporation

Employer State of Situs: Minnesota

Name of Issuer: Blue Cross Blue Shield of MN

Plan Marketing Name: Traditional Plan, Healthy Savings Plan

Plan Year: 2027

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
1	Accidental Injury – Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing		Pg. 11	Yes
3	Bone Anchored Hearing Aids		Pgs. 17 & 35	Yes
4	Durable Medical Equipment		Pg. 13	Yes
5	Hospice		Pg. 28	Yes
6	Infertility (Fertility) Treatment		Pgs. 23 – 24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)		Pgs. 15 – 16	Yes
9	Private-Duty Nursing		Pgs. 17 & 34	Yes
10	Prosthetics/Orthotics		Pg. 13	Yes
11	Sterilization (Vasectomy Men)		Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)		Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency Services	Pg. 7	Yes
14	Emergency Transportation/Ambulance		Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy		Pgs. 24 – 25	Yes
17	Reconstructive Surgery		Pgs. 25 – 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)		Pg. 15	Yes
19	Skilled Nursing Facility		Pg. 21	Yes
20	Transplants – Human Organ Transplants (Including Transportation & Lodging)		Pgs. 18 & 31	Yes

2020-2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
21	Diagnostic Services	Laboratory Services	Pgs. 6 & 12	Yes
22	Intranasal Opioid Reversal Agent Associated with Opioid Prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)		Pgs. 8 – 9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)		Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)		Pgs. 9 & 21	Yes
26	Tele-Psychiatry		Pg. 11	Yes
27	Topical Anti-Inflammatory Acute and Chronic Pain Medication		Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See All Kids Pediatric Dental Document	Yes
29	Pediatric Vision Coverage		Pgs. 26 – 27	Yes
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription Drugs	Pgs. 29 – 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services		Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education		Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes		Pgs. 31– 32	Yes
36	Mammography – Screening		Pgs. 12, 15, & 24	Yes
37	Osteoporosis – Bone Mass Measurement		Pgs. 12 & 16	Yes
38	Pap Tests/Prostate-Specific Antigen Tests/Ovarian Cancer Surveillance Test		Pg. 16	Yes
39	Preventive Care Services		Pg. 18	Yes
40	Sterilization (Women)		Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 – 13	Yes
42	Habilitative and Rehabilitative Services		Pgs. 8, 9, 11, 12, 22, & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

Important Contacts

Medical
Blue Cross Blue Shield of MN
866-537-7721
bluecrossmn.com/hormelfoods
Policy #: 17991

Pharmacy
Prime Therapeutics
855-457-0002
myprime.com

Supplemental Health (Accident, Critical Illness, Hospital Indemnity)
Voya
877-236-7564
claimscenter.voya.com

Telemedicine
Doctor On Demand
doctorondemand.com/BCBSMN

Dental
Delta Dental of MN
800-448-3815
deltadentalmn.org
Policy #: 050582

Vision
VSP
800-877-7195
vsp.com
VSP Signature

Health Savings Account
Wex
866-451 3399
wexinc.com

Flexible Spending Accounts
Wex
866-451 3399
wexinc.com

Life and AD&D
MetLife
800-638-6420
metlife.com
Policy #: 213074

Employee Assistance Program
Spring Health
855-629 0554
benefits.springhealth.com/hormel
Policy #: Work-life code: hormel

Prepaid Legal Coverage
MetLife
800-821-6400
members.legalplans.com

Pet Insurance
Nationwide
877-738-7874
petinsurance.com/hormelfoods

Hormel Foods Horizon Solution Center
1 Hormel Place
Austin, MN 55912
866-449-7712

Notes

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Hormel Foods