



2026 EDITION

Your benefits, clearly labeled.

A guide to what Hormel Foods offers you — organized around what you do, not how it was filed.

Benefit Facts

One book · you and your family · read time: less than your first coffee break

Plan year begins	January 1, 2026
Written for	New Hires at Hormel Foods
Benefit sections	8
Source pages read	53
People you can call	20 contacts
What governs	Official plan documents

Official plan documents govern. This guide is informational. Contact your HR Solution Center with questions.

KNOW MORE. STRESS LESS.

This guide summarizes a machine reading of the printed 2026 handbook. No person has checked it line by line. Official plan documents govern.

Read this page once. Trust the rest faster.

This book is rebuilt from the printed 2026 handbook the way food gets labeled: the important numbers up front, the fine print traceable, nothing invented.

1 • Actions come first

Every page opens with the one thing to do, then explains. If you only read the **DO THIS** lines, you will still land enrolled and covered.

DO THIS

Like this. One move, then the details.

2 • Benefits get labels, like food

Each plan is set as a **Benefit Facts** panel — same rows, same order, so two plans compare like two cans on a shelf. Anything you pay is marked **You**.

Benefit Facts	
Deductible	\$2,000 [†]
Plan pays	80% [†]

3 • Deadlines look like date stamps

Anything with a clock on it is stamped, the way a package carries a best-by date. Miss a stamp and coverage can lapse — the stamp tells you the window.

VERIFY DEPENDENTS
WITHIN 30 DAYS[†]

4 • Three marks say where a figure came from

A figure marked [†] was read by a machine from the printed page and has not been human-verified line by line. A figure marked * was on no printed page at all: a person at Hormel supplied it directly, on a date this book records, and the weekly contribution rates are the figures that carry it. A figure marked ‡ is not in the printed page at all: it comes from Hormel's benefits database, which decides the value when the two disagree. That is a rule about which record governs, not a claim that the database is newer — one figure carrying this mark comes from a snapshot whose own plan year reads 2024. No mark has been confirmed against a plan document. When a number matters, ask HR.

\$850[†]

5 • Every page ends with a receipt

The gray line at the foot of each page names the printed source page it was built from and how confidently the machine read it. Nothing in this book floats free of the source.

SOURCE P.11 • MACHINE AGREEMENT
0.688 • AUTHORED SURFACE

If anything in this book disagrees with the official plan documents, the plan documents win. This book is a guide, not the source of your rights.

Next: see which decisions are yours →

START

What is yours to choose, when you can change it, and who counts as family.

Which benefits do I have to choose, and which come with the job?	4
How do I get into Oracle and enroll?	5
How long do I have to prove a dependent or report a life event?	6
Who counts as my dependent?	7

Half of this is already yours. The other half is your call.

Fourteen benefits, one honest split — read from the handbook's own “who pays” column. Page numbers point into the printed source book.

DO THIS

Scan the left column only. Those are the decisions on your desk.

Your call

You elect these — and pay some or all of the cost. They only happen if you act.

Medical coverage and Prescription drug coverage Health Plan Options	SHARED	Page 10 [†]
Tax Advantaged Accounts Health Savings Account (HSA)	YOU PAY	Page 16 [†]
Tax Advantaged Accounts Flexible Spending Account (FSA)	YOU PAY	Page 16 [†]
Dental and Vision Coverage Dental and Vision Plan	SHARED	Page 21 [†]
Optional Life Life Insurance	YOU PAY	Page 27 [†]
Optional Child Life Dependent Life Insurance	YOU PAY	Page 27 [†]
Optional Spouse Life Dependent Life Insurance	YOU PAY	Page 27 [†]
Optional AD&D Accidental Death & Dismemberment (AD&D)	YOU PAY	Page 29 [†]
Retirement Plan 401(k) Plan	SHARED	Page 32

Comes with the job

Hormel Foods pays for these. No election cost decisions to make here.

Basic Life Life Insurance	HORMEL PAYS	Page 26 [†]
Basic Child Life Dependent Life Insurance	HORMEL PAYS	Page 27 [†]
Short-Term Disability Disability	HORMEL PAYS	Page 28 [†]
Long-Term Disability Disability	HORMEL PAYS	Page 28 [†]
Basic AD&D Accidental Death & Dismemberment (AD&D)	HORMEL PAYS	Page 29 [†]

NOTE · [†] marks a page reference read from this page's machine text. The 401(k) Plan row carries no marker because that entire row, page reference included, is absent from the machine text and is read from the page image. The printed page governs.

Next: make your first moves →

Move one: get into Oracle.

Much of your information is accessed and managed in Oracle. There are two ways in - online or the mobile app - then you enroll from the Home screen.

DO THIS

Find the row that describes you. You only have to do that one, then enroll.

New to Oracle? Web based access

Visit yoursource.hormel.com[†], click Oracle Cloud, then follow the log in instructions below.

New to Oracle? Mobile access

Search "Oracle HCM Cloud" in your App Store or Google Play Store, download it and open it. You might see a legal terms screen - review it and hit agree. On the next screen enter ekkh.fa.us2.oraclecloud.com[†]; this initial log in is the only time you will have to enter that address. You might get a pop up asking to allow notifications - choosing Allow is recommended so you can be made aware of notifications in the system. That takes you to the main log in page, then follow the log in instructions 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, your username is your nine digit person number / employee ID and your password is the one you created. If you do not remember it, 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.

Where to enroll

From the Home screen, click Benefits. Then click the button at the top center of that page. The screenshot reads: click the YELLOW button below to enroll in benefits. The yellow button is labelled Make Changes.

Not planning 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.

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

NOTE · The elections checklist is drawn as a handwritten sticky note. Its indenting puts HSA and LPFSA contributions under the Healthy Savings Plan and the FSA contribution under the Traditional Plan Option, but the page never says whether the two plan options are alternatives. The page tells you to call the Horizon Solution Center but prints no phone number for it here, and does not name which local HR office. Official plan documents govern.

Next: verify your dependents →

Move two: prove your people. Move three: know the windows.

DO THIS

Read the two windows first. Everything below is only how to satisfy them.

● BENEFIT
● ELIGIBILITY
● BEGINS

DEPENDENT DOCUMENTS IN
before 30[†] days

● LIFE EVENT

REPORT THE EVENT IN ORACLE
60[†] days

provide documentation for proof of the event within 30[†] days — the page does not say what starts that clock. Changes to your benefits are effective when reported.

OPEN ENROLLMENT, TYPICALLY EACH YEAR
NOVEMBER[†]

These are examples of documentation. All documents listed are REQUIRED, and additional documentation may be requested.

- 1 Spouse
Both: a copy of your registered marriage certificate and a 1040[†] tax form. For the tax form, the 1st[†] page showing filing status is needed if married for more than 2[†] years. Black out any financial information.
- 2 Domestic partner
Both: a completed "Declaration of Domestic Partnership" form and the required documents listed on that form. The form is in Oracle under Help Desk / My Knowledge.
- 3 Children, stepchildren and domestic partner's children
A copy of the registered birth certificate showing names of parents(s). The same document is required for your children and for stepchildren / domestic partner's children.
- 4 Legal ward children
Court or legal paperwork granting guardianship/custodianship.
- 5 Upload them
Scan and upload online in Oracle under Me / Benefits / Document Records, or use the Oracle mobile app to take a picture and upload. The steps are in Oracle under Help Desk / My Knowledge.
- 6 Submit before the deadline
You must submit all necessary documentation to verify your dependents before 30[†] days following your benefit eligibility. Any unverified dependents will be removed and are unable to be added back until open enrollment.

Also on the printed page: domestic partner tax effect — source p.7.

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.

- 1 Open Enrollment
You may change your benefit elections during this enrollment period. Open enrollment typically occurs each year in November[†]. Watch for communication materials sent to you with enrollment information, instructions and deadlines — those materials tell you when you are able to change your elections.
- 2 Mid-year election changes
You may change your benefits coverage during the year if you have a permitted mid-year event. The page lists five examples: marriage; divorce; birth or adoption; death of a dependent; gain or loss of other health coverage.
- 3 Report it within 60[†] days
You have 60[†] days from the date of the event to report the event and request changes to your coverage. Submit the 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. Changes to your benefits are effective when reported. The quick reference guide is in Oracle under Help Desk / My Knowledge.

Also on source p.8: adding dependents mid-year · changing your HSA contribution · FSA changes.

Next: pick your medical plan →

Who counts as your dependent.

Coverage is available to you and your eligible dependents, which includes your spouse/domestic partner and children up to age 26[†].

DO THIS

Find the row that describes the person you want to cover, then gather the paperwork it names.

DEPENDENT VERIFICATION
30 DAYS FROM
BENEFIT START
DATE[†]

Your dependent's coverage will not be sent to the carriers until the documentation has been received and approved.

Children	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 [†] .
Which children qualify	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); and, 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.
Domestic partners	If you meet the requirements, 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. You must meet paragraph 1 [†] or 2 [†] .
The two routes	Paragraph 1 [†] : your domestic partner is your registered domestic partner or civil union partner from a jurisdiction that recognizes domestic partnerships or civil unions. Or paragraph 2 [†] : you are same or opposite gender adults; you are both at least 18 [†] years of age, not married to or legally separated from anyone else, and have no other domestic partners; you are in a committed and mutually exclusive relationship of at least 12 [†] months 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; and you are each mentally competent.
The form you must file	You 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. The form is in Oracle under Help Desk / My Knowledge.

WHAT GOVERNS · Official plan documents govern. Where this page points to the Summary Plan Descriptions — for example the requirements disabled children must meet — those documents control.

Also on source p.7: Spouse verification documents.

Next: pick your medical plan →

CARE

Two medical plans, one network, and what each one asks of your wallet.

How do the two plans compare, row by row?	9	Where do I go to check a drug, a price, or an approval?	15
What do I actually owe after a doctor visit?	10	How much of a doctor's bill do I pay?	16
Where should I go when I'm sick?	11	What do I pay each week for medical coverage?	17
What are my two medical plan choices?	12	What does my dental plan pay for?	18
Where do the two plans actually differ?	13	How often can I get new glasses?	19
What will my prescriptions cost?	14		

Two plans. Same shelf. Read the labels.

In-network comparisons. This is where the two plans actually diverge on cost. The deductible is the first money out of your pocket, and it is the first row of each label.

DO THIS
Read these two figures first.

WHERE THEY DIVERGE	
HEALTHY SAVINGS PLAN	TRADITIONAL PLAN
\$2,000 [†]	\$850 [†]
Single deductible, in-network.	

Benefit Facts	
Healthy Savings Plan · in-network · per plan year	
DEDUCTIBLE — YOU PAY FIRST	
Single	\$2,000 [†]
Family	\$4,000 [†]
OUT-OF-POCKET MAXIMUM — YOUR CEILING	
Medical, single	\$4,500 [†]
Medical, family	\$7,900 [‡] per person or \$9,000 [‡] per family
Drug, single	Included in Medical OOP [†]
Drug, family	Included in Medical OOP [†]
WHEN YOU USE CARE	
Preventive care	Plan pays 100% [†] ; you pay \$0 [†]
Non-preventive	After deductible: plan pays 80% [†] , you pay 20% [†]
Emergency room	After deductible: plan pays 80% [†] , you pay 20% [†]
Prescription drug	After deductible: you pay 20% [†] , plan pays 80% [†]
Hospital indemnity	Included [†]

Benefit Facts	
Traditional Plan · in-network · per plan year	
DEDUCTIBLE — YOU PAY FIRST	
Single	\$850 [†]
Family	\$850 + \$850 [†] = \$1,700 [†]
OUT-OF-POCKET MAXIMUM — YOUR CEILING	
Medical, single	\$4,000 [†]
Medical, family	\$4,000 [†] + \$4,000 [†] = \$8,000 [†]
Drug, single	\$2,500 [†]
Drug, family	\$5,000 [†]
WHEN YOU USE CARE	
Preventive care	Plan pays 100% [†] ; you pay \$0 [†]
Non-preventive	After deductible: plan pays 80% [†] , you pay 20% [†]
Emergency room	After \$100 [‡] co-pay & deductible, you pay 20% [‡]
Prescription drug	Generic you pay 10% [†] , Brand you pay 20% [†] , Non-Form you pay 35% [†] , with a printed minimum (see note)
Hospital indemnity	Not Included [†]

HONESTY ROW · All plans pay 100%[†] once the out-of-pocket maximum is reached. Out-of-network care may have higher co-insurance and out-of-pocket maximums. Traditional Plan family deductible: \$850[†] per person capped at \$1,700[†], and the \$1,700[†] must be met by 2[†] people. Under the Healthy Savings Plan the prescription drug, emergency room and non-preventive services cells are printed as one merged block. The printed page gives two Healthy Savings Plan family medical out-of-pocket amounts and does not say which applies; the figures marked [‡] above are the ones stored in Hormel's benefits database. The Traditional Plan drug column also prints a \$5 minimum above its percentages.

Next: see how a claim plays out →

The bill is a rhythm, not a surprise.

See an in-network provider and you get the highest level of benefits, and the provider files claims for you. For in-network preventive care services, the plan pays 100[†] percent of eligible costs. Out of network, you pay more for the cost of your care.

DO THIS

Read the worked total first. The seven steps beside it are only how the paper gets there.

JANE'S \$75[†] CLAIM

WORKED EXAMPLE · STATEMENT OF HEALTH

bill

\$75[†]

– plan payment

\$60[†]

JANE PAYS

\$15[†]

Jane visits her doctor and receives an SOH showing she has met her deductible and that the plan will cover \$60[†] of the \$75[†] bill. Her provider then bills her \$15[†], the SOH and bill match, and Jane pays it.

The SOH is not a bill. It shows what your responsibility should be.

SOH · NOT A BILL

Also on source p.20: the source also calls claims information an "explanation of benefits" in one place. It never says whether that's the same document as your SOH.

- 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 shows if a copay is required, and the amount is listed in the copay field.
- 2

Your in-network provider submits your claim

In network, the provider submits your claim to Blue Cross Blue Shield. Out of network, you may need to submit it yourself — call Blue Cross Blue Shield at 1-866-537-7721[†] for assistance if you do.
- 3

Blue Cross Blue Shield processes your claim

This typically happens after they receive all the necessary paperwork from your provider.
- 4

You receive a Statement of Health

A Statement of Health [SOH] arrives in the mail. It is not a bill — it shows what your responsibility should be, and your provider's bill should match it. Note: each covered family member can see their own SOHs on their home page after signing in at [bluecrossmn.com/hormelfoods](#). SOHs for minors under the age of 12[†] can be viewed under the employee's sign in; children over the age of 12[†] need their own log in.
- 5

Your provider's bill arrives

Provider bills typically arrive within two weeks after you receive your SOH.
- 6

Compare your SOH to your provider bill

Make sure the amount on the bill matches what is listed on your SOH. If it does not, contact Blue Cross Blue Shield customer service for clarification.
- 7

Pay your provider

You must pay with your personal funds or with available funds in a health savings account or flexible spending account. Keep your SOH and any receipts — they are the best documents to validate your expenses or to reimburse yourself from the HSA or FSA.

Next: know where to go for care →

When something hurts, start at the top of the menu.

Knowing your options can save you time and money. The page ranks five care settings by relative cost, from \$ to \$\$\$\$\$. One more sits outside that scale: preventive care costs nothing.

DO THIS

Read down the price column, not the names. The first setting that fits your problem is the cheapest one that does.

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

Quick, convenient and affordable treatment for many common illnesses. Typically located in retail stores, supermarkets, or pharmacies.

\$\$\$\$

Physician's Office

A wide variety of services, from routine checkups to immunizations, during normal business hours.

\$\$\$\$

Urgent Care Center

Handles the same problems treated in a provider's office after normal business hours.

\$\$\$\$

Emergency Room

For the most serious or life-threatening conditions.

\$\$\$\$

Free preventive services

FREE

Preventive care at NO cost to you, included in your health plan: Lab Tests, Cancer Screenings, Vaccinations, Routine Visits, Pregnancy Care.

HONESTY ROW · The dollar signs are the page's own relative cost scale, not prices — the page prints no amounts. Online Care and Retail Health Clinic sit at the same \$ level. Nothing in the care-setting table is marked free; FREE appears only in the separate green-bordered preventive-services box below the table, which is not on the cost scale. The Online Care row prints the Doctor On Demand logo and describes the benefit as "online access" — the page does not say what form a visit takes. A corner badge reads "30 days[†] ELIGIBILITY" and nothing on this page explains what the 30 days applies to. Items marked [†] are machine-read and unverified; official plan documents govern.

Next: put the right numbers in your phone →

One network. Two very different price tags.

Medical and prescription drug coverage. Both options use the same Blue Cross Blue Shield network; they differ in deductible level, in how medical and prescription spending are counted, and in which savings account you can use.

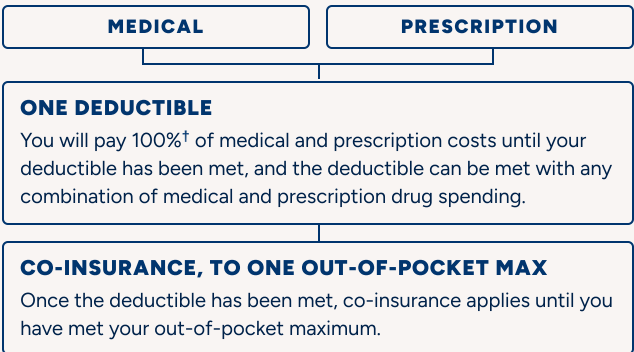
DO THIS

Read the deductible sentence in each card below first — it decides which savings account you can use, and how your drug spending gets counted.

You have two health plan options available to you so you can select the option that meets the needs of you and your family. 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. The plan comparison chart in this booklet contains each health plan option's deductibles and out-of-pocket maximums — this page does not print them.

Healthy Savings Plan

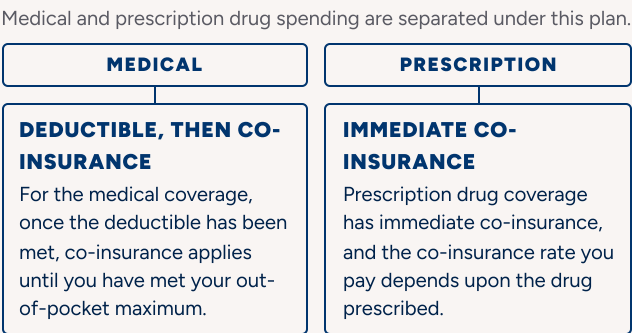
The Healthy Savings Plan Option is a high deductible health plan.



HSA **LPFSA** 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).

Traditional Plan

The Traditional Plan Option is a lower deductible health plan.



FSA You may contribute to a health care Flexible Spending Account (FSA).

TWO CARDS IN YOUR WALLET

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, and 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 7[†] (**p.6 here**), for your dependents before they will be mailed their cards.

WHERE THE ACCOUNT DETAILS LIVE

An asterisk on the page marks three accounts by name — the Health Savings Account (HSA), the Limited Purpose Flexible Spending Account (LPFSA) and the health care Flexible Spending Account (FSA). The footnote sends you to pages 16-19[†] (**p.21–24 here**) for more information about those accounts. The reference is to the accounts, not to the plans.

Also on source p.10: Want to learn more?. The weekly contribution rule on that page, and the amounts behind it, have their own sheet in this section.

Next: see where the two plans agree, and where they split →

The rows where they split are the whole decision.

Determining which plan fits can be difficult. Start by adding up a year of health care cost, then look at what the plans share and where they split. It helps to think about your annual health care costs. That means your weekly contributions, your deductible, and your coinsurance expenses. Then compare the two plans' similarities and differences.

DO THIS

Find the row that matters most to you, then read across it.

THE DIFFERENCE	HEALTHY SAVINGS PLAN	TRADITIONAL PLAN
Employee contributions (premiums)	lower	higher
Deductible	higher	lower
Out-of-pocket maximum	medical and Rx combined	one for medical with a separate Rx maximum
Access to medical savings accounts	a Health Savings Account and a Limited Purpose Flexible Spending Account	a Health Care Flexible Spending Account
Prescription drugs	you pay 100% [†] until the deductible is met	you pay a percentage of the drug cost

What both plans share

In-network preventive care is covered 100%[†].

You get access to the same health care management programs and resources.

You get access to the same Blue Cross Blue Shield (BCBS) PPO networks of doctors and medical providers at discounted rates.

Register on the Blue Cross Blue Shield portal

Wait until your medical card from Blue Cross Blue Shield arrives — you need it first. Then visit www.bluecrossmn.com/hormelfoods[†] to register and access the tools available online. The portal shows your explanation of benefits for any claims processed and a summary of your claims activity, plus tools such as: Find a doctor; Care Cost Estimator (ex. Estimating costs of procedures); Information on Preventive Care; Interactive health care tool; Quitting Tobacco Support.

READ BEFORE YOU ASSUME · The difference table on the source page ends with a sixth row that is printed blank in all three columns; the source does not say whether another comparison was intended. The page names "Pay % of drug cost" for the Traditional Plan without printing the percentage, and this page does not say where that percentage is published. The page also carries the handbook's grey "30 days / ELIGIBILITY" badge in the top-right corner without stating what the 30 days applies to. Items marked [†] are machine-read and unverified. This handbook is a guide; the official plan documents govern.

Next: see the prescription drug cost bars →

Same card. Different bars.

The prescription drug claims administrated by Prime Therapeutics. Your cost for prescription drugs will depend on what medical plan you're enrolled in and the type of prescription prescribed: generic, formulary brand or non-formulary brand.

DO THIS

Healthy Savings Plan: find where you are against your deductible.
Traditional Plan: find your drug type.

YOU PAY HORMEL PAYS

Healthy Savings Plan

Before your deductible is met — medical + drug combined



After your deductible, before your max

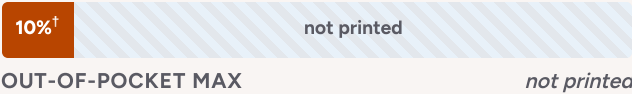


At your out-of-pocket max

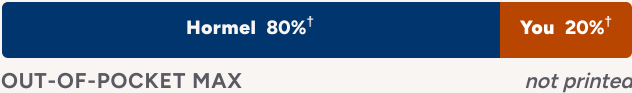


Traditional Plan

Generic, on formulary



Brand name, on formulary



Not on formulary



WHAT NEVER COUNTS TOWARD YOUR MAX · 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.

WHAT THE SOURCE LEAVES BLANK · The page carries the handbook's "30 days ELIGIBILITY" badge†. The badge appears without accompanying text, so the page does not state on its own what the 30 days applies to. On the Traditional Plan's generic-on-formulary bar only "you pay 10%" is labelled — the plan's share of that bar is left blank. None of the Out-of Pocket Max bars name who pays that 100% — they are simply set in the same navy the charts use elsewhere for the plan's share — so the page does not state the payer.

Next: see how a drug gets approved →

Three questions. One address.

The page's own three questions, and the destination each one ends at. Prior authorization, step therapy and quantity limit are not obstacles — they are the plan's own words for a second look before it approves a prescription.

DO THIS

Find your question in the list, then go to the address on its right. The three terms beneath explain what a second look means.

What can I do to help lower my prescription drug costs?**myprime.com[†]**

You can ask for a generic drug, home delivery pharmacy, or go online to compare prices amongst your local pharmacies by registering on myprime.com[†].

How do I know what medications are covered?**myprime.com[†]**

Your plan covers many different types of prescription medications. You can review a list of the medications your plan covers by checking the formulary. The formulary can be found on myprime.com[†].

What does it mean if I am told I need prior authorization, step therapy or quantity limit approval?**myprime.com[†]**

In these scenarios, the prescription drug claims administrator may require additional information to determine benefit coverage. A form will need to be completed by your physician and can be found on the myprime.com[†] website.

Prior Authorization, Step Therapy, Quantity Limit

Prior Authorization

Certain drugs require authorization to help promote safe, quality and affordable pharmacy care.

Quantity Limit

If your prescribed medication dosage is greater or different than the recommended dosage, the administrator may request additional explanation.

Step Therapy

A step approach to providing medications that treat your condition, that may require you to try a more clinically appropriate or cost effective medication before certain higher cost medications will be approved.

Next: see what a year actually costs →

The same visit, billed three ways.

Blue Cross Blue Shield of Minnesota administers your health care plan — a comprehensive preferred provider organization (PPO) plan covering both medical and prescription drugs.

DO THIS

Read the receipt first. Your share of one identical visit changes three times in a plan year, and the stage you are in is the only reason why.

ONE OFFICE VISIT

WORKED EXAMPLE · \$125 · SAME VISIT, THREE TIMES

Before the deductible	\$125
Deductible met, co-insurance begins	\$25
Out-of-pocket max reached	\$0

YOUR YEAR'S CEILING

\$4,500[†]



WHAT YOU PAY

100% — what your plan pays once you reach your out-of-pocket max

STANDING OUTSIDE THE LADDER · There is no deductible for preventive and cancer screenings services.

WHOSE EXAMPLE THIS IS · Jane elected the Healthy Savings Plan Option, Employee Only coverage. Her plan deductible is \$2,000[†], her co-insurance is 20%[†], and her out-of-pocket max is \$4,500[†]. The coverage period runs Jan. 1st[†] through Dec. 31st[†].

- 1 Before the deductible**

YOU PAY

Jane hasn't reached her \$2,000[†] deductible yet. She pays 100%[†] and her plan pays 0%[†] — the plan doesn't pay any of the costs.

Before the deductible Jane pays \$125 and her plan pays \$0.
- 2 Deductible met, co-insurance begins**

SHARED

Jane has seen her doctor several times and paid \$2,000[†] in total. Now she pays 20%[†] and her plan pays 80%[†], so the plan pays some of the costs for her next visit.

Once co-insurance begins she pays 20% of \$125 = \$25 and her plan pays 80% of \$125 = \$100.
- 3 Out-of-pocket max reached**

HORMEL PAYS

Jane has seen her doctor often and paid \$4,500[†] out of pocket in total. She pays 0%[†], her plan pays 100%[†], and the plan pays the full cost of her covered health care services for the rest of the year.

After the out-of-pocket max she pays \$0 and her plan pays \$125.

Also on source p.15: prescription drug cost tiers — generic, formulary and non-formulary · the source's own "30 days / Eligibility" badge.

Next: see what your coverage costs each week →

What comes out of every paycheck.

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

DO THIS

Find your tier in the left column, then read across to the coverage you actually carry. The same nine rows are priced twice — once under each plan.

Benefit Facts			
Healthy Savings Plan · what you contribute · per week			
YOUR TIER	EMPLOYEE	+ CHILDREN	FAMILY
Tier 1	\$23*	\$31*	\$50*
Tier 2	\$30*	\$45*	\$74*
Tier 3	\$36*	\$55*	\$91*

Benefit Facts			
Traditional Plan · what you contribute · per week			
YOUR TIER	EMPLOYEE	+ CHILDREN	FAMILY
Tier 1	\$42*	\$67*	\$114*
Tier 2	\$48*	\$75*	\$132*
Tier 3	\$54*	\$87*	\$146*

WHICH EMPLOYEES THESE AMOUNTS COVER · These are the rates for the same rate group the plan figures elsewhere in this book resolve from. Hormel's internal code for that group is HC2. This guide has not established its employee-facing name, and the company's other four rate groups pay different amounts — check your own enrollment materials before budgeting from this page.

Of source p.10, which carries the rule above: "This page states the rule only; it does not print the amounts." The eighteen figures on this sheet were supplied by Hormel on 2026-08-25 and agree, row for row, with the benefits database.

Next: see how dental and vision are packaged →

One election. Two administrators.

One package plan covers both. Delta Dental of Minnesota administers the dental side; Vision Service Plan (VSP)[†] administers the vision side.

DO THIS

Elect the package once — the network you pick in the label below decides how much of the bill is yours.

Benefit Facts

Dental · per covered person · per plan year

PER COVERED PERSON	DELTA PPO	DELTA PREMIER	NONPARTICIPATING
MAXIMUMS			
Deductible	\$50 [†] person / \$150 [†] family	\$50 [†] person / \$150 [†] family	\$50 [†] person / \$150 [†] family
Plan annual maximum payment	\$3,000 [†]	\$3,000 [†]	\$3,000 [†]
TMJ lifetime maximum	\$1,500 [†]	\$1,500 [†]	\$1,500 [†]
Orthodontics lifetime maximum	\$3,000 [†]	\$2,500 [†]	\$2,500 [†]
YOU PAY			
You pay: diagnostic and preventive — no deductible applies	0% [†]	0% [†]	0% [†]
You pay: basic services, oral surgery, endodontics, periodontics, major restorative, prosthetic repairs and adjustments, prosthetics	20% [†]	20% [†]	20% [†]
You pay: orthodontics — no deductible applies	50% [†]	50% [†]	50% [†]

Deductibles and maximums are per covered person. The percentages are your share after the deductible, except diagnostic and preventive care and orthodontics, which the page marks as having no deductible. With a nonparticipating dentist you may be responsible for additional out-of-pocket expenses if charges are above the Table of Allowance amount. It depends on the provider, but typically you must pay the provider yourself and then submit documentation to Delta Dental or VSP[†] for reimbursement.

HANDBOOK CLAIM · Top 5%[†] — The page claims Hormel is in the top 5% of peer companies for dental coverage. No methodology is shown, so treat it as the handbook's own claim.

Also on source p.21: the orthodontics coverage percentage · checking your dentist's network · the full benefits site.

Next: see what vision covers →

Every vision benefit is on its own clock.

Vision Service Plan (VSP) is the claims administrator of the vision benefits. The page groups them under vision examination, prescription glasses and laser vision correction, and each benefit has its own frequency.

DO THIS

Find the benefit you want, read its reset window, then read what it costs in network.

WELLVISION EXAM (VISION EXAMINATION)

Every calendar year[†]

\$10[†] copay

FRAME (PRESCRIPTION GLASSES)

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 (PRESCRIPTION GLASSES)

Every calendar year[†]

Single vision, lined bifocal and lined trifocal lenses; polycarbonate lenses for dependent children

LENS ENHANCEMENTS (PRESCRIPTION GLASSES)

Every calendar year[†]

Average savings of 35-40%[†] on other lens enhancements

CONTACT LENSES, INSTEAD OF GLASSES (PRESCRIPTION GLASSES)

Every calendar year[†]

\$0[†] copay; \$150[†] allowance for contacts and the contact lens exam (fitting and evaluation); 15%[†] savings on a contact lens exam (fitting and evaluation)

LASER VISIONCARE PREFERRED PROGRAM (LASER VISION CORRECTION)

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

OUT-OF-NETWORK CAPS · Your coverage with out of network providers is capped at set amounts: exam up to \$60[†], frame up to \$70[†], single vision lenses up to \$60[†], lined bifocal lenses up to \$89[†], lined trifocal lenses up to \$100[†], progressive lenses up to \$100[†], contacts up to \$105[†].

QUESTIONS TO ASK

The source leaves this page blank for you to write on. It is stationery, not plan content.

NOTES

THINGS TO REMEMBER

Also on source p.23: medically-necessary eye exams route through medical coverage · finding an in-network doctor · the source's own "Eligibility" badge.

Next: open the account that pays for it →

MONEY

The accounts that pay for care with money the tax man never sees.

How much do I actually save with an HSA or FSA?	21
How much can I put into each account?	22
Can I have an HSA, and how much can I put in?	23
Which spending account am I allowed to use?	24

The same paycheck. Two different tax bills.

ACCOUNT ELIGIBILITY
30 DAYS[†] ELIGIBILITY

An account with tax-saving benefits: you put money in pre-tax, and don't have to pay taxes on the money coming out either. The page's examples are the Health Savings Account (HSA) or the Flexible Spending Account (FSA).

DO THIS

Compare the two receipts below line by line — the gap between them is the whole case for enrolling.

WITH HSA/FSA

WORKED EXAMPLE · TAX TREATMENT

Annual Pay	\$35,000
- Pre-tax Contribution	\$1,500
= Taxable Income	\$33,500
- After-Tax Spent	\$0
= Spendable Income	\$26,138

TAX SAVINGS

\$490



WORKED EXAMPLE

NO HSA/FSA

WORKED EXAMPLE · TAX TREATMENT

Annual Pay	\$35,000
- Pre-tax Contribution	\$0 [†]
= Taxable Income	\$35,000 [†]
- After-Tax Spent	\$1,500 [†]
= Spendable Income	\$25,648 [†]

TAX SAVINGS

\$0[†]



WORKED EXAMPLE

Tax advantages

Since contributions are not taxed, you can reduce your taxable income by the amount you contribute to your account. You can then use those pre-tax dollars to pay for qualified health care expenses that would have otherwise been paid with after-tax dollars.

Also on source p.16: Easy to access · Multiple uses — depending upon which account you have · Rapid reimbursements.

READ BEFORE YOU COMPARE · Provenance: both OCR passes dropped the entire WITH HSA/FSA column and the Annual Pay row, so those amounts were read from the page image and carry no machine-read tick; the five ticked NO HSA/FSA figures and the two callout figures survived machine reading. The page prints its own limits under the table: 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. "Depending upon which account you have" is the page's own condition — this page does not say which expenses each account covers. The 30 days ELIGIBILITY badge states a duration with no stated start point and no stated place to confirm it, so read the eligibility window as unresolved on this page.

Next: see what you can put in each account →

Your plan decides what you can save into.

Your medical plan option decides which of these accounts you can use and how much you can put in — except the dependent care account, which needs no health plan at all.

DO THIS

Find your plan column below, then read down — the three account rows are the same, the limits are not.

Benefit Facts

Healthy Savings Plan Option · pre-tax contribution options

HSA

Self\$0[†] to \$4,400[†]

Family\$0[†] to \$8,750[†]

Catch-up, age 55[†]+\$1,000[†]

LPFSA / FSA

Limit\$3,300[†] *
(LPFSA)

DEPENDENT CARE FSA

Limit\$5,000[†]

*The maximum FSA/LPFSA rollover amount from one calendar year to the next is unconfirmed pending Hormel, and only if you enroll in the FSA or LPFSA the next year. Any remaining balance over the maximum amount will be lost.

Benefit Facts

Traditional Plan Option · pre-tax contribution options

HSA

AvailabilityNA

LPFSA / FSA

Limit\$3,300[†] *
(FSA)

DEPENDENT CARE FSA

Limit\$5,000[†]

*The maximum FSA/LPFSA rollover amount from one calendar year to the next is unconfirmed pending Hormel, and only if you enroll in the FSA or LPFSA the next year. Any remaining balance over the maximum amount will be lost.

READ BEFORE YOU COMPARE · The middle row is one printed row, not two. The same \$3,300 sits in both columns, and the only cue for which account is which is the small label under each column's icons — (LPFSA) under Healthy Savings, (FSA) under Traditional. The page never states that the FSA is unavailable under Healthy Savings, or the LPFSA under Traditional. It never prints "not applicable" either; "NA" appears in one cell only, HSA under Traditional Plan Option. The two HSA amounts are told apart by icons alone — one person, then a group — so this page names no coverage tier in words. No plan year is printed anywhere here, so treat every figure as undated and check the current year's limits before you elect. A "30 days[†] ELIGIBILITY" badge sits in the top corner with nothing on source p.17 explaining it.

Next: go deeper on the HSA →

The HSA: a 401(k) for health care

A Health Savings Account (HSA) is available if you enroll in the Healthy Savings Plan Option. It is tax-advantaged, accumulates interest, can earn investment returns, and the money is yours to keep.

DO THIS

If you enroll in the Healthy Savings Plan, this account is on. Check the eligibility gate below before you count on it.

Benefit Facts

Health Savings Account · contribution limits · per calendar year

CONTRIBUTION LIMITS — PER CALENDAR YEAR

Self	\$4,400 [†]
Family	\$8,750 [†]

Contributions begin on the first earned paycheck that includes the first of the month following eligibility for the health care plans. Check that timing if you expect a medical expense soon after you enroll.

- 1 Pre-tax deferred going in
- 2 Grows tax free while it sits
- 3 Withdraw tax free

Spend now or save it

Funds can pay qualified medical expenses today or be saved for future expenses. The account is portable and yours to keep, you can save for retirement, you can change your contribution anytime, and it is 100%[†] rollover.

HSA eligibility

The IRS requires you to be enrolled in a qualified high deductible health care plan to be eligible to contribute to a health savings account. Even then, some situations can still make you ineligible.

EXAMPLES THAT MAKE YOU INELIGIBLE

- 1 Non-HSA-qualified coverage
Your care is covered by your own or your spouse's non-HSA-qualified health plan (Traditional Plan Option, Tri-Care, Medicare), Flexible Spending Account (FSA), or Health Reimbursement Arrangement (HRA).
- 2 Claimed as a dependent
You can be claimed as a tax dependent on another person's taxes.

Also on source p.17: the HSA catch-up contribution for older savers, and how these limits sit beside the Traditional Plan.

READ BEFORE YOU ENROLL · The page prints these contribution limits without a plan year, so confirm the current figures before you enroll. It also introduces the two ineligibility situations with "Some examples include" — that is not a complete list, so check your own circumstances. A badge in the corner of the page reads "30 days[†] ELIGIBILITY" and nothing on source p.18 explains it.

Next: meet the three FSA accounts →

Your plan picks the account, not you.

An FSA is a special account you put money into to pay certain out-of-pocket care costs. You don't pay taxes on this money, so you save an amount equal to the taxes you would have paid on what you set aside.

DO THIS

Find your own row on the left. The account named on its right is the one you are allowed to fund.

You are enrolled in the Traditional Plan or waived healthcare.

Health Care Flexible Spending Account (FSA) — The limit for 2026[†] is \$3,300[†]. The funds cover eligible medical, dental, vision, and prescription drug expenses for you and your eligible dependents.

You are enrolled in the Healthy Savings Plan.

Limited Purpose Flexible Spending Account (LPFSA) — The limit for 2026[†] is \$3,300[†]. The funds cover eligible dental and vision expenses only, for you and your eligible dependents.

No matter which healthcare plan you elect, or even if you waive healthcare.

Dependent Care Flexible Spending Account — The limit is \$5,000[†]. The funds cover eligible daycare expenses for children under the age of 13[†] or elder care expenses.

ELIGIBLE EXPENSES · For a list of eligible expenses, visit <https://www.wexinc.com/insights/benefits-toolkit/eligible-expenses/†>

When does it make sense to contribute to the LPFSA?

When you're making the maximum contribution to the HSA — this account lets you budget for dental and vision expenses without using your HSA. Also when you're enrolled in the Healthy Savings Plan and not eligible to contribute to the HSA, so you can still budget for dental and vision expenses.

WORDING ANOMALY · The LPFSA section's opening sentence on this page names the health care flexible spending account, not the LPFSA, even though the section heading and both bullets under it are about the LPFSA. This guide reports what the page prints and does not pick a winner. The page also dates the FSA and LPFSA limits to 2026 but prints no year with the \$5,000 dependent care limit, and a '30 days ELIGIBILITY' badge sits in the top corner without being explained on source p.19.





PROTECT

What happens to your income, and to the people who depend on it, when life interrupts.

Will I have to answer health questions to get life insurance?	26
How much life insurance can I elect?	27
Who do I call if illness keeps me from working?	28
What would my family get if I die?	29

Elect at new hire. Approval is guaranteed.

The handbook says it is wise to purchase life insurance no matter your age or marital status.

DO THIS

Find your own situation in the three rows below before you elect anything.

NEW-HIRE GUARANTEED APPROVAL
\$350,000[†]

As a new hire	You are guaranteed approval of insurance up to \$350,000 [†] — if available up to this amount — when electing during your new hire enrollment.
Adding insurance after new hire enrollment	You must 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 keep any amount you have already been approved for. You must still provide Statement of Health (SOH) when electing coverage any time after your new hire enrollment, and there is no guarantee of approval.

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

HORMEL PAYS Basic is provided by the company at no cost to you.

YOU PAY Optional is offered to you to purchase for additional financial security.

- 1 **Funeral costs**
The average funeral costs more than \$7,000[†].
- 2 **Debt**
Ease the financial burden of your loved ones.
- 3 **Replace your income**
Provide your family with financial security for the future.
- 4 **Children's college fund**
Ensure the educational expenses for your children will be covered.

Next: see your election maximums →

Elect once. The maximums are already set.

Basic coverage is company provided; Optional coverage is elected by you. Refer to your benefit features for your offered coverages, and to the benefits enrollment site[†] for cost of coverage.

Life Insurance Elections

EMPLOYEE	
Maximum you may elect	up to 8 times your salary [†] , or up to \$1,000,000 [†] , whichever is less
Statement of Health	subject to Statement of Health (SOH).
SPOUSE OR DOMESTIC PARTNER	
Maximum you may elect	up to \$100,000 [†] of coverage
Statement of Health	subject to Statement of Health (SOH).
CHILD	
Maximum you may elect	up to \$20,000 [†]
Covers	children age 14 days to age 26 [†] .
Statement of Health	does not apply to child life insurance.

MetLife[†] will mail you a health questionnaire to complete. Until MetLife[†] determines approval or denial, the election will remain in a pending status.

DO THIS

You must list your eligible children on the my contact page in Oracle[†] so the company can provide this coverage to them.

ONE-TIME NO-SOH WINDOW
2026[†]

WHERE THEY OVERLAP · The page does not say which governs where they overlap, and gives no window or deadline beyond the year 2026.

Also on source p.27: the plan increments for the one-time options.

Next: see what happens if you cannot work →

It may replace income. It won't say how much.

If injury or illness keeps you from working, disability benefits may continue a portion of your income during your absence from work.

DO THIS

Review your benefit features and plan documents for coverage and benefit eligibility. This handbook cannot establish either.

The page says benefits may continue a portion of your income. It does not say they will. No percentage, no dollar amount, no time limit and no eligibility rule is printed here.

HORMEL PAYS

Short-term and long-term disability are provided at no cost to the employee. These are company provided benefits.

Leave & disability line	855-249-6318 [†]
When they answer	8am-8pm ET [†]
Web address printed on the page	Hormel.MyLeaveProService.com [†]

UNLABELED MARK · The Alight wordmark is printed above the eligibility line and the phone number, but the page never says what role Alight plays - it does not say Alight administers, manages or decides disability benefits. Treat these as the contact details the page gives you, not as a statement of who decides your benefits. The web address carries no label saying what it is for, and the hours do not say which days they apply to. Official plan documents govern.

If something happens, the payouts are already mapped.

Optional Survivor Benefit Insurance pays your family a monthly benefit if you die. AD&D pays for severe injury, dismemberment, or accidental death.

DO THIS

Write your questions below before you call about this coverage — the page leaves the specifics for you to confirm.

ELIGIBILITY WINDOW
30 DAYS[†]

Survivor Benefit

A percentage of the first \$5,000[†] of your monthly earnings.

EACH BAR: SHARE OF THE FIRST \$5,000[†] OF MONTHLY EARNINGS

Spouse only — 30%[†] of monthly earnings

\$1,500[†]/mo max

Children only — 30%[†] of monthly earnings

\$1,500[†]/mo max

Spouse 30%[†] + children 15%[†]

\$1,500[†] + \$750[†]

Statement of Health (SOH) is not required.

AD&D

This insurance pays a benefit in the event of severe injury, dismemberment, or accidental death.

BASIC AD&D

Coverage	1 [†] times salary, with a max of \$50,000 [†]
Statement of Health	The page says nothing about SOH for Basic AD&D.

OPTIONAL AD&D

Coverage	You elect 1-10 [†] times your annual salary. The maximum amount is \$500,000 [†] or 10 [†] times your annual salary, whichever is less.
Statement of Health	No Statement of Health (SOH) is ever required.

ELIGIBILITY WINDOW · It does not say what starts the clock, and it names no place to confirm your date. The page also does not say how or where to elect either coverage.

The source leaves this page to you. It prints three prompts and gives you blank space to write.

QUESTIONS TO ASK:

NOTES:

THINGS TO REMEMBER:

GROW

**The money Hormel adds to yours, and
what it takes to keep it.**

What does waiting to start my 401(k) cost me?	31
Who do I call about my 401(k)?	32

One weekly amount. Three very different endings.

The source names three components of success — TIME, AMOUNT YOU INVEST, and INVESTMENT RETURNS. Its table holds the amount steady and changes only when you start.

DO THIS

Find your age on the three bars below. The bar you land closest to is roughly what waiting costs you.

SAME AMOUNT, EVERY WEEK **\$25[†]/week (\$1,300[†]/Year)**

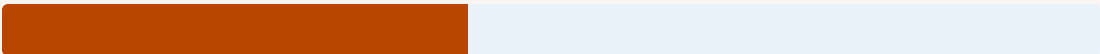
40 Years (ages 25-65)[†]



\$382,859^{†*}

Total invested: \$52,000[†]

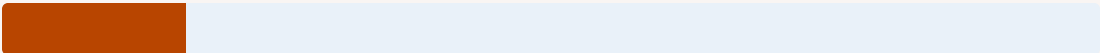
30 Years (ages 35-65)[†]



\$162,825^{†*}

Total invested: \$39,000[†]

20 Years (ages 45-65)[†]



\$64,221^{†*}

Total invested: \$26,000[†]

READ AS AN EXAMPLE, NOT A PROMISE · * Includes compound interest assuming an average annual return of 8%[†] until age 65[†]. Compound interest means you earn interest not only on the money you contribute but also on the interest you have already earned — which is why the source tells you to start saving early. Figures marked [†] are machine-read. These are the source's own illustrative figures, not a promise of return. The 8% average annual return is an assumption the page makes to draw the comparison; your actual result depends on what you contribute and how your investments perform. Official plan documents govern.

Next: see how Empower can help you use it →

One number to call. A few clicks to lower your fees.

Your Total Retirement Snapshot: how to reach Empower, and how to help keep your fees down.

DO THIS

Save the phone number, then turn on e-Delivery — both take less time than reading this page.

Empower Telephone Services

1-844-465-4455[†]

Customer Service Representatives take calls 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[†]

The participant site for your retirement plan.

EMPOWER RETIREMENT MOBILE APP

The 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.

Source p.33 headline: "Lower Fees = More Money for your Retirement"

WHAT THIS PAGE DOES NOT PROMISE · Contacts, hours and steps here are machine-read[†] from the source page. The app screenshots carry two names the page never reconciles — a listing reading "Empower® Finance" and a "Touch ID for 'RetireSmart'" prompt — while the caption calls it the "Empower Retirement mobile app". No app store or download link appears anywhere on the page, so none is given here. The page says online delivery helps keep fees down; it does not promise a fee reduction. Official plan documents govern.

You do this yourself on the Empower site.

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

Also on source p.34: How do you picture retirement? — a write-in reflection page with three retirement pictures and blank space for your own notes. It sets no plan terms, figures or deadlines.

Next: see everything else you already have →

EXTRAS

The programs you already have and have probably never used.

Do I have to be on a Hormel medical plan to use these?	34	How much does Hormel pay toward an adoption?	41
Is there a program for my back pain or my diabetes risk?	35	What can I earn or buy beyond my paycheck?	42
How many therapy sessions do I get?	36	What is the difference between a co-payment and co-insurance?	43
How do I get breast milk home when I travel?	37	Why does my plan have to approve some care first?	44
Where do I turn if I hit a hardship?	38	What does it mean when my 401(k) is vested?	45
How long do I have to claim my WW reimbursement?	39		
What else can I buy on top of my medical plan?	40		

Same BCBS card, two more doors.

Who can use each one	
Doctor On Demand	is free of charge to all team members and their dependents.
Progyny	requires that you be enrolled in one of our medical plans.

DO THIS

Save the Doctor On Demand site and Progyny's line before you need either one.

Telemedicine: Doctor On Demand

Physicians and psychologists diagnose your issues and give you a treatment plan over video, without you leaving home. You need a front-facing camera on a tablet or smartphone. A Video Visit is not intended to replace an annual, in-person visit with a primary care physician. Care comes from licensed physicians in independently owned practices called "Doctor On Demand Professionals".

Cold & Flu · Stomach Issues · Prescription Refills* · Allergies · Sore Throat · Travel Illness · Skin & Eye Issues · Pediatric Issues · UTI & Yeast Infections

WHAT THE ASTERISK LIMITS · 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.

Also on source p.36: the discount site link, consultation costs, and which states each part of this coverage runs in.

BEFORE YOU RELY ON THIS PAGE · Disclaimer, cost and eligibility wording is summarised here, not reproduced. The page prints no consultation-cost amounts; it sends you to the Doctor On Demand BCBS MN site. No conflicts or stale dates are recorded for this page. Official plan documents govern.

Progyny: fertility benefit

Coverage for fertility treatments for any member wishing to have a child. Includes a credentialed provider network and a concierge-style member support team (Patient Care Advocates) offering education, support and coordinated care.

Progyny does not require a medical diagnosis of infertility to access fertility treatment services, which ensures members of the LGBTQ+ community and single parents by choice receive equitable access to coverage.

With questions, call your dedicated Progyny Patient Care Advocate or the Progyny General Enterprise line at 844-470-1752[†].

Doctor On Demand cost & availability. Free of charge to all team members and their dependents. Put in your BCBS number to get the discount.

One gate, two ways through.

Two health programs — and a hard requirement: you must be enrolled in a company health plan to use either one.

You must be enrolled in one of the company's health plans to participate in Progyny, Hinge Health, or Omada Health programs.

DO THIS

Check the gate above, then take the row that matches your own problem.

Back and joint pain

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

Be at risk for type 2 diabetes[†] or heart disease

Omada — An online program that coordinates everything you need to adopt and maintain healthier habits. When you join you get a professional health coach, a wireless smart scale, weekly online lessons with games and quizzes, and a peer group of participants through the core 16-week[†] program.

Hinge Health: what your plan includes

Benefit Facts

WHAT YOUR TREATMENT PLAN CAN INCLUDE	
Care team	a physical therapist and health coach.
Sessions	Personal physical therapy sessions as needed.
Delivery	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.

Omada: who is eligible

You must meet both conditions.

- First, be an employee or adult family member who is eligible and enrolled in one of the Hormel Foods Plan Options through Blue Cross® and Blue Shield® of Minnesota.
- Second, be at risk for type 2 diabetes[†] or heart disease.

If you're eligible, Hormel Foods will cover the entire cost. Check eligibility at www.omadahealth.com/hormel[†].

READ THIS BEFORE YOU CLICK THROUGH · The sentence pointing you to the Omada site contains a typo in the source ("to find out if you are eligible of for more information"); read it as directing you there to check eligibility. Official plan documents govern eligibility, not this handbook.

Next: see how many therapy sessions you get →

Support that follows you home.

Printed under the banner INSPIRED HEALTH AND WELLBEING, this page carries two separate benefits from two different vendors: Spring Health for mental health and work-life support, and Milk Stork for shipping breast milk home while you travel for work.

DO THIS

Start with the session count below, then take the service that matches today's problem.

Benefit Facts

Spring Health · sessions per year

COMPANY-SPONSORED THERAPY	
Free sessions · age 6+ [†]	8 [†]
MEDICATION MANAGEMENT	
Drawn from those covered sessions	2 [†]

Those 2 come out of your covered therapy sessions, so they are not additional.



If needed, 2[†] of your covered therapy sessions can be used for a medication management consultation with a doctor.

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.

Company-sponsored therapy

Get support when it's convenient for you, either virtually or in person.

Coaching

Connect with a coach to help you reach goals related to personal development, health and wellness, relationships, or parenting.

Diverse providers

Choose an experienced therapist you feel comfortable with.

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.

READ BEFORE YOU RELY ON THIS PAGE · The source page carries no native document text, so every line here rests on machine reading of the page image rather than on extracted text.

Also on source p.38: whether the therapy footnote's age line covers the other services too — undecided in the source.

Next: ship breast milk home while you travel →

Milk that ships without you.

DO THIS

Call before your trip — the service is arranged in advance, not at the airport.

Milk Stork	510-356-0221 [†]	Note: only available while traveling for work.
------------	---------------------------	--

The page frames this for mothers returning to the workforce after maternity leave, and specifically for traveling moms. Shipping breast milk home alleviates the need to create a surplus of milk (in advance) to cover a mother's absence, and it bypasses the stress of going through airport security with large quantities of highly perishable breast milk.

A fund employees built.

Emergency and hardship help funded by employees, and WW at special monthly pricing with a reimbursement request you have to send yourself.

DO THIS

If you are in hardship, start with your local HR — the fund is applied for, not automatic.

WHO PAYS FOR IT

It is entirely funded by employees, for employees and their families.

The Crisis Assistance Relief Effort Program (CARE Program) is designed to help team members and their families in emergency or hardship situations. It is entirely funded by employees, for employees and their families. The CARE logo on this page carries the line "Supporting our team during life's challenges: Crisis Assistance Relief Effort."

1 Contact HR

For information on making donations or submitting an application, contact your local HR.

2 Or check Pivot

For information on making donations or submitting an application, or view it on Pivot under Career and Total Rewards / Inspired Health / CARE Program.

3 QR code

A QR code is printed beside the CARE logo.



Next: claim your WW reimbursement in time →

A plan you pay less for.

DO THIS

Track your WW weeks yourself — you request the reimbursement, not WW.

To be eligible for reimbursement you must actively participate in the WW® program:

● CALENDAR MONTH

YOU PARTICIPATE
four[†] weeks

CLAIM YOUR REIMBURSEMENT
within 30[†] days

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.

The page sets out the participation condition and the submission step; it does not state a reimbursement amount or what the reimbursement covers.

WW (Weight Watchers)

You can join and participate in Weight Watchers for special monthly pricing. Online Plus is the named option on this page: easily follow the plan step-by-step entirely online with digital and mobile tools, including a weight tracker, progress charts, restaurant guides and much more. It is available for men and women, with tailored content that speaks directly to each audience. For more information, visit wellness.weightwatchers.com[†]

WHAT THIS PAGE DOES NOT SAY · The page prints a QR code beside the CARE logo but does not say where it leads. Reimbursement requests are directed to wellness@hormel.com[†], not to WW, and this page states no reimbursement amount or covered expense. Official plan documents govern.



Next: look at what you can buy on top →

More coverage, your call, your cost.

READ THIS BEFORE YOU BUY · Five optional coverages. Critical Illness Insurance and Accident Insurance are limited benefit policies — not health insurance, and they do not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

DO THIS

Shop the cards below — check the flagged one if you were counting on hospital indemnity from the old chart.

Critical Illness Insurance

Pays a lump-sum benefit if you are diagnosed with a covered disease or condition on or after your coverage effective date. Use the money however you like: expenses your medical plan doesn't cover, lost wages, child care, travel, home health care costs, or regular household expenses.

Accident Insurance

Pays you benefits for specific injuries and events resulting from a covered accident that occurs on or after your coverage effective date. Spend it on deductibles, groceries, gas, utilities, or anything you'd like.

Hospital Indemnity Insurance

A supplemental benefit designed to work alongside your existing medical coverage, not replace it. Instead of paying healthcare providers directly, it pays you a cash benefit for a covered hospital stay, and you choose how to use it. Coverage amounts may vary. Examples the page gives: out of pocket medical expenses such as deductibles and co-pays; travel, food and lodging expenses for family members; child care; everyday expenses like utilities and groceries.

**OPENS TO EVERYONE
2026[†]**

Previously this benefit was only available to team members enrolled in the Healthy Savings Plan. Starting this year all team members can enroll, regardless of their medical plan. The cost of coverage is automatically deducted from your paycheck on a weekly basis, so you don't get a separate bill to pay.

FLAG — PAGE 9 SAYS OTHERWISE · Page 11 (**p.9 here**) of the source handbook shows Hospital Indemnity as included with the Healthy Savings Plan and not included with the Traditional Plan; this page says all team members can enroll for 2026 regardless of medical plan. The handbook does not resolve that difference — confirm with HR. The superscript 1 after 'coverage effective date' (Critical Illness and Accident) and the asterisk after 'age 26' have no matching footnote printed anywhere on this page. Official plan documents govern.

MetLife Legal Services

Unlimited, full coverage for covered matters when you use an in-network attorney. Key covered services include immigration assistance, estate planning, family and personal services including divorce, enforcement or modifications of support orders, real estate services, traffic ticket defense and identity management services — the page calls these some of the key services, not the full list. Multilingual, by office visit, phone, email, mail or fax. Visit members.legalplans.com[†] or call (800) 821-6400[†].

Nationwide Pet insurance

Medical and wellness plans for dogs, cats, birds and exotic animals kept as household pets, with reimbursement when veterinary care is needed for an accident or illness. The coverage provides 90%[†] reimbursement on qualified expenses for receiving care and treatment, plus preferred pricing with multi-pet discounts and free 24/7[†] access to a veterinary professional through Vet Helpline. It is intended to protect you from financial loss when a significant veterinary bill becomes inevitable. This is the only benefit deducted on a monthly basis. Visit www.petinsurance.com/hormelfoods[†] or call (877) 738-7874[†].

Also on source p.40: spouse and child coverage · how to file a claim · where the plan documents live.

Next: grow your money and your family →

Starting a family.

Four programs: stock purchase, Inspired Pathways, Workforce Edge tuition reimbursement, and adoption reimbursement.

Adoption Reimbursement

Up to \$10,000[†] toward eligible expenses per child, per household.

adoption reimbursement, per child, per household		\$10,000 [†]
Service required	at least one year of service	
When you are eligible	within 12 months [†] of a finalized adoption	
If both parents are eligible	the maximum benefit applies jointly.	

Expenses incurred during your first year of employment count if you reach one year of service before you apply. You must be actively employed by the Company or on an authorized leave at the time of reimbursement. Details: Pivot / Knowledge Resources / Policy Library, search adoption assistance.

NO STATED SUBJECT ON THE SOURCE PAGE · The adoption paragraph on the source page has no subject: it reads “To help those who are building a family, will reimburse up to \$10,000...” and never says who reimburses. The official policy governs.

Next: see what else you can earn or buy →

Stock, school, and what comes next.

DO THIS

Skip straight to whichever of these fits your year.

Employee Stock Purchase Plan

Buy Hormel Foods Corporation Common Stock at market value through systematic payroll deductions. In effect since July 1, 1972[†], administered by Etrade. You're eligible at the legal age of majority in your state of residence. The minimum you may invest is \$10.00[†] per week. The company pays all brokerage commissions. Plan details are in the "Terms and Conditions" on Pivot or from the HR Solution Center. To take part, visit etrade.com/enroll[†] and make your elections.

Inspired Pathways — two parts

Hormel Foods provides two-year community or technical college tuition to the dependent children of all benefits eligible U.S. team members. Part one is the Hormel Inspired Pathways Scholarship: two years of tuition-free community and technical college for children of Hormel Foods team members. Part two is a College Admission Guidance program created and led by former college admissions professionals. More at <https://hormelinspiredpathways.com>[†]

Workforce Edge tuition reimbursement

The Hormel Foods Tuition Reimbursement program financially assists eligible team members with education courses that are career-related or in specified areas beneficial to Hormel Foods. Courses must be pre-approved. Hormel Foods partners with Workforce Edge, which has strategic relationships with educational institutions across the United States, connecting you to online degree and non-degree programs and tuition savings. To review the policy, visit Pivot and search for tuition reimbursement.



Next: learn the words this book uses →

What these benefits words mean.

This glossary has many commonly used terms but isn't a full list. The definitions are educational and may differ from the terms in your plan; in any such case, the policy or plan governs. See your Summary of Benefits and Coverage for how to get a copy of your policy or plan document.

THE SAME \$100[†] ALLOWED AMOUNT, THREE WAYS

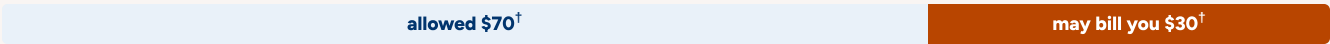
Co-payment — a fixed amount



Co-insurance — a percent of the allowed amount



Balance billing — provider charges \$100[†]



Allowed Amount

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

Balance Billing

A provider billing you for the gap between their charge and the allowed amount. A preferred provider may not balance bill you for covered services.

Co-insurance

Your share of a covered service, as a percent (for example, 20%[†]) of the allowed amount. You pay it plus any deductibles you owe; the plan pays the rest.

Co-payment

A fixed amount you pay for a covered service, usually when you receive it. It can vary by type of service.

Deductible

What you pay before your plan begins to pay — with a \$2000[†] deductible, the plan pays nothing until you've met that \$2000[†] for covered services subject to it. It 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

Proof of good health in order to be approved for coverage. SOH is required for some types of coverage. When you apply for insurance, you must confirm your physical fitness in writing, through a questionnaire or a medical examination.

Excluded Services

Health care services your health insurance or plan doesn't pay for or cover.

Imputed Income

For health care coverage: if your domestic partner isn't a "tax dependent" under federal law, their coverage goes into your gross income at fair market value and may affect your taxable income and liability. For group term life: coverage above \$50,000[†] and some dependent life coverage may be taxable, valued by an IRS table.

In-network Co-insurance

The percent (for example, 20%[†]) of the allowed amount you pay at providers who contract with your health plan — usually less than out-of-network co-insurance.

In-network Co-payment

A fixed amount (for example, \$15[†]) at providers who contract with your health plan — usually less than out-of-network co-payments.

FLAGS ON THIS PAGE · This page defines Statement of Health (SOH) as proof of good health for approval of coverage. Elsewhere the handbook uses SOH in a claims and payment context. The handbook doesn't reconcile the two uses, so don't assume they mean the same thing — ask about your specific plan. The glossary continues on the next page. It also prints out of A–Z order here, between Emergency Services and Excluded Services on the source page — left in place rather than resequenced, so check here first if you're hunting for it under S.

Next: more glossary words ahead →

Your costs have a ceiling. Some care needs a yes first.

The glossary continues from the previous page, where the handbook notes these definitions are educational and that the policy or plan governs if they differ.

Medically Necessary

Services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, meeting 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 without a contract with your health plan. You'll pay more to see one. Check your policy: you may not be able to use every contracted provider, and a "tiered" network can mean paying extra for some.

Out-of-network Co-insurance

The percent (for example, 35%[†]) of the allowed amount you pay at providers who do not contract with your health plan — usually 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 plan. Usually more than in-network co-payments.

Out-of-pocket Maximum

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

Plan

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

Preauthorization

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

The last of the plan words.

Preferred Provider

A provider under contract with your plan to serve you at a discount. Check your policy to see whether you can use all preferred providers, or whether your plan has a "tiered" network where you must pay extra to see some providers. Some preferred providers are also "participating" providers: they contract with your plan too, 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 group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider with 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 there usually charge for the same or similar medical service. UCR is sometimes 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: each year an employee vests, or owns, a certain percentage of their account in the plan. An employee who is 100%[†] vested owns 100%[†] of the account balance, and the employer cannot forfeit it, or take it back, for any reason.

THE RULE THAT SETTLES IT · These definitions are educational. If your policy or plan document says something different, the policy or plan governs.

**Every phone number, portal and person,
gathered into one place.**

1 PAGE · 47-47

The numbers that answer before the internet does.

Twenty source-table rows, kept one-to-one so every vendor stays attached to its own contact details. The first row is the front door — start there when you are not sure who owns your question.

DO THIS

Add the first contact to your phone now, before you need it.

Horizon Solution Center Printed at the top of the table beside the Horizon Solution Center logo. The Details and App cells for this row are blank on the page. Toll free (866) 449-7712[†] · internal direct extension 7712[†] · Fax (507) 437-9810[†] · Email Address hrsolutioncenter@hormel.com[†]
Oracle HCM Human resources, benefits yoursource.hormel.com
ADP Payroll myadp.com
Empower 401(k) plan recordkeeper (844) 465-4455 empowermyretirement.com
E*Trade Universal Stock Option Award and Employee Stock Purchase Plan (800) 838-0908 etrade.com
Spring Health Work/life resource program (855) 629-0554 Hormel.SpringHealth.com
VOYA Accidental Injury, Critical Illness and Hospital Indemnity (877) 236-7564[†]
Legal Services Legal Services (800) 821-6400[†] members.legalplans.com
Pet Insurance (Nationwide) Pet Insurance (877) 738-7874[†] petinsurance.com/hormelfoods
MetLife Life/AD&D Insurance/ Long Term Disability. Legal Services, Pet Insurance and MetLife are marked No App Available. (800) 638-6420[†]

Blue Cross Blue Shield of MN Medical doctor, health and fitness (866) 537-7721[†] · bluecrossmn.com/hormelfoods
Wex Health Flexible Spending Account · Health Savings Account · Limited Purpose Flexible Spending Account (866) 451-3399[†] · wexinc.com
Delta Dental of MN Dental (800) 448-3815[†] · deltadentalmn.org
Doctor On Demand Online doctor doctorondemand.com/BCBSMN
Hinge Health Back and joint pain program (855) 902-2777[†] hingehealth.com/for/hormel
Omada Diabetes management. The page prints a web address only for Doctor On Demand — no phone number. (888) 409-8687[†] go.omadahealth.com/Hormel
Prime Therapeutics Prescription drug (855) 457-0002[†] myprime.com
Progyny Fertility benefits (866) 946-0675[†] progyny.com
Alight Leave management. Prime Therapeutics is marked No App Available. (855) 249-6318[†] Hormel.myleaveproservice.com
VSP Vision. Last row of the printed table. (800) 877-7195[†] · vsp.com

DIRECTORY NOTE · Printed phone numbers, addresses and sites are not externally validated. Each source-table vendor remains its own entry here; [†] marks a machine-read value. Check the printed page before relying on a contact.

Next: know what governs →

The legal notices, your rights, and the documents that win any disagreement.

Can I keep my health coverage after I lose it?	49	Can my state help pay my share of the premium?	53
What else does the plan have to tell me every year?	50	Where do I find my state's Medicaid or CHIP contact?	54
Who can see my health information, and what can I stop?	51	Something happened — which page do I turn to?	55
When can I join a Medicare drug plan without a penalty?	52	Which document wins if this book is wrong?	56

When coverage would end, COBRA can extend it.

COBRA is a temporary extension of group health coverage when a life event — called a qualifying event — would otherwise end it. Read this if you, your spouse or your children are covered.

● QUALIFYING EVENT

NOTIFY THE PLAN IN WRITING
within 60 days[†]

CONTINUATION COVERAGE
the 18[†]-month period

▶

The arrow: two ways the 18[†]-month period can be extended — a Social Security disability determination, or a second qualifying event.

Who must notify the Plan

The covered employee or a qualified beneficiary must notify the Plan Administrator in writing.

DIVORCE, OR A DEPENDENT LOSES ELIGIBILITY
WITHIN 60 DAYS[†]

Qualified beneficiaries who elect COBRA pay for it.

Two ways to extend the 18 months

DISABILITY DETERMINATION, GIVE THE PLAN
60[†] DAYS

SAME EVENT, SECOND DEADLINE
18[†] MONTHS

Both extensions are conditional, and both depend on the Plan being notified in time. The tightest deadline is the disability one — you must give the Plan Administrator a copy of Social Security's determination within 60[†] days of the determination date and within 18[†] months of the qualifying event. Health FSA COBRA has its own limit and ends with the calendar year.

SOURCE CONTRADICTS ITSELF · The Introduction contradicts itself on this page: one sentence says the Plan has two group health components (Medical and Dental), the next says three (Medical, Dental and Health Flexible Spending Account). The duration section then names only the Medical and Dental components. The handbook does not resolve this. Check the Plan's Summary Plan Description or contact the Plan Administrator — the official plan documents govern.

QUESTIONS, NOTICES, ADDRESS CHANGES · Questions, notices and address changes go to Hormel Foods Corporation, Attn: HR Solution Center, 1 Hormel Place, Austin, MN 55912[†]; telephone 1-866-449-7712[†] (toll free) or 1-507-437-5996[†]; fax 1-507-437-9810[†]. Official plan documents govern.

Three more notices. Each one still applies to you.

Three notices begin here. Read the machine text and official plan documents for every condition and exception.

1 Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act notice describes coverage after a mastectomy.

2 Special Enrollment Rights

Special Enrollment Rights describes two 60⁺-day request windows when coverage was previously declined or Medicaid or CHIP status changes.

COVERAGE PREVIOUSLY DECLINED, OR MEDICAID/CHIP STATUS CHANGE
60⁺-DAY WINDOW

3 HIPAA privacy notice

The HIPAA privacy notice then begins and continues on the next page, explaining how health information may be used, disclosed and accessed.

READ THIS AS A GUIDE · Read it as a guide only — official plan documents govern.

Next: read what happens to your health information →

What moves without asking. What only you can start.

A compressed read of the Plan's HIPAA privacy notice — one side is already in motion, the other side waits on you.

Without your OK

It names the purposes for which the Plan may use or disclose your health information:

running the plan in motion

talking with you and your family in motion

the disclosures state or federal law requires or permits in motion

§ When your signature is required

One part asks something of you. Hormel Foods Corporation and its subsidiaries and affiliated companies generally will not discuss your health information with you or your family members without a specific signed authorization. Basic eligibility or enrollment questions go to the appropriate third-party administrator instead. That administrator may also share information relevant to your care with a family member or another person involved in your care unless you object — and you can restrict that disclosure at any time, subject to certain limitations.

Your five rights

Request any of the five listed privacy rights in writing to the Director of Employee Benefits at the Contact Person address.

Right to Request Restrictions

Right to Receive Confidential Communications

Right to Inspect and Copy Your Health Information

Right to Amend Your Health Information

Right to an Accounting

THE GAP IN THIS PAGE · The address is the gap: every request here goes to the Director of Employee Benefits "at the address listed under Contact Person", and that address is not printed on this page. The page also opens mid-notice, so the earlier disclosure categories are on the previous page. Official plan documents govern.

Miss the window. The penalty never stops.

This is the Creditable Coverage notice: how your prescription drug coverage through the health plan options works alongside a Medicare drug plan. It matters if you are Medicare eligible or will be soon.

DO THIS

Check both windows below before you assume you can join a Medicare drug plan anytime.

J	F	M	A	M	J	J	A	S	O	N	D
---	---	---	---	---	---	---	---	---	---	---	---

Join a Medicare drug plan each year **October 15[†] — December 7[†]**

CREDITABLE
COVERAGE
ENDS

A GAP OF
63[†] continuous days

The arrow: or longer without creditable prescription drug coverage can raise your monthly premium.

SPECIAL ENROLLMENT PERIOD

two (2)[†] month

if you lose creditable coverage through no fault of your own

It sets out three options for your current coverage. Keep this notice — if you join a Medicare drug plan you may be required to provide a copy.

FRESHNESS CONFLICT · Flagged critical by the canon and not resolved: the contact block closing this notice is dated October 1, 2021[†], earlier than the current plan year. Both the printed date and the current plan year stand as-is here; this layer does not decide which governs. Confirm current details with the Horizon Solution Center. Official plan documents govern — this handbook cannot establish eligibility or legal rights.

Questions on this notice

Questions go to the Horizon Solution Center at 1-866-449-7712[†].



Next: check whether your state helps with premiums →

Your state may help pay the employer-plan premium.

If you are not enrolled in Medicaid or CHIP yet, the notice sends you to one of two places:

Call

1-877-KIDS NOW[†]

Or go to

www.insurekidsnow.gov[†]

If the notice's premium-assistance conditions apply, request special enrollment within the printed 60[†]-day deadline.

The directory begins with Alabama through Kentucky; each State entry has its own mix of programs, websites and phone numbers.

The page's printed conditions and official plan documents govern.

SPECIAL ENROLLMENT WINDOW

60[†]-DAY DEADLINE

NOT SETTLED HERE · Freshness conflict, flagged critical by the canon and left unresolved here: the printed notice states that the list of States is current as of July 31, 2023[†], which predates the current plan year. This layer does not choose between the printed currency date and the current plan year. The printed web addresses, email addresses, fax and phone numbers have not been checked against the States' live contact details — confirm with your State Medicaid or CHIP office before relying on any of them. This summary is not verbatim and has not been human-verified; the printed notice and the official plan documents govern, and this handbook cannot establish eligibility or legal rights.

The rest of the directory, then who to call federally.

This page finishes the state list, then adds federal contacts and the paperwork notice. Find the line that fits you before you call or click.

State contacts, continued

The State directory continues with the rest of Kentucky, then runs from Louisiana through Vermont. It contains 22 entries, but not every State in that alphabetic range appears. Read each State header first: some entries cover Medicaid and CHIP, others Medicaid alone, and their websites and phone lines vary by program. These are State contacts, not Hormel contacts; confirm the line that matches what you need before using it.

Last states, federal contacts, and the Paperwork Reduction Act Statement

The State directory ends with Virginia, Washington, West Virginia, Wisconsin and Wyoming. The page then gives federal Department of Labor and Health and Human Services contacts for checking whether other States have added premium-assistance programs and for questions about special enrollment rights. A Paperwork Reduction Act Statement closes the notice and provides a Department of Labor address and email for comments on the reporting burden.

OMB CONTROL NUMBER EXPIRES
1/31/2026[†]

NOT SETTLED HERE · The web addresses, phone numbers and email addresses printed here have not been checked against the states' live contact details, and this layer does not decide whether the printed list is still accurate. The canon records an unresolved critical freshness conflict covering this page: the Medicaid and CHIP state list states a currency date of July 31, 2023[†]. That conflict is disclosed here, not settled. Several entries are visibly imperfect in the source, and this is not a complete list of them: Maine's private health insurance premium line prints "Phone: -800-977-6740." without its leading digit and with a stray trailing period; Pennsylvania's CHIP Website line prints a link title, "Children's Health Insurance Program (CHIP) (pa.gov)", instead of an address; and a stray black rule boxes Utah's CHIP Website and Phone lines. Confirm any address or number with the state program before relying on it. Two freshness conflicts touch this page, both flagged critical by the canon and neither resolved here. First, the page asks you to check whether other states have added a premium assistance program since July 31, 2023 — a date earlier than this plan year. Second, the grey line at the lower right prints OMB Control Number 1210-0137 with an expiration of 1/31/2026. This layer reports both as printed and does not decide whether either is still current. Confirm state programs with your State Medicaid or CHIP office, or with the federal contacts on this page.

The mark above belongs to this restated figure only. The same dates repeat inside the note below without a matching mark — that gap is in this layer's marking, not a claim that those dates are confirmed. Read every date on this sheet as unverified until you check it against the printed page.

Official plan documents govern — this handbook cannot establish eligibility or legal rights.

Start with what happened to you.

This book is indexed by situation, not by alphabet — you rarely know the benefits word before you need the benefit. Find your situation, then the question you were about to ask. A question that belongs to two situations is printed under both.

I'M NEW HERE

How do I read this book?	2
Which benefits do I have to choose, and which come with the job?	4
How do I get into Oracle and enroll?	5
How long do I have to prove a dependent or report a life event?	6
Who counts as my dependent?	7
What is the difference between a co-payment and co-insurance?	43

I'M CHOOSING MY PLANS

Which benefits do I have to choose, and which come with the job?	4
How do the two plans compare, row by row?	9
What are my two medical plan choices?	12
Where do the two plans actually differ?	13
What will my prescriptions cost?	14
What does my dental plan pay for?	18
How often can I get new glasses?	19
How much can I put into each account?	22
Can I have an HSA, and how much can I put in?	23
Which spending account am I allowed to use?	24
Will I have to answer health questions to get life insurance?	26
How much life insurance can I elect?	27
Do I have to be on a Hormel medical plan to use these?	34
Where do I turn if I hit a hardship?	38
What else can I buy on top of my medical plan?	40

I'M SICK OR HURT

What do I actually owe after a doctor visit?	10
Where should I go when I'm sick?	11
What will my prescriptions cost?	14
Where do I go to check a drug, a price, or an approval?	15
How much of a doctor's bill do I pay?	16
Who do I call if illness keeps me from working?	28
Is there a program for my back pain or my diabetes risk?	35
How many therapy sessions do I get?	36
What else can I buy on top of my medical plan?	40
How much does Hormel pay toward an adoption?	41

I'M HAVING A BABY

How long do I have to prove a dependent or report a life event?	6
Who counts as my dependent?	7
How much can I put into each account?	22
Which spending account am I allowed to use?	24
How much life insurance can I elect?	27
How long do I have to claim my WW reimbursement?	39

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What governs, and what still needs a human.

This handbook is not a legal document, and it does not establish your eligibility to participate in any benefit plan.

HR SOLUTION CENTER, TOLL FREE
1-866-449-7712[†]

- §

The plan document wins
If any information in this handbook conflicts in any way with the official plan document, the provisions of the plan document govern. Treat this book as a guide to your benefits, not as the source of your rights.
- §

Where the full detail lives
Refer to your summary plan descriptions or life insurance certificates for additional information about your benefits. If you need to be certain about a term, a limit or an exception, go to those documents.
- §

Questions
Contact the HR Solution Center toll free at 1-866-449-7712[†], or email hrosolutioncenter@hormel.com[†]. The customer service line is staffed Monday through Friday from 7:00[†] a.m. to 5[†] p.m. CST.

Treat this book as the label, not the contents. The plan documents are the contents.

Before anyone calls this verified

This edition is a **candidate**. The canon lists its own release blockers — unchecked until a human signs each one:

- ☐ Human line-by-line verification of every OCR transcription
- ☐ Human verification of every table relationship and merged cell
- ☐ Human verification of every number, date, deadline, phone, email, URL, footnote, and legal notice
- ☐ Adjudication against official plan documents for source conflicts and stale notices

Source Ledger

53 source pages read across 8 sections — closed out

HOW IT WAS READ	
Machine-read figures	382 NOT YET HUMAN-VERIFIED LINE BY LINE
Machine agreement	0.000–1.000 RANGE ACROSS ALL SOURCE PAGES

Counted from source data at build time — never retyped.



KNOW MORE. STRESS LESS.

PROVISIONS EDITION · DRAFT V0.2.0
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FIGTREE · FUELING REAL LIFE PALETTE



PURPOSE

Fueling every day with real food for real life.

MISSION

We create trusted, protein-powered solutions that nourish people and strengthen communities.

VALUES

We act like owners.

We own the outcome — we move with speed to deliver results that matter.

We earn trust in every relationship.

We listen and engage — we create value for all our stakeholders.

We play for the whole team.

We lead with intent, appreciate differences and have each other's backs — we win as one team.

We do the right thing.

We act with integrity in all we do — we prioritize safety, quality and transparency.

We originate what's next.

We stay true to our founder's call to "Originate don't imitate" — we lead with curiosity and explore what's possible.

Hormel's words and photographs, reproduced from the supplied Fueling Real Life Purpose, Mission and Values one-page (May 2026). This page describes the company's culture; it does not establish or change a benefit.