



HEALTH CARE PROGRAM

SUMMARY PLAN DESCRIPTION Effective January 1, 2026

for Team Members of
Hormel Foods Corporation and Eligible Subsidiaries

LANGUAGE ACCESS SERVICES

Medical Program Language Access Services

This information is also available in other ways to people with disabilities or who need it translated into another language by calling 1-800-382-2000. For TTY call 711.

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမူနာကတိတ်ကညီကိုင်နီ: တစ်ကယုန်နုကိုင်တစ်မာတကလီတတပိုင်နုလီ. ကိ: 1-866-251-6744 လာ TTYဘက်, ကိ: 711 တကုန်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهااتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專線 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

හැමදාම ඉංග්‍රීසි හැසිරීමේ සේවාවක් ලබාගත හැකිය. 1-855-315-4030 දුරකථන මගින් TTY ට 711 දුරකථන මගින්.

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສໍາລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ អ្នកអាចទទួលបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehji yánilt'igo saad bee yát'í éí t'áájiik'e bee níká'a'doowolgo éí ná'ahoot'í. Kojí éí béésh bee hodiilnih áqjeeqííáqjeeqíí. TTY biniyégo éí áááji' béésh bee hodiilnih.

Prescription Drug Program Language Access Services

For help in a non-English language, please call Prime's customer service at 1-855-457-0002.

Si necesita ayuda en español, llame al número de teléfono del servicio de atención al cliente que figura en la primera página de este documento.

Si aad u heshid kaalmo xagga Soomaali, fadlan wac nambarka telefoonka adeegga macaamilka ee ku yaala bogga kowaad dokumentigaan.

Để được giúp đỡ bằng Tiếng Việt, xin gọi số điện thoại của phòng dịch vụ khách hàng ở trang đầu của tài liệu này.

Xav tau kev pab rau Lus Hmoob, thov hu rau chaw pab txais tos qhua tus xov tooj ntawm thawj nplooj hauv tsab ntawv no.

如欲以 中文求助，请致电给本文件第一页上的客服电话号码。

Vision program language access services

English: ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call **1.800.877.7195 (TTY: 1.800.428.4833)**.

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.877.7195 (TTY: 1.800.428.4833)**.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1.800.877.7195 (TTY: 1.800.428.4833)**。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1.800.877.7195 (TTY: 1.800.428.4833)**.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1.800.877.7195 (TTY: 1.800.428.4833)** 번으로 전화해 주십시오.

Tagalog–Filipino: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1.800.877.7195**

(TTY: 1.800.428.4833).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1.800.877.7195 (телетайп: 1.800.428.4833)**.

Armenian: ՌԻՇԱԴՐՈՒԹՅՈՒՆ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Չանգահարեք **1.800.877.7195 (TTY (հեռատիպ)` 1.800.428.4833).**

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1.800-877-7195 (ATS : 1.800.428.4833)**.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

1.800.877.7195 (TTY: 1.800.428.4833)まで、お電話にてご連絡ください。

Tongan: FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai **1.800.877.7195**

(TTY: 1.800.428.4833).

Serbo-Croatian: OBAVJEŠTENJE: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite **1.800.877.7195 (TTY-Telefon za osobe sa oštećenim govorom ili sluhom: 1.800.428.4833).**

Cambodian: ប្រយ័ត្ន៖ បររំលឹកសូម នឹងអ្នកនយោបាយខុសៗគ្នា, បង្កើនការចូលរួមរបស់ពលរដ្ឋក្នុងការ
ជួយសង្គ្រោះអ្នកដែលបានរងការរំលោភបំពាន។ **1.800.877.7195(TTY: 1.800.428.4833)**។

Punjabi: ਿਧਆਨ ਿਧਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਿੰਦੇ, ਤਾਂ ਭਾਸ਼ਾ ਧ ਿੱਚ ਸਹਾਇਤਾ ਸੇ ਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1.800.877.7195 (TTY: 1.800.428.4833)** 'ਤੇਕਾਲ ਕਰੋ।

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche
Hilfsdienstleistungen zur Verfügung. Rufnummer: **1.800.877.7195 (TTY: 1.800.428.4833)**.

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1.800.877.7195** (ሞስማት ለተሳናቸው: **1.800.428.4833**).

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1.800.877.7195** (телетайп:(телетайп: **1.800.428.4833**)).

Nepali:  नदिनुहोस्: तपाइले नेपाली बोल्नुहुन्छ भने तपाइको दनदतत भाषा सहायता सेवाहरू दिन: शु  पामा उपल 
छ फोन गनुहोस् **1.800.877.7195** (दिदिदवाइर: (दिदिदवाइर: **1.800.428.4833**)) ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1.800.877.7195 (TTY: 1.800.428.4833)**.

Sudan (Fulfulde): MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1.800.877.7195 (TTY: 1.800.428.4833).

Thai: เรียน: ถัดคนพูดภาษาไทยคนสามารถให้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1.800.877.7195 (TTY: 1.800.428.4833).

Laotian: ໂປດຊາບ: ຖ້າວາ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.800.877.7195 (TTY: 1.800.428.4833).

Cushite/Oromo: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1.800.877.7195 (TTY: 1.800.428.4833).

Persian (Farsi):

Arabic: 1.800.877.7195 (TTY: 1.800.428.4833) 1.800.877.7195 (TTY: 1.800.428.4833)

Navajo: 1.800.877.7195 (TTY: 1.800.428.4833)

हिंदी (Hindi):

ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1.800.877.7195 (TTY: 1.800.428.4833) पर कॉल करें।

CONTACT INFORMATION

Plan/Service	Provider/Administrator	Contact Information
Plan Sponsor and Plan Administrator	Hormel Foods Corporation	Horizon Solution Center 1 Hormel Place Austin, MN 55912 Phone: 1-866-449-7712 Email: HRSolutionCenter@hormel.com
Medical Plan Claims Administrator	Blue Cross Blue Shield of Minnesota (BCBS)	For customer service, coverage, prior authorization, emergency admission notification. Member Services: 1-866-537-7721 Website: www.bluecrossmn.com/hormelfoods Mobile App:
Blue Care Advisor	Blue Cross Blue Shield of Minnesota (BCBS)	Search for Blue Care Advisor in your mobile App Website: www.bluecrossmn.com/BCA 
BlueCard Program	Blue Cross Blue Shield of Minnesota (BCBS)	Find medical providers who participate with Blue Cross and Blue Shield plans nationwide Phone: 1-800-810-BLUE (2583)
Maternity Management	Blue Cross Blue Shield of Minnesota (BCBS)	To speak with a Health Care Advocate: 8 a.m. – 4:30 p.m. Monday-Friday, Central time Phone: 1-800-793-6916
Quitting Tobacco Support	Blue Cross Blue Shield of Minnesota (BCBS)	To connect with a Wellness Coach: Phone: 1-888-662-BLUE (2583)
Prescription Drug Plan Claims Administrator	Prime Therapeutics	Prime Therapeutics LLC Mail route: DTE PO Box 21870 Lehigh Valley, PA 18002-1870 Phone: 1-855-457-0002 Website: www.myprime.com
Exercise Therapy Program	Hinge Health	Phone: 1-855-902-2777 Website: Hinge.health/hormel
Fertility Program	Progyny	Phone: 1-866-946-0675 Member Portal: Progyny.com/progyny-member-portal/
Dental Plan Claims Administrator	Delta Dental of Minnesota If you have questions or need to request prior authorization, please refer to the customer service number on the back of your member ID card.	P.O Box 9124 Farmington Hills, MI 48333-9124 Phone: 1-800-448-3815 Website: www.DeltaDentalMN.org
Vision Plan Claims Administrator	VSP	PO Box 385018 Birmingham, AL 35238 Phone: 1-800-877-7195 Website: http://www.vsp.com
COBRA Administrator	WEX Health, Inc.	Address for correspondence and premium payments: PO Box 2079 Omaha, NE 68103-2079 Phone: 866-451-3399 Member Login: https://cobralogin.wexhealth.com

Austin, MN clinic	Premise Health	1906 8 th Street NW Austin, MN 55912 Phone: 507-494-6982 Website: MyPremiseHealth.com
Willmar, MN clinic	Marathon Health	2505 Willmar Ave. SW Willmar, MN 56201 Website: my.marathon.health

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HEALTH CARE PROGRAM

INTRODUCTION

This Summary Plan Description (“SPD”) contains information on the medical, prescription drug, dental and vision benefits of the Health Care Program which offers certain health benefits to eligible team members and their dependents, if enrolled. The Health Care Program is a component of the Hormel Foods Corporation Comprehensive Welfare Benefit Plan (the “Plan”). The following programs are described in this SPD and are components of the Health Care Program (each of which may collectively or individually be referred to as the “Program”, “health plan” or “Plan”, as applicable):

- Medical and Prescription Drug Programs –
 - Traditional Plan Option (low deductible) and
 - Healthy Savings Plan (high deductible)
- Fertility Program
- Exercise Therapy Program
- Dental and Vision Program

The Health Care Program is sponsored and maintained on a self-funded basis by Hormel Foods Corporation (the “Company”). This means that when you have a claim, the Plan pays for the claim out of its own assets. The Company is also the Plan Administrator of the Program. Third-party claims administrators may be used to perform claims processing and other functions in the operation of the Program.

This SPD also contains information on the Premium Payment Program (which apply to your ability to pay for certain benefits, including health benefits, with pre-tax dollars through a cafeteria plan) are summarized in this SPD rather than in a separate Benefit Description.

Eligibility or participation in the Program does not guarantee benefits. Neither the receipt of this SPD nor the use of the term “you” indicates that you are eligible for a benefit under the Program. The use of the terms “you” or “your” may collectively or individually refer to the employee and other covered dependents. Only employees and former employees enrolled through COBRA who satisfy the eligibility requirements and other criteria contained in the Program are eligible for a benefit. Neither the receipt of this SPD nor the terms of the Program creates a right for you to be retained in employment. A list of participating employers specific to the classes covered by this SPD is contained in the *PARTICIPATING EMPLOYERS* section at the back of this SPD. Any reference in this SPD to “Employer” may include the Company as well as the Participating Employers, as applicable.

This SPD is a summary in English of the benefits provided under the Program and your rights and obligations under the Program. If you have difficulty understanding any part of this SPD, contact the Horizon Solution Center at 1 Hormel Place, Austin, Minnesota 55912-3680. Office hours are from 7:00 a.m. to 5:00 p.m Central time, Monday through Friday. You may also call the Horizon Solution Center (866) 449-7712 for assistance.

Este folleto contiene un resumen escrito en inglés de los derechos del Plan de Salud y sus derechos y obligaciones según el Programa. Si usted tiene dificultad en comprender lo descrito en el folleto, póngase en contact con Horizon Solution Center en 1 Hormel Place, Austin, Minnesota 55912-3680. Las horas de oficina son de las 7:00 a.m. a 5:00 p.m. zona horaria central, de lunes a viernes. También puede llamar al Horizon Solution Center (866) 449 7712 para obtener ayuda.

Buug-yarahan waxa uu ka kooban yahay kooban oo Ingiriis ku qoran oo ku saabsan xuquuqdaada Qorshaha Caafimaadka iyo xuquuqdaada iyo waajibaadkaaga hoos yimaada barnaamijka. Haddii aadan fahmin tilmaamaha buug-yarahan, waxaad u qori kartaa Horizon Solution Center shaqaalaha Jennie O Turkey Store Inc., P.O. Box 778, Willmar, Minnesota 56201 0778. Haddii isaga/iyada u baahan tahay caawimo waxaa sidoo kale si toos ah looga wici karaa Agaasimaha Khayraadka Aadanaha, telifoon (320) 235 2622. Saacadaha shaqadu waa 7:00 a.m. 5 galabnimo. aagga waqtiga dhexe, Isniinta ilaa Jimcaha. Waxa kale oo aad wici kartaa Horizon Solution Center (866) 449-7712 wixii gargaar ah.

ELIGIBILITY

ELIGIBLE EMPLOYEES

You are eligible to participate in the Program if you (1) have completed the waiting period¹; (2) are an employee of a Participating Employer (refer to the *PARTICIPATING EMPLOYERS* section); and (3) are classified by your Employer as:

- A salaried employee who is exempt from the Fair Labor Standards Act; or
- A full-time hourly employee; or
- A full-time eligible employee² who has worked an average of at least 30 hours per week during an initial measurement period³ or a standard measurement period.⁴

The Employer's classification of a person as an employee or a non-employee, salaried or hourly, full-time or part-time and temporary or regular is conclusive for purposes of benefit eligibility. You are not eligible if you were not classified by a Participating Employer as an employee but rather as an independent contractor, leased employee or any other non-employee classification. If for any reason a person is reclassified from a non-employee to an employee status, that person will not be retroactively or prospectively eligible for benefits.

If you are rehired within 13 weeks of your most recent termination from the Company and you were eligible for coverage at the time of termination, your previous coverage will be automatically reinstated upon your rehire, unless you elect to make changes or opt-out within 30 days. If you are rehired more than 13 weeks since your most recent termination from the Company, you will be treated as a new employee and have to satisfy a new waiting period.

Employees, whose terms and conditions of employment are subject to a collective bargaining agreement between the Employer and a union representing the employees, are not eligible for any plans described in this SPD unless the collective bargaining agreement provides for their inclusion. Certain bargaining unit locations and subsidiaries of the Company participate in the plans and programs described in this SPD at the discretion of the Company (referred to as Participating Employers). Unless the formal documents otherwise indicate, employees of subsidiary corporations and/or affiliated corporations which are not Participating Employers are specifically excluded from participation in these plans and programs.

The Exercise Therapy Program and Fertility Program have different eligibility criteria. Please refer to those sections of this SPD that pertain to those Programs.

¹ "Waiting period" is the amount of time that must pass before you and your eligible dependents are eligible for coverage under the Program. The waiting period for purposes of this Program is 30 days of service⁷ with your Employer. Employment by a temporary service while physically working full-time at your Employer's location will be included as service if you are employed by your Employer immediately following such service. Part time service will be included if converted to full time.

² You are a "full-time eligible employee" if (1) you are not classified by your Employer as a full-time employee; (2) at the time you were hired, your Employer classified you as a seasonal employee or your Employer could not reasonably determine how many hours you would actually work; and (3) your Employer measured your hours of work during a set period of time and determined that you worked an average of 30 hours or more per week during that measurement period.

³ If the future number of hours that you will work is uncertain when you are hired, your hours will be measured during the "initial measurement period." This initial measurement period is an 11-month period generally beginning on the first day of the month following or coincident with your hire date. If at the end of this period it is determined that you worked an average of 30 hours or more per week, you will be eligible for benefits for a 12-month period (called the "stability period"), regardless of how many hours you work during the stability period.

⁴ If you are an ongoing employee, your hours will be measured during the "standard measurement period." This standard measurement period is a 12-month period, generally beginning in mid-October of each year, and is used to measure your hours in order to determine your eligibility for annual enrollment in the Program. If you worked an average of 30 hours or more per week, you will be eligible for benefits during the next calendar year (also called a "stability period"), regardless of how many hours you work during the stability period.

ELIGIBLE DEPENDENTS

1. Your spouse by legal marriage.
2. Domestic partner⁵ – Meets the requirements of paragraph (a) OR (b) below:
 - (a) You and your domestic partner have a registered domestic partner or civil union partner from a jurisdiction that recognizes domestic partnerships or civil unions;

-OR-

 - (b) You and your domestic partner meet all of the following requirements:
 - You and your domestic partner are same or opposite gender adults;
 - You are both at least 18 years of age and are not married to or legally separated from anyone else and do not have other domestic partners;
 - You are in a committed and mutually exclusive relationship of at least 12 months that is intended to be permanent;
 - You have joint responsibility for welfare and financial obligations;
 - You reside in the same principal residence and intend to do so permanently;
 - You are not related by blood to a degree of closeness that would prohibit marriage; and
 - You are each mentally competent.
3. Children up to age 26 as follows:
 - (a) Natural-born children.
 - (b) Legally adopted children and children placed with you for adoption. Date of placement means the assumption and retention by a person of a legal obligation for total or partial support in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation.
 - (c) Stepchildren.
 - (d) Your domestic partner's natural born children legally adopted children and children placed with your domestic partner for adoption⁵ (only if your domestic partner is on coverage),
 - (e) Legal Ward.
4. Children who are required to be covered by reason of a Qualified Medical Child Support Order ("QMCSO"), as defined in ERISA §609(a). The Program has detailed procedures for determining whether an Order qualifies as a QMCSO. You can obtain, without charge, a copy of such procedures from the Plan Administrator. You can contact the Horizon Solution Center to request a copy.
5. Disabled children who reach the limiting age while covered under this Program if all of the following apply to the child:
 - (a) is a child as defined in paragraph 3 above;
 - (b) became disabled prior to reaching age 26;
 - (c) is primarily dependent upon you; and
 - (d) is incapable of self-sustaining employment because of physical disability, developmental disability, mental illness or mental disorders.

To qualify for this disabled child coverage extension, the Plan Administrator must receive a valid claim form and written proof of the requirements above within 31 days after the date coverage would have ended because the child reached age 26. After this initial proof, the Plan Administrator may request proof again two (2) years later, and each year thereafter.

A dependent will not be eligible for coverage while covered as an active or retired employee. You and your

⁵ Under federal tax law (and under most state tax laws), your employer must report to you as taxable income the value of its subsidy of your domestic partner's coverage (and children of your domestic partner, if applicable). You also pay your share of the cost of this coverage with after-tax dollars. If, however, your domestic partner qualifies as your "tax dependent" (for purposes of employer provided health coverage), your employer can exclude the value of this coverage from your income tax. If you think your domestic partner may be your tax dependent, you will need to provide an affidavit to your employer satisfying the required support and residence requirements. Employees who have filed a declaration of domestic partnership are required to notify the Plan Administrator if there is any change in circumstances that make any statement in the declaration no longer correct.

dependents can only have coverage under one employee in any Company-sponsored health care program at a time. Appropriate documentation to support dependent eligibility must be received and approved by the Plan Administrator before the dependent is eligible for coverage. **You must provide eligibility documentation in the Company's online enrollment system no later than 30 days after you have a newly eligible dependent.** Failure to provide required dependent verification documents in 30 days or less may result in denial of your dependent coverage. You are required to notify the Plan Administrator or Horizon Solution Center when your dependent no longer meets the eligibility requirements above.

When you enroll a dependent in the Program, you represent that the individual is eligible under the terms of the Program and that you will provide evidence of eligibility. Your failure to provide the required evidence of eligibility will be considered fraud and material misrepresentation and will result in disenrollment of the dependent, which may be retroactive to the date the dependent became ineligible for coverage. In addition to being considered fraud on the Plan and an intentional misrepresentation, enrolling ineligible dependents or maintaining coverage for a person who no longer satisfies the dependent eligibility rules violates Company policy. If the Employer determines that an ineligible dependent has been enrolled or coverage has been maintained for a person who does not satisfy the dependent eligibility rules, coverage may be canceled retroactively for your ineligible dependent and may be canceled prospectively for you and other dependents. The Company reserves the right to recover any and all benefit payments made for services received by ineligible dependents.

If you are planning on retiring, please contact the Horizon Solution Center for eligibility and cost of coverage for retiree medical, prescription drug and vision benefits. Retiree health care coverage does not include dental benefits. If you are eligible and choose coverage under the retiree medical benefits program, you waive your rights to COBRA continuation coverage.

ENROLLMENT

In order to enroll in any of the Programs (or make changes to your enrollment), you must make your elections and enter information on your dependents by logging into the Company's online enrollment system. Separate elections are needed for the Medical and Prescription Drug Program and the Dental and Vision Program. Please contact the Horizon Solution Center if you need assistance.

INITIAL ENROLLMENT

You can enroll in the Program within 30 days before or after your benefits eligibility date⁶. Generally, medical, prescription drug, dental and vision coverage for you and your dependents will begin on your benefits eligibility date. Elections made within the 30 days after your benefits eligibility date cannot be changed. **If you do not enroll within 30 days before or after your benefits eligibility date, you must wait until the Plan's next annual open enrollment unless you experience a special enrollment event or mid-year election change event (described below).**

Premium Payment Program. Generally, if you enroll in a Program providing health care coverage, such as medical, dental or vision, you will automatically be enrolled in the Premium Payment Program and your contributions toward such benefits will be deducted from your pay on a pre-tax basis to the extent permissible by law.

New Employees and Newly Eligible Employees

If you are a new employee or are a newly eligible employee, then upon your timely enrollment (described above), coverage for you and your eligible dependents starts on your benefits eligibility date. Required contributions for your elections will be deducted from your paycheck beginning with the pay period in which you become eligible for coverage if you elect coverage prior to your benefits eligibility date. If you enroll within the 30 days after your benefits eligibility date, any required contributions for your elections which are in arrears will be deducted in full from your next paycheck or until all late contribution payments are paid in full unless you

⁶ "Benefits eligibility date" is the day the waiting period has been met, and you and your eligible dependents are eligible for coverage. For employees transferring to an Employer from the Company or a subsidiary or transferring into this covered class, this is the date they are eligible for coverage. For full-time eligible employees, this is the date you are determined to be eligible for benefits based on meeting the hour requirement during the measurement period.

contact the Horizon Solution Center to set up other arrangements. Such late contribution payments will be deducted in addition to your regular required contributions for the then current pay period.

Part-time Employees

If it is determined that you are a full-time eligible employee after your initial measurement period, you will be eligible for benefits at the end of the measurement period for the remainder of the calendar year. You must make your elections within 30 days after your benefits eligibility date, your coverage starts on your benefits eligibility date. If it is determined that you are a full-time eligible employee after the standard measurement period, you will be eligible for benefits on January 1st of the next calendar year and can make elections during annual enrollment for the next calendar year.

Intercompany Transferring Employees

If you transfer between the Participating Employers covered under this Program, your current coverage will automatically continue. If you transfer from a bargaining unit covered under another Company-sponsored welfare plan, your prior service⁷ as a bargaining unit team member of the Company or its wholly-owned subsidiaries is applied toward the waiting period. If you have 30 days of service with the Company or subsidiary prior to transferring, your benefits eligibility date will be your transfer date and you will have 30 days to enroll in the Program. Upon your timely enrollment (described above), coverage for you and your eligible dependents starts on your benefits eligibility date.

ANNUAL OPEN ENROLLMENT

If you did not enroll in the Program during your initial enrollment opportunity, you have an opportunity to enroll (if eligible) and/or make changes to your benefit elections during the Program's annual open enrollment period held each year in the Fall, for coverage effective on January 1 of the next calendar year. **Once the annual open enrollment period ends, you may not make any changes until the next annual open enrollment, unless you experience a special enrollment event or mid-year election change event (described below).**

If you are enrolled in the Program at the time of open enrollment and you fail to make changes to your elections, your current elections will automatically carry over to the following year.

SPECIAL ENROLLMENT PERIOD

Special enrollment periods are periods when an eligible employee or dependent may enroll in the health plan under certain circumstances **after they were first eligible for coverage**. You may enroll yourself and/or eligible dependents or revoke any existing enrollment election in the Program at a time during the year if you or your eligible dependent experiences a special enrollment event or a permitted mid-year election change event. **You must initiate and complete a mid-year election change event in the Company's online enrollment system no later than 60 days after you or your dependents experience the triggering special enrollment event.** Failure to initiate the event no later than 60 days after the event will result in denial of your special enrollment change request. You may be required to certify or otherwise provide documentation establishing the special enrollment event or permitted election change event. Failure to provide such certification or documentation within 30 days after you initiate the mid-year special enrollment event will result in denial of a requested change. Coverage will be effective the date you initiated a special enrollment event in the Company's online enrollment system. If you are enrolling in coverage due to a birth, adoption, or placement of a child with you for adoption, coverage for the newly enrolled will be effective retroactively to the date of the event, if it is reported no more than 60 days from the date of the event.

A **special enrollment event** occurs if:

- you and/or your eligible dependents lose minimum essential coverage (does not include loss due to failure to pay premiums) due to exhaustion of COBRA coverage under another group health plan, due to loss of eligibility for other employer-sponsored coverage due to divorce, legal separation, death, termination of employment or reduction in the number of hours of employment or termination of another employer's contributions to the other coverage, or loss of dependent child status.

⁷ "Service" for purposes of this Plan refers to the period of time during which you are continuously employed part-time or full-time at your Employer. Employment by a temporary service while physically working full-time at your Employer's location will be included as service if you are employed by your Employer immediately following such service.

- you and/or your eligible dependents decline coverage because you, your spouse/domestic partner or your dependent had other coverage; and the loss of other coverage is not due to a failure to pay premiums or termination for cause, such as making fraudulent claims or intentional misrepresentation.
- you gain a new dependent through marriage, birth, adoption or placement of a child with you for adoption.
- you or your dependents lose Medicaid or coverage under the Children's Health Insurance Plan (CHIP) due to no longer being eligible for such coverage, or you or your dependents become eligible for a state's premium assistance program under Medicaid or CHIP.

Example: Daniel is hired on July 10, 2026. He is eligible to participate in the program on August 9, 2026. Daniel enrolls in the Program on August 1, 2026. His coverage is effective as of August 9, 2026. The annual open enrollment for coverage for 2027 was held from November 1, 2026 through November 16, 2026. However, Daniel forgot to make his election changes online. The elections that Daniel made on August 1, 2026 for health care coverage from August 9, 2026 through December 31, 2026, will carry over for the same health care coverage from January 1, 2027 through December 31, 2027. He will not be able to make any additional changes until the annual open enrollment in the Fall of 2027 for coverage in 2028, unless he becomes eligible for a permitted mid-year election change event.

Note: Your enrollment in the Flexible Spending Program (health savings account and flexible spending accounts) must be made each year and does not automatically carry-over from year to year. Please see the Flexible Spending Program Summary Plan Description for more information on these tax-advantaged accounts.

MID-YEAR ELECTION CHANGES

Your benefit elections are subject to IRS regulations that limit your ability to enroll or change your benefit elections during the year. Generally, once you make your pre-tax elections at initial or open enrollment, those elections are in effect for the remainder of the year. Changes to coverage due to a permitted mid-year election change will be effective as of the date you entered your permitted mid-year election change event in the online enrollment system. However, if you are making a change due to the event of birth, adoption, or placement of a child with you for adoption, the new election will be effective the date of the event if it is reported no more than 60 days from the date of the event. If you request to enroll the dependent child more than 60 days after the birth, adoption, or placement of a child with you for adoption or for foster care, the child's coverage will be effective as of the date you initiated your mid-year event in the Company's online enrollment system as long as the pre-tax contribution amount remains the same. If your cost of coverage changes as a result of your permitted mid-year election change, the Company will automatically increase or decrease your weekly pre-tax contributions. You must initiate a mid-year election change within 60 days from the date of the event through the Company's online enrollment system. Please contact the Horizon Solution Center if you need assistance.

A permitted mid-year election change must adhere to the Consistency Rule described in the *Consistency Rule* section below. Mid-year election change events require you to submit substantiating documents within 30 days of the date you initiated the event. If you fail to provide required documentation, your mid-year election change event will be denied.

As described below in more detail, if you choose not to enroll in the Program when you are first eligible, you must wait until the next annual open enrollment period for another opportunity to enroll, unless you satisfy the mid-year election change rules described in this section.

PERMITTED MID-YEAR ELECTION CHANGE EVENTS

A **permitted mid-year election change event** occurs if you or one of your eligible dependents experience a change listed below:

- **Change in Status Events** – The following are change in status events:
 - **Marital Status:** Your legal marital status changes for reasons such as marriage, divorce, annulment or death of a spouse.
 - **Dependents:** Your number of eligible dependents changes for reasons such as a birth, adoption, placement of a child with you for adoption, or death of a dependent.
 - **Employment Status:** You or your dependent experience a change in employment status, including:
 - termination or commencement of employment;
 - commencement or return from an unpaid leave (only after benefits have expired);
 - a change in worksite that affects benefit eligibility;
 - a change from part-time to full-time employment or vice versa (subject to the Consistency Rule); or
 - any other change in employment status that affects benefit eligibility.
 - **Change in Dependent Status:** Your dependent satisfies or ceases to satisfy the eligibility requirements of dependents.
 - **Residence:** You or your dependent change residence and such change affects eligibility (i.e. you move to or from the United States).
- **Change in Coverage Under Another Employer Plan.** If you or your dependent is entitled to make a change to coverage under another employer plan due to a permitted election change or during the plan's annual open enrollment period, if different from the Employer's annual open enrollment period, you may make a permitted election change that is on account of and corresponds with the change in coverage.
- **Significant Change in Cost of Coverage.** You experience a significant change in the cost of coverage under the Program, as determined in the sole discretion of your Employer. If the change is a significant decrease in cost, you can enroll for coverage or increase a coverage level by adding eligible dependents. If the change is a significant increase in cost, you can elect coverage under another benefit option offered by your Employer providing similar coverage or, if no other benefit option providing similar coverage is available, cancel coverage.
- **Overall Reduction in Benefits.** You experience a significant overall reduction or termination of benefits provided under the Program, as determined in the sole discretion of your Employer. In general, a significant overall reduction includes a significant increase in the deductible, copay, or out-of-pocket maximum, but does not include your provider ceasing to be a preferred or in-network provider.
- **Significant Reduction in Coverage.** Your coverage is significantly reduced or limited causing you to lose coverage, as determined in the sole discretion of your Employer. In general, a significant reduction in coverage includes elimination of a benefit option you elected or that option is no longer available to you, as well as a substantial reduction in providers available under your elected benefit option such as a major hospital ceasing to be a member of the network.
- **Judgment, Decree or Order.** If you have a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (such as a Qualified Medical Child Support Order) that requires health care coverage for your child or for your foster child, you may change your election to add or drop coverage consistent with the order. Coverage may be dropped for a child if an order requires another person (e.g., a spouse or former spouse) to cover the child.

The following documents may be required for a Permitted Mid-Year Election Change:

- Marriage certificate
- Death certificate
- Divorce decree
- Birth certificate
- Court orders
- Loss of coverage letter
- Passport
- Visa
- Social Security Card
- Declaration forms
- Tax forms

It is not considered a significant change if your weekly contribution increases or decreases as a result of being subject to a different rate schedule or compensation tier when making an inter-company transfer of employment.

If the court order ends, this does not qualify as an event to remove dependents from coverage. You must wait until the next annual open enrollment period to make changes to your dependents.

- **Addition of Benefit Options.** The Employer adds a benefit package option or coverage option under the Program that affects you.
- **Medicare Eligibility.** You or your dependent gain or lose eligibility for Medicare or Medicaid (this event does not apply to other state benefit plans).

CONSISTENCY RULE

Election changes must be consistent with a Change in Status Event (described above). This means that the election change must be on account of and correspond with the event. For example, if a dependent ceases to be an eligible dependent, the change in coverage must only apply to that dependent and you are not able to make changes to other covered dependents. This is called the consistency rule.

Limitations and exceptions to the consistency rule:

- **Changes Due to Loss of Dependent Eligibility.** If the event is divorce, annulment, death of a dependent, or a dependent ceasing to satisfy the eligibility requirements and you are enrolled in the Program, you may only cancel the coverage for that particular dependent. Coverage may not be cancelled for you or any other covered dependent, unless some other permitted election change applies.
- **Gaining Eligibility Under Another Employer Plan.** If, due to a change in marital status or employment status, you or your dependent become eligible for coverage under a plan sponsored by your dependent's employer, you may decrease or cancel coverage for yourself and/or your dependent as long as a corresponding election to add or increase coverage is made under the other employer's plan.
- **Tag Along Rule.** If, due to a Change in Status Event, you elect to increase coverage, at that time you may enroll your eligible dependent(s) who were not previously covered (regardless of whether they experienced the event).
- **Special Consistency Rules.** In addition to these rules, there are additional special consistency rules that apply to some of the permitted election change events. Contact the Horizon Solution Center if you have questions regarding a change you wish to make to your enrollment election.

AUTOMATIC ELECTION CHANGE EVENTS

Certain events will automatically change your enrollment elections. You do not need to do anything in these cases:

- **Loss of Eligibility.** Your benefit elections will be terminated as of the day in which you terminate employment or lose eligibility.
- **A Change in Cost of Coverage.** If your share of the cost of coverage increases or decreases, your pre-tax payment for the coverage elected will automatically be increased or decreased, as appropriate, to equal the entire cost to you for such coverage.
- **Court Mandated Coverage.** If you are an eligible employee, and you are required by a Qualified Medical Child Support Order ("QMCSO") to provide coverage for a child, you will be enrolled in the Program as specified in the QMCSO and you will automatically be enrolled in the Program at the applicable coverage level necessary to provide such coverage. You will be responsible for the premium payments applicable to such coverage.

Example: Sarah is currently covered in the Medical and Prescription Drug Program and has “employee only” coverage. On March 1, she has a child placed with her for adoption. Sarah takes a leave of absence and forgets to initiate a change for additional coverage in the Company’s online enrollment system until June 1. Sarah needs to change her coverage level from “employee only” to “employee + children”. Because her initiation is more than 60 days after her life event, she will need to wait until the next open enrollment to change her coverage level and add her dependent.

David and his spouse and child are currently covered in the Medical and Prescription Drug Program and has “employee + family” coverage. On March 1, David has a child born. David forgets to initiate a change for additional coverage in the Company’s online enrollment system until June 1. Because he does not need to change his coverage level (he already has family coverage), the effective date of coverage for the child will be

CONTRIBUTIONS FOR COVERAGE

The Program’s contributions are made up of employer and employee contributions. The amount employees contribute towards medical and prescription drug coverage and dental and vision coverage are determined from time to time by the Plan Sponsor. Generally, contributions are reviewed and set annually by the Company’s Employee Benefits Committee. The Company has the authority and discretion to increase or decrease employee contributions as determined by the Employee Benefits Committee at any time.

You will receive notice each October advising you of the contribution rates for the next calendar year. You pay your weekly contribution on a pre-tax basis through automatic payroll deduction. Any required contributions for your elections which are in arrears will be deducted in full from your next paycheck or until all late contribution payments are paid in full, unless you contact the Horizon Solution Center **on the day you return to work** to set up other arrangements. Such late contribution payments will be deducted in addition to your regular required contributions for the then current pay period. Please refer to the *PARTICIPATING EMPLOYERS* section of this SPD for a description of which rate schedule you will receive.

If your weekly contribution rate is determined based on your salary, the amount you pay will be based on your annual base salary and the coverage level appropriate for you and your dependents enrolled in coverage. Your annual base salary is determined by taking your weekly salary x 52 weeks (if you are paid hourly, your earnings are calculated by multiplying your hourly rate x 40 hours x 52 weeks). The calculation will be calculated as of the beginning of October each year.

TERMINATION OF YOUR COVERAGE

TERMINATION EVENTS

Coverage ends on the earliest of the following dates:

1. **For you and your dependents**, the date on which the Program terminates.
2. **For you and your dependents**, the date on which:
 - (a) Required payment for coverage is not received when due.
 - (b) You are no longer eligible.
 - (c) If the Company terminates the Program or amends the Program so that you no longer meet the eligibility requirements.
 - (d) You enter military service for duty lasting 31 or more calendar days.
 - (e) You are no longer covered under the continuation of benefits provision.
 - (f) You enroll ineligible dependents, allow dependents who lose eligibility to continue to participate in the Program, submit a false claim or otherwise make a misrepresentation to the Program, an insurer, a Claims Administrator, or the Employer. **Note that in addition to losing coverage for yourself and your dependents, such actions are considered fraud or an intentional misrepresentation. Coverage may be cancelled retroactive to the time of misrepresentation.**
 - (g) You do not actively work for a combined total of 26 weeks during the previous 12 month rolling period and are not on a protected leave of absence.
 - (h) Coverage would have been effective had you not failed to submit documents within 30 days after initiating coverage on the Company’s online enrollment system.
3. **For your spouse** (in addition to the above), the date your spouse is no longer eligible for coverage. This is the date on which:

- (a) You and your spouse divorce or legally separate. Your spouse loses coverage upon divorce even if a court issues an order requiring you to maintain coverage for your former spouse. You can maintain coverage after divorce for an ex-spouse for a limited period of time by electing COBRA.
 - (b) Your spouse becomes covered under a health care program sponsored by the Employer as an active or retired employee.
4. **For your domestic partner** (in addition to the above), the date your domestic partner is no longer eligible for coverage. This is the date on which:
- (a) You and your domestic partner no longer meet the domestic partner eligibility requirements (you should file an Affidavit of Termination of Domestic Partnership form with the Plan Administrator).
 - (b) Your domestic partner becomes covered under a health care program sponsored by the Employer as an active or retired employee.
5. **For a child** (in addition to the above), the date the child is no longer eligible for coverage. This is the date on which:
- (a) A covered stepchild is no longer eligible because you and your spouse divorce, legally separate or your spouse dies.
 - (b) A covered child of your domestic partner is no longer eligible because you and your domestic partner no longer meet the domestic partner eligibility requirements.
 - (c) A covered child reaches the dependent-child age limit. Coverage for a child reaching the child age limit will terminate on the last day of the month in which the child reaches the limiting age. (i.e. if the child's date of birth is January 5, coverage will end on January 31.)
 - (d) A covered disabled dependent is no longer eligible.
 - (e) A covered child becomes covered as an employee under a plan sponsored by the Employer.
6. **For you and your dependents**, if you are retiring and are eligible for the Company's retiree health care plan coverage ends on the last day of the month in which you terminate employment. For retiring employees who are not eligible for retiree health care coverage, coverage ends on the date of termination of employment. *(If you plan on retiring, please contact the Horizon Solution Center.)*

RESCISSION OF COVERAGE

A rescission is a discontinuation of coverage with retroactive effect that results from an individual or a person seeking coverage on behalf of an individual committing fraud or making an intentional misrepresentation of material fact, as prohibited by the terms of the Program. It is considered fraud on the Program and an intentional misrepresentation of material fact that is prohibited by the terms of the Program to enroll an ineligible dependent, maintain coverage for a person who no longer satisfies the dependent eligibility rules, fail to provide evidence of eligibility for your enrolled dependent(s) or submit false statements relating to participation in the Program.

Not all retroactive terminations of coverage are rescissions. Rescissions, for example, do not include retroactive cancellations of coverage for failure to pay required premiums or contributions toward the cost of coverage on time. A prospective cancellation of coverage is not a rescission. If your coverage is going to be rescinded, you will receive written notice 30 days before the coverage will be cancelled. A rescission will be considered a claim denial that you may appeal as described in the claim procedures for the affected health plan.

CONTINUATION OF COVERAGE

DEATH OF AN ACTIVE EMPLOYEE

In the event of your death, coverage under this Program for your eligible dependents who are then currently enrolled in the Program will continue until the end of the month following the month of death. However, if your date of death is on the first day of the month, then coverage ends on the last day of the same month. (For example, if your date of death is May 8, coverage for your dependents will continue until June 30. If your date of death is August 1, coverage for your dependents will continue until August 31.) No premiums will be due from your dependents for coverage during this period of time.

After this period, coverage may be continued for your eligible dependents (for no later than six (6) months following your death) under the active employee contribution rate schedule on a self-pay basis. If eligible dependents are not covered under this Program at the time of the death of an active employee, the dependents

will not be eligible nor offered continuation of coverage under this Program. Continuation coverage will terminate upon the earliest of the following:

- (a) six (6) months after the employee's death;
- (b) with respect to your child, the date such child ceases to meet the eligibility requirements;
- (c) with respect to your spouse, the date your spouse remarries;
- (d) with respect to your domestic partner, the date your domestic partner becomes a domestic partner or civil union partner with another person;
- (e) the date of termination of the Program or dependent coverage under the Program; or
- (f) the date required payment for coverage is not received when due.

If, at the time of your death you would have otherwise qualified for the Retiree Health Care Plan (if applicable), your eligible dependents may be eligible to continue coverage under the retiree program. *(Please contact the Horizon Solution Center for more information on retiree coverage and to see if retiree coverage may be applicable to you. Please note that different eligibility rules apply towards retiree coverage.)*

For purposes of calculating the deductible and out of pocket maximums for the Traditional Plan, the surviving spouse/domestic partner or, if there is no surviving spouse or domestic partner, then one of the surviving dependents, would be treated as the employee after the death of an active employee (refer to the Medical Program's *Benefit Overview* section within this SPD for deductible and out of pocket maximum information).

Any continuation of benefits described in this section runs concurrently with any rights under COBRA, after the first of the month following the death of an active employee (see the *COBRA Continuation Coverage* section). For example, if you are age 55 or older with less than 10 years of service, your eligible dependents may continue coverage for six (6) months following your death as described above. Those six (6) months of coverage count towards the 36 months that your dependents may elect under COBRA.

*In the event of your death, your eligible dependents may elect COBRA continuation coverage (see the COBRA Continuation Coverage section of this SPD). **Please be aware that any election of COBRA coverage for continued benefits under this Program will immediately and permanently disqualify that individual from eligibility for coverage under the Company's Retiree Health Care Plan (if eligible).** However, election of COBRA coverage for only the continuation of active dental and vision coverage under the Company's Dental and Vision Plan, will not disqualify you for medical coverage under the Retiree Health Care Plan, if eligible. Please contact the Horizon Solution Center for additional information on your continued coverage options.*

LAYOFFS, LEAVES AND TERMINATIONS

1. **Leaves of Absence** - Coverage for you and your eligible dependents may be continued for any combination of approved leave up to 26 weeks (182 calendar days) during any 12-month period (or as otherwise required by law).
2. **Permanent Layoff** –Coverage for you and your eligible dependents may be continued under the active employee contribution schedule until the end of the month in which the permanent layoff occurred. The Company will accrue the required employee contributions due for the benefits through the end of said month. The accrued contributions will be deducted from any monies due you.
3. **FMLA Leave** – Coverage for you and your eligible dependents will be continued during the period of time you are on family and/or medical leave under the Family and Medical Leave Act of 1993 ("FMLA"). Your contributions for coverage during any paid medical leave will be deducted from any Company payment made to you. Your contributions for coverage during any unpaid portion of the leave will be accrued and deducted from any monies due you. If you do not return to work (as defined by FMLA) from the FMLA leave, you will be required to pay the Company both the employer and employee cost of the coverage for the unpaid leave period. This payment will be deducted from any monies due you. You will be responsible to pay any amount remaining and unable to be deducted from monies due you. Upon your return to work from an unpaid leave, you may contact the Horizon Solution Center to set up a repayment arrangement for any payments that are in arrears. If you do not immediately contact the Horizon Solution Center the day you return, money due will be deducted entirely from your first paycheck and subsequent checks until the time

arrears are paid in full.

4. **Temp Layoff/Furlough** - Coverage for you and your eligible dependents may be continued for up to six months following the date in which the temporary layoff/furlough occurred. During this time, the Company will accrue the required employee contributions due for said benefits. The accrued contributions will be deducted from any monies due you.
5. **Terminations (voluntary or involuntary)** - Coverage terminates immediately upon your termination of employment.
6. **Military Leave** – For short-term military leaves of 30 days or less, coverage for you and your eligible dependents continues under the active employee contribution schedule for the period of the short-term military leave, and your accrued contributions will be deducted from any Company payment made to you. For long-term military leaves of 31 or more consecutive calendar days, your coverage terminates immediately upon induction into service. You have the right to elect to continue coverage for up to 24 months while in the military provided you pay 102% of the full premium. If you return to work within 90 days after completion of your military service, your coverage will be effective immediately provided you return to full-time employment and return to work in compliance with the Uniformed Service Employment and Re-employment Act (“USERRA”).

Please refer to the *COBRA Continuation Coverage* section of this SPD on situations that may be considered a qualifying event. COBRA coverage can become available to you and to other members of your family who are covered under the Program when you would otherwise lose your group coverage.

COBRA CONTINUATION COVERAGE

This section contains important information about your right to COBRA continuation coverage. COBRA continuation coverage is a temporary extension of coverage after you or your eligible dependents lose coverage in certain circumstances. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”). COBRA continuation coverage can become available to you and to your dependents who are covered under the Program when you or your dependents would otherwise lose health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your dependents and what you need to do to protect the right to receive it.

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

All written correspondence and premium payments should be sent to:

WEX Health, Inc.
P.O. Box 2079
Omaha, NE 68103-2079

Payment must be in the form of a check or money order made payable to WEX Health, Inc. (“WEX”). DO NOT send cash. Payments may also be made online at <https://cobralogin.wexhealth.com> or through the WEX COBRA mobile app. Please pay only the amount due. If overpayment is made and you continue your COBRA continuation coverage, the overpayment is applied to the next month's premium. To check the status of your payments or to confirm whether your COBRA coverage is active, log in to your online account at <https://cobralogin.wexhealth.com> or contact WEX at (866) 451-3399.

COBRA Eligibility

COBRA continuation coverage is a continuation of coverage under the Program when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Program is lost because of a qualifying event. [Note that while COBRA itself does not apply to domestic partners and the children of domestic partners, the Company has determined to provide continuation coverage similar to COBRA to domestic partners and the children of domestic partners.] Under the Program,

qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Employee. If you are an employee, you will become a “qualified beneficiary” if you lose coverage under the Program because either one of the following “qualifying events” occur:

- Your hours of employment are reduced.
- Your employment ends for any reason other than your gross misconduct.
- Your leave of absence exceeds 26 weeks except as necessary to comply with Family Medical Leave Act and other legally mandated leaves as applicable.

Spouse/Domestic Partner. If you are the spouse or domestic partner of an employee, you will become a “qualified beneficiary” if you lose coverage under the Program because any of the following “qualifying events” occur:

- Your spouse or domestic partner dies.
- Your spouse’s or domestic partner’s hours of employment are reduced.
- Your spouse’s or domestic partner’s employment ends for reason other than gross misconduct.
- You become divorced or legally separated from your spouse, or you or the employee terminates your domestic partnership relationship. (Also, if an employee eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the administrator within 60 days after the later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)
- Your spouse or domestic partner becomes entitled to Medicare benefits (under Part A, Part B, or both).

Dependent Children. Your dependent children, including your domestic partner’s children, and children participating under a qualified medical child support order (“QMCSO”) will become qualified beneficiaries if they lose coverage under the Program because any of the following qualifying events occur:

- Parent-employee dies.
- Parent-employee’s hours of employment are reduced.
- Parent-employee’s employment ends for any reason other than gross misconduct.
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both).
- Parents become divorced or legally separated.
- Child stops being eligible for coverage under the Program.

Notification of COBRA Continuation Coverage Election

The Program will offer COBRA continuation coverage to qualified beneficiaries only after WEX has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or commencement of a proceeding in bankruptcy with respect to the Company or a Participating Employer, then the Company or Participating Employer will notify WEX of the qualifying event.

You Must Give Notice of Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage), you or your dependents must notify WEX **within 60 days** after the qualifying event occurs; except that you must notify WEX **within 30 days after a domestic partnership terminates**. If you do not notify WEX on time, your spouse/domestic partner or dependent child who loses coverage will not be offered the option to elect COBRA continuation coverage.

How is COBRA Coverage Provided?

Once WEX or the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. For each qualified beneficiary who timely elects COBRA continuation coverage, COBRA continuation coverage will begin the first of the month following the qualifying event. If you or your spouse/domestic partner and dependent children do not elect continuation

coverage within this 60-day election period, you will lose your right to elect continuation coverage.

What is the Length of COBRA Continuation Coverage?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, divorce or legal separation or a dependent child losing eligibility, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for up to 18 months. The 18-month period of COBRA continuation coverage may be extended, as described below.

Disability Extension of 18-Month Period of Continuation Coverage

If qualified beneficiary is determined to be disabled by the Social Security Administration and you notify WEX on time, qualified beneficiaries may get up to an additional 11 months of coverage (totaling 29 months). The disability must start before the 61st day after your employment ends or hours are reduced and last until the end of the 18-month period. You must notify WEX in writing within 60 days of (i) the Social Security Administration's determination, (ii) the qualifying event or (iii) loss of coverage, whichever is later, and before the end of the 18-month period.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If another qualifying event occurs while receiving the 18 or 29 months of COBRA coverage, your spouse and dependent children can get up to 18 more months of coverage (totaling 36 months). This applies if the employee/former employee dies, becomes eligible for Medicare (under Part A, Part B, or both), gets divorced or legally separated, or if a dependent child who is a qualified beneficiary loses eligibility. The extension is only available if the second event would have caused a loss of coverage had the first event not occurred. You must notify WEX in writing within 60 days of the second qualifying event. If you don't, the extension will not be granted.

Election of COBRA Continuation Coverage (or extension of coverage)

To elect COBRA continuation coverage (or an extension of coverage), you must make such election (1) through the member portal at <https://cobralogin.wexhealth.com>, (2) through the WEX COBRA mobile app, or (3) by completing an election form and submitting it to WEX in accordance with the directions on the form.

Each qualified beneficiary has a separate right to elect COBRA continuation coverage. For example, the employee's spouse may elect COBRA continuation coverage even if the employee does not. COBRA continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect COBRA continuation coverage on behalf of any dependent children. The employee or the employee's spouse can elect COBRA continuation coverage on behalf of all the qualified beneficiaries.

A qualified beneficiary must elect coverage in writing within **60 days** of the later of the date coverage is lost because of a qualifying event or the date a COBRA election notice is provided. To elect coverage, you must use the election form provided by WEX and follow the procedures specified on the election form. Any extension of coverage based on disability must be made within 60 days of (i) the Social Security Administration's determination, (ii) the qualifying event or (iii) loss of coverage, whichever is later, and before the end of the 18-month period. Any extensions of coverage based on a second qualifying event must be made within 60 days of the second qualifying event. **If coverage is not elected within the 60-day period, the right to elect continuation coverage will be lost.**

What to Consider in Deciding Whether to Elect COBRA Continuation Coverage

If you experience a qualifying event, in considering whether to elect COBRA continuation coverage, you should consider that a failure to continue your group health coverage will affect your future rights under federal law. You should also consider that you have Special Enrollment rights under federal law. You have the right to request Special Enrollment in certain group health plans for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event. If you elect COBRA, you will also have the same Special Enrollment right at the end of COBRA continuation coverage but you must remain covered under COBRA continuation coverage for the maximum time available to you.

You may find cheaper coverage the Health Insurance Marketplace, which offers ways to compare private health

insurance options. In the Marketplace, you could be eligible for a tax credits and cost-sharing reductions that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace. You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage. To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

If you elect COBRA coverage for continued benefits under this Program, it will immediately and permanently disqualify you from eligibility for coverage under the Company's Retiree Health Care Plan (if eligible).

COBRA Continuation Coverage and Medicare

In general, if you are eligible for Medicare, you should keep in mind that if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period⁸ to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

Cost of COBRA Continuation Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of COBRA continuation coverage.

⁸ <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>.

The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage.

Payment for COBRA Continuation Coverage

First payment for COBRA continuation coverage. If you elect COBRA continuation coverage, you do not have to send any payment with the COBRA continuation coverage election form. However, you must make your first payment for COBRA continuation coverage no later than 45 days after the date of your election. (This is the date the election form is postmarked, if mailed.) If you do not make your first payment for COBRA continuation coverage in full no later than 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Program. You are responsible for making sure that the amount of your first payment is correct. You may contact WEX at 866-451-3399 to confirm the correct amount of your first payment.

Your first payment for COBRA continuation coverage should be sent to WEX at the address listed at the beginning of this *COBRA Continuation Coverage* section.

Note: Although you are not required to make your first COBRA payment until the end of the 45-day period described above, your coverage will not be reinstated until your payment is received.

Monthly payments for COBRA continuation coverage. After you make your first payment for COBRA continuation coverage, you will be required to make payments for each subsequent month of coverage. Under the Program, these monthly payments for COBRA continuation coverage are due on the first of each month. If you make a monthly payment on or before the first day of the month to which it applies, your coverage under the Program will continue for that month without any break. The Program intends to send periodic notices of payments due each month; however, you are responsible for all payments, regardless of whether you receive any notice that payment is due.

Grace periods for monthly payments. Although monthly payments are due on the first of each month, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. The grace period does not apply for purposes of your first payment as discussed above. However, if you pay a monthly payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the month, your coverage under the plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA continuation coverage under the Program. Payments postmarked after the grace period are late and will not be accepted and coverage will be terminated and you will have no further rights to COBRA continuation coverage.

Termination of COBRA Continuation Coverage Before the End of the Maximum Coverage Period

COBRA continuation coverage will be terminated before the end of the maximum period if (i) any required premium is not paid on time, (ii) after electing COBRA continuation coverage a qualified beneficiary becomes covered under another group health plan (iii) after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare or (iv) the Company ceases to provide any group health plan for its employees. COBRA continuation coverage may also be terminated for any reason the Program would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

If You Have Questions

If you have questions about your COBRA continuation coverage, you can contact WEX at 866-451-3399, the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect you and your family's rights, you should keep your Employer, the Plan Administrator and WEX informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to or receive from WEX and the Plan Administrator.

GENERAL EXCLUSIONS

Certain types of expenses will be listed as excluded from coverage as the various types of benefits are explained in this SPD.

1. Expenses that can be compensated under any workers' compensation law, occupational disease law or similar legislation. If a medical and/or prescription drug claim is paid under the Program and, at a later date, it is determined that the injury or disease was work-related and medical and/or prescription drug benefits have been paid under any workers' compensation law, occupational disease law, or similar legislation, the employee will reimburse the Company. The reimbursement will either be made directly, or by appropriate offset from other future compensation.
2. The portion of any charge for covered expenses that are considered in excess of the usual and prevailing charge for the locality where the service or procedure was performed.
3. Expenses incurred prior to the date the person became covered by the Program and expenses incurred after termination of coverage under the Program.
4. Services or supplies (a) furnished by or for the United States government or any other government, unless payment of the charge is required by law, or (b) to the extent that the service or supply, or any benefit for the charge, is provided by any law or governmental plan under which the patient is or could be covered. Provision (b) above does not apply to any state plan under Medicaid or other plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.
5. Expenses incurred in connection with an injury or disease resulting from war or any act of war occurring while covered under the Program.
6. Services for injuries incurred at any time throughout the course of commission of a felony, unless the services are related to an act of domestic violence or the felonious act is related to a physical or mental health condition.
7. Expenses incurred as a result of injuries from professional sport participation (auto or cycle racing, rodeoing, etc.).
8. All claims submitted one (1) year or more after date of service.
9. Expenses incurred that do not meet the "time period" requirement (exact date to exact date) as specified under the benefits.

GENERAL LIMITATIONS

To be covered, all services:

1. Must be received from or provided under the order, direction and approval of an eligible provider. Services received from other than an eligible provider are not covered unless specifically indicated herein;
2. Must be medically necessary and not primarily educational in nature or for the vocation, comfort, convenience, appearance or recreation of the member;
3. Will be subject to the exclusions and limitations set forth in any of the *General Exclusions* sections and elsewhere in this SPD; and
4. Will be subject to all copayment and coinsurance amounts and deductibles as stated.

Providers are not authorized to determine which services are covered under the Program. As a result, not all services or treatments that may be prescribed or recommended by providers are necessarily covered under the Program. You are encouraged to call the Program's Claims Administrators to find out whether certain services are covered. If you receive a non-covered service, you will be responsible for the bill.

ADMINISTRATIVE REQUESTS FOR ELIGIBILITY AND ENROLLMENT

If you contact the Horizon Solution Center with an enrollment or eligibility request and the Horizon Solution Center determines that your requested change cannot be made, you will then have the opportunity to submit a written administrative request. If your claim relating to eligibility involves a rescission (defined as a retroactive loss of coverage) under a health plan that is subject to health care reform, the claim will be treated as an ERISA claim for benefits. The claims procedures in the affected health plan, not this section, will apply to such a claim. Additionally, if your claim related to eligibility or enrollment also relates to a claim for benefits under the Program, the claims procedures in the affected health plan will apply.

FILING AN ADMINISTRATIVE REQUEST

Filing a Request. If you wish to file an administrative request, you must submit a written request to the Horizon Solution Center. Your request should include your name, a detailed description of the issue (including important dates, summaries of conversations, etc.), and any documentation you would like taken under consideration. Your request should be mailed, emailed or faxed to:

Hormel Foods Corporation
Attn: Horizon Solution Center
1 Hormel Place
Austin, MN 55912
Fax: 1-507-437-9810
Email: hresolutioncenter@hormel.com

Time for Filing a Request. Your request must be received by the Horizon Solution Center within 30 days of the date you were advised that your requested change cannot be made, or, if later, within 60 days from the date of your change in status or special enrollment event.

Decision. The Director of Employee Benefits will have 30 days to decide your request and to notify you if your claim is denied in whole or in part. You may be notified that an extension of up to 30 days is needed to decide your request. If the extension is required because you need to provide additional information in order for your request to be decided, you will be given 30 days to provide that information. The time it takes you to provide that information will not count against the time the Director of Employee Benefits has to make the decision.

APPEALS

Filing an Appeal. If you disagree with the decision and wish to file an appeal, you must submit a written appeal to the Employee Benefits Committee within 30 days after the date you received notice that your administrative request was denied. Your appeal should include your name and any new or additional information not provided in your original administrative request. Your appeal should be mailed, emailed or faxed to:

Hormel Foods Corporation
Attn: Employee Benefits Committee
1 Hormel Place
Austin, MN 55912
Fax: 1-507-437-9810
Email: hresolutioncenter@hormel.com

Claim Decision. The Employee Benefits Committee has 30 days to decide and to notify you of that decision. The Employee Benefits Committee's decision is final and binding on all parties.

GENERAL RULES

Your casual inquiries and questions will not be treated as requests or appeals. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to any denied claim.

Authority. The Plan Administrator has delegated discretion, authority and responsibility to interpret and construe the Program and to determine all factual and legal questions under the Program with respect to all claims relating to eligibility, enrollment and plan administrative matters. The Director of Employee Benefits has authority and responsibility for deciding all administrative requests relating to eligibility, enrollment and plan administrative matters. The Employee Benefits Committee has the sole authority and responsibility to

make final determinations on all appeals relating to eligibility, enrollment and plan administrative matters.

The authority of the Director of Employee Benefits and the Employee Benefits Committee includes interpreting and construing the Program and any ambiguous or unclear terms. The Director of Employee Benefits and the Employee Benefits Committee may rely on any applicable statute of limitations as a basis to deny a claim or appeal. The Employee Benefits Committee's decisions are conclusive and binding on all persons having or claiming to have any interest or right under the Program.

Exhaustion of Administrative Remedies. Exhaustion of the claim and review procedure is mandatory for resolving every claim and dispute under the Program. In addition, in any legal action brought after you have exhausted administrative remedies, all determinations made by the Employee Benefits Committee shall be afforded the maximum deference permitted by law.

COORDINATION OF BENEFITS

Members of a family are frequently covered under more than one group plan providing benefits or have claims paid as a result of other insurance. Most health plans, including the medical, dental and vision benefits under this Program, contain a coordination of benefits (COB) provision to help maximize coverage and prevent duplicate payments. The COB provision is used when you, your spouse, or your covered dependents received a health care service and had active benefits under more than one plan at the time of that service. Please contact the Programs Claims Administrator for complete coordination of benefit rules.

Generally, when you have health care coverage under more than one plan, benefits will be coordinated. The "Order of Benefits Rules" determines which plan provides benefits first. Your benefits under this plan are not reduced if the rules require this plan to pay first. Your benefits under this plan may be reduced if another plan pays first.

Coordination of benefits is to ensure that your covered expenses will be processed, while ensuring that the claim charges are not overpaid. If you receive funds to pay a provider directly, and you receive more funds than you should have, you will be expected to repay any overpayment.

Definitions

These definitions apply only to this section.

1. "Plan" is any of the following that provides benefits or services for, or because of, medical or dental care or treatment:
 - a. group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, individual practice coverage, and group coverage other than school accident-type coverage;
 - b. coverage under a government plan or one required or provided by law; or
 - c. individual coverage.

"Plan" does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). "Plan" does not include any benefits that, by law, are excess to any private or other nongovernmental program.

"Plan" does not include hospital indemnity, specified accident, specified disease, or limited benefit insurance policies.

Each contract or other arrangement for coverage is a separate plan. Also, if an arrangement has two (2) parts and this section applies only to one (1) part, each of the parts is a separate plan.

2. "This plan" means the part of the plan document that provides health care benefits.
3. "Primary plan/secondary plan" means the Order of Benefits Rules establishing whether this plan is the primary plan or secondary plan when compared to the other plan covering the person.

When this plan is a primary plan, its benefits are determined before any other plan and without considering the other plan's benefits. When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

When you are covered under more than two (2) plans, this plan may be a primary plan as to some plans, and may be a secondary plan as to other plans.

4. "Allowable expense" means the necessary, reasonable, and customary item of expense for health care,

covered at least in part by one (1) or more plans covering the person making the claim. "Allowable expense" does not include an item of expense that exceeds benefits that are limited by statute or this plan. "Allowable expense" does not include outpatient prescription drugs, except those eligible under Medicare.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an allowable expense and a benefit paid.

5. "Claim determination period" means a calendar year. However, it does not include any part of a year the person is not covered under this plan, or any part of a year before the date this section takes effect.

Order of Benefits Rules

This plan uses the following rules to establish which plan is the primary plan:

You and Your Dependents

1. When your other plan does not include order of benefit rules, then that plan is the primary plan.
2. The plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) is the primary plan over the plan that covers the member as a dependent.

Dependent Children

1. Birthday Rule
 - a. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan.
 - b. If both parents have the same birthday, the plan that covered the parent longer is the primary plan.
2. Separated or Divorced Parents
 - a. The plan of the parent with custody of the child is the primary plan.
 - b. The plan of the spouse of the parent with custody is the secondary plan.
 - c. When a court decree specifies the parent who is financially responsible for the child's health care expenses, and the plan of that parent has actual knowledge of those terms, the plan of that parent is the primary plan. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree.

Other

The plan of an individual who is covered as an employee is the primary plan over the plan of an individual who is either laid-off or retired.

When the member who received care is covered under the No-Fault Automobile Insurance Act or similar law or traditional automobile "fault" type coverage, that coverage applies benefits first.

When none of these circumstances applies, the plan that has continuously covered the individual for the longest time is the primary plan.

Medicare and TRICARE

This plan will comply with the Medicare Secondary Payor (MSP) and TRICARE provisions of federal law to determine which plan is a primary plan and which is a secondary plan. Medicare or TRICARE will be primary and this plan will be secondary only to the extent permitted by MSP or TRICARE rules. When Medicare or TRICARE is the primary plan, this plan will coordinate benefits up to Medicare's or TRICARE's allowed amount.

Coordination of Benefits Specific to the Medical Program

When this section applies under the Healthy Savings Plan:

1. When the Order of Benefits Rules require this health plan to be a secondary plan, this part applies. Benefits of this health plan may be reduced.
2. Reduction in this plan's benefits may occur under circumstances such as the following:
 - a. The benefits that would be payable under this health plan without applying coordination of benefits are reduced by the benefits payable under the other plans for the expenses covered in whole or in part under this health plan. This applies whether or not claim is made under a plan.
 - b. When a plan provides benefits in the form of services, the reasonable cash value of each service rendered is considered both an expense incurred and a benefit payable.

When benefits of this health plan are reduced each benefit is reduced in proportion to any applicable benefit limit, such as the deductible, of this health plan.

When this section applies under the Traditional Plan:

1. When the Order of Benefits Rules require this health plan to be a secondary plan, this part applies. Benefits of this health plan may be reduced.
2. Reduction in this plan's benefits may occur under circumstances such as the following:

When the sum of:

- a. the benefits payable for allowable medical expenses under this health plan, without applying coordination of benefits, and,
- b. the benefits payable for allowable medical expenses under the other plans, without applying coordination of benefits or a similar provision, whether or not claim is made, exceed those allowable medical expenses in a claim determination period. In that case, the benefits of this health plan are reduced so that benefits payable under all plans do not exceed allowable medical expenses.

When medical benefits of this health plan are reduced, each benefit is reduced in proportion and charged against any applicable benefit limit of this health plan.

Coordination of Benefits Specific to the Vision Program

When VSP administers the secondary plan, the member will receive a specified allowance for each service (exam, lenses, frame or contacts) that will be used to pay up to, but not more than the billed amount. Only services received on the primary benefit may be used for coordinating like services on the secondary benefit. Secondary allowances are applied first to the same service of the primary plan. Any remaining amount may be used to cover additional expenses on other services. For services from Non-VSP Providers, VSP will reimburse the patient according to each benefit's out of network schedule of allowances, not to exceed the actual exam fee and cost of corrective eyewear. Note: Coordination of benefits does not guarantee that all out-of-pocket expenses will be covered in full. Members are responsible for any remaining expenses.

Right to Receive and Release Needed Information

Certain facts are needed to apply these coordination of benefits rules. The Medical Claims Administrator has the right to decide which facts are needed. The Medical Claims Administrator may get needed facts from, or give them to, any other organization or person. They do not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts needed to pay the claim.

Facility of Payment and Right of Recovery

When another plan pays an amount that should have been paid under this plan, this plan may pay that amount to the organization that made that payment. That amount will then be considered a benefit under this plan. This plan will not have to pay that amount again. If this plan pays more than it should have paid under these coordination of benefit rules, this plan may recover the excess from any of the following:

1. the persons this plan paid for whom this plan has paid;
2. insurance companies; or
3. other organizations.

Any payment made or amount paid includes the reasonable cash value of any benefits provided in the form of services

REIMBURSEMENT AND SUBROGATION

This Program maintains both a right of reimbursement and a separate right of subrogation. **As an express condition of your participation in this Program, you agree that the Program has the subrogation rights and reimbursement rights explained below.**

THE PROGRAM'S RIGHT OF SUBROGATION

If you or your dependents receive benefits under this Program arising out of an illness or injury for which a responsible party is or may be liable, this Program shall be subrogated to your claims and/or your dependents' claims against the responsible party.

OBLIGATION TO REIMBURSE THE PROGRAM

You are obligated to reimburse the Program in accordance with this provision if the Program pays any benefits and you, or your dependent(s), heirs, guardians, executors, trustees, or other representatives recover

compensation or receive payment related in any manner to an illness, accident or condition, regardless of how characterized, from a responsible party, a responsible party's insurer or your own (first party) insurer. You must reimburse the Program for 100% of benefits paid by the Program before you or your dependents, including minors, are entitled to keep or benefit by any payment, regardless of whether you or your dependent has been fully compensated and regardless of whether medical, prescription or dental expenses are itemized in a settlement agreement, award or verdict.

You are also obligated to reimburse the Program from amounts you receive as compensation or other payments as a result of settlements or judgments, including amounts designated as compensation for pain and suffering, non-economic damages and/or general damages. The Program is entitled to recover from any plan, person, entity, insurer (first party or third party), and/or insurance policy (including no-fault automobile insurance, an uninsured motorist's plan, a homeowner's plan, a renter's plan, or a liability plan) that is or may be liable for:

1. the accident, injury, sickness, or condition that resulted in benefits being paid under the Program; and/or,
2. the medical, dental, and other expenses incurred by you or your dependents for which benefits are paid or will be paid under the Program.

Until the Program has been fully reimbursed, all payments received by you, your dependents, heirs, guardians, executors, trustees, attorneys or other representatives in relation to a judgment or settlement of any claim of yours or of your dependent(s) that arises from the same event as to which payment by the Program is related shall be held by the recipient in constructive trust for the satisfaction of the Program's subrogation and/or reimbursement claims.

Complying with these obligations to reimburse the Program is a condition of your continued coverage and the continued coverage of your dependents.

DUTY TO COOPERATE

You, your dependents, your attorneys or other representatives must cooperate to secure enforcement of these subrogation and reimbursement rights. This means you must take no action - including, but not limited to, settlement of any claim - that prejudices or may prejudice these subrogation or reimbursement rights. As soon as you become aware of any claims for which the Program is or may be entitled to assert subrogation and reimbursement rights, you must inform the Program by providing written notification to the Claims Administrator of:

1. the potential or actual claims that you and your dependents have or may have;
2. the identity of any and all parties who are or may be liable; and
3. the date and nature of the accident, injury, sickness or condition for which the Program has or will pay benefits and for which it may be entitled to subrogate or be reimbursed.

You and your dependents must provide this information as soon as possible, and in any event, before the earlier of the date on which you, your dependents, your attorneys or other representatives:

1. agree to any settlement or compromise of such claims; or
2. bring a legal action against any other party.

You have a continuing obligation to notify the Claims Administrator of information about your efforts or your dependents' efforts to recover compensation.

In addition, as part of your duty to cooperate, **you and your dependents must complete and sign all forms and papers, including a Reimbursement Agreement**, as required by the Program and/or applicable Claims Administrator and provide any other information required by the Program. A violation of the reimbursement agreement is considered a violation of the terms of the Program.

The Program may take such action as may be necessary and appropriate to preserve its rights, including bringing suit in your name or intervening in any lawsuit involving you or your dependent(s) following injury. The Program may require you to assign your rights of recovery to the extent of benefits provided under the Program. The Program may initiate any suit against you or your dependent(s) or your legal representatives to enforce the terms of this plan. The Program may commence a court proceeding with respect to this provision in any court of competent jurisdiction that the Program may elect.

ATTORNEY'S FEES AND OTHER EXPENSES YOU INCUR

The Program will not be responsible for any attorneys' fees or costs incurred by you or your dependents in

connection with any claim or lawsuit against any party, unless, prior to incurring such fees or costs, the Program in the exercise of its sole and complete discretion has agreed in writing to pay all or some portion of fees or costs. The common fund doctrine or attorneys' fund doctrine shall not govern the allocation of attorney's fees incurred by you or your dependents in connection with any claim or lawsuit against any other party and no portion of such fees or costs shall be an offset against the Program's right to reimbursement without the express written consent of the Claims Administrator.

The Plan Administrator may delegate any or all functions or decisions it may have under this *Reimbursement and Subrogation* section to a Claims Administrator.

WHAT MAY HAPPEN TO YOUR FUTURE BENEFITS

If you or your dependent(s) obtain a settlement, judgment, or other recovery from any person or entity, including your own automobile or liability carrier, without first reimbursing the Program, the Plan Administrator in the exercise of its sole and complete discretion, may determine that you, your dependents, your attorneys or other representatives have failed to cooperate with the Program's subrogation and reimbursement efforts. If the Plan Administrator determines that you have failed to cooperate, the Plan Administrator may decline to pay for any additional care or treatment for you or your dependent(s) until the Program is reimbursed in accordance with the Program terms or until the additional care or treatment exceeds any amounts that you or your dependent(s) recover. This right to offset will not be limited to benefits for the insured person or to treatment related to the injury but will apply to all benefits otherwise payable under the Program for you and your dependents.

INTERPRETATION

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision. The Plan Administrator may delegate any and all such authority and responsibility to any Claims Administrator, committee, insurer or other person or persons.

GENERAL PLAN INFORMATION

This section contains information on the administration of the Company's benefit plans summarized in this SPD. Some administrative information only applies to certain types of plans, so this section has been divided into separate subsections for easier reference.

PLAN ADMINISTRATOR / PLAN SPONSOR

Hormel Foods Corporation is the Plan Administrator and Plan Sponsor and will make determinations that may be required from time to time in the administration of the plans/programs. The Company will have the sole authority, discretion and responsibility to interpret and apply the terms of the plans/programs and to determine all factual and legal questions under the plans/programs, including entitlement to benefits and resolution of claims and appeals related to benefits, unless authority to make such determinations is delegated by the Plan Administrator to another person or third-party. Benefits under these plans/programs will be paid only if the Plan Administrator or the person or entity to whom it has delegated authority decides in its discretion that the claimant is entitled to them. The Employee Benefits Committee will have the authority to perform the duties on behalf of the Company.

ACTIONS OF THE PLAN ADMINISTRATOR

The Plan Administrator may adopt such rules as it deems necessary, desirable, or appropriate. All determinations, interpretations, rules, and decisions of the Plan Administrator shall be made in its sole discretion and shall be conclusive and binding upon all persons having or claiming to have any interest or right under the plans/programs except with respect to claim determinations where final authority has been delegated to a Claims Administrator. All rules and decisions of the Plan Administrator will be uniformly and consistently applied so that all individuals who are similarly situated will receive substantially the same treatment.

The Plan Administrator may contract with one (1) or more service agents, including the Medical Claims Administrator and Prescription Drug Claims Administrator, to assist in the handling of claims under the Program and/or to provide advice and assistance in the general administration of the Program. Such service agents may also be given the authority to make payments of benefits under the Program on behalf of and subject to the authority of the Plan Administrator. Such service agents may also be given the authority to determine claims in

accordance with procedures, policies, interpretation, rules or practices made, adopted or approved by the Plan Administrator.

PLAN DOCUMENTS

This SPD includes summaries of the plans and programs listed in the chart below. For the plans subject to ERISA, these summaries comply with the disclosure requirements for SPDs imposed by ERISA. The terms and conditions of the plans are governed by the separate plan documents, and the terms of the separate plan documents govern in the case of a conflict between the language of the SPD and the plan document.

The official plan document for the plans and programs summarized in this SPD is entitled Hormel Foods Corporation Comprehensive Welfare Benefit Plan.

IMPORTANT FACTS ABOUT YOUR PLANS

The following information applies to all benefit programs under the Plan.

Plan Name	Hormel Foods Corporation Comprehensive Welfare Benefit Plan
Plan Sponsor	Hormel Foods Corporation, a Delaware Corporation
Plan Sponsor EIN Number	41-0319970
Plan Number	503
Plan Year	A fifty-two (52) or fifty-three (53) week period ending on any last Sunday in October
Plan Type	An ERISA welfare plan
Source of Contributions	The Plan is funded with employer contributions from its general assets and employee contributions.
Plan Administrator/Insurer	The Medical and Prescription Drug Program, Fertility Program, Exercise Therapy Program, and Dental and Vision Program are self-funded and administered by Hormel Foods Corporation.
Agent for Service of Legal Process	Corporate Secretary Hormel Foods Corporation 1 Hormel Place Austin, MN 55912-3680

AMENDMENT AND TERMINATION OF THE PROGRAM

The Company, through action of the Employee Benefits Committee, reserves the right to change or terminate any of the benefits described in this SPD, including the right to terminate any Program or Plan, at any time, for any reason and in any respect at its sole discretion. The following sections further explain the potential application of the Company's reservation of right to amend or terminate different types of benefits.

With respect to the welfare plans described in this SPD, the Company's right to amend or terminate the plans includes, but is not limited to, changes in the eligibility requirements, premiums or other employee payments charged, benefits provided and termination of all or a portion of the coverages provided under the plans. If a plan is amended or terminated, you will be subject to all the changes effective as a result of such amendment or termination and your rights will be reduced, terminated, altered or increased accordingly, as of the effective date of the amendment or termination. You do not have ongoing rights to any plan benefit, other than payment of any covered expenses you incurred or benefits to which you become otherwise entitled prior to the plan amendment or termination.

Correction of Errors and Recovery of Excess Payments

Your Employer has the right to correct any errors that may occur in administering the plans. Erroneous contributions can be returned to the Company as permitted by law. Contributions may also be returned if they don't meet the requirements for deductibility under applicable tax laws.

As a condition of the plans, your Employer has a right to recover any excess benefit payments. Excess payments can occur if benefits from your Employer, or from your Employer and other sources combined, exceed those due to you under a plan. Excess payments may also occur if benefits were paid because of a mistake or incorrect information regarding your entitlement to benefits. Failure to inform your Employer of an event that results in an enrolled individual becoming ineligible for some reason (such as loss of dependent

status for dependents or divorce for spouses) is a violation of Company policy. If your Employer determines that an ineligible individual has been enrolled or that you failed to inform the Company of an event resulting in an enrolled individual becoming ineligible, coverage will be cancelled retroactively. Your Employer reserves the right to take disciplinary action against you up to and including termination of your employment and to recover any excess amount paid to you by:

- reducing or suspending future benefit payments,
- requesting direct payment from you, or withholding wages, and/or
- any other method allowed by law.

Assignment of Benefits Prohibited

Except as permitted under applicable federal and state law, you cannot assign, encumber or otherwise anticipate the payments to be made under any of the plans described in this SPD, and the benefits provided under such plans will not be subject to seizure for payment of any order or judgment against you. A claim for benefits, and any other right or benefit under the plan or ERISA (including the right to sue), cannot be assigned or transferred in whole or in part to any person or entity, including any provider, at any time before or after covered services are rendered. Coverage under the plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage, or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer will be null and void. Notwithstanding the foregoing, the Claims Administrator may make any benefit payments directly to the provider and the Claims Administrator for the plan is specifically authorized by you to determine to whom any benefit payment should be made. Once covered services are rendered by a provider, you cannot request that the plan ignore the claim submitted by such provider. No such request will be given effect.

No Employment Rights

Becoming a participant in any of the plans described in this SPD does not assure you continued employment or right to benefits except as outlined by such plans.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

This continuation right runs concurrently with your continuation right under COBRA when you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty, the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States.

Employee and dependents may extend coverage for a maximum period of 24 months.

Time Periods

When the time of day is important for benefits or determining when coverage starts and ends, a day begins at 12:00 a.m. United States Central time and ends at 12:00 a.m. United States Central time the following day.

Termination or Changes to the Plan

No agent can legally change the health plan or waive any of its terms.

The employer reserves the power at any time and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the code or ERISA) to terminate, modify or amend, in whole or in part, any or all provisions of the health plan, provided, however that no modification or amendment shall divest an employee of a right to those benefits to which they have become entitled under the health plan. Any amendment to this health plan may be affected by a written resolution adopted by the Plan Administrator. The Plan Administrator will communicate any adopted changes to the employees.

Funding

This Program is a self-insured medical plan funded by contributions from the employer and/or employees. Funds for benefit payments are provided by the employer according to the terms of its agreement with the Claims Administrator. Your contributions toward the cost of coverage under the health plan will be determined by the employer each year. The Claims Administrator provides administrative services only and does not assume any financial risk or obligation with respect to providing benefits. The Claims Administrator's payment of claims is contingent upon the Plan Administrator continuing to provide sufficient funds for benefits.

Controlling Law

Except as they may be subject to federal law, including ERISA, any questions, claims, disputes, or litigation concerning or arising from any plan will be governed by the laws of the State of Minnesota.

Fraudulent Practices

Coverage for you or your dependent will be terminated if you or your dependent engage in fraud of any type, including, but not limited to, submitting fraudulent misstatements about your medical history or eligibility status on the application for coverage; submitting fraudulent, altered, or duplicate billings for personal gain; and/or allowing another party not eligible for coverage under the health plan to use your or your dependent's coverage.

Payments Made in Error

Payments made in error or overpayments may be recovered by the Claims Administrator as provided by law or equity. This includes the right to recoup from any future benefits to be paid to or on behalf of you or your eligible dependents. Payment made for a specific service or erroneous payment shall not make the Claims Administrator or the Plan Administrator liable for further payment for the same service.

Your claims may be reprocessed due to errors in the allowed amount relating to in-network provider, out-of-network participating provider, or nonparticipating provider services. Claim reprocessing may result in changes to the amount paid at the time your claim was originally processed.

NOTICES

ERISA STATEMENT OF RIGHTS

As a participant in any ERISA plan described in this SPD you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). To determine whether a plan is an ERISA plan, you should refer to the chart in the *Important Facts About Your Plans* section.

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Program, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

WOMEN’S HEALTH AND CANCER RIGHTS ACT

Under the Federal Women’s Health and Cancer Rights Act of 1998, you are entitled to the following services: All stages of reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis physical complications at all stages of mastectomy, including lymphedema, in a manner determined in consultation with the attending physician and patient.

Coverage may be subject to annual deductible, copay, and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan of coverage.

COVERAGE OF HEALTH CARE SERVICES ON THE BASIS OF GENDER

Federal law prohibits denying or limiting health services, that are ordinarily or exclusively available to individuals of one sex, to a transgender individual because of the individual’s sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available. Eligible, covered services must be medically necessary and appropriate, and remain subject to any requirements outlined in the Claims Administrator’s applicable medical and behavioral health policies and/or federal law.

NONDISCRIMINATION

The Program shall not discriminate in favor of “highly compensated employees” as defined in Section 105(h) of the Internal Revenue Code, as to eligibility to participate or as to benefits.

MEMBER RIGHTS AND RESPONSIBILITIES

You have the right as a health plan member to:

- be treated with respect, dignity and privacy;
- have available and accessible medically necessary and appropriate covered services, including emergency services, 24 hours a day, seven (7) days a week;
- be informed of your health problems and to receive information regarding treatment alternatives and their risk in order to make an informed choice regardless if the health plan pays for treatment;
- participate with your health care provider in decisions about your treatment;
- give your health care provider a health care directive or a living will (a list of instructions about health treatments to be carried out in the event of incapacity);
- refuse treatment;
- privacy of medical and financial records maintained by the health plan, the Claims Administrator and its health care providers in accordance with existing law;
- receive information about the health plan, its services, its providers, and your rights and responsibilities;
- make recommendations regarding these rights and responsibilities policies;
- have a resource at the health plan, the Claims Administrator or at the clinic that you can contact with any concerns about services;
- file an appeal with the Claims Administrator and receive a prompt and fair review; and
 - initiate a legal proceeding when experiencing a problem with the health plan or its providers.

You have the responsibility as a health plan member to:

- know your health plan benefits and requirements;
- provide, to the extent possible, information that the health plan, the Claims Administrator and its providers need in order to care for you;
- understand your health problems and work with your doctor to set mutually agreed upon treatment goals;
- follow the treatment plan prescribed by your health care provider or to discuss with your provider why you are unable to follow the treatment plan;
- provide proof of coverage when you receive services and to update the clinic with any personal changes;
- pay copays at the time of service and to promptly pay deductibles, coinsurance and, if applicable, charges for services that are not covered; and
- keep appointments for care or to give early notice if you need to cancel a scheduled appointment.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Use and Disclosure of Health Information

The Program may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. The Program has established a policy to guard against unnecessary use or disclosure of your health information.

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

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

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

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.

- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits. (The Program may not, however, use or disclose any health information that is genetic information for underwriting purposes).
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses, formulary development, and retiree medical valuations.
- Business management and general administrative activities of the Program, including customer service and resolution of internal grievances.

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

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

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

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

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

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

For Communication with You and Your Family – Generally, Hormel Foods Corporation and its subsidiaries and affiliated companies will not discuss your health information with you or your family members without a specific signed authorization, unless it relates to basic eligibility or enrollment questions. Rather, inquiries from you or your family members will be directed to the appropriate third-party administrator. Unless you object, the third-party administrator may disclose your health information to a family member, other relative, person authorized by law, or any other person you identify as involved in your care or the payment related to your care. Only health information relevant to that person’s involvement in your care or the payment related to your care will be disclosed. You can restrict this disclosure at any time, subject to certain limitations. If you are incapacitated or in the event of an emergency, the third-party administrator will exercise professional judgment to determine whether a disclosure of this type is in your best interest.

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

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

In Connection With Judicial and Administrative Proceedings - As permitted or required by state law, the

Program may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Program makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

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

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

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

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

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

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

Authorization to Use or Disclose Health Information

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

Your Rights with Respect to Your Health Information

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

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

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

Right to Inspect and Copy Your Health Information - You have the right to inspect and copy your health information and in many cases you may have the right to receive the health information that you request in an electronic format. You may also choose to have such information transmitted directly to an entity or person you clearly designate. A request to inspect and copy records containing your health information must be made in writing to the Director of Employee Benefits at the address listed under Contact Person. If you request a copy of

your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

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

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

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

The request should specify the time period for which you are requesting the information. Accounting requests may not be made for periods of time going back more than six (6) years. The Program will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Program will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice - You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Horizon Solution Center.

Duties of the Program

The Program is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Program is required to abide by the terms of this Notice, which may be amended from time to time. The Program reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Program changes its policies and procedures in a way that materially impacts the content of this Notice, the Program will revise the Notice and will provide a copy of the revised Notice to you within sixty (60) days of the change. You have the right to express complaints to the Program and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Program should be made in writing to the Director of Employee Benefits at the address listed under Contact Person.

The Program encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

The Program is obligated to notify you if unsecured Health Information is breached.

Contact Person

The Program has designated the **Director of Employee Benefits** as its Privacy Officer and Contact Person for all issues regarding patient privacy and your privacy rights. You may contact this person at:

Hormel Foods Corporate Services, LLC
1 Hormel Place
Austin, MN 55912-3680
Telephone: 1-866-449-7712 (toll free)

If you have any questions regarding this Notice, please contact the Director of Employee Benefits at the address or telephone number listed under Contact Person above.

STATEMENT OF SECURITY POLICY

The Program will secure you and your dependents' electronic health information (known as e-PHI) in accordance with HIPAA. It is the Program's policy to:

- Ensure the confidentiality, integrity and availability of the Program's e-PHI;

- Protect against any reasonable anticipated threats or hazards to the security or integrity of the e-PHI;
- Protect against any reasonably anticipated uses or disclosures that are not permitted by the HIPAA Privacy Rule; and
- Ensure workforce compliance.

The Program will maintain a security infrastructure containing administrative, physical and technical safeguards for e-PHI.

When e-PHI is shared with a Business Associate providing services to the Program, the Program will obtain satisfactory assurances from the Business Associate that it will appropriately safeguard e-PHI it creates, receives, maintains or transmits on the Program's behalf.

When the Company receives e-PHI to assist in plan administration, it will adhere to its own procedures to protect the information. Among the procedures in place are:

- Reasonable and appropriate safeguards to protect the confidentiality, integrity and availability of the e-PHI that it creates, receives, maintains or transmits on the Program's behalf;
- Reasonable and appropriate security measures to ensure adequate separation between the Program's e-PHI and the Plan Sponsor;
- Requirements for agents and subcontractors to implement similar security measures; and
- Obligations to report to the Program any security incidents of which the Company is aware.

The Program may update this policy at any time. The Program will also update this policy to reflect any change required by law. Any changes to this policy will be effective for all e-PHI that the Program may maintain. This includes e-PHI that was previously created or received, not just e-PHI created or received after the policy is changed.

MEDICAL PROGRAM

INTRODUCTION

This Medical Program contains a summary of the medical coverage offered through the Traditional Plan and Healthy Savings Plan (collectively the "Health Plan" or "Program") and is a component of the Hormel Foods Corporation Comprehensive Welfare Benefit Plan (the "Plan") for benefits effective January 1, 2026.

All coverage for dependents and all references to dependents in this Summary Plan Description are inapplicable for employee-only coverage.

This Medical Program, sponsored and maintained by Hormel Foods Corporation, is a self-funded medical plan. Blue Cross and Blue Shield of Minnesota (Blue Cross) is the Medical Claims Administrator and provides administrative services only. The Medical Claims Administrator does not assume any financial risk or obligation with respect to claims. Coverage is subject to all terms and conditions of this SPD, including medical necessity and appropriateness.

IMPORTANT! When receiving care, present your identification (ID) card to the provider who is rendering the services. If you have questions about your coverage, please contact the Medical Claims Administrator at the address or telephone numbers listed on the following page.

If you have any questions on your Medical Program benefits, please contact customer service at the telephone number listed on the back of your member ID card

BENEFIT OVERVIEW

YOUR BENEFITS

This benefit booklet outlines the general coverage under this Health Plan. Please be certain to check the "Benefit Chart" section to identify specifically covered benefits. All services must be medically necessary and appropriate to be covered.

Please also review the "Not Covered" sections of the Benefit Chart and "General Exclusions" to determine services that are not covered. Some services and supplies are not covered, even if a provider considers them to be medically necessary and appropriate.

The "Terms You Should Know" section defines terms used in this benefit booklet. If you have questions, contact customer service using the telephone number listed on the back of your member ID card.

Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during your covered calendar year will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.

BENEFIT PERIOD

Your health plan's benefit period is based on a calendar year. The calendar year is January 1 to December 31. During this time, charges for covered services must be incurred in order to be eligible for payment by Blue Cross. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

NETWORKS

Your online provider directory lists in-network providers in our service area and may change from time to time, including as providers or the Medical Claims Administrator initiate or terminate network contracts. Prior to receiving services, it is recommended that you verify your provider's network status with the Medical Claims Administrator, including whether the provider is in-network for your particular plan. Not every provider is in-network for every plan. To find an in-network provider, visit bluecrossmn.com/hormelfoods or contact customer service at the telephone number listed on the back of your member ID card.

- In-network Providers - In Minnesota - Outside Minnesota	Aware network providers PPO network providers
Georgia In-network Providers	Georgia Blue Open Access POS network providers
- Wisconsin In-network Providers - In-network Providers - Out-of-network Providers	Blue Preferred POS network providers Eligible providers other than Blue Preferred POS network providers

PLAN OPTIONS - BENEFIT OVERVIEW

Eligible participants may enroll in either the Traditional Plan or the Healthy Savings Plan. Enrollment in either plan will also automatically enroll you in the corresponding Prescription Drug Plan. Please refer to the descriptions of each plan option below.

TRADITIONAL PLAN (LOW DEDUCTIBLE)

The Traditional Plan is one of the plan options under this Health Plan. If you are enrolled in the Traditional Plan, your premiums are higher and the deductibles are lower than if you are enrolled in the Healthy Savings Plan option. You will be required to pay for medical claim costs in full, until the deductible is met.

The Traditional Plan is subject to an Emergency Room Facility Copay.

Expenses incurred for prescription drug expenses are subject to a separate out of pocket maximum. Please see the *Prescription and Drug Plan* section of this SPD.

You are not eligible to participate in a health savings account (HSA) if you are enrolled in the Traditional Plan because it is considered a low-deductible plan.

<u>GENERAL PROVISIONS</u>		
Benefits	In-network Providers	Out-of-network Providers
Emergency Room Facility Copay	You pay \$100 per visit	You pay \$100 per visit
Deductible - Individual - Family	You pay \$850 You pay \$1,700	
Deductible - Embedded If you have other family members on the plan, each family member must meet their own deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. (see example below)		
Coinsurance	Generally, you pay 20% coinsurance after deductible of the allowed amount until out-of-pocket limit is met; then you pay nothing to the end of the calendar year	Generally, you pay 35% coinsurance after deductible of the allowed amount until out-of-pocket limit is met; then you pay nothing to the end of the calendar year

Out-of-pocket Limits - eligible medical services - Individual - Family	You pay \$4,000 You pay \$8,000	You pay \$7,500 You pay \$15,000
Out-of-pocket limits – eligible prescription services - Individual - Family	You pay \$2,500 You pay \$5,000	n/a
Out-of-pocket Limit - Embedded If you have other family members on the plan, each family member must meet their own individual out-of-pocket limit until the total amount of the out-of-pocket limits paid by all family members meets the overall family out-of-pocket limit.		
The amounts accumulated toward the in-network out-of-pocket limit also accumulate toward the out-of-network out-of-pocket limit. When the in-network out-of-pocket limit is satisfied, covered services from in-network providers are paid at 100% of the allowed amount.		
Lifetime Maximum (per person) Total benefits paid to all providers combined	Not applicable	

Example: John incurred a medical charge totaling \$1,000. Of this amount, \$850 was applied to his deductible. John's spouse incurred a medical charge of \$300. The entire \$300 was applied to her deductible. Later, John required additional medical care and incurred a medical charge for \$1,200. Because John had already met his individual deductible, John was only required to pay a 20% co-insurance of \$240.

The following items are applied toward the medical out-of-pocket maximum:

1. coinsurance;
2. deductibles; and
3. emergency room copays.

The following items are NOT applied toward the medical out-of-pocket maximum:

1. transplant specific copays; and
2. penalties for not giving the Medical Claims Administrator preadmission notification.

HEALTHY SAVINGS PLAN (HIGH DEDUCTIBLE)

The Healthy Savings Plan is one of the plan options under this Health Plan. If you are enrolled in the Healthy Savings plan, your premiums are lower and your deductibles are higher than if you are enrolled in the Traditional Plan. Both medical and prescription drug costs will be paid in full by the team member until the deductible is met.

Expenses incurred for medical and prescription drug expenses are applied towards the deductibles and out of pocket maximums stated below.

You may be eligible to participate in a health savings account (HSA) if you are enrolled in the Healthy Savings Plan because it is considered a high deductible plan that meets certain statutory requirements with a health savings account (HSA). The Company's HSA plans are covered under a separate summary plan description.

Your deductible and out of pocket maximums are for your combined medical and prescription drug expenses.

General Provisions		
Benefits	In-network Providers	Out-of-network Providers
Deductible including pharmacy - Individual - Family	You pay \$2,000 You pay \$4,000	
Deductible - Non-embedded The family pays all costs from providers up to the family deductible amount before the plan begins to pay. The family deductible can be met by one (1) or a combination of any or all of the covered family members. (see example below)		
Coinsurance	Generally, you pay 20% coinsurance after deductible of the allowed amount until out-of-pocket limit is met; then you pay nothing to the end of the calendar year	Generally, you pay 35% coinsurance after deductible of the allowed amount until out-of-pocket limit is met; then you pay nothing to the end of the calendar year
Out-of-pocket Limits - eligible medical services (including pharmacy) - Single coverage only - Family coverage – per person - Family	You pay \$4,500 You pay \$7,900 You pay \$9,000	You pay \$7,600 You pay \$7,900 You pay \$15,200
Out-of-pocket limits – eligible prescription services - Individual - Family	Out of pocket expenses are applied towards your medical out-of-pocket	n/a
Out-of-pocket Limit - Embedded If you have family coverage, one person cannot spend more than \$7,900 to reach their out-of-pocket maximum. At least one other covered individual will need to spend the additional \$1,100 to reach the family maximum of \$9000 for in network providers.		
The amounts accumulated toward the in-network out-of-pocket limit also accumulate toward the out-of-network out-of-pocket limit. When the in-network out-of-pocket limit is satisfied, covered services from in-network providers are paid at 100% of the allowed amount.		
Lifetime Maximum (per person) Total benefits paid to all providers combined	Not applicable	

Example: Marie and her husband and two children are enrolled in the Healthy Savings Plan. After payment of deductibles and co-insurance, Marie's total in-network out-of-pocket expenses were \$8,000. This amount exceeded her individual out of pocket for in-network family coverage of \$7,900. The Plan paid \$100 of this expense and will pay all other eligible in-network expenses for Marie for the remainder of the calendar year. Later, Marie's husband incurred in-network medical expenses totaling \$3,000. Because Marie had already met her out-of-pocket maximum, \$1,100 is applied towards the remainder of the family in-network out-of-pocket maximum, and the plan will pay all other in-network expenses for the entire family for the remainder of the calendar year.

The following items are applied toward the medical out-of-pocket maximum:

1. coinsurance; and
2. deductibles

The following items are NOT applied toward the medical out-of-pocket maximum:

1. transplant specific copays; and

2. penalties for not giving the Medical Claims Administrator preadmission notification.

The health plan provides coverage of benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate and be in accordance with any treatment plan prescribed by your treating health care provider. All benefit limits, deductibles and copays amounts are described in "Benefit Overview." In-network care is generally covered at a higher level of benefits than out-of-network care.

Except as specifically provided in the health plan or as mandated or required to be provided based on state or federal law, no benefits will be provided for services, supplies, prescription drugs, or charges that are noted under "Not Covered" in the benefit charts or in the "General Exclusions."

Prior authorization, admission notification, emergency admission notification, and continued stay approvals are required for specific services. Please refer to "Health Care Management." You are required to obtain prior authorization and continued stay approvals for specific services when you use nonparticipating providers in Minnesota and any provider outside of Minnesota. For more information, please call customer service at the telephone number listed on the back of your member ID card.

BENEFIT DESCRIPTIONS

Please refer to the following pages for a more detailed description of benefits.

Ambulance

The Plan Covers:	In-network Providers	Out-of-network Providers
Emergency medically necessary and appropriate air or ground ambulance transportation licensed to provide basic or advanced life support from the place of departure to the nearest medical facility equipped to treat the condition	You pay 20% coinsurance after deductible	Same as in-network services
Non-emergency medically necessary and appropriate air or ground ambulance transportation licensed to provide basic or advanced life support from the place of departure to the nearest medical facility equipped to treat the condition	You pay 20% coinsurance after deductible	Same as in-network services

Ambulance – Notes

- Ambulance service providing transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:
 - from your home, the scene of an accident or medical emergency to a hospital or skilled nursing facility provider;
 - between hospitals; or
 - between a hospital and a skilled nursing facility provider;
 when such facility provider is the closest institution that can provide covered services appropriate for your condition. If there is no facility provider in the local area that can provide covered services appropriate for your condition, then ambulance service means transportation to the closest facility provider outside the local area that can provide the necessary service.
- Transportation and related emergency service provided by an ambulance service will be considered emergency ambulance service if the injury or condition is considered emergency care. Use of an ambulance as transportation to an emergency room for an injury or condition that is not considered emergency care will not be covered as emergency ambulance service. Please refer to "Terms You Should Know" for a definition of medical emergency.
- Benefits include non-emergency medically necessary and appropriate prearranged or scheduled ambulance service requested by an attending physician or nurse from the place of departure to the closest facility provider that can provide the necessary service.
- Eligible services you receive from out-of-network providers apply to the in-network out-of-pocket limit.

Ambulance – Not Covered

- Ambulance transportation costs that exceed the allowable cost applicable to transport from the place of departure to the nearest medical facility capable of treating your condition (example: facility A is the closest medical facility capable of treating your condition but you are transported to facility B. The plan will cover eligible medically necessary and appropriate ambulance transportation costs that would otherwise apply to transportation to facility A. If you are transported by ambulance to facility B, the cost of transportation service in excess of the eligible ambulance transportation costs that would otherwise apply to transportation to facility A are not covered under the plan, and you will be responsible for those costs).
- Travel, transportation, or living expenses, whether or not recommended by a physician, except as provided herein.
- Ambulance transportation services that are not medically necessary and appropriate for basic or advanced life support.
- Transportation services, including ambulance services that are mainly for your convenience.
- Transportation to a residence.
- Conventional air services, such as commercial airlines.

BARIATRIC SURGERY (ALL PLANS EXCEPT GEORGIA)

The Plan Covers:	In-network Providers	Out-of-network Providers
- Medically necessary and appropriate inpatient hospital/facility services for bariatric surgery from admission to discharge: - room and board and general nursing care - intensive care and other special care units - operating, recovery, and treatment rooms - anesthesia - prescription drugs and supplies used during a covered hospital stay - laboratory and diagnostic imaging	Eligible members age 18 and older: You pay 10% coinsurance after deductible when you use Blue Distinction Centers for bariatric surgery Eligible members age 17 and younger: You pay 10% coinsurance after deductible when you use in-network providers	Eligible members age 18 and older: You pay 35% coinsurance after deductible when you use an out-of-network participating provider You pay 55% coinsurance after deductible when you use a nonparticipating provider Eligible members age 17 and younger: You pay 55% coinsurance after deductible when you use out-of-network providers
- Medically necessary and appropriate outpatient hospital/facility services for bariatric surgery: - scheduled bariatric surgery/anesthesia - laboratory and diagnostic imaging - all other eligible outpatient hospital care related to the scheduled bariatric surgery provided on the day of surgery	Eligible members age 18 and older: You pay 10% coinsurance after deductible when you use Blue Distinction Centers for bariatric surgery Eligible members age 17 and younger: You pay 10% coinsurance after deductible when you use in-network providers	Eligible members age 18 and older: You pay 35% coinsurance after deductible when you use an out-of-network participating provider You pay 55% coinsurance after deductible when you use a nonparticipating provider Eligible members age 17 and younger: You pay 55% coinsurance after deductible when you use out-of-network providers
Notes: - Outpatient hospital/facilities include designated freestanding ambulatory surgery centers. - Blue Distinction Centers for Bariatric Surgery are designated facilities within participating Blue Plans' service areas that have been selected after a rigorous evaluation of clinical data that provide insight into the facility's structures, processes, and outcomes of care. Nationally established evaluation criteria were developed with input from medical experts and organizations. These evaluation criteria support the consistent, objective assessment of specialty care capabilities. Blue Distinction Centers for Bariatric Surgery meet stringent quality criteria, as established by expert physician panels, surgeons, behaviorists, and nutritionists. The national Blue Distinction Centers for Bariatric Surgery have been developed in conjunction with other Blue Cross and Blue Shield Plans and the Blue Cross and Blue Shield Association. - For a list of Blue Distinction Centers for Bariatric Surgery call Customer Service or visit bluecrossmn.com/hormelfoods.		

BARIATRIC SURGERY (FOR GEORGIA MEMBERS)

The Plan Covers:	In-Network Providers	Out-of-Network Providers
- Medically necessary and appropriate inpatient hospital/facility services for bariatric surgery from admission to discharge: - room and board and general nursing care - intensive care and other special care units - operating, recovery, and treatment rooms - anesthesia - prescription drugs and supplies used during a covered hospital stay - laboratory and diagnostic imaging	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
- Medically necessary and appropriate outpatient hospital/facility services for bariatric surgery: - scheduled bariatric surgery/anesthesia - laboratory and diagnostic imaging - all other eligible outpatient hospital care related to the scheduled bariatric surgery provided on the day of surgery	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible

NOTES:

- Outpatient hospital/facilities include designated freestanding ambulatory surgery centers.

BEHAVIORAL HEALTH MENTAL HEALTH CARE

Your mental health is just as important as your physical health. That is why your health plan provides professional, confidential mental health care that addresses your individual needs. You have access to a wide range of mental health and substance use disorder professional providers, so you can get the appropriate level of responsive, confidential care.

The Plan Covers:	In-network Providers	Out-of-network Providers
- Outpatient health care professional services including: - office visit - telehealth services - individual/group/family therapy (office/in-home mental health services)	You pay nothing when you use Doctor on Demand Healthy Savings Plan Option: You pay 20% coinsurance after deductible for all other providers Traditional Plan Option: You pay 20% coinsurance	You pay 35% coinsurance after deductible
- all other professional services in an office or clinic - assessment and diagnostic services such as psychological/neuropsychological testing and evaluation	Healthy Savings Plan Option: You pay 20% coinsurance after deductible Traditional Plan Option: You pay 20% coinsurance	You pay 35% coinsurance after deductible
- all other professional services in an outpatient hospital/facility - assessment and diagnostic services such as psychological/neuropsychological testing and evaluation	Healthy Savings Plan Option: You pay 20% coinsurance after deductible Traditional Plan Option: You pay 20% coinsurance	You pay 35% coinsurance after deductible
- Outpatient hospital/outpatient behavioral health treatment facility services including: - assessment and diagnostic services - individual/group/family therapy - crisis evaluations - observation beds	Healthy Savings Plan Option: You pay 20% coinsurance after deductible Traditional Plan Option: You pay 20% coinsurance	You pay 35% coinsurance after deductible
- Professional health care services including: - clinic-based partial programs - clinic-based day treatment - clinic-based Intensive Outpatient Programs (IOP)	Healthy Savings Plan Option: You pay 20% coinsurance after deductible Traditional Plan Option: You pay 20% coinsurance	You pay 35% coinsurance after deductible
- Facility health services including: - hospital-based partial programs - hospital-based day treatment - hospital-based Intensive Outpatient Programs (IOP)	Healthy Savings Plan Option: You pay 20% coinsurance after deductible Traditional Plan Option: You pay 20% coinsurance	You pay 35% coinsurance after deductible

• Inpatient health care professional services including: ▪ individual psychotherapy ▪ group psychotherapy ▪ psychological testing ▪ counseling with family members to assist in your diagnosis and treatment	Healthy Savings Plan Option: You pay 20% coinsurance after deductible Traditional Plan Option: You pay 20% coinsurance	You pay 35% coinsurance after deductible
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The Plan Covers:	In-network Providers	Out-of-network Providers
• Inpatient hospital/residential behavioral health treatment facility services including: ▪ all eligible inpatient services ▪ emergency holds	Healthy Savings Plan Option: You pay 20% coinsurance after deductible Traditional Plan Option: You pay 20% coinsurance	You pay 35% coinsurance after deductible

Behavioral Health Mental Health Care – Notes
1. For home health related services, please refer to "Home Health Care." 2. For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care." 3. Coverage is provided for crisis evaluations delivered by mobile crisis units. 4. Court-ordered treatment for mental health care that is based on an evaluation and recommendation for such treatment or services by a licensed psychiatrist or a doctoral level licensed psychologist, is deemed medically necessary and appropriate. 5. Court-ordered treatment for mental health care that is not based on an evaluation and recommendation by a licensed psychiatrist or doctoral level licensed psychologist will be evaluated to determine medical necessity and appropriateness. Court-ordered treatment that does not meet the criteria above will be covered if it is determined to be medically necessary and appropriate and otherwise covered under this health plan. 6. Outpatient family therapy is covered if rendered by a health care professional and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis. 7. Admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold. 8. Benefits are only available for mental health care services provided on a partial hospitalization basis when received through a partial hospitalization program. A mental health care service provided on a partial hospitalization basis will be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts. 9. Coverage is provided for medical nutrition therapy and nutritional counseling. 10. Coverage is provided for inpatient care and outpatient care for the treatment of mental illness. A mental illness service provided on a partial hospitalization basis will be deemed to be an outpatient care visit subject to any outpatient care cost-sharing amounts. 11. Inpatient facility service and inpatient medical benefits (except room and board) provided by a facility provider or professional provider as previously described, are also available when you are an outpatient. 12. Based on the federal Mental Health Parity and Addiction Equity Act, members have the right to parity with respect to mental health and substance use disorder treatment. Generally, this law provides that: a. mental health and substance use disorder services are to be covered on the same basis as similar medical services; b. cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services; and c. treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.

13. Coverage is provided on the same basis as other benefits for treatment of emotionally disabled dependent children in a licensed residential behavioral health treatment facility. "Emotionally disabled child" shall have the meaning set forth by the Minnesota Commissioner of Human services in the rules relating to residential treatment facilities.

14. Coverage is provided for treatment for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and for treatment for pediatric acute-onset neuropsychiatric syndrome (PANS). Treatments must be recommended by your health care provider and include, but are not limited to: antibiotics, drugs and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.

Behavioral Health Mental Health Care – Notes

15. Benefits are provided for intensive behavioral therapy programs including, but not limited to: Early Intensive Behavioral Intervention (EIBI), Applied Behavioral Analysis (ABA), Intensive Behavioral Intervention (IBI), and Lovaas Therapy for the treatment of autism spectrum disorders, which are any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor.

16. The plan covers telehealth services.

17. Coverage is provided for outpatient Certified Peer Specialist and Certified Family Specialist services (also known as peer support services).

Behavioral Health Mental Health Care – Not Covered

1. Services related to mental illness not listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*.

2. Custodial care.

3. Evaluations that are not performed for the purpose of diagnosing or treating mental health or substance use disorder conditions such as: custody evaluations; parenting assessments; educational classes for Driving Under the Influence (DUI) or Driving While Intoxicated (DWI) offences; competency evaluations; adoption home status; parental competency; and domestic violence programs.

4. Services or room and board for foster care, group homes, shelter care and lodging programs, and halfway house services.

5. Services for skills training.

6. Services for or related to therapeutic support of foster care (services designed to enable the foster family to provide a therapeutic family environment for support for the foster child's improved functioning).

7. Services for therapeutic day care and therapeutic camp services.

8. Services for or related to marriage/couples counseling.

BEHAVIORAL HEALTH SUBSTANCE USE CARE

The Plan Covers:	In-network Providers	Out-of-network Providers
- Outpatient health care professional services including: - office visit - telehealth services - individual/group/family therapy	You pay nothing when you use Doctor on Demand Healthy Savings Plan Option: You pay 20% coinsurance after deductible Traditional Plan Option: You pay 20% coinsurance	You pay 35% coinsurance after deductible
- all other professional services in an office or clinic - assessment and diagnostic services - opioid treatment, including Medication Assisted Treatment (MAT)	Healthy Savings Plan Option: You pay 20% coinsurance after deductible Traditional Plan Option: You pay 20% coinsurance	You pay 35% coinsurance after deductible
- all other professional services in an outpatient hospital/facility - assessment and diagnostic services - opioid treatment, including Medication Assisted Treatment (MAT)	Healthy Savings Plan Option: You pay 20% coinsurance after deductible Traditional Plan Option: You pay 20% coinsurance	You pay 35% coinsurance after deductible
- Outpatient hospital/outpatient behavioral health treatment facility services including: - Intensive Outpatient Programs (IOP) and related aftercare services - partial hospitalization	Healthy Savings Plan Option: You pay 20% coinsurance after deductible Traditional Plan Option: You pay 20% coinsurance	You pay 35% coinsurance after deductible
Inpatient health care professional services	Healthy Savings Plan Option: You pay 20% coinsurance after deductible Traditional Plan Option: You pay 20% coinsurance	You pay 35% coinsurance after deductible
- Inpatient hospital/facility services - Residential behavioral health treatment facility services	Healthy Savings Plan Option: You pay 20% coinsurance after deductible Traditional Plan Option: You pay 20% coinsurance	You pay 35% coinsurance after deductible

Behavioral Health Substance Use Care – Notes

- Outpatient family therapy is covered if rendered by a health care professional, and the identified patient must be a covered member. The family therapy services must be for the treatment of a behavioral health diagnosis.
- Benefits provided for individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of substance use disorder include the following:
 - inpatient hospital or substance use disorder treatment facility provider services for detoxification;
 - substance use disorder treatment facility provider services for non-hospital inpatient residential treatment and rehabilitation services;

Behavioral Health Substance Use Care – Notes

- c. outpatient hospital/facility or substance use disorder treatment facility provider or outpatient substance use disorder treatment facility provider services for rehabilitation therapy;
 - d. court-ordered treatment provided by the Department of Corrections is covered when included in a sentencing order and is based on a chemical assessment conducted by the Department of Corrections;
 - e. admissions that qualify as "emergency holds," as the term is defined in Minnesota statutes, are considered medically necessary and appropriate for the entire hold; and
 - f. coverage includes Medication Assisted Treatment (MAT) for opioid use disorder.
3. For purposes of this benefit, a substance use disorder service provided on a partial hospitalization basis shall be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.
4. For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
5. For home health related services, please refer to "Home Health Care."
6. For medical stabilization during detoxification services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
7. Based on the federal Mental Health Parity and Addiction Equity Act, members have the right to parity with respect to mental health and substance use disorder treatment. Generally, this law provides that:
- a. mental health and substance use disorder services are to be covered on the same basis as similar medical services;
 - b. cost-sharing for mental health and substance use disorder services can be no more restrictive than cost-sharing for similar medical services; and
 - c. treatment restrictions and limitations such as prior authorization and medical necessity can be no more restrictive than for similar medical services.
8. The plan covers telehealth services.
9. Coverage is provided for outpatient Certified Peer Recovery and Certified Family Specialist services (also known as peer support services).

Behavioral Health Substance Use Care – Not Covered

- 1. Services for substance use disorder or addiction not listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*.
- 2. Custodial care.
- 3. Services or confinements ordered by a court or law enforcement officer that are not medically necessary and appropriate.
- 4. Evaluations that are not performed for the purpose of diagnosing or treating substance use disorder or addictions including, but not limited to: custody evaluations; parenting assessments; educational classes for Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) offenses; competency evaluations; adoption home status; and parental competency and domestic violence programs.
- 5. Services or room and board for foster care, group homes, shelter care, and lodging programs, and halfway house services.
- 6. Services for skills training.
- 7. Substance use disorder interventions, defined as a meeting or meetings, with or without the affected person, of a group of people who are concerned with the current behavioral health of the affected person, with the intent of convincing the affected person to enter treatment for the condition.
- 8. Services for therapeutic day care and therapeutic camp services.
- 9. Services for hippotherapy (equine movement therapy).

CHIROPRACTIC CARE

The Plan Covers:	In-network Providers	Out-of-network Providers
Spinal manipulations - includes office visit	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
Other chiropractic services including therapies	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
Acupuncture services	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible

Chiropractic Care – Notes

- Benefits include coverage for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.
- For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
- Eligible acupuncture services when performed by a chiropractor are limited to 20 visits per person per calendar year for all providers combined.
- Spinal manipulations and other chiropractic services including therapies are limited to 20 visits per person per calendar year.

Chiropractic Care – Not Covered

- Services for outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate.
- Services for or related to therapeutic massage.
- Maintenance services.
- Services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and appropriate and part of specialized maintenance therapy to treat the member's condition.
- Custodial care.

DENTAL CARE

The Plan Covers:	In-network Providers	Out-of-network Providers
This is not a dental plan. The following limited dental-related coverage is provided: • Accident-related dental services from a physician or dentist for the treatment of an injury to sound natural teeth • Treatment of cleft lip and palate including: ▪ dental implants ▪ removal of impacted teeth or tooth extractions ▪ related orthodontia ▪ related oral surgery ▪ bone grafts • Diagnostic evaluation, surgical and nonsurgical treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD) including: ▪ orthognathic surgery ▪ related orthodontia	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible

Dental Care – Notes
1. For medical services, please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," "Office Visit and Professional Services," etc. 2. For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care." 3. Mandibular staple implant is covered, provided the procedure is not done to prepare the mouth for dentures. 4. Bone grafts (the building up of bone in the upper or lower jaw) for the purpose of reconstruction of the jaw is a covered service, but not for the sole purpose of supporting a dental implant, dentures or a dental prosthesis. 5. Sound natural teeth means teeth and tissue that are viable, functional and free of disease. A sound natural tooth: a. has no decay, b. has no filling on more than two (2) surfaces, c. does not have bone loss of more than 50%, d. has not had a root canal procedure (removing the tissue inside the tooth root), and e. has not been replaced by any artificial means (for example, implants, fixed or removable bridges, dentures, dental appliance, or crowns). 6. Accident-related dental services from a physician or dentist for the treatment of an injury to sound natural teeth if the treatment is received within 12 months of the injury. 7. The health plan covers anesthesia and inpatient and outpatient hospital charges when necessary to provide dental care to a member who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. For hospital/facility charges please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care." Dental services are not covered unless otherwise noted. 8. Services for diagnostic evaluation, surgical, and nonsurgical treatment of temporomandibular disorder and craniomandibular disorder, including orthognathic surgery and related orthodontia, must be covered on the same basis as any other body joint and administered or prescribed by a physician or dentist.

Dental Care – Not Covered
1. Services for or related to orthodontia, except as provided herein. 2. Oral surgery procedures, except as provided herein. 3. Services for or related to treatment of cracked or broken teeth due to biting or chewing. 4. Dentures, regardless of the cause or the condition, and any associated services including bone grafts.

Dental Care – Not Covered
5. Dental implants and associated services, except when related to services for cleft lip and palate. 6. Removal of impacted teeth and/or tooth extractions and any associated charges including but not limited to imaging studies and pre-operative examinations, except as provided herein. 7. Services for or related to replacement of a damaged dental bridge from an accident-related injury. 8. Osteotomies (cutting of the bone), osteoplasty (building up the bone), and other procedures associated with the fitting of dentures or dental implants, except as provided herein. 9. Services for or related to dental or oral care, treatment, orthodontics, surgery, supplies, anesthesia, or facility charges, except as provided herein. 10. Services to treat bruxism (excessive grinding of teeth or clenching of the jaw), including dental splints. 11. Charges for routine dental care, except as provided herein. 12. Services for or related to gingival and periodontal (the gums and bone that surround and support the teeth) procedures.

EMERGENCY CARE

The Plan Covers:	In-network Providers	Out-of-network Providers
Outpatient health care professional services to treat an emergency medical condition	You pay 20% coinsurance after deductible	Same as in-network services
Outpatient hospital/facility services to treat an emergency medical condition	Healthy Savings Plan Option: You pay 20% coinsurance after deductible Traditional Plan Option: You pay 20% coinsurance after deductible and emergency room facility provider \$100 copay	Same as in-network services

Emergency Care – Notes
- In emergency situations, where you must be treated immediately, go directly to your nearest hospital emergency provider; or call "911" or your area's emergency number. The decision to reimburse the emergency care is not made solely on the basis of the actual diagnosis. When determining if a situation is a medical emergency the Medical Claims Administrator will take into consideration presenting symptoms including, but not limited to, severe pain and a reasonable layperson's belief that the circumstances required immediate medical care that could not wait until the next business day. - For follow up care, please refer to "Hospital Outpatient Care," "Hospital Inpatient Care" and "Office Visit and Professional Services." - In some circumstances where you were not able to choose the provider who rendered care, you are not responsible for any amounts above what you would have been required to pay (such as deductibles) had you used a participating provider, unless you gave advance written consent to the nonparticipating provider. Please refer to "Special Circumstances." - If the care you receive is due to a medical emergency, prior authorization is not required. - Please refer to "Terms You Should Know" for a definition of medical emergency. - For inpatient services, please refer to "Hospital Inpatient Care" and "Office Visit and Professional Services." - If you are enrolled in the Traditional Plan Option, the emergency room facility provider copay is waived if you are admitted within 24 hours of transportation by ambulance. - For urgent care visits, please refer to "Hospital Outpatient Care" and "Office Visit and Professional Services." - Eligible services you receive from out-of-network providers apply to the in-network out-of-pocket limit.

GENDER AFFIRMING CARE

We are committed to supporting transgender and gender diverse individuals in receiving medically necessary and appropriate gender affirming healthcare as outlined in the Standards of Care for the Health of Transgender and Gender Diverse People, from the World Professional Association for Transgender Health (WPATH).

The Plan Covers:	In-network Providers	Out-of-network Providers
- Outpatient health care professional services including: - office visit	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
Professional services for gender affirming procedures for the treatment of gender dysphoria	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible

Gender Affirming Care – Notes
- Gender affirming care includes, but is not limited to, breast/chest procedures, genital procedures, facial procedures, thyroid cartilage reduction, voice therapy, voice surgery, hair removal, puberty blockers, and hormone therapy. These services are covered when they are medically necessary and appropriate for the treatment of gender dysphoria. - Services include related preparation and follow-up care. - Gender-specific preventive services are covered for transgender persons appropriate to their anatomy. For preventive care services, please refer to "Preventive Care." - For outpatient counseling services, please refer to "Behavioral Health Mental Health Care." - For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care." - For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care." - For drugs administered by a health care provider, please refer to "Hospital Outpatient Care" or "Office Visit and Professional Services." - For more information contact customer service at the telephone number on the back of your member ID card or visit bluecrossmn.com/hormelfoods.

HOME HEALTH CARE

The Plan Covers:	In-network Providers	Out-of-network Providers
• Skilled care and other home care services ordered by a physician and provided by employees of an approved home health agency including, but not limited to: ▪ intermittent skilled nursing care in your home by a: • licensed registered nurse • licensed practical nurse ▪ physical therapy and occupational therapy by a licensed therapist and speech therapy by a certified speech and language pathologist ▪ services provided by a medical technologist ▪ services provided by a licensed registered dietitian ▪ services provided by a respiratory therapist ▪ services of a home health aide or master's level social worker employed by the home health agency when provided in conjunction with covered services ▪ use of appliances that are owned or rented by the home health agency ▪ home health care following early maternity discharge ▪ palliative care	You pay 10% coinsurance after deductible	You pay 35% coinsurance after deductible

Home Health Care – Notes
1. Intermittent skilled nursing care consists of up to two (2) consecutive hours of care per date of service in the member's home. 2. Extended hours skilled nursing care (also known as private-duty nursing) consists of greater than two (2) consecutive hours of care per date of service in the member's home. Extended hours skilled nursing care services provide complex, direct skilled nursing care to develop caregiver competencies through training and education to optimize the member's health status and outcomes. The frequency of the nursing tasks is continuous and temporary in nature and is not intended to be provided on a permanent, ongoing basis. 3. Health aide services when you are also receiving covered nursing services or therapy and rehabilitation services. 4. Benefits for home/suite infusion therapy and related home health care are listed under "Infusion Therapy." 5. For supplies and durable medical equipment billed by a home health agency, please refer to "Medical Equipment and Supplies." 6. The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care. 7. Home health care visit following early maternity discharge provided by a registered nurse including, but not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four (4) days following the discharge of the mother and newborn child.

Home Health Care – Not Covered
1. Homemaker services. 2. Maintenance services. 3. Services for dialysis treatment you receive from a home health agency. 4. Custodial care. 5. Services for food or home-delivered meals you receive from a home health agency. 6. Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care.

HOSPICE CARE

The Plan Covers:	In-network Providers	Out-of-network Providers
Hospice care for terminal condition	You pay nothing	You pay nothing

Hospice Care – Notes

- Benefits are limited to members with a terminal condition, which requires the member's primary physician to certify, in writing, a life expectancy for the member of six (6) months or fewer. Hospice benefits begin on the date of admission to a hospice program.
- Hospice program inpatient respite care is for the relief of the member's primary caregiver and is limited to a maximum of five (5) consecutive days at a time.
- Home respite care is for the relief of the member's primary caregiver and is limited to a maximum of five (5) consecutive days per admission to the hospice program.
- Hospice program general inpatient care is for control of pain or other symptom management that cannot be managed in a less intense setting.
- Benefits include family counseling related to the member's terminal condition.
- Medical care services unrelated to the terminal condition under the hospice program are covered but are separate from the hospice benefit.

Hospice Care – Not Covered

- Services for respite care, except as provided herein.
- Room and board expenses in a residential hospice facility.
- Services for dialysis treatment you receive from hospice or a hospital program for hospice care.
- Custodial care.
- Services for food or home-delivered meals you receive from hospice or a hospital program for hospice care.

HOSPITAL INPATIENT CARE

The Plan Covers:	In-network Providers	Out-of-network Providers
- Hospital room and board, and general nursing services - Special care unit which is a designated unit which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients - Use of operating, delivery, and treatment rooms and equipment - Anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending health care provider and rendered by a health care provider other than the surgeon or assistant at surgery - Medical and surgical dressings, supplies, casts, and splints - Prescription drugs provided to you while you are inpatient in a facility - Whole blood, administration of blood, blood processing, and blood derivatives - Diagnostic services - Communication services of a private-duty nurse or a personal care assistant up to 120 hours per hospital admission for ventilator dependent persons - Therapy and rehabilitation services	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible

Hospital Inpatient Care – Notes

- The health plan covers inpatient services from a facility provider. Benefits will be covered only when, and so long as, they are determined to be medically necessary and appropriate for the treatment of the member's condition.
- The plan covers the following organ donor services when billed under the donor recipient's name and the donor recipient is covered for the organ transplant under the plan:
 - potential donor testing;
 - donor evaluation and work-up; and
 - hospital and professional services related to organ procurement.
- Diagnostic services include the following when ordered by a health care provider:
 - diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine;
 - diagnostic pathology consisting of laboratory and pathology tests;
 - diagnostic medical procedures consisting of ElectroCardioGram (ECG), ElectroEncephaloGram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by the Medical Claims Administrator; and
 - allergy testing consisting of percutaneous, intracutaneous, and patch tests.
- The health plan covers anesthesia and inpatient hospital services when necessary to provide dental care to a member who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted.
- For facility services related to bariatric surgery, please refer to "Bariatric Surgery."
- The plan covers telehealth services.

Hospital Inpatient Care – Not Covered

- Charges for inpatient admissions which are primarily for diagnostic studies.
- Personal comfort items such as telephone, television.
- Communication services provided on an outpatient basis or in the home.
- Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care.

HOSPITAL OUTPATIENT CARE

The Plan Covers:	In-network Providers	Out-of-network Providers
• Outpatient hospital/facility services • Surgeon or assistant at surgery • Use of operating, delivery, and treatment rooms and equipment • Medical and surgical dressings, supplies, casts and splints • Radiation and chemotherapy • Dialysis treatment • Respiratory therapy • Cardiac rehabilitation • Physical, occupational, and speech therapy • Diabetes outpatient self-management training and education, including medical nutrition therapy • Palliative care • Prescription drugs provided to you while you are outpatient in a facility • Whole blood, administration of blood, blood processing, and blood derivatives	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
• Laboratory services	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
• Diagnostic imaging services	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
• Facility freestanding ambulatory surgery center services	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
• Urgent care center visits including: ▪ facility billed services	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
▪ facility laboratory services	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
▪ facility diagnostic imaging services	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible

Hospital Outpatient Care – Notes

1. Pre-admission testing is covered for tests and studies required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient.
2. Coverage is provided for hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, anesthesia supplies and services rendered by an employee of the facility provider, other than the surgeon or assistant at surgery.
3. Coverage is provided for the administration of anesthesia ordered by the attending health care provider and rendered by a health care provider other than the surgeon or assistant at surgery.
4. The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care.

Hospital Outpatient Care – Notes
5. The health plan covers anesthesia and outpatient hospital services when necessary to provide dental care to a member who is a child under age five (5); is severely disabled; or has a medical condition that requires hospitalization or general anesthesia for dental treatment. Dental services are not covered unless otherwise noted. 6. For facility services related to bariatric surgery, please refer to “Bariatric Surgery.” 7. The plan covers telehealth services.

INFUSION THERAPY

The Plan Covers:	In-network Providers	Out-of-network Providers
• Home infusion and suite infusion therapy services • Intravenous solutions and pharmaceutical additives, pharmacy compounding and dispensing services • Medical/surgical supplies • Nursing services associated with infusion therapy	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible

Infusion Therapy – Notes
1. Benefits will be provided when performed by a home infusion and/or suite infusion therapy provider at an infusion suite or home setting. 2. Specific adjunct non-intravenous therapies are included when administered only in conjunction with infusion therapy.

Infusion Therapy – Not Covered
1. Home/suite infusion services or supplies not specifically listed as covered services. 2. Nursing services to administer home/suite infusion therapy when the patient or caregiver can be successfully trained to administer therapy.

MATERNITY CARE

The Plan Covers:	In-network Providers	Out-of-network Providers
Prenatal hospital/facility services	You pay nothing	You pay 35% coinsurance after deductible
Prenatal professional services	You pay nothing	You pay 35% coinsurance after deductible
- Health care professional services for: - delivery in a hospital/facility - examination of the newborn infant while the birthing person/mother is inpatient	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
- postpartum care - office visit	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
all other eligible services - office/clinic	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
all other eligible services – outpatient hospital/facility	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
- Hospital/facility services for: - delivery - postpartum care	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
Acupuncture services	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible

Maternity Care – Notes

- Home health care visit following early maternity discharge provided by a registered nurse including, but not limited to, parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four (4) days following the discharge of the mother and newborn child.
- Services related to miscarriage, ectopic pregnancy, and cesarean section are covered as delivery.
- Prenatal care is the comprehensive package of medical and psychosocial support provided throughout the pregnancy, includes risk assessment, gestational diabetes screening, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.
- Postpartum care is the comprehensive postnatal visits to provide a full assessment of the mother's and infant's physical, social, and psychological well-being. Covered services include but are not limited to care for mood and emotional well-being, infant care and feeding, sexuality, contraception, birth spacing, sleep and fatigue, physical recovery from birth, chronic disease management, and health maintenance.
- The plan covers services provided to the newborn child from the moment of birth, if added to the health plan, including care for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity, and routine nursery care.
- Under federal law, this health plan may not restrict benefits for any hospital length of stay in connection with childbirth as follows:
 - inpatient hospital coverage for the mother, if covered under this health plan, is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this health plan. Please refer to "Home Health Care."

Maternity Care – Notes

- b. inpatient hospital coverage for the newborn, if added to this health plan, is provided for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section. If the length of stay is less than these minimums, one (1) home health care visit within four (4) days after discharge from the hospital is covered under this plan. Please refer to "Home Health Care."
7. Under federal law, the health plan may require that a provider obtain authorization from the health plan for prescribing a length of stay greater than the 48 hours (or 96 hours) mentioned above.
8. For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."
9. Eligible acupuncture services when performed by a chiropractor are limited to 20 visits per person per calendar year for all providers combined.

Maternity Care – Not Covered

1. Services for or related to childbirth deliveries in the home.
2. Adoption fees.
3. Services for or related to surrogate pregnancy including: diagnostic screening, physician services, assisted reproductive technology, and prenatal/delivery/postnatal services when the surrogate is not a covered member under this plan.
4. Childbirth classes.
5. Services for or related to preservation, storage, and thawing of human tissue including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue.
6. Services for donor ova or sperm.
7. Services for or related to an elective cesarean (C)-section for nonmedical indications.
8. Services for or related to the selection of gender in embryos.
9. Services for or related to abortion are not covered unless it is determined by the attending physician to be medically necessary and appropriate.

MEDICAL EQUIPMENT AND SUPPLIES

The Plan Covers:	In-network Providers	Out-of-network Providers
- Durable medical equipment (DME) - Amino acid-based elemental formula - Continuous Glucose Monitors (CGMs) - Corrective lenses, frames and contact lenses after cataract surgery (purchased within 24 months of cataract surgery) - Wigs (scalp hair prostheses) for hair loss due to alopecia areata or cancer - Hearing aids for hearing loss that cannot be corrected by other covered procedures. Maximum of one (1) hearing aid for each ear every three (3) years	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
Insulin infusion devices	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
Blood Glucose Meters (BGMs)	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
Orthotics (up to 2 pair of custom foot orthotics, per person, per benefit period)	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
Prosthetics, such as breast prostheses, artificial limbs, and artificial eyes	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
Cochlear implants	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible
Non-investigative bone conductive hearing devices	You pay 20% coinsurance after deductible	You pay 20% coinsurance after deductible

Medical Equipment and Supplies – Notes

1. The health plan covers the approved rental, purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues, or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered.
2. The health plan covers the approved rental, purchase, adjustment, repairs and replacement of durable medical equipment for therapeutic use including supplies and accessories necessary for the effective functioning of covered durable medical equipment.
3. Rental costs cannot exceed the total cost of purchase.

Medical Equipment and Supplies – Notes

4. Amino acid-based elemental formula, a type of exempt formula which is regulated by the U.S. Food and Drug Administration (FDA) and is prescribed for specific medical or dietary problems. An amino acid-based formula contains proteins which are broken down into their simplest and purest form making it easier for the body to process and digest. A member may be placed on an amino acid-based formula when unable to digest or tolerate whole proteins found in other formulas due to certain allergies or gastrointestinal conditions. Examples of amino acid-based elemental formulas include Neocate®, EleCare®, Vivonex®, and Tolerex®.
5. The health plan covers the approved rental, purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive orthotic device which restricts or eliminates motion of a weak or diseased body part.
6. The plan covers wigs (scalp hair prostheses, including all equipment and accessories) when prescribed by a health care provider. Maximum of one (1) wig per person per calendar year. Coverage is limited to a maximum benefit of \$1,000 per calendar year. When hair loss is due to alopecia areata, there is no dollar limit for a wig.
7. Corrective lenses, frames and contact lenses must be purchased within 24 months of cataract surgery.
8. Hearing aids. Maximum of \$2,500 per person per calendar year for both ears.

Medical Equipment and Supplies – Not Covered

1. Services for or related to hearing aids or devices, except as provided herein.
2. Durable medical equipment, supplies, and prosthetics for convenience, personal, or recreational use.
3. Services or supplies that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment; air purifiers; air conditioners; dehumidifiers; heat/cold appliances; water purifiers; hot tubs; whirlpools; hypoallergenic mattresses; waterbeds; computers and related equipment; car seats; feeding chairs; pillows; food or weight scales; and incontinence pads or pants.
4. Modifications to home, vehicle, and/or workplace, including vehicle lifts and ramps.
5. Blood pressure monitoring devices.
6. Replacement of properly functioning durable medical equipment.
7. Repair, maintenance or replacement of rental equipment (this is included in the price of the rental equipment).
8. Duplicate equipment, prosthetics, or supplies.
9. Communication devices, except when exclusively used for the communication of daily medical needs and without such communication the patient's medical condition would deteriorate.
10. Devices for maintenance services.
11. Biofeedback devices in the home.
12. Wigs (scalp hair prostheses), except as provided herein.
13. Charges for breast pumps, except as provided herein.
14. Services for eyeglasses or contact lenses, or prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury).

OFFICE VISIT AND PROFESSIONAL SERVICES

The Plan Covers:	In-network Providers	Out-of-network Providers
Primary care office visits	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
Specialty care office visits	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
- Doctor on Demand - urgent care	You pay nothing	NO COVERAGE
- E-visits - Telephone consultations	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
- Urgent care center visits including: - office visit for urgent care - professional laboratory services for urgent care - professional diagnostic imaging services for urgent care - all other professional services for urgent care	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
- Retail health clinic - office visit - laboratory services - all other professional services	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
Professional office and outpatient laboratory services	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
Professional office and outpatient diagnostic imaging services	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
Professional services received at a freestanding ambulatory surgery center	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
- Omada program for members age 18 or older for: - Omada for prevention - diabetes management	You pay nothing	NO COVERAGE
Hinge Health musculoskeletal (MSK) condition management program	You pay nothing	NO COVERAGE
Acupuncture services	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible

• All other professional services – office/clinic	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
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The Plan Covers:	In-network Providers	Out-of-network Providers
• All other professional services – outpatient hospital/facility	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible

Office Visit and Professional Services – Notes
1. Diabetes Self-Management Education and Support (DSMES) Services: When your health care provider certifies that you require diabetes education and support either individually or in a group setting, coverage is provided for the following situations when rendered through DSMES services: - when diabetes is diagnosed; - when a new drug is prescribed; - when diagnosed with eye disease, foot problems, or kidney disease related to diabetes; - treatment for diabetic related complications such as uncontrolled blood sugar levels; - emergency room visit or hospital stay to treat your diabetes. 2. The plan covers eligible services for the treatment of diagnosed Lyme disease. 3. Coverage is provided for the administration of anesthesia ordered by the attending health care provider and rendered by a health care provider other than the surgeon or assistant at surgery. 4. A retail health clinic is located in a retail establishment and provides medical services for a limited list of eligible symptoms. The list of medical services and/or treatable symptoms is available at the retail health clinic. 5. The plan covers the following organ donor services when billed under the donor recipient's name and the donor recipient is covered for the organ transplant under the plan: - potential donor testing; - donor evaluation and workup; and - hospital and professional services related to organ procurement. 6. For a member participating in an approved clinical trial, the plan only covers services that would be covered if not enrolled in an approved clinical trial. 7. Diagnostic services include the following when ordered by a health care provider: - diagnostic imaging consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine - diagnostic pathology consisting of laboratory and pathology tests - diagnostic medical procedures consisting of ElectroCardioGram (ECG), ElectroEncephaloGram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by the Medical Claims Administrator; and - allergy testing consisting of percutaneous, intracutaneous, and patch tests. 8. The plan covers eligible drugs, including specialty drugs, administered by a health care provider required in the diagnosis, prevention and treatment of an injury or illness, provided that the drugs are not "usually self-administered" by a member and when the administration of the drug is billed by the health care provider and eligible under the "Office Visit and Professional Services" benefit.

Office Visit and Professional Services – Notes
9. The plan covers outpatient palliative care for members with a new or established diagnosis of progressive debilitating illness, including illness which may limit the member's life expectancy to two (2) years or less. The services must be within the scope of the provider's license to be covered. Palliative care does not include hospice or respite care. 10. Please refer to "Preventive Care" for female sterilization.

11. Omada Health helps people stay healthy and avoid diabetes and heart disease. You will have access to online programs for losing weight and for lowering your blood sugar and blood pressure. For more information about Omada Health options, log onto the member website at bluecrossmn.com/hormelfoods or call customer service at the telephone number listed on the back of your member ID card. The Omada Program is from Omada Health, Inc. an independent virtual healthcare provider.

12. Omada Health helps people stay healthy and control diabetes. You will have access to online programs for losing weight and for lowering your blood sugar. For more information about Omada Health options, log onto the member website at bluecrossmn.com/hormelfoods or call customer service at the telephone number listed on the back of your member ID card. The Omada Program is from Omada Health, Inc., an independent virtual healthcare provider.

13. E-visit is a patient-initiated, limited, written online evaluation and management service provided by a health care provider to communicate with an established patient. E-visits are not real-time interactions with a health care provider. For more information about virtual care options, log onto the member website at bluecrossmn.com/hormelfoods or call customer service at the telephone number listed on the back of your member ID card.

14. The plan covers telehealth services.

15. The plan covers virtual at-home exercise therapy for members experiencing chronic musculoskeletal (MSK) related joint, bone or muscle pain. Hinge Health is an independent company that provides musculoskeletal care solutions.

16. The plan covers hearing aid examinations/fitting/adjustments.

17. Eligible acupuncture services when performed by a chiropractor are limited to 20 visits per person per calendar year for all providers combined.

Office Visit and Professional Services – Not Covered

1. Separate charges for pre-operative and post-operative care for surgery.
2. Services for or related to weight reduction programs, including all diagnostic testing related to weight reduction programs, except as provided herein.
3. Services for or related to vision correction surgery such as the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.
4. Services provided during an e-visit for the sole purpose of: scheduling medical appointments; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
5. Services for or related to reversal of sterilization.

PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY

The Plan Covers:	In-network Providers	Out-of-network Providers
Habilitative and rehabilitative office visits from a physical therapist	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
Habilitative and rehabilitative therapies from a physical therapist	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
Habilitative and rehabilitative office visits from an occupational therapist	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
Habilitative and rehabilitative therapies from an occupational therapist	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
Habilitative and rehabilitative office visits from a speech or language pathologist	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible
Habilitative and rehabilitative therapies from a speech or language pathologist	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible

Physical, Occupational, and Speech Therapy – Notes

1. Coverage includes benefits for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.
2. For physical, occupational and speech therapy services billed by a hospital/facility, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."
3. Office visits include an evaluation or re-evaluation of the following therapies:
 - a. physical;
 - b. occupational;
 - c. speech; or
 - d. swallowing.
4. For laboratory and diagnostic imaging services billed by a health care professional, please refer to "Office Visit and Professional Services." For laboratory and diagnostic imaging services billed by a hospital/facility, please refer to "Hospital Inpatient Care" or "Hospital Outpatient Care."

Physical, Occupational, and Speech Therapy – Not Covered

1. Services for outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless medically necessary and appropriate.

PREVENTIVE CARE

The Plan Covers:	In-network Providers	Out-of-network Providers
Preventive care services to prevent illness, disease or other health problems before symptoms occur are covered according to a predefined schedule based on certain risk factors. These include, but are not limited to, recommendations of the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, Health Resources and Services Administration (HRSA), American Academy of Pediatrics (AAP), and the Internal Revenue Service (IRS). For more information regarding preventive care services, log onto the member website at bluecrossmn.com/hormelfoods or call customer service at the telephone number listed on the back of your member ID card.		
• Adults and children age six (6) and older ▪ preventive physical examinations	You pay nothing	You pay 35% coinsurance
▪ hearing screening	You pay nothing	You pay 35% coinsurance
▪ adult immunizations that require administration by a health care provider, including the immunizing agent, when required for the prevention of disease	You pay nothing	You pay 35% coinsurance
▪ diagnostic services and procedures ▪ surveillance tests for ovarian cancer - (CA125 tumor marker, trans-vaginal ultrasound, pelvic examination)	You pay nothing	You pay 35% coinsurance
▪ routine gynecological examinations, including a Papanicolaou (PAP) test	You pay nothing	You pay 35% coinsurance
▪ mammograms, 2 dimensional (2D) or 3 dimensional (3D), annual routine and medically necessary and appropriate	You pay nothing	You pay 35% coinsurance
▪ colorectal cancer screening ▪ prostate specific antigen (PSA) tests and digital rectal examinations for men of all ages	You pay nothing	You pay 35% coinsurance
• Infants and children ▪ preventive physical examinations from birth to age six (6) ▪ developmental assessments from birth to age six (6)	You pay nothing	You pay 35% coinsurance
▪ pediatric immunizations from birth to age 18	You pay nothing	You pay 35% coinsurance

Preventive Care – Notes
1. Preventive care services are consistent with applicable state and federal statutes, regulations, and related guidance. 2. Preventive examinations include a complete medical history, complete physical examination, as well as screening and counseling for obesity, depression, and tobacco cessation.

Preventive Care – Notes

3. Benefits are provided for surgical implants and tubal ligation for elective sterilization for females which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA). For more information regarding elective sterilization coverage log onto the member website at bluecrossmn.com/hormelfoods or call customer service at the telephone number listed on the back of your member ID card.
4. Benefits are provided for a full range of FDA-approved preventive contraceptive methods and for patient education/counseling, for women with reproductive capacity as prescribed which meet the recommendations and criteria established by the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control, and the Health Resources and Services Administration (HRSA), as applicable. Medical management may apply.
5. Services for complications related to female contraceptive drugs, devices, and services for women with reproductive capacity may be covered under other plan benefits. Please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," "Office Visit and Professional Services," etc. for appropriate benefit levels.
6. The plan covers: an initial physical examination to confirm pregnancy, folic acid supplement for members planning to become pregnant, counseling for contraceptive methods, counseling and support for breastfeeding, and the purchase of an electric or manual breast pump, or rental charges for a hospital-grade breast pump, and breast pump supplies. Personal electric breast pumps are limited to one (1) per pregnancy.
7. Please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," "Office Visit and Professional Services," etc. when services are for: complications or an illness/injury diagnosed as a result of preventive care services, or preventive care services in excess of applicable state and federal preventive recommendations and criteria.
8. Benefits are provided for the following tests or procedures when ordered by a physician for the purpose of early detection of colorectal cancer:
 - a. diagnostic laboratory and pathology screening services such as a fecal-occult blood or fecal immunochemical test
 - b. diagnostic imaging screening services such as barium enema
 - c. surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services
 - d. such other diagnostic pathology and laboratory, diagnostic imaging, surgical screening tests and diagnostic screening services consistent with approved medical standards and practices for the detection of colon cancer.
9. The plan covers follow-up diagnostic services or testing that your health care provider determines you require following your preventive mammogram. Preventive benefits will be applied for these follow up services after you have satisfied your deductible.

RECONSTRUCTIVE SURGERY

The Plan Covers:	In-network Providers	Out-of-network Providers
- Reconstructive surgery which is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved body part - Reconstructive surgery performed on a dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending health care provider. - Treatment of cleft lip and palate including: - dental implants - removal of impacted teeth or tooth extractions - related orthodontia - related oral surgery - bone grafts - Elimination or maximum feasible treatment of port wine stains	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible

Reconstructive Surgery – Notes

1. Congenital means present at birth.
2. For hospital/facility services, please refer to "Hospital Inpatient Care" and "Hospital Outpatient Care."

Reconstructive Surgery – Not Covered

1. Dentures, regardless of the cause or condition, and any associated services including bone grafts.
2. Dental implants and associated services, except when related to services for cleft lip and palate.

SKILLED NURSING FACILITY CARE

The Plan Covers:	In-network Providers	Out-of-network Providers
• Skilled care ordered by a physician • Room and board • General nursing care • Prescription drugs used during a covered admission • Physical, occupational, and speech therapy	You pay 20% coinsurance after deductible	You pay 35% coinsurance after deductible

Skilled Nursing Facility Care – Notes

1. Skilled care ordered by a physician includes skilled care ordered by an advanced practice nurse or physician assistant when ordered within the scope of their licensure.
2. Coverage is limited to a maximum benefit of 120 days per person per calendar year.
3. You must be admitted within 30 days of a prior hospital/facility stay of at least three (3) consecutive days for the same illness.

Skilled Nursing Facility Care – Not Covered

1. Custodial care.
2. Services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care.
3. Services when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience.
4. Services for or related to extended hours skilled nursing care, also referred to as private-duty nursing care.

TRANSPLANT

The Plan Covers:	In-network Providers	Out-of-network Providers
- Bone marrow/stem cell - Heart - Heart-lung - Liver - Liver-kidney - Lung	Healthy Savings Plan Option: You pay nothing of the transplant payment allowance for the transplant admission after deductible when you use a Blue Distinction Centers for Transplant (BDCT) provider Traditional Plan Option: You pay nothing of the transplant payment allowance for the transplant admission when you use a Blue Distinction Centers for Transplant (BDCT) provider	You pay 20% coinsurance of the transplant payment allowance after deductible and \$5,000 transplant specific copay when you use a participating transplant provider You pay 35% coinsurance of the transplant payment allowance after deductible and \$5,000 transplant specific copay when you use a nonparticipating provider

Transplant – Notes

1. Prior authorization must be obtained before a transplant procedure.
2. The donor's medical expenses directly related to the organ donation are covered under the recipient's plan. Treatment of any medical complications that occur to the donor are not covered under the recipient's plan.
3. Eligible transplants not performed in conjunction with a major organ transplant noted above are covered on the same basis as any other illness. Please refer to "Hospital Inpatient Care," "Hospital Outpatient Care," and "Office Visit and Professional Services." For services not included in the transplant payment allowance, refer to the individual benefit sections that apply to the services being performed to determine the correct level of coverage.
4. BDCT facilities have a contract with the Blue Cross and Blue Shield Association (an association of independent Blue Cross and Blue Shield plans) to provide transplant procedures. These facilities have been selected to participate in this nationwide network based on their ability to meet defined clinical criteria that are unique for each type of transplant. Facilities are reevaluated regularly to ensure that they continue to meet the established criteria to participate in this network.
5. Eligible transplant services provided by participating transplant providers will be paid at the Blue Distinction Centers for Transplant (BDCT) provider level of benefits when the transplant services are not available at a BDCT provider.
6. If you live more than 50 miles from a BDCT provider, there is a benefit available for travel expenses (consistent with IRS guidelines) directly related to a preauthorized transplant.

Transplant – Not Covered

1. Services for or related to nonhuman or mechanical devices that serve as a human organ. An exception is services for the use of an FDA-approved Total Artificial Heart (TAH) to serve as a temporary bridge to a heart transplant.
2. Benefits for travel expenses when you are using a Non-BDCT provider.

GENERAL EXCLUSIONS

Except as specifically provided in this health plan or as the Medical Claims Administrator is mandated or required to provide based on state or federal law, no benefits will be provided for services, supplies, prescription drugs or charges noted under "Not Covered" in the Benefit Chart and as noted below.

No benefits will be provided for the following:

1. Services which are not medically necessary and appropriate based on the definition of "medically necessary and appropriate" in "Terms You Should Know."
2. Services which are experimental/investigative in nature.
3. Services that are prohibited by law or regulation.
4. Services rendered prior to your effective date of coverage.
5. Services incurred after the date of termination of your coverage, except as provided herein.
6. Services for dependents if you have employee-only coverage.
7. Services that are provided without charge, including services of the clergy.
8. Services rendered by a provider who is a member of your immediate family.
9. Services that are not within the scope of licensure or certification of a provider.
10. Services from providers who are not health care providers.
11. To the extent benefits are provided to members of the armed forces while on active duty or to members in Veteran's Administration facilities for service-connected illness or injury, unless you have a legal obligation to pay.
12. Autopsy.
13. Custodial care, nonskilled care, or adult daycare.
14. Personal care attendants, except as provided herein.
15. Services for or related to care that can be provided by a non-skilled caregiver who has been trained or is capable of being trained.
16. Room and board for outpatient services.
17. Services for or related to cosmetic health services or surgery and related services, and treatment for conditions or problems related to cosmetic surgery or services, except as provided herein.
18. Any portion of a charge for a covered service or supply that exceeds the allowed amount, except as provided herein.
19. Services for or related to evaluations performed for administrative purposes including, but not limited to, obtaining/maintaining employment, disability determination, insurance, licensing, certification, or for participation in activities such as school, camp, or sports.
20. Services for or related to adult preventive vision screenings.
21. Services for or related to lenses, frames, contact lenses, and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as provided herein.
22. Services, testing, equipment, devices, technologies and supplies purchased or available over-the-counter, whether or not prescribed by a health care provider, unless covered under preventive care.
23. Services for or related to hearing aid devices and tinnitus maskers, except as provided herein.
24. Physical, occupational, and speech therapy services for or related to the treatment of learning disabilities and disorders, that are not medically necessary and appropriate, such as services provided in a school setting.
25. New to market FDA-approved drugs, devices, diagnostics, therapies, and medical treatments until they have been reviewed and approved by the Medical Claims Administrator and deemed eligible for coverage.

26. To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this health plan and you elect this coverage as primary.
27. Charges for the covered patient's failure to keep a scheduled visit.
28. Charges billed by your provider for the completion of a claim form.
29. Any other medical or dental service or treatment or prescription drug, except as provided herein.
30. For treatment or services for injuries resulting from the maintenance or use of a motor vehicle, including a motor vehicle accident, if such treatment or service is eligible, paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable. Charges that are eligible, paid, or payable under any medical payment, automobile personal injury protection that is payable without regard to fault, including charges for services that are applied toward any deductible, copay or coinsurance requirement of such a policy.
31. Fees, dues, exercise therapy, or any non-prescription substance utilized for the sole purpose of weight management.
32. Services for or related to care that is custodial or not normally provided as preventive care or for treatment of an illness/injury.
33. Services which are not prescribed by or performed by or upon the direction of a professional provider.
34. Services which are submitted by another professional provider of the same specialty for the same services performed on the same date for the same member.
35. Services performed by a professional provider enrolled in an education or training program when such services are related to the education or training program.
36. Services after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care.
37. Services for or related to tobacco cessation program fees and/or supplies, except as provided herein.
38. Services for or related to any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.
39. Expenses incurred for services, supplies, medical care or treatment received at a health care provider that represents to a patient that they will not owe the required cost-sharing amount (including, for example, deductibles, copays, and coinsurance) described in this plan.
40. Services for or related to the prescribed use of recreational therapy or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional, and/or social disadvantages.
41. Services for or related to educational therapy and other nonmedical services normally provided in an educational setting including, but not limited to, special education classes, tutoring, boarding school, or school tuition.
42. Services for or related to nonmedical self-care or self-help training including, but not limited to, health club memberships, aerobic conditioning, therapeutic exercises, work hardening programs, or spas.
43. Services for furnishing medical records or reports and associated delivery services.
44. Services for transportation, other than local ambulance service, to the nearest medical facility provider that can provide the necessary services/is equipped to treat the condition, except as provided herein.
45. Ambulance transportation costs that exceed the allowable cost from the place of departure to the nearest medical facility that can provide the necessary service/is equipped to treat the condition.
46. Services for or related to therapeutic massage.
47. Services for or related to experimental infertility treatment procedures, surrogacy services, or cryopreservation of eggs or sperm, except as provided herein.

48. Charges for donor ova or sperm (however, this may be covered through the Fertility Program).
49. Services for or related to preservation, storage, and thawing of human tissue, including, but not limited to: sperm; ova; embryos; stem cells; cord blood; and any other human tissue.
50. Services provided during an e-visit for the sole purpose of: scheduling medical appointments; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
51. Services provided during a telehealth visit for the sole purpose of: scheduling appointments; filling or renewing existing prescription drugs; reporting normal medical test results; providing educational materials; updating patient information; requesting a referral; additional communication on the same day as an onsite medical office visit; and services that would similarly not be charged for in an onsite medical office visit.
52. Services and fees for or related to health clubs and spas.
53. Services for or related to the repair of scars and blemishes on skin surfaces, except as provided herein.
54. Services for hippotherapy (equine movement therapy).
55. Maintenance services unless part of a specialized therapy for the member's condition.
56. Services that do not involve direct patient contact such as delivery services and recordkeeping billed by an out-of-network provider.
57. Out-of-network provider-initiated communications.
58. Services for educational classes, educational programs, and services primarily educational in nature, except for services such as medical nutrition therapy and nutritional counseling, parent education following early maternity discharge, prenatal education, diabetes outpatient self-management training and education, specialty drug patient education that cannot be provided by a retail pharmacy, preventive patient education/counseling, or as otherwise required by law. Services for or related to preparing a person with disabilities for employment, or assisting an individual to return to work.
59. Services for or related to gene therapy or cellular therapy until they have been evaluated by the Medical Claims Administrator and deemed eligible for coverage.
60. Services for or related to any treatment, equipment, drug, and/or device that does not meet generally accepted standards of practice in the medical community, including but not limited to, homeopathy, naturopathy, and reiki.
61. Services for or related to chelation therapy that are not medically necessary and appropriate.
62. Drugs that are not approved by the Food and Drug Administration (FDA).
63. Prescription drugs including, but not limited to, biological products, biosimilars, and gene or cellular therapies, that have an alternative drug available that is similar in safety and effectiveness and is more cost-effective.
64. Solid or liquid food, any formula (including infant formula, with intact proteins), banked breast milk, nutritional supplements, and electrolyte solution, except as provided in the "Benefit Chart."
65. Enteral feedings, except as provided in the "Benefit Chart."
66. Charges for administering drugs that can be self-administered.
67. Self-administered drugs that are available for coverage under any applicable pharmacy/prescription drug benefit.
68. Vitamin or dietary supplements, except as provided herein.
69. Charges for food supplements.
70. Nonprescription supplies such as alcohol, cotton balls, and alcohol swabs.
71. Intact protein/protein isolates, including but not limited to, semisynthetic, natural, plant-based, or hydrolyzed, when taken orally (for example, protein powders).

72. Bulk powders, chemicals, ingredients, and products used in prescription drug compounding.
73. Services for or related to fetal tissue transplantation.
74. Travel expenses for an organ donor.
75. Organ donor expenses for complications incurred after the organ is removed if the donor is not covered under this health plan.
76. Organ donor expenses when the recipient is not covered for the organ transplant under this health plan.
77. Services for or related to the treatment of compulsive gambling.
78. Outpatient prescription drugs whether purchased through a mail service pharmacy/90dayRx or a retail pharmacy, are not covered under this plan. Refer to your employer for prescription drug plan materials that explain your coverage.
79. Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances).

HEALTH CARE MANAGEMENT

MEDICAL AND BEHAVIORAL HEALTH CARE MANAGEMENT

The Medical Claims Administrator reviews services to verify that they are medically necessary and appropriate, and that the treatment provided is the proper level of care. The Medical Claims Administrator's review includes applying evidence-based benefit coverage criteria that may require a provider to submit a treatment plan. All applicable terms and conditions of your Health Plan including exclusions, deductibles, copays, and coinsurance provisions continue to apply after a prior authorization is approved or admission notification is completed.

Prior authorization and admission notification are only required for specific services. These requirements apply to the start of services and ongoing services you may receive.

If the care you receive is due to a medical emergency, prior authorization is not required.

If you are admitted to the hospital due to an emergency, admission notification is required as soon as reasonably possible, and no later than two (2) business days, following the admission.

Prior Authorization Including Concurrent Review

The prior authorization process ensures that you receive medically necessary, high-quality care in the appropriate clinical setting (level of care), in accordance with evidence-based standards. The initial prior authorization should be obtained before a service is rendered. The Medical Claims Administrator's prior authorization list describes the services for which prior authorization is required. The prior authorization list is subject to change due to changes in the Medical Claims Administrator's medical and behavioral health policies. The Medical Claims Administrator reserves the right to revise, update and/or add to this list at any time without notice.

If additional services that require prior authorization are needed beyond what was initially approved, a new authorization is required and should be completed before any additional services are received. For inpatient facility services, this is referred to as a concurrent review of a continued stay.

The most current list of services requiring prior authorization is available on the Medical Claims Administrator's website at bluecrossmn.com/hormelfoods or by contacting customer service at the telephone number listed on the back of your member ID card.

Participating Providers in Minnesota and Bordering Counties

When you receive services that require prior authorization from a participating provider in Minnesota and bordering counties, the provider is required to obtain prior authorization for you. Participating providers in Minnesota and bordering counties who do not obtain required prior authorization are responsible for the charges (except where other benefit exclusions apply).

Nonparticipating Providers and Participating Providers Located Outside of Minnesota and Bordering Counties

When you receive services that require prior authorization from a nonparticipating provider or any provider outside of Minnesota/bordering counties, you may have to obtain prior authorization yourself. Some of

these providers may obtain prior authorization for you. Verify with your providers if this is a service they will perform for you or not. If prior authorization is not completed and at the point the claim is processed it is found that services received from a nonparticipating provider or any provider outside of Minnesota/bordering counties were non-emergent and/or not medically necessary and appropriate, you are liable for all of the charges.

The Medical Claims Administrator prefers that all requests for prior authorization be submitted in writing to ensure accuracy. **Please contact customer service at the telephone number listed on the back of your member ID card for the appropriate fax number or mailing address for prior authorization requests.**

Standard review process

The Medical Claims Administrator requires that you or the provider contact them at least 10 business days prior to the provider scheduling the care/services to determine if the services are eligible. The Medical Claims Administrator will notify you of their decision within 10 business days, provided that the prior authorization request contains all the information needed to review the service.

Expedited review process

The Medical Claims Administrator will use an expedited review process when the application of a standard review could seriously jeopardize your life or health or if the attending health care professional believes an expedited review is warranted. When an expedited review is requested, the Medical Claims Administrator will notify you as expeditiously as the medical condition requires, but no later than 72 hours from the initial request, unless more information is needed to determine whether the requested benefits are covered. If the expedited determination is to not authorize services, you may submit an expedited appeal. Please refer to "Appeals of Adverse Benefit Determinations" for more information about submitting an expedited appeal.

The Medical Claims Administrator prefers that all requests for prior authorization be submitted to them in writing to ensure accuracy. Please contact customer service at the telephone number listed on the back of your member ID card for the appropriate fax number or mailing address for prior authorization requests.

Admission Notifications

- **Planned Admissions** - Your provider, or you, must inform the Medical Claims Administrator that you will be admitted for inpatient hospitalization services at least two (2) days prior to being admitted, or as soon as reasonably possible, no later than two (2) business days, following the admission.
- **Emergency/unplanned admissions** - Your provider, or you, must inform the Medical Claims Administrator of an unplanned or emergency admission to a hospital as soon as reasonably possible, no later than two (2) business days, following the admission.

Upon receipt of an admission notification, the Medical Claims Administrator may reach out to you or your provider to ensure your needs are met and to help you when you are discharged.

Acknowledgement of an admission notification is not the same as prior authorization. You, or your provider, may also be required to obtain prior authorization for the services or procedures performed during a hospital stay; such as, an elective surgery or treatment that requires you to be admitted to the hospital. Please refer to "Prior Authorization" in this section to determine if you, or your provider, is responsible for obtaining any required prior authorization(s).

Participating Providers

Participating providers in Minnesota and participating providers outside of Minnesota are required to provide admission notification and emergency admission notification for you. You will not be held responsible if notification is not completed when using participating providers.

Nonparticipating Providers

You are required to provide admission notification to the Medical Claims Administrator if you are going to receive care from any nonparticipating providers. Some of these providers may provide admission notification for you. Verify with your provider if this is a service they will perform for you or not.

You may be held financially responsible if notification is not completed when using non-participating facilities. To provide admission notification, contact customer service at the telephone number listed on the back of your member ID card.

Note: If, at the point the claim is processed, it is found that any services received from a nonparticipating facility were not medically necessary and appropriate, you are liable for all the charges.

Medical and Behavioral Health Care Management Overview

The following chart is an overview of the information outlined in the previous section. For more detail, refer to the previous section.

Services received from:	Services that Require Prior Authorization	Planned Admission Notification	Emergency/Unplanned Admission Notification
Participating Provider Minnesota/Bordering Counties	Provider is responsible to request this for you and the provider must send the request in writing at least 10 business days prior to services.	Provider is responsible for completing the notification at least two (2) days prior to the admission, or as soon as reasonably possible, no later than two (2) business days, following the admission.	Provider is responsible for completing the notification as soon as reasonably possible, no later than two (2) business days, following the admission.
Participating Provider Outside of Minnesota/Bordering Counties	You are responsible for obtaining the prior authorization and you must send the request in writing at least 10 business days prior to services.	Provider is responsible for completing the notification at least two (2) days prior to the admission or as soon as reasonably possible, no later than two (2) business days, following the admission.	Provider is responsible for completing the notification as soon as reasonably possible, no later than two (2) business days, following the admission.
Nonparticipating Provider Nationwide	You are responsible for obtaining the prior authorization and you must send the request in writing at least 10 business days prior to services.	You are responsible for completing the notification and you must call at least two (2) days prior to the admission or as soon as reasonably possible, no later than two (2) business days, following the admission.	You are responsible for completing the notification and you must call as soon as reasonably possible, no later than two (2) business days, following the admission.

HOW YOUR MEDICAL PROGRAM WORKS

Your health plan lets you get the care you want from the provider you select. When you or a covered family member needs medical care, you can choose between two (2) levels of health care services: **in-network** or **out-of-network**.

IN-NETWORK CARE

In-network care is care you receive from providers in the health plan's network.

When you receive health care within the network, you enjoy maximum coverage and maximum convenience. You present your member ID card to the provider who submits your claim.

OUT-OF-NETWORK CARE

Out-of-network care is care you receive from providers who are not in-network.

When you go outside the network, you will still be covered for eligible services. However, your benefits generally will be paid at the lower, out-of-network level. Additionally, prior authorization may be required from the Medical Claims Administrator before services are received. For specific details, please refer to "Health Care Management."

Please note that you may incur significantly higher financial liability when you use nonparticipating providers compared to the cost of receiving care from in-network providers. If you receive services from a nonparticipating provider, you will be responsible for any deductibles or coinsurance plus the difference between what the Medical Claims Administrator would reimburse for the nonparticipating provider and the actual charges the nonparticipating provider bills. This difference does not apply to your out-of-pocket limit. This is in addition to any applicable deductible, copay or coinsurance. Benefit payments are calculated on the Medical Claims Administrator's allowed amount, which is typically lower than the amount billed by the provider. In addition, participating facilities may have nonparticipating professionals practicing at the facility and you may be responsible for significantly higher out-of-pocket expenses for the nonparticipating professional services.

OUT-OF-AREA CARE

Your health plan also provides coverage for you and your eligible dependents who are temporarily away from home, or those dependents who permanently reside away from home.

Services received from providers across the country who are part of the local Blue Cross and Blue Shield BlueCard PPO network will be covered at the higher level of benefits. If you receive covered non-emergency services from a provider who is not part of the local Blue Cross and Blue Shield BlueCard PPO network, these services will be covered at the lower, out-of-network level of benefits.

If you are traveling and an urgent injury or illness occurs, you should seek treatment immediately.

Emergency services will be covered at the higher benefit level. If the treatment results in an admission, please refer to "Health Care Management" for admission notification requirements.

Non-emergency benefits apply to follow-up or scheduled services once your condition has stabilized.

If the illness or injury is not an emergency, services will be paid at the lower, out-of-network level. See "Out-of-network Care" for more information about coverage.

GENERAL PROVIDER PAYMENT METHODS

This is a general summary of provider payment methodologies only. Provider payment methodologies may change from time to time and every current provider payment methodology may not be reflected in this summary. Please note that some of these payment methodologies may not apply to your particular plan.

Participating Providers

Under the payment arrangements of the participating provider agreements, providers have agreed to provide care and receive the contractual allowed amount as payment in full, less member cost-sharing (e.g., deductible, coinsurance, copays) or amounts paid by other insurance for health services. The allowed amount may vary from one (1) provider to another for the same service. These payment amounts generally result in the provider being paid less overall than its billed charges.

The allowed amount may not include other payment adjustments which may occur periodically including settlements to capture complex claims accurately, settlements for withhold, capitation, outlier cases, fee schedule adjustments, rebates, prospective payments, or other methods. Such adjustments are completed without reprocessing individual claims. These settlements will not cause any change in the amount members paid at the time of claims processing. If the payment to the provider is decreased, the amount of the decrease is credited to the Medical Claims Administrator, and if the payment to the provider is increased, the Medical Claims Administrator will pay that cost.

Several industry-standard methods are used to pay health care providers. If the provider is "participating" they are under contract and the method of payment is part of the contract. Most contracts and payment rates are negotiated or revised on an annual basis.

Depending upon your health plan, a participating provider may be an in-network provider or may be an out-of-network provider. Payment will be based upon which network the participating provider is in for your health plan. Please refer to "How Your Medical Program Works" for additional detail on covered services received in the in-network and out-of-network.

- Professional (i.e., doctor visits, office visits)
- **Fee-for-Service or Discounted Fee-for-Service** - Providers are paid for each service or bundle of services. Payment is based on a fee schedule allowance for each service or a percentage of the provider's billed charges.

- **Withhold and Bonus Payments** - Providers are paid based upon a fee schedule or percentage of billed charges, and a portion is withheld. As an incentive to promote high quality and cost-effective care, the provider may receive all or a portion of the withhold amount based upon the cost-effectiveness of the care while demonstrating the optimal treatment for patients.
- **Capitation Payments** – Providers may be paid in part based upon a per person per month capitation amount. This amount is calculated based upon historical costs and volumes to determine the average costs for providing medically necessary care to a patient.
- Institutional (i.e., hospital and other facility provider)
 - Inpatient care
 - **Payments for each Case (case rate) or for each day (per diem)** - Providers are paid a fixed amount based upon the member's diagnosis at the time of admission in a hospital facility.
 - **Percentage of Billed Charges** - Providers are paid a percentage of the hospital's or facility provider's billed charges for inpatient services.
 - **DRG Payments** – All Patient Refined Diagnosis Related Groups (APR DRG) or other DRG payments apply to most inpatient claims. DRG payments are based upon the full range of services the patient typically receives to treat the condition.
 - Outpatient care
 - **Enhanced Ambulatory Patient Groupings (EAPG)** – Used for payment on most outpatient claims. EAPG payments are based upon the full range of services the patient typically receives to treat the condition.
 - **Payments for each Category of Services** - Providers are paid a fixed or bundled amount for each category of outpatient services a member receives during one (1) or more related visits.
 - **Payments for each visit** - Providers are paid a fixed or bundled amount for all related services a member receives during one (1) visit.
 - **Percentage of Billed Charges** – Providers are paid a percentage of their regular billed charges for services.
- Special Incentive Payments

As an incentive to promote high quality, cost-effective care and to recognize those providers that participate in certain quality improvement projects, providers may be paid extra amounts based on the quality of the care and on savings that the provider may generate through cost effective care. Certain providers also may be paid in advance in recognition of their efficiency in managing the total cost of providing high quality care and implementing programs such as care coordination. Quality is measured against adherence to recognized quality criteria and improvement such as optimal diabetes care, supporting tobacco cessation, cancer screenings, and other services. Cost of care is based on quantifiable criteria to demonstrate managing claims costs. These quality and cost incentives are not reflected in claims payment.
- Pharmacy Payment

Generally, four (4) types of pricing are compared and the lowest amount is paid the:

 - average wholesale price of the prescription drug, less a discount, plus a dispensing fee;
 - pharmacy's retail price;
 - maximum allowable cost the Medical Claims Administrator determines by comparing market prices (for generic drugs only); or
 - pharmacy's billed charge.

Nonparticipating Providers

A nonparticipating provider does not have any agreement with the Medical Claims Administrator or another Blue Cross and/or Blue Shield plan. Nonparticipating providers are not credentialed or subject to the requirements of a participating agreement.

The allowed amount for a nonparticipating provider is not the amount billed and is usually less than the allowed amount for a participating provider for the same service and can be significantly less than the billed charge. Members are responsible to pay the difference between the Medical Claims Administrator's allowed amount

and the nonparticipating provider's billed charge, except as described in "Special Circumstances." This amount can be significant and does not count toward any out-of-pocket limit contained in the plan.

Payment for covered services provided by a nonparticipating provider will be made at the out-of-network level. Please refer to "Out-of-network Care" and "In-network Care" for additional detail on covered services received in-network and out-of-network.

Example

The following illustrates the different out-of-pocket costs you may incur using nonparticipating versus participating providers. The example presumes that your deductible has been satisfied and that the health plan covers 80% for participating providers and 65% for nonparticipating providers.

	Participating Provider	Nonparticipating Provider
Provider charge:	\$150	\$150
Allowed amount:	\$100	\$80
Medical Claims Administrator pays:	80% (\$80)	65% (\$52)
Coinsurance you owe:	20% (\$20)	35% (\$28)
Difference up to billed charge you owe:	None	\$70 (\$150 minus \$80)
You pay:	\$20	\$98

Special Circumstances

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copay, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

What is "balance billing" (sometimes called "surprise billing")?

Nonparticipating providers and facilities that have not signed a contract with your health plan may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care-like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by a nonparticipating provider.

Your Rights and Protections Against Surprise Medical Bills

There may be circumstances where you require medical or surgical care and you do not have the opportunity to select the provider of care. These circumstances could include nonparticipating providers in an in-network hospital, your in-network physician using a nonparticipating laboratory, post-stabilization following emergency services, or medically necessary air ambulance services.

When you get emergency care or get treated by a nonparticipating provider at an in-network hospital or ambulatory surgery center, you are protected from surprise billing or balance billing. In-network cost-sharing for these services must be applied to your in-network deductible/out-of-pocket maximum.

When a claim is identified as a special circumstance, payment will be made to the nonparticipating provider when required by law. These nonparticipating providers can negotiate with the Medical Claims Administrator for a higher allowed amount after the initial payment has been made. This may result in an increase to the amount applied to your in-network cost-sharing. For additional information, you can contact customer service at the telephone number listed on the back of your member ID card or log onto your Medical Claims Administrator's website at bluecrossmn.com/hormelfoods.

You are protected from balance billing for:

- Certain services at an in-network hospital or ambulatory surgery center - When you get services from an in-network hospital or ambulatory surgery center, certain providers may be nonparticipating providers. In

these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.

- Emergency services - If you have an emergency medical condition and get emergency services from a nonparticipating provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- Surprise Air Ambulance Bills – Emergency air ambulance transportation that is provided to you by nonparticipating providers will be reimbursed at in-network cost-sharing rates. Nonparticipating air ambulance providers cannot balance bill you. They can only bill you for the usual cost-sharing amount set by your plan. In addition, in-network cost-sharing for these services must be applied to your in-network deductible/out-of-pocket maximum. Please refer to "Ambulance" for coverage of benefits.

Steps You Can Take

If you receive a bill from a nonparticipating provider while using a participating hospital or facility, and you did not provide written consent to receive the services, this could be a "surprise" or "balance" bill. If you have questions regarding what a "surprise" or "balance" bill is, call customer service at the number on the back of your ID card or visit the Medical Claims Administrator's website at bluecrossmn.com/hornelfoods. The extent of reimbursement in certain medical emergency circumstances may also be subject to state and federal law, please refer to "Emergency Care" for coverage of benefits. You may appeal a decision that your claim does not qualify as a special circumstance. Please refer to "Appeal Process."

INTER-PLAN ARRANGEMENTS

Out-of-area Services

The Medical Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These inter-plan arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access health care services outside the geographic area the Medical Claims Administrator serves, the claim for those services may be processed through one (1) of these inter-plan arrangements. The inter-plan arrangements are described below.

Plan Arrangements

When you receive care outside of the Medical Claims Administrator's service area, you will receive it from one (1) of two (2) kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. The Medical Claims Administrator explains below how the Medical Claims Administrator pays both kinds of providers.

INTER-PLAN ARRANGEMENTS ELIGIBILITY - CLAIM TYPES

All claim types are eligible to be processed through inter-plan arrangements, as described above, except for all dental care benefits except when paid as medical claims/benefits, and those vision care benefits that may be administered by a third party contracted by the Plan Administrator to provide the specific service or services.

BLUECARD® PROGRAM

Under the BlueCard® Program, when you receive covered health care services within the geographic area served by a Host Blue, the Medical Claims Administrator will remain responsible for doing what the Medical Claims Administrator agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

Whenever you receive covered health care services outside the Medical Claims Administrator's service area and the claim is processed through the BlueCard program, the amount you pay for covered health care services is calculated based on the lower of:

- the billed charges for covered services; or
- the negotiated price that the Host Blue makes available to the Medical Claims Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to

your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price the Medical Claims Administrator has used for your claim because they will not be applied after a claim has already been paid.

NEGOTIATED (NON-BLUECARD PROGRAM) ARRANGEMENTS (WISCONSIN AND GEORGIA EMPLOYEES ONLY)

With respect to one (1) or more Host Blues, instead of using the BlueCard program, the Medical Claims Administrator may process your claims for covered health care services through Negotiated Arrangements for National Accounts.

The amount you pay for covered health care services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (refer to the description of negotiated price under BlueCard program section) made available to the Medical Claims Administrator by the Host Blue.

SPECIAL CASES: VALUE-BASED PROGRAMS

BlueCard® Program

If you receive covered health care services under a value-based program inside a Host Blue's service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Medical Claims Administrator through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements

If the Medical Claims Administrator has entered into a Negotiated Arrangement with a Host Blue to provide value-based programs to employer on your behalf, the Medical Claims Administrator will follow the same procedures for value-based programs administration and care coordinator fees as noted above for the BlueCard program.

INTER-PLAN PROGRAMS: FEDERAL/STATE TAXES/SURCHARGES/FEES

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the Medical Claims Administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

NONPARTICIPATING PROVIDERS OUTSIDE THE MEDICAL CLAIMS ADMINISTRATOR'S SERVICE AREA

When covered health care services are provided outside of the Medical Claims Administrator's service area by nonparticipating providers, the amount you pay for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment the Medical Claims Administrator will make for the covered health care services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

BLUE CROSS BLUE SHIELD GLOBAL® CORE

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing covered health care services. Blue Cross Blue Shield Global Core is unlike the BlueCard program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service

area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven (7) days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered health care services. **You must contact the Medical Claims Administrator to obtain approval for non-emergency inpatient services.**

Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered health care services.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for covered health care services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Medical Claims Administrator, the service center or online at bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven (7) days a week.

OUT-OF-COUNTRY BENEFITS

Eligible services coordinated through the Blue Cross Blue Shield Global Core program (please refer to "Inter-Plan Arrangements," "Blue Cross Blue Shield Global Core") will process at the network level of coverage.

Call the Blue Cross Blue Shield Global Core service center within 24 hours of a medical emergency at 1-804-673-1177. You will be advised by the service center if services are not eligible under this program.

If you do not call the Blue Cross Blue Shield Global Core service center or services are not eligible under this program, eligible services will process at the out-of-network level of benefits.

Services not covered under the plan will not be considered for benefits.

YOUR PROVIDER NETWORK

Your provider network is your key to receiving the higher level of benefits. The network includes: thousands of physicians; a wide range of specialists; a wide variety of mental health and substance use disorder providers; community and specialty hospitals; and laboratories in the health plan service area.

To determine if your physician is in-network, call the customer service toll-free telephone number listed on the back of your member ID card.

Getting your care "through the network" also assures you get quality care. All physicians are carefully evaluated before they are accepted into the network. The Medical Claims Administrator considers educational background, office procedures and performance history to determine eligibility. Then the Medical Claims Administrator monitors care on an ongoing basis through office record reviews and member satisfaction surveys.

Please note that while you or a family member can use the services of any in-network physician or specialist without a referral and receive the maximum coverage under your health plan, you are encouraged to select a personal physician. This helps establish an ongoing relationship based on knowledge and trust and helps make your care consistent. Your personal physician can help you select an appropriate specialist and work closely with that specialist when the need arises. In addition, primary care providers or their covering physicians are on call 24/7.

Remember: If you want to enjoy the higher level of benefits, it is *your* responsibility to ensure that you receive in-network care. You may want to double-check any provider recommendations to make sure the doctor or

facility provider is in-network. Your provider directory lists in-network providers in our service area and may change from time to time, including as providers or the Medical Claims Administrator initiate or terminate network contracts. Prior to receiving services, it is recommended that you verify your provider's network status with the Medical Claims Administrator, including whether the provider is an in-network provider for your particular plan. Not every provider is an in-network provider for every plan. For a list of providers in the directory, visit bluecrossmn.com/hormelfoods or call the customer service toll-free telephone number listed on the back of your member ID card. For benefit information, please refer to "Benefit Overview."

HOW TO GET YOUR PHYSICIANS' PROFESSIONAL QUALIFICATIONS

To view Board Certification information, hospital affiliation or other professional qualifications of your provider, visit your member website at bluecrossmn.com/hormelfoods, or contact customer service at the telephone number listed on the back of your member ID card.

CONTINUITY OF CARE

Continuity of Care for New Members

If you are a member of a group that is new to the Medical Claims Administrator, this section applies to you. If you are currently receiving care from an out-of-network physician or specialist, you may request to continue to receive care from this physician for a special medical need or condition for a reasonable period of time before transferring to an in-network physician as required under the terms of your coverage under the health plan. The Medical Claims Administrator will authorize this continuation of care for a terminal illness in the final stages or for the rest of your life if a physician, advanced practice nurse, or physician assistant certifies that your life expectancy is 180 days or less. The Medical Claims Administrator will also authorize this continuation of care if you are engaged in a current course of treatment for any of the following conditions or situations:

Continuation for up to 120 days if you:

1. have an acute condition;
2. have a life-threatening mental or physical illness;
3. have a physical or mental disability rendering you unable to engage in one (1) or more major life activities provided that the disability has lasted or can be expected to last for at least one (1) year, or that has a terminal outcome;
4. have a disabling or chronic condition in an acute phase or that is expected to last permanently;
5. are receiving culturally appropriate services from a provider with special expertise in delivering those services; or
6. are receiving services from a provider that speaks a language other than English.

Continuation through the postpartum period (six (6) weeks post-delivery) for a pregnancy beyond the first trimester.

Transition to In-network Providers - The Medical Claims Administrator will assist you in making the transition from an out-of-network to an in-network provider if you request them to do so. Please contact customer service for a written description of the transition process, procedures, criteria, and guidelines.

Limitation - Continuity of Care applies only if your provider agrees to: 1) adhere to all of the Medical Claims Administrator's prior authorization requirements; and 2) provide the Medical Claims Administrator with necessary medical information related to your care.

Continuity of Care does not apply to services that are not covered under the health plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one (1) plan to another.

Provider Termination for Cause - If it is known that the Medical Claims Administrator has terminated its relationship with your provider for cause, the Medical Claims Administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to an in-network provider must occur on or prior to the date of such termination for you to continue to receive in-network benefits.

Continuity of Care for Current Members

If you are a current member or dependent, this section applies to you. If the relationship between your in-network clinic or physician and the Medical Claims Administrator ends, rendering your clinic or provider out-of-network, and the termination was by the Medical Claims Administrator and was not for cause, you may request to continue to receive care for a special medical need or condition for a reasonable period of time before

transferring to a participating provider as required under the terms of your coverage under the health plan. The Medical Claims Administrator will authorize this continuation of care for a terminal illness in the final stages or for the rest of your life if a physician, advanced practice nurse, or physician assistant certifies that your life expectancy is 180 days or less. The Medical Claims Administrator will also authorize this continuation of care if you are engaged in a current course of treatment for any of the following conditions or situations:

Continuation for up to 120 days if you:

1. have an acute condition;
2. have a life-threatening mental or physical illness;
3. have a physical or mental disability rendering you unable to engage in one (1) or more major life activities provided that the disability has lasted or can be expected to last for at least one (1) year, or that has a terminal outcome;
4. have a disabling or chronic condition in an acute phase or that is expected to last permanently;
5. are receiving culturally appropriate services from a provider with special expertise in delivering those services; or
6. are receiving services from a provider that speaks a language other than English.

Continuation through the postpartum period (six (6) weeks post-delivery) for a pregnancy beyond the first trimester.

Continuation for members who are undergoing treatment within the first trimester of pregnancy is up to 90 days of coverage.

Transition to In-network Providers - The Medical Claims Administrator will assist you in making the transition from an out-of-network to an in-network provider if you request them to do so. Please contact customer service for a written description of the transition process, procedures, criteria, and guidelines.

Limitation - Continuity of Care applies only if your provider agrees to: 1) adhere to all of the Medical Claims Administrator's prior authorization requirements; and 2) provide the Medical Claims Administrator with necessary medical information related to your care.

Continuity of Care does not apply to services that are not covered under the health plan, does not extend benefits beyond any existing limits, dollar maximums, or coverage termination dates, and does not extend benefits from one (1) plan to another.

Provider Termination for Cause - If it is known that the Medical Claims Administrator has terminated its relationship with your provider for cause, the Medical Claims Administrator will not authorize continuation of care with, or transition of care to, that provider. Your transition to an in-network provider must occur on or prior to the date of such termination for you to continue to receive in-network benefits.

GENERAL INFORMATION

MEDICARE END STAGE RENAL DISEASE PROGRAM REGISTRATION

For members diagnosed with End Stage Renal Disease (ESRD), your provider is required to complete the Centers for Medicare and Medicaid Services (CMS) form CMS-2728-U3 ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration. Your provider must send the completed form to CMS and the Medical Claims Administrator. Please verify with your provider that form CMS-2728-U3 has been completed and submitted.

CHARGES THAT ARE YOUR RESPONSIBILITY

In-network Providers

When you use in-network providers for covered services, payment is based on the allowed amount. You are not required to pay for charges that exceed the allowed amount. You are required to pay the following amounts:

1. deductibles and coinsurance;
2. copays;
3. charges that exceed the benefit maximum; and
4. charges for services that are not covered.

Out-of-network Providers

Out-of-network Participating Providers

When you use out-of-network participating providers for covered services, payment is based on the allowed amount. You may not be required to pay for charges that exceed the allowed amount. All out-of-network participating providers in Minnesota accept the Medical Claims Administrator's payment based on the allowed amount. Most out-of-network participating providers outside Minnesota accept the Medical Claims Administrator's payment based on the allowed amount. However, contact your out-of-network participating provider outside Minnesota to verify if they accept the Medical Claims Administrator's payment based on the allowed amount (to determine if you will have additional financial liability). You are required to pay the following amounts:

1. charges that exceed the allowed amount if the out-of-network participating provider outside Minnesota does not accept the Medical Claims Administrator's payment based on the allowed amount;
2. deductibles and coinsurance;
3. copays;
4. charges that exceed the benefit maximum; and
5. charges for services that are not covered.

Nonparticipating Providers

When you use nonparticipating providers for covered services, payment is still based on the allowed amount. However, because a nonparticipating provider has not entered into a network contract with the Medical Claims Administrator or the local Blue Cross and/or Blue Shield plan, the nonparticipating provider is not obligated to accept the allowed amount as payment in full, except as described in "Special Circumstances." This means that you may have substantial out-of-pocket expense when you use a nonparticipating provider. You are required to pay the following amounts:

1. charges that exceed the allowed amount;
2. deductibles and coinsurance;
3. copays;
4. charges that exceed the benefit maximum;
5. charges for services that are not covered including services that the Medical Claims Administrator determined are not covered based on claims coding guidelines; and
6. charges for services that are investigative or not medically necessary and appropriate.

MEDICAL AND BEHAVIORAL HEALTH POLICY COMMITTEE AND MEDICAL POLICIES

The Medical Claims Administrator uses externally-developed criteria, as well as internally-developed medical policies to apply benefits consistently for members. Internally developed policies are subject to approval by the Medical Claims Administrator's Medical and Behavioral Health Policy Committee, which consists of independent community physicians who represent a variety of specialties as well as a clinical psychologist and pharmacist. The remaining policies are approved by other external specialists. For all policies, the Medical Claims Administrator's goal is to find the right balance between making improved treatments available and guarding against unsafe or unproven approaches. From time-to-time, new policies may be created or existing policies may change. Covered benefits will be determined in accordance with the policies in effect at the time treatment is rendered or, if applicable, prior authorization may also be required. Internally developed medical and behavioral health policies can be found at the member website. All medical and behavioral health policies are available upon request.

HOW TO FILE A CLAIM

Under Department of Labor regulations, claimants are entitled to a full and fair review of any claims made under this Health Plan. The claims procedures described in this SPD are intended to comply with those regulations by providing reasonable procedures governing the filing of claims, notification of benefit decisions, and appeals of adverse benefit determinations. A claimant must follow these procedures in order to obtain payment of benefits under this Health Plan. If the Medical Claims Administrator, in its sole discretion, determines that a claimant has not incurred a covered expense or that the benefit is not covered under this Health Plan, no benefits will be payable under this Health Plan. All claims and questions regarding claims should be directed to the Medical Claims Administrator.

TYPES OF CLAIMS

A “claim” is any request for a Health Plan benefit made in accordance with these claims procedures. You become a “claimant” when you make a request for a Health Plan benefit in accordance with these claims procedures. There are four types of claims, each with different claim and appeal rules. The primary difference is the timeframe within which claims and appeals must be determined. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a claim.

Pre-Service Claim

A “pre-service claim” is any request for a Health Plan benefit where the Health Plan specifically conditions receipt of the benefit, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the claim involves urgent care, as defined below. If the Health Plan does not require a claimant to obtain approval of a medical service prior to getting treatment, then there is no “pre-service claim.” The claimant simply follows these claims procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a post-service claim.

Urgent Care Claim

An “urgent care claim” is a special type of pre-service claim. An “urgent care claim” is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the life or health of the claimant or the claimant’s ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The Medical Claims Administrator will determine whether a pre-service claim involves urgent care, provided that, if a physician with knowledge of the claimant’s medical condition determines that a claim involves urgent care, the claim will be treated as an urgent care claim.

IMPORTANT: If a claimant needs medical care for a condition that could seriously jeopardize their life, there is no need to contact the Medical Claims Administrator for prior approval. The claimant should obtain such care without delay.

Concurrent Care Claim

A “concurrent care claim” arises when the Medical Claims Administrator has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the Medical Claims Administrator determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the Medical Claims Administrator has approved. If the Health Plan does not require a claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Medical Claims Administrator to request an extension of a course of treatment. The claimant follows these claims procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a post-service claim.

Post-Service Claim

A “post-service claim” is any request for a Health Plan benefit that is not a pre-service claim or an urgent care claim.

Change in Claim Type

The claim type is determined when the claim is initially filed. However, if the nature of the claim changes as it proceeds through these claims procedures, the claim may be re-characterized. For example, a claim may initially be an urgent care claim. If the urgency subsides, it may be re-characterized as a pre-service claim. It is very important to follow the requirements that apply to your particular type of claim. If you have any questions regarding the type of claim and/or what claims procedure to follow, contact the Medical Claims Administrator.

FILING CLAIMS

Except for urgent care claims, discussed below, a claim is made when a claimant (or authorized representative) submits a request for Health Plan benefits to the Medical Claims Administrator. A claimant is not responsible for submitting claims for services received from in-network or out-of-network participating providers. These providers will submit claims directly to the local Blue Cross and Blue Shield plan on the claimant’s behalf and payment will be made directly to these providers. If a claimant receives services from nonparticipating providers, they may have to submit the claims themselves. If the provider does not submit the claims on behalf

of the claimant, the claimant should send the claims to the Medical Claims Administrator. The necessary forms may be obtained by contacting the Medical Claims Administrator. A claimant may be required to provide copies of bills, proof of payment, or other satisfactory evidence showing that they have incurred a covered expense that is eligible for reimbursement.

Payment of a claim does not preclude the right of the Medical Claims Administrator to deny future claims or take any action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid.

Urgent Care Claims

An urgent care claim may be submitted to the Medical by calling the telephone number located on the back of your ID card.

Pre-Service Claims

A pre-service claim (including a Concurrent Care claim that is also a pre-service claim) is considered filed when the request for approval of treatment or services is made and received by the Medical Claims Administrator.

A post-service Claim must be filed within 30 days following receipt of the medical service, treatment or product to which the claim relates unless (a) it was not reasonably possible to file the claim within such time; and (b) the claim is filed as soon as possible and in no event (except in the case of legal incapacity of the claimant) later than 12 months after the date of receipt of the service, treatment or product to which the claim relates.

Post-Service Claims

A post-service claim must be filed within 30 days following receipt of the medical service, treatment or product to which the claim relates unless (a) it was not reasonably possible to file the claim within such time; and (b) the claim is filed as soon as possible and in no event (except in the case of legal incapacity of the claimant) later than 12 months after the date of receipt of the service, treatment or product to which the claim relates.

Incorrectly Filed Claims

These claims procedures do not apply to any request for benefits that is not made in accordance with these claims procedures, except that (a) in the case of an incorrectly-filed pre-service claim, the Medical Claims Administrator will notify the claimant as soon as possible but no later than five (5) days following receipt of the incorrectly-filed claim; and (b) in the case of an incorrectly-filed urgent care claim, the Medical Claims Administrator will notify the claimant as soon as possible, but no later than 24 hours following receipt of the incorrectly-filed claim. The notice will explain that the request is not a claim and describe the proper procedures for filing a claim. The notice may be oral unless the claimant specifically requests written notice.

TIMEFRAMES FOR DECIDING CLAIMS

Urgent Care Claims

The Medical Claims Administrator will decide an urgent care claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.

Pre-Service Claims

The Medical Claims Administrator will decide a pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim.

Concurrent Care Extension Request

If a claim is a request to extend a concurrent care decision involving urgent care and if the claim is made at least 24 hours prior to the end of the approved period of time or number of treatments, the Medical Claims Administrator will decide the claim within 24 hours after receipt of the claim. Any other request to extend a concurrent care decision will be decided in the otherwise applicable timeframes for pre-service, urgent care, or post-service claims.

Concurrent Care Reduction or Early Termination

The Medical Claims Administrator's decision to reduce or terminate an approved course of treatment is an

adverse benefit determination that a claimant may appeal under these claims procedures, as explained below. The Medical Claims Administrator will notify the claimant of the decision to reduce or terminate an approved course of treatment sufficiently in advance of the reduction or termination to allow the claimant to appeal the adverse benefit determination and receive a decision on appeal before the reduction or termination.

Post-Service Claims

The Medical Claims Administrator will decide a post-service claim within a reasonable time, but no later than 30 days after receipt of the claim.

Extensions of Time

A claimant may voluntarily agree to extend the timeframes described above. In addition, if the Medical Claims Administrator is not able to decide a pre-service or post-service claim within the timeframes described above due to matters beyond its control, these timeframes may be extended for up to 15 days, provided the claimant is notified in writing prior to the expiration of the initial timeframe applicable to the claim. The notice will describe the matters beyond the Medical Claims Administrator's control that justify the extension and the date by which the Medical Claims Administrator expects to render a decision. No extension of time is permitted for urgent care claims.

INCOMPLETE CLAIMS

If any information needed to process a claim is missing, the claim will be treated as an incomplete claim. If an urgent care claim is incomplete, the Medical Claims Administrator will notify the claimant as soon as possible, but no later than 24 hours following receipt of the incomplete claim. The notice will explain that the claim is incomplete, describe the information necessary to complete the claim and specify a reasonable time, no less than 48 hours, within which the claim must be completed. The notice may be oral unless the claimant specifically requests written notice. The Medical Claims Administrator will decide the claim as soon as possible but no later than 48 hours after the earlier of (a) receipt of the specified information, or (b) the end of the period of time provided to submit the specified information.

If a pre-service or post-service claim is incomplete, the Medical Claims Administrator will notify the claimant as soon as possible. The notice will explain that the claim is incomplete and describe the information needed to complete the claim. The timeframe for deciding the claim will be suspended from the date the claimant receives the notice until the date the necessary information is provided to the Medical Claims Administrator. The Medical Claims Administrator will decide the claim following receipt of the requested information and provide the claimant with written notice of the decision.

NOTIFICATION OF INITIAL BENEFIT DECISION

The Medical Claims Administrator will provide the claimant with written notice of an adverse benefit determination on a claim. A decision on a claim is an "adverse benefit determination" if it is (a) a denial, reduction, or termination of, or (b) a failure to provide or make payment (in whole or in part) for a benefit. The Medical Claims Administrator will provide the claimant written notice of the decision on a pre-service or urgent care claim whether the decision is adverse or not. The Medical Claims Administrator may provide the claimant with oral notice of an adverse benefit determination on an urgent care claim, but written notice will be furnished no later than three (3) days after the oral notice.

Right of Examination

The Medical Claims Administrator and the Plan Administrator each have the right to ask a claimant to be examined by a provider during the review of any claim. The plan pays for the examination whenever either the Medical Claims Administrator or the Plan Administrator requests the examination. A claimant's failure to comply with this request may result in denial of the claimant's claim.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeal Procedures

A claimant has a right to appeal an adverse benefit determination under these claims procedures. These appeal procedures provide a claimant with a reasonable opportunity for a full and fair review of an adverse benefit determination.

The Medical Claims Administrator will follow these procedures when deciding an appeal:

1. An adverse benefit determination includes a denial, reduction, termination of or failure to make a payment

for a benefit, or a rescission of coverage;

2. A claimant must file an appeal within 180 days following receipt of a notice of an adverse benefit determination;
3. A claimant will have the opportunity to submit written comments, documents, records, other information, other evidence, and testimony relating to the claim for benefits;
4. The individual who reviews and decides the appeal will be a different individual than the individual who made the initial benefit decision and will not be a subordinate of that individual, and no individual who reviews and decides appeals is compensated or promoted based on the individual's support of a denial of benefits;
5. The Medical Claims Administrator will give no deference to the initial benefit decision;
6. The Medical Claims Administrator will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit decision;
7. The Medical Claims Administrator will, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, consult with a health care professional with the appropriate training and experience who is neither the same individual who was consulted regarding the initial benefit decision nor a subordinate of that individual;
8. The Medical Claims Administrator will provide the claimant, upon request, the names of any medical or vocational experts whose advice was obtained in connection with the initial benefit decision, even if the Medical Claims Administrator did not rely upon their advice;
9. The Medical Claims Administrator will provide the claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim; any internal rule, guideline, protocol or other similar criterion relied upon in making the initial benefit decision; an explanation of the scientific or clinical judgment for the determination, applying the terms of the Health Plan to the claimant's medical circumstances; and information regarding any voluntary appeals offered by the Medical Claims Administrator;
10. The Medical Claims Administrator will provide a claimant any new evidence considered, generated, or relied upon prior to making a final benefit determination;
11. The Medical Claims Administrator will provide a claimant any new rationale for an adverse benefit determination prior to making a final benefit determination; and
12. The Medical Claims Administrator will provide required notices in a culturally and linguistically appropriate manner as directed by the Plan Administrator.

Filing Appeals

A claimant must file an appeal within 180 days following receipt of the notice of an adverse benefit determination. A claimant's failure to comply with this important deadline may cause the claimant to forfeit any right to any further review under these claims procedures or in a court of law. An appeal is filed when a claimant (or authorized representative) submits a written request for review to the Medical Claims Administrator. A claimant is responsible for submitting proof that the claim for benefits is covered and payable under the Health Plan.

Urgent Care Appeals

An urgent care appeal may be submitted to the Medical Claims Administrator by telephone at 1-866-873-5943. The Medical Claims Administrator will transmit all necessary information, including the Medical Claims Administrator's determination on review, by telephone, fax, or other available similar methods.

TIMEFRAMES FOR DECIDING APPEALS

Urgent Care Claims

The Medical Claims Administrator will decide the appeal of an urgent care claim as soon as possible, taking into account the medical emergencies, but no later than 72 hours after receipt of the request for review.

Pre-Service Claims

The Medical Claims Administrator will decide the appeal of a pre-service claim within a reasonable time appropriate to the medical circumstances, but no later than 30 days after receipt of the written request for review.

Post-Service Claims

The Medical Claims Administrator will decide the appeal of a post-service claim within a reasonable period, but no later than 60 days after receipt of the written request for review.

Concurrent Care Claims

The Medical Claims Administrator will decide the appeal of a decision to reduce or terminate an initially approved course of treatment before the proposed reduction or termination takes place. The Medical Claims Administrator will decide the appeal of a denied request to extend a concurrent care decision in the appeal timeframe for pre-service, urgent care, or post-service claims described above, as appropriate to the request.

APPEAL PROCESS

NOTIFICATION OF APPEAL DECISION

The Medical Claims Administrator will provide the claimant with written notice of the appeal decision. The notification will include the reason for the final adverse benefit determination, reference to the relevant plan provision(s) and other information as required by ERISA. The Medical Claims Administrator may provide the claimant with oral notice of an adverse decision on an urgent care claim appeal, but written notice will be furnished no later than three (3) days after the oral notice. If the claimant does not receive a written response to the appeal within the timeframes described above, the claimant may assume that the appeal has been denied. Unless these procedures are deemed to be exhausted, the decision by the Medical Claims Administrator on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law.

These claims procedures must be exhausted before any legal action is commenced.

Following notification of the appeal decision, a claimant may appeal further to a voluntary internal appeal or to an external appeal (for eligible claims). An adverse benefit determination relating to a claimant's failure to meet eligibility requirements is not eligible for external review.

VOLUNTARY APPEALS

A voluntary appeal may be available to a claimant receiving an adverse decision on a pre-service or post-service claim appeal. A claimant must file a voluntary appeal within 60 days following receipt of the adverse pre-service or post-service claim appeal decision. A voluntary appeal is filed when a claimant (or authorized representative) submits a written request for a voluntary appeal to the Medical Claims Administrator. The Medical Claims Administrator will provide the claimant with written notice of voluntary appeal decision. For more information on the voluntary appeals process, contact the Medical Claims Administrator.

EXTERNAL REVIEW

Standard External Review

You may file a request for an external review within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

1. Within five (5) business days following the date of receipt of the external review request, the Medical Claims Administrator will complete a preliminary review of the request to determine whether:
 - a. you are or were covered under the Health Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Health Plan at the time the health care item or service was provided;
 - b. the adverse benefit determination or the final adverse benefit determination is not based on the fact that you were not eligible under the Health Plan;
 - c. you have exhausted the Health Plan's internal appeal process (unless exhaustion is not required); and
 - d. you have provided all the information and forms required to process an external review. You will be notified if the request is not eligible for external review. If your request is not complete, but eligible, the Medical Claims Administrator will tell you what information or materials are needed to complete the

request and will give you 48 hours (or more) to provide the required information.

2. The Medical Claims Administrator will assign an accredited independent review organization (IRO) to conduct the external review.

The IRO will utilize legal experts where appropriate to make coverage determinations under the Health Plan and will notify you in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within 10 business days that the IRO must consider when conducting the external review.

The Medical Claims Administrator will provide documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO.

The IRO will review all of the information and documents timely received and is not bound by the Medical Claims Administrator's prior determination. The IRO may consider the following in reaching a decision:

- a. your medical records;
- b. the attending health care professional's recommendation;
- c. reports from appropriate health care professionals and other documents submitted by the Medical Claims Administrator, you, or your treating provider;
- d. the terms of your Health Plan;
- e. evidence-based practice guidelines;
- f. any applicable clinical review criteria developed and used by the Medical Claims Administrator; and
- g. the opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

Expedited External Review

1. You may request an expedited external review when you receive:
 - a. an adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
 - b. a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.
2. Immediately upon receipt of the request for expedited external review, the Medical Claims Administrator will determine whether the request meets the reviewability requirements noted above for standard external review and will notify you of its eligibility determination.
3. When the Medical Claims Administrator determines that your request is eligible for external review an IRO will be assigned. The Medical Claims Administrator will provide all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO by any available expeditious method.

The IRO must consider the information or documents provided and is not bound by the Medical Claims Administrator's prior determination.

4. The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO's notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours to the claimant and the Health Plan.

ADDITIONAL PROVISIONS

Authorized Representative

A claimant may appoint an “authorized representative” to act on their behalf solely with respect to an appeal of an adverse benefit determination or an inquiry concerning an adverse benefit decision. To appoint an authorized representative, a claimant must complete a form that can be obtained from the Medical Claims Administrator. However, in connection with an urgent care claim, the Medical Claims Administrator will permit a health care professional with knowledge of the claimant's medical condition to act as the claimant's authorized representative without completion of this form. Once an authorized representative is appointed, all future communication from the Medical Claims Administrator will be made with the representative rather than the claimant, unless the claimant provides specific written direction otherwise. An assignment for purposes of payment (e.g., to a health care professional) does not constitute an appointment of an authorized representative under these claims procedures. Any reference in these claims procedures to claimant is intended to include the authorized representative of such claimant.

A claimant may not assign to any other person or entity their right to legally challenge any decision, action, or inaction of the Medical Claims Administrator.

Claims Payment

When a claimant uses in-network or out-of-network Participating Providers, the Health Plan pays the provider. When a claimant uses a nonparticipating provider, the Health Plan pays the claimant. A claimant may not assign their benefits to a nonparticipating provider, except when parents are divorced. In that case, the custodial parent may request, in writing, that the Health Plan pay a nonparticipating provider for covered services for a child. When the Health Plan pays the provider at the request of the custodial parent, the Health Plan has satisfied its payment obligation. This provision may be waived for ambulance providers in Minnesota and certain institutional and medical/surgical providers outside the state of Minnesota at the discretion of the Medical Claims Administrator.

The Health Plan does not pay claims to providers or to employees for services received in countries that are sanctioned by the United States Department of Treasury's Office of Foreign Assets Control (OFAC), except for medical emergency services when payment of such services is authorized by OFAC. Countries currently sanctioned by OFAC include Cuba, Iran, and Syria. OFAC may add or remove countries from time to time.

No Third Party Beneficiaries

The Health Plan benefits described in this Summary Plan Description are intended solely for the benefit of you and your covered dependents. No person who is not a Health Plan participant or dependent of a Health Plan participant may bring a legal or equitable claim or cause of action pursuant to this Summary Plan Description as an intended or third party beneficiary or assignee hereof.

Release of Records

Claimants agree to allow all health care providers to give the Medical Claims Administrator needed information about the care that they provide to them. This includes information about care received prior to the claimants enrollment with the Medical Claims Administrator where necessary. The Medical Claims Administrator may need this information to process claims, conduct utilization review, care management, quality improvement activities, reimbursement and subrogation, and for other health plan activities as permitted by law. If a provider requires special authorization for release of records, claimants agree to provide this authorization. A claimant's failure to provide authorization or requested information may result in denial of the claimant's claim.

Right of Examination

The Medical Claims Administrator and the Plan Administrator each have the right to ask a claimant to be examined by a provider during the review of any claim. The Health Plan pays for the exam whenever either the Medical Claims Administrator or the Plan Administrator requests the examination. A claimant's failure to comply with this request may result in denial of the claimant's claim.

PRIVACY OF PROTECTED HEALTH INFORMATION

Protected Health Information (PHI) is individually identifiable information created or received by a health care provider or a Health plan. This information is related to your past, present, or future health or the payment for such health care. PHI includes demographic information that either identifies you or provides a reasonable

basis to believe that it could be used to identify you.

RESTRICTIONS ON THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The employer may not use or disclose PHI for employment-related actions or decisions. The employer may only use or further disclose PHI as permitted or required by law and will report any use or disclosure of PHI that is inconsistent with the allowed uses and disclosures.

SEPARATION BETWEEN THE EMPLOYER AND THE PLAN

The employees, classes of employees or other workforce members below will have access to PHI only to perform the plan administration functions that the employer provides for the plan. The following may be given access to PHI: Plan Administrator.

This list includes every employee or class of employees or other workforce members under the control of the employer who may receive PHI relating to the ordinary course of business.

The employees, classes of employees or other workforce members identified above will be subject to disciplinary action and sanctions for any use or disclosure of PHI that is in violation of these provisions. The employer will promptly report such instances to the plan and will cooperate to correct the problem. The employer will impose appropriate disciplinary actions on each employee or workforce member and will reduce any harmful effects of the violation.

TERMS YOU SHOULD KNOW

Accountable Care Organization (ACO) - A group of physicians, other health care professionals, hospitals, and other health care providers that accept a shared responsibility to deliver a broad set of medical services to a defined set of patients.

Admissions - A period of one (1) or more days and nights while you occupy a bed and receive inpatient care in a facility.

Adverse Benefit Determination - A decision relating to a health care service or claim that is partially or wholly adverse to the complainant. This includes:

- a decision relating to the coverage of nonparticipating provider services as described in "Special Circumstances."
- a determination for health care services that is less intensive than the service specified in the original prior authorization request.

Aftercare/Continuing Care Services - The stage following discharge, when the patient no longer requires services at the intensity required during primary treatment.

Allowed Amount - The amount that payment is based on for a given covered service of a specific provider. The allowed amount may vary from one (1) provider to another for the same service. All benefits are based on the allowed amount, except as provided in "Benefit Overview." The allowed amount may include the provider's applicable taxes, for example, the MinnesotaCare tax.

The allowed amount for participating providers

For participating providers, the allowed amount is the negotiated amount of payment that the in-network provider has agreed to accept as full payment for a covered service at the time your claim is processed. The Medical Claims Administrator periodically may adjust the negotiated amount of payment at the time your claim is processed for covered services at in-network providers as a result of expected settlements or other factors. The negotiated amount of payment with in-network providers for certain covered services may not be based on a specified charge for each service. Through annual or other global settlements, which may include an agreed upon fee schedule rate, case rate, withhold and/or capitation agreements, rebates, prospective payments or other methods, the Medical Claims Administrator may adjust the amount due to in-network providers without reprocessing individual claims. These annual or other global adjustments will not cause any change in the amount you paid at the time your claim was processed. If the payment to the provider is decreased, the amount of the decrease is credited to the Medical Claims Administrator, and the percentage of the allowed amount paid by the Medical Claims Administrator is lower than the stated percentage for the covered service. If the payment to the provider is increased, the Medical Claims Administrator pays that cost on your behalf, and the percentage of the allowed amount paid is higher than the stated percentage.

The allowed amount for all nonparticipating providers

For nonparticipating providers, the allowed amount may also be determined by the provider type, provider location, and the availability of certain pricing methods. The allowed amount may not be based upon or related to a usual, customary or reasonable charge. The Medical Claims Administrator will pay the stated percentage of the allowed amount for a covered service. In most cases, the Medical Claims Administrator will pay this amount to you. The determination of the allowed amount is subject to all business rules as defined in the Medical Claims Administrator's Provider Policy and Procedure Manual. As a result, the Medical Claims Administrator may bundle services, take multiple procedure discounts and/or other reductions as a result of the procedures performed and billed on the claim. No fee schedule amounts include any applicable tax.

The allowed amount for nonparticipating providers in Minnesota

For nonparticipating provider services within Minnesota, except those described in "Special Circumstances," the allowed amount will be based upon one (1) of the following payment options to be determined at the Medical Claims Administrator's discretion: (1) a percentage, not less than 100%, of the Medicare allowed charge for the same or similar service; (2) a percentage of billed charges; (3) provider reimbursement databases, median costs from a benchmark of like claims, or fee negotiations; or, (4) as may be required by federal law. The payment option selected by the Medical Claims Administrator may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare allowed charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the Medical Claims Administrator.

The allowed amount for nonparticipating provider services outside Minnesota

For nonparticipating provider physician or clinic services outside of Minnesota, except those described in "Special Circumstances," the allowed amount will be based upon one (1) of the following payment options to be determined at the Medical Claims Administrator's discretion: (1) a percentage, not less than 100%, of the Medicare allowed charge for the same or similar service; (2) a percentage of billed charges; (3) pricing determined by another Blue Cross or Blue Shield plan; (4) provider reimbursement databases, median costs from a benchmark of like claims, or fee negotiations; or, (5) as may be required by federal law. The payment option selected by the Medical Claims Administrator may result in an allowed amount that is a lower amount than if calculated by another payment option. When the Medicare allowed charge is not available, the pricing method may also be determined by factors such as type of service, place of service, reason for care, and type of provider at the point the claim is received by the Medical Claims Administrator.

Applied Behavioral Analysis - The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Artificial Insemination (AI) - A procedure in which semen is placed in a vagina, cervix, or uterus.

Assisted Reproductive Technology (ART) - Treatments or procedures that are done to start a pregnancy. This may include handling eggs and sperm or embryos.

Attending Health Care Professional - A health care professional with primary responsibility for the care provided to a sick or injured person.

Autism Spectrum Disorders - Any of the pervasive developmental disorders defined by the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

Behavioral Health Care Treatment - Treatment for mental health disorders and substance use disorder/addiction diagnoses as listed in the most recent editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*. Does not include developmental disability.

Biological Products - Products that are regulated by the Food and Drug Administration (FDA) and are medicines made from living organisms through highly complex manufacturing processes and must be handled and administered under carefully monitored conditions. There are a wide variety of biological products such as drugs, gene and cellular therapies and vaccines.

Biosimilars - Products that are regulated by the Food and Drug Administration (FDA) and are highly similar to

the reference biological brand name product in terms of safety, purity and potency, but may have minor differences in clinically inactive components.

BlueCard Program - A Blue Cross and Blue Shield program which allows you to access covered health care services while traveling outside of your service area. You must use in-network providers of a Host Blue and show your member ID card to secure BlueCard program access.

Board-Certified - A designation given to those physicians who, after meeting strict standards of knowledge and practices, are certified by the professional board representing their specialty.

Calendar Year - The period starting on January 1st of each year and ending at midnight December 31st of that year.

Care Coordination - Organized, information-driven patient care activities intended to facilitate the appropriate responses to your health care needs across the continuum of care.

Care/Case Management Plan - A plan for health care services developed for a specific patient by a care/case manager after an assessment of the patient's condition in collaboration with the patient and the patient's health care team. The plan sets forth both the immediate and the ongoing skilled health care needs of the patient to sustain or achieve optimal health status.

Cellular Therapy - The transfer of cells into a person with the goal of improving a disease. Gene modified cell therapy removes the cells from a person's body and alters the genetic material of the cell. The modified cells are then reintroduced into the body.

Chronic Condition - Any physical or mental condition that requires long-term monitoring and/or management to control symptoms and to shape the course of the disease.

Claim - A request for prior approval of a covered service or for the payment or reimbursement of the charges or costs associated with a covered service. Claims include:

- **Pre-service claim** - A request for prior approval of a covered service which under the terms of your coverage must be approved before you receive the covered service.
- **Urgent care claim** - A pre-service claim which, if decided within the time periods established for making non-urgent care pre-service claim decisions, could seriously jeopardize your life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service. Whether a request involves an urgent care claim will be determined by your attending health care provider.
- **Post-service claim** - A request for payment or reimbursement of the charges or costs associated with a covered service that you have received.

Coinsurance - The percentage of the allowed amount you must pay for certain covered services after you have paid any applicable deductibles and copays until you reach your out-of-pocket limits. For covered services from participating providers, coinsurance is calculated based on the lesser of the allowed amount or the billed charge. Because payment amounts are negotiated to achieve overall lower costs, the allowed amount for participating providers is generally lower than the billed charge. However, the amount used to calculate your coinsurance will not exceed the billed charge. When your coinsurance is calculated on the billed charge rather than the allowed amount for participating providers, the percentage of the allowed amount paid by us will be greater than the stated percentage.

For covered services from nonparticipating providers, coinsurance is calculated based on the allowed amount. In addition, you are responsible for any excess charge over the allowed amount.

Your coinsurance and deductible amount will be based on the negotiated payment amount we have established with the provider or the provider's charge, whichever is less. The negotiated payment amount includes discounts that are known and can be calculated when the claim is processed. In some cases, after a claim is processed, that negotiated payment amount may be adjusted at a later time if the agreement with the provider so provides. Coinsurance calculation will not be changed by such subsequent adjustments or any other subsequent reimbursements we may receive from other parties.

Coinurance Example:

You are responsible for payment of any applicable coinsurance amounts for covered services. The following is an example of how coinsurance would work for a typical claim:

For instance, when Blue Cross pays 80% of the allowed amount for a covered service, you are responsible for the coinsurance, which is 20% of the allowed amount. In addition, you would be responsible for any excess charge over our allowed amount when a nonparticipating provider is used. For example, if a nonparticipating provider ordinarily charges \$100 for a service, but our allowed amount is \$95, Blue Cross will pay 80% of the allowed amount (\$76). You must pay the 20% coinsurance on the Blue Cross allowed amount (\$19), plus the difference between the billed charge and the allowed amount (\$5), for a total responsibility of \$24.

Remember, if participating providers are used, your share of the covered charges (after meeting any deductibles) is limited to the stated coinsurance amounts based on the Blue Cross allowed amount. If nonparticipating providers are used, your out-of-pocket costs will be higher as shown in the example above.

Continued Stay - A continuation of inpatient care services for a member with an existing prior authorization. A continued stay review determines if continued inpatient care is medically necessary and/or if the current health care facility is still the most appropriate to provide the level of care required for the patient. Also known as concurrent review.

Copay - The dollar amount you must pay for certain covered services. The "Benefit Overview" lists the copays and services that require copays. A negotiated payment amount with the provider for a service requiring a copay will not change the dollar amount of the copay.

Cosmetic Services - Surgery and other services performed primarily to enhance or otherwise alter physical appearance without correcting or improving a physiological function.

Covered Services - A health service or supply that is eligible for benefits when performed and billed by an eligible provider. You incur a charge on the date a service is received or a supply or a drug is purchased.

Custodial Care - Care provided primarily for maintenance of the member or which is designed essentially to assist the member in meeting activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition.

Cycle - One (1) partial or complete fertilization attempt extending through the implantation phase only.

Day Treatment - Behavioral health services that may include a combination of group and individual therapy or counseling for a minimum of three (3) hours per day, three (3) to five (5) days per week.

Deductible - The deductible is a specified dollar amount you must pay for most covered services each calendar year before the health plan begins to provide payment for benefits. Services such as prenatal care, pediatric preventive care, and primary network preventive care services for adults are not subject to the deductible. Please refer to "Benefit Overview" for the deductible amount.

Dental Implant - Metal, screwlike posts surgically inserted in the jawbone to replace damaged or missing teeth with artificial teeth that look and function like real ones.

Dependent - Your spouse, child to the dependent child age limit provided in "Who is Eligible," child whom you or your spouse have adopted or been appointed legal guardian to the dependent child age limit provided in "Who is Eligible," grandchild who meets the eligibility requirements as provided in "Who is Eligible" to the dependent child age limit provided in "Who is Eligible," disabled dependent or dependent child as provided in "Who is Eligible," or any other person whom state or federal law requires be treated as a dependent under this health coverage.

Designated Agent - An entity that has contracted, either directly or indirectly, with the Medical Claims Administrator to perform a function and/or service in the administration of this health plan. Such function and/or service may include, but is not limited to, medical management and provider referral.

Diabetes Self-Management Education (DSME) - The process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. Diabetes self-management support (DSMS) refers to the support that is required for implementing and sustaining coping skills and behaviors needed to self-manage on an ongoing basis. The overall objectives are to support informed decision making, self-care behaviors, problem solving, and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life. Support can be behavioral, educational, psychosocial, or clinical. DSMES will be provided by one (1) or more instructors. The instructors will have recent educational and experiential preparation in education and diabetes management or will be a certified diabetes educator. The instructor(s) will obtain regular continuing education in the field of diabetes management and education. At least one (1) of the instructors will be a registered nurse, dietitian, or pharmacist. DSMES must be consistent with the National Standards for Diabetes Self-Management Education.

Durable Medical Equipment - Medical equipment prescribed by a physician that meets each of the following requirements:

1. able to withstand repeated use;
2. used primarily for a medical purpose;
3. generally not useful in the absence of illness or injury;
4. determined to be reasonable and necessary; and
5. represents the most cost-effective alternative.

Enrollment Date - The first day of coverage, or if there is a waiting period, the first day of the waiting period (typically the date employment begins).

E-Visit - A patient-initiated, limited written online evaluation and management health care service provided by a physician or other qualified health care provider using the internet or similar secure communications network to communicate with an established patient. E-visits are not real-time interactions with a health care provider.

Experimental/Investigative - The use of any treatment, service, procedure, facility, equipment, prescription drug, device or supply (intervention) which is not determined by the Medical Claims Administrator to be medically effective for the condition being treated. The Medical Claims Administrator will consider an intervention to be experimental/investigative if: the intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s); or available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or the intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or the intervention does not improve health outcomes; or the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be experimental/investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date. Medical researchers constantly experiment with new medical equipment, prescription drugs and other technologies. In turn, health plans must evaluate these technologies. The Medical Claims Administrator believes that decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. Certain routine patient costs for participation in an approved clinical trial will not be considered experimental/investigative. Routine patient costs include items and services that would be covered if the member was not enrolled in an approved clinical trial.

Extended Hours Skilled Nursing Care (Private Duty Nursing) - Extended hours home care are continuous and complex skilled nursing services greater than two (2) consecutive hours per date of service in the member's home. Extended hours services provide complex, direct, skilled nursing care to develop caregiver competencies through training and education to optimize the member's health status and outcomes. The frequency of the nursing tasks is continuous and temporary in nature and is not intended to be provided on a permanent, ongoing basis.

Facility - A hospital, skilled nursing facility, residential behavioral health treatment facility, or outpatient behavioral health treatment facility licensed under state law in the state in which it is located to provide the health services billed by that facility. Facility may also include a licensed home/suite infusion therapy provider, freestanding ambulatory surgery center, a home health agency, or freestanding birthing center when services are billed on a facility claim.

Foot Orthoses - Appliances or devices used to stabilize, support, align, or immobilize the foot in order to prevent deformity, protect against injury, or assist with function. Foot orthoses generally refer to orthopedic shoes, and devices or inserts that are placed in shoes including heel wedges and arch supports. Foot orthoses are used to decrease pain, increase function, correct some foot deformities, and provide shock absorption to the foot. Orthoses can be classified as pre-fabricated or custom-made. Pre-fabricated orthoses are manufactured in quantity and are not designed for a specific member. Custom-fitted orthoses are specifically made for an individual member.

Freestanding Ambulatory Surgery Center - A freestanding facility that is not part of a hospital and performs medical and surgical services on an outpatient basis.

Gene Therapy - The introduction, removal, or change in the content of a person's genetic material with the goal of treating or curing a disease. It includes therapies such as gene transfer, gene modified cell therapy, and gene editing.

Habilitative Services - Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to attain, maintain, or improve daily living skills or functions never learned or acquired due to a disabling condition.

Halfway House - Specialized residences for individuals who no longer require the complete facilities of a hospital or institution but are not yet prepared to return to independent living.

Health Care Provider - A health care professional, licensed for independent practice, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that health care professional. Health care professionals include physicians, chiropractors, mental health professionals, advanced practice nurses, physician assistants, pharmacists, audiologists, physical, speech, and occupational therapists, licensed nutritionists, licensed registered dietitians, licensed acupuncture practitioners, and supervised employees.

Home Health Agency - A preapproved facility that sends health care professionals and home health aides into a person's home to provide health services.

Hospice Care - A coordinated set of services provided at home or in an inpatient hospital setting for covered individuals diagnosed with a terminal disease or condition.

Hospital - A facility that provides diagnostic, therapeutic and surgical services to sick and injured persons on an inpatient or outpatient basis. Such services are performed by or under the direction of a staff of licensed doctors of medicine (M.D.), or osteopathy (D.O.). A hospital provides 24-hour-a-day professional registered nursing (R.N.) services.

Host Blue - A Blue Cross and/or Blue Shield licensee outside of Minnesota that has contractual relationships with providers in its designated service area that deliver the benefit of its arrangements with its local and ancillary providers eligible for Inter-Plan Programs, on behalf of Control/Home Licensee Members who incur claims within its service area.

Illness - A sickness, injury, pregnancy, mental illness, substance use disorder, or condition involving a physical disorder.

Immediate Family - Your spouse, child, stepchild, parent, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-in-law, daughter-in-law, son-in-law, grandchild, grandparent, stepparent, stepbrother or stepsister.

Infertility - The medically documented inability to conceive with unprotected sexual intercourse between partners for a period of at least 12 months. The inability to conceive may be due to either partner.

In-network - Depending on where you receive services, the in-network is designated as one (1) of the following:

- When you receive services within the health plan service area, the designated in-network for professional providers and facility providers is the Open Access POS network.
- When you receive services within the Medical Claims Administrator's service area, the designated in-network for professional providers and facility providers is the Open Access POS network.
- When you receive services outside Minnesota, the designated participating in-network for professional providers and facility providers is the local BlueCard PPO network.

In-network Provider - An ancillary provider, professional provider or facility provider who has entered into an agreement, either directly or indirectly, with the Medical Claims Administrator or with any licensee of the Blue Cross and Blue Shield Association located out-of-area, pertaining to payment as a participant in a network for covered services rendered to a member.

Inpatient Care - Care that provides 24-hour-a-day professional registered nursing (R.N.) services for short-term medical and behavioral health services in a hospital setting.

Intensive Outpatient Programs (IOPs) - A behavioral health care service setting that provides structured, multidisciplinary diagnostic and therapeutic services. IOPs operate at least three (3) hours per day, three (3) days per week. Substance use disorder treatment is typically provided in an IOP setting. Some IOPs provide treatment for mental health disorders.

Intermittent Skilled Nursing Care - Services consisting of up to two (2) consecutive hours per date of service in the member's home provided by a licensed registered nurse or licensed practical nurse who are employees of an approved home health agency.

Lifetime Maximum - The cumulative maximum payable for specified covered services incurred by a member during their lifetime or by each covered dependent during their lifetime under all health plans with the employer. The lifetime maximum does not include amounts which are the member's responsibility, such as deductibles, coinsurance, copays, and other amounts. Please refer to "Benefit Overview" for specific dollar maximums on certain services.

Maintenance Services - Services that are neither habilitative nor rehabilitative that are not expected to make measurable or sustainable improvement within a reasonable period of time.

Marriage/Couples Counseling - Behavioral health care services for the primary purpose of working through relationship issues.

Marriage/Couples Training - Services for the primary purpose of relationship enhancement including, but not limited to: premarital education; or marriage/couples retreats, encounters, or seminars.

Medical Claims Administrator - Blue Cross and Blue Shield of Minnesota (Blue Cross).

Medical Emergency - Medically necessary and appropriate care which a reasonable layperson believes is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or mental health of the member in serious jeopardy.

Medically Necessary and Appropriate (Medical Necessity and Appropriateness) - Services, supplies or covered drugs that a provider, exercising prudent clinical judgment, would provide to a member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's illness, injury or disease; and (iii) not primarily for the convenience of the member, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's illness, injury or disease. The Medical Claims Administrator reserves the right, utilizing the criteria set forth in this definition, to render the final determination as to whether a service, supply or covered drug is medically necessary and appropriate. No benefits will be provided unless the Medical Claims Administrator determines that the service, supply or covered drug is medically necessary and appropriate.

With respect to mental health care services: services appropriate, in terms of type, frequency, level, setting, and duration, to the member's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary and appropriate care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

- (1) help restore or maintain the member's health; or
- (2) prevent deterioration of the member's condition.

Medicare - A federal health insurance program established under Title XVIII of the Social Security Act. Medicare is a program for people age 65 or older; some people with disabilities under age 65; and people with end-stage renal disease. The program includes Part A, Part B, and Part D. Part A generally covers some costs of inpatient care in hospitals and skilled nursing facilities. Part B generally covers some costs of physician, medical, and other services. Part D generally covers outpatient prescription drugs defined as those drugs covered under the Medicaid program plus insulin, insulin-related supplies, certain vaccines, and smoking cessation agents. Medicare Parts A, B, and D do not pay the entire cost of services and are subject to cost-sharing requirements and certain benefit limitations.

Mental Illness - A mental disorder as defined in the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*. It does not include substance dependence, nondependent substance use disorder, or developmental disability.

Nonparticipating Provider - A provider who has not entered into a network contract with the Medical Claims Administrator or the local Blue Cross and/or Blue Shield plan.

Opioid Treatment - Treatment that uses Medication Assisted Treatment (MAT) to control withdrawal symptoms of opioid addiction.

Out-of-network Participating Provider - Providers who have a contract with the Medical Claims Administrator or the local Blue Cross and/or Blue Shield plan (participating providers), but are not in-network providers because the contract is not specific to this plan.

Out-of-network Provider - Any provider that is not an in-network provider. These providers are considered out-of-network, and nonparticipating providers.

Out-of-pocket Limit - The out-of-pocket limit refers to the specified dollar amount of member cost-sharing incurred for covered services in a calendar year. When the specified dollar amount is attained, the Medical Claims Administrator begins to pay 100% of the allowed amount for all covered expenses. Please refer to "Benefit Overview" for the out-of-pocket limit.

Outpatient Behavioral Health Treatment Facility - A facility that provides outpatient treatment by, or under the direction of, a licensed mental health care professional for mental health disorders, or a licensed substance use professional for substance use disorders.

Outpatient Care - Services received without being admitted for an inpatient stay. Services received at an ambulatory surgery center are considered outpatient care.

Palliative Care - Services specifically designed to alleviate the physical, psychological, psychosocial, or spiritual impact of a disease, rather than providing a cure for members with a new or established diagnosis of a progressive, debilitating illness. Services are focused on improving quality of life by enabling a patient to address social, emotional and spiritual needs, and supporting the patient and family.

Partial Hospitalization - The provision of medical, nursing, counseling or therapeutic mental health care services or substance use disorder services on a planned and regularly scheduled basis in a facility provider designed for a member or client who would benefit from more intensive services than are generally offered through outpatient treatment but who does not require inpatient care.

Partial Programs - An intensive, structured behavioral health care setting that provides medically supervised diagnostic and therapeutic services. Partial programs operate five (5) to six (6) hours per day, five (5) days per week although some patients may not require daily attendance.

Participating Provider - A provider who has entered into either a specific network contract or a general broader network contract with the Medical Claims Administrator or the local Blue Cross and/or Blue Shield plan.

Physician - A doctor of medicine (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), or optometry (O.D.) practicing within the scope of their license.

Place of Service - Clinic and hospital providers submit claims using national standards established by the Centers for Medicare & Medicaid Services (CMS) and state guidelines. The benefit paid for a service is based on provider billing and the place of service. For example, the benefits for diagnostic imaging performed in a physician's office may be different than diagnostic imaging delivered in an outpatient facility setting.

Plan - The plan of benefits established by the Plan Administrator.

Provider - A health care professional or facility licensed, certified or otherwise qualified under state law, in the state in which the services are rendered, to provide the health services billed by that provider. Provider also includes home/suite infusion therapy providers, pharmacies, medical supply companies, independent laboratories and ambulances.

Rehabilitative Services - Services, including devices, that are expected to make measurable or sustainable improvement within a reasonable period of time and assist a member to regain, maintain, or prevent deterioration of daily living skills or functions acquired but then lost or impaired due to an illness, injury, or disabling condition.

Rescission - A cancellation or discontinuation of coverage.

Residential Behavioral Health Treatment Facility - A facility licensed under state law in the state in which it is located that provides residential treatment under the direction of, a licensed mental health professional for mental health disorders, or a licensed substance use professional for substance use disorders.

The facility provides continuous, 24-hour supervision by a skilled staff who are directly supervised by health care professionals. Skilled nursing and medical care are available each day.

Respite Care - Short-term inpatient or home care provided when necessary to relieve family members or other persons caring for the member.

Retail Health Clinic - A clinic located in a retail establishment. The clinic provides medical services for a limited list of eligible symptoms (e.g., sore throat, cold).

Services - Health care services, procedures, treatments, durable medical equipment, medical supplies, and prescription drugs, including specialty drugs.

Skilled Care - Services rendered that are medically necessary and appropriate and provided by a licensed nurse or other licensed health care provider. A service shall not be considered skilled care merely because it is performed by, or under the direct supervision of, a licensed health care provider. Services such as tracheotomy suctioning or ventilator monitoring, that can be safely and effectively performed by a non-medical person (or self-administered) without direct supervision of a licensed health care provider, shall not be regarded as skilled care, whether or not a licensed health care provider actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it skilled care when a licensed health care provider provides the service. Only the skilled care component(s) of combined services that include non-skilled care are covered under the plan.

Skilled Nursing Facility - A Medicare-approved facility that provides skilled transitional care by, or under the direction of, a doctor of medicine (M.D.) or osteopathy (D.O.). A skilled nursing facility provides 24-hour-a-day professional registered nursing (R.N.) services.

Skills Training - Training of basic living and social skills that restore a patient's skills essential for managing their illness, treatment, and the requirements of everyday independent living.

Specialist - A health care provider who limits their practice to a particular branch of medicine or surgery.

Specialty Drugs - Specialty drugs are designated complex injectable and oral drugs that have very specific manufacturing, storage, and dilution requirements that are subject to restricted distribution by the U.S. Food and Drug Administration (FDA); or require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

Specialty Pharmacy Network Supplier - A pharmaceutical specialty provider that has an agreement with the Medical Claims Administrator pertaining to the payment and exclusive dispensing of selected specialty prescription drugs provided to you.

Step Therapy - Step therapy includes, but is not limited to, drugs in specific categories or drug classes. If your health care provider prescribes one (1) of these drugs, there must be documented evidence that you have tried another eligible drug(s) that is safe, more clinically effective, and in some cases more cost-effective before the drugs subject to step therapy drugs will be paid under the drug benefit.

Substance Use Disorder and/or Addictions - Alcohol, drug dependence or other addictions as defined in the most current editions of the *International Classification of Diseases (ICD)* and *Diagnostic and Statistical Manual for Mental Disorders (DSM)*.

Supervised Employees - Health care professionals employed by a doctor of medicine, osteopathy, chiropractic, dental surgery, or a Minnesota Rule 29 behavioral health treatment facility licensed by the Minnesota Department of Human Services. The employing MD, DO, DC, DDS, or mental health professional must be physically present and immediately available in the same office suite more than 50% of each day when the employed health care professional is providing services. Independent contractors are not eligible.

Supplies - Health care materials prescribed by a physician that are not reusable. They are used primarily for a medical purpose and are generally not useful in the absence of illness or injury.

Supplies include, but are not limited to:

1. ostomy supplies;
2. catheters;
3. oxygen; and

4. diabetic supplies.

Surrogate Pregnancy - An arrangement in which a person agrees to carry a pregnancy for another person.

Telehealth Services - The delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a member's health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a member located at an originating site and a provider located at a distant site. Originating site means a site where the member is located at the time health care services are provided to the member by means of telehealth. Coverage is provided for health care services delivered through telehealth by means of the use of audio-only communication if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication. Telehealth does not include communication between providers that consists solely of a telephone conversation, e-mail, or facsimile transmission. Telehealth does not include communication between a provider and a member that consists solely of an e-mail or facsimile transmission.

Tobacco Cessation Drugs and Products - Prescription drugs and over-the-counter products that aid in reducing or eliminating the use of nicotine.

Totally Disabled (or Total Disability) - A condition resulting from illness or injury as a result of which, and as certified by a physician, for an initial period of 24 months, you are continuously unable to perform all of the substantial and material duties of your regular occupation. However: (i) after 24 months of continuous disability, "totally disabled" (or total disability) means your inability to perform all of the substantial and material duties of any occupation for which you are reasonably suited by education, training or experience; (ii) during the entire period of total disability, you may not be engaged in any activity whatsoever for wage or profit and must be under the regular care and attendance of a physician, other than your Immediate Family. If you do not usually engage in any occupation for wages or profits, "totally disabled" (or total disability) means you are substantially unable to engage in the normal activities of an individual of the same age and sex.

Treatment - The management and care of a patient for the purpose of combating illness or injury. Treatment includes medical care, surgical care, diagnostic evaluation, giving medical advice, monitoring and taking medication.

Value-Based Program - An outcomes-based payment arrangement and/or a coordinated care model facilitated with one (1) or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

Waiting Period - The period of time that must pass before you or your dependents are eligible for coverage under this plan.

SPECIAL FEATURES OF THE HEALTH PLAN

If you are enrolled in the Health Plan, you have access to the following special features offered by Blue Cross® and Blue Shield® of Minnesota.

MATERNITY MANAGEMENT

The Maternity Management program provides expectant mothers with education and support throughout their pregnancy. This support includes access to a specially trained Health Coach (RN) and online educational information. All pregnant women have access to the program, regardless of their risk. To request further information or to enroll call 1-866-489-6948.

QUITTING TOBACCO SUPPORT

Quitting Tobacco Support provides a behavior change program to support members that want to reduce tobacco use. This service is available to all members 18 years of age or older, including those that use smokeless tobacco products. Quitting Tobacco Support is a telephone-based service designed to help you quit using tobacco your way and at your pace. To participate, call the support line at 1-888-662-BLUE (2583). A Quit Coach will work with you one-on-one to develop a personalized quitting plan that addresses your specific concerns.

CARE MANAGEMENT

If you or a covered dependent has an ongoing condition like diabetes or heart disease – or you experience a major health event or illness—you may be eligible to take advantage of Care Management programs. These programs are voluntary and confidential. A Health Coach (registered nurse or behavioral health specialist) can help you coordinate care and navigate the healthcare system, identify resources to assist you in achieving your personal health goals, and talk to you over the phone and provide you with information that is specific to your condition. Each member is matched with a primary health coach who gets to know you over time so you do not have to start over every time you call.

If you think you are eligible to participate in the program, you may call the customer service telephone number listed on the back of your ID card. Once enrolled, you may choose not to participate at any time by calling the Customer Service telephone number listed on the back of your ID card.

DIABETES AND HEART DISEASE PREVENTION (OMADA)

This feature helps at-risk participants prevent and manage diabetes and/or heart disease through a digital intensive behavioral counseling program administered by Omada Health, Inc., an independent third-party. Certain eligibility requirements apply. This interactive program provides a wireless smart scale, weekly online lessons, a professional health coach and small group discussions. For more information you can call 1-888-987-8337 or visit omadahealth.com/BCBSMN1.

WELLNESS DISCOUNT

Use Blue 365® to save on local and national wellness products and services. Visit blue365deals.com/bcbsmn or log into your member website.

BLUE CARE ADVISOR

The Blue Care Advisor is a health and wellbeing platform. You can explore tools, insights and information on how to improve your health and live your healthiest life. You can take a health assessment, perform health tracking and obtain personalized resources.

or

Blue Care AdvisorSM lets you seamlessly connect to all your benefits, claims, programs, rewards and more. You'll get information based on your benefits and history along with recommendations on steps you can take to improve your health. Log in to the member website or download the app to get started.

DOCTOR ON DEMAND

Doctor on Demand is available to those who are enrolled in the Medical Program. This feature provides you with immediate live video access to board-certified doctors 24/7, 365 days a year to treat many common medical conditions from any device with a front facing camera. You can also schedule next-day appointments to see licenses psychologist and psychiatrists between the hours of 7 a.m. and 10 p.m. local time. Doctor on Demand appointments are generally less than an in-person visit. To learn more, or to sign up, visit doctorondemand.com/bluecrossmn.

NEAR-SITE Clinics

The Near-Site Clinics are only available to those who are enrolled in the Medical Program (aged 2+). The clinics provide health care services in Austin and Willmar, Minnesota. If you are enrolled in the Traditional plan, the services you receive from the clinics are free. If you are enrolled in the Healthy Savings Plan, any preventative care you receive is free but other services will result in a copay. The Austin clinic is administered by Premise Health. The Willmar clinic is administered by Marathon. Both clinics provide primary care, annual physicals, biometric screenings, physical therapy, acute care, preventative exams, allergy and flu shots, laboratory services, condition management and limited pre-packaged pharmacy.

HINGE HEALTH - EXERCISE THERAPY PROGRAM

The Exercise Therapy Program is a component of the Medical Program and is only available to those who are enrolled in the Medical Program. The exercise therapy program is administered by Hinge Health and is available to help prevent and treat injuries and joint and/or muscle pains. It consists of virtual sessions, unlimited 1-on-1 coaching and motion-tracking for instant body form correction. Hinge Health is available at no additional cost to you if you are enrolled in the Health Plan. To enroll in the Program you must create an account online at Hingehealth.com or call 1-855-902-2777.

PROGYNY - FERTILITY PROGRAM

The Fertility Program is a component of the Medical Program and is only available to those who are enrolled in the Medical Program. This feature is administered by Progyny and provides you with a fertility and family-building program to help support preconception, fertility, adoption and surrogacy. Progyny provides for one successful Smart Cycle per family (with a maximum of two trials) which leads to a successful birth of a child. Progyny works in conjunction with the Health Plan Claims Administrator to administer your fertility benefit. Coverage includes, but is not limited to, 3 office visits, 2 ultrasounds, hormone testing, infections disease testing, and 2 semen analyses. The Fertility Plan works to support you through various types of treatment including timed intercourse (TIC), intrauterine insemination (IUI), in vitro fertilization (IVF), or any combination that you and your doctor think is best. Progyny works with you. Your benefit is subject to the same deductible, co-insurance and out-of-pocket maximums as your Health Plan. If you would like more information about this benefit, you can call Progyny at 1-833-233-0871. To activate your benefit, you must call 1-866-946-0675. You can also login to Progyny.com/progyny-member-portal/.

PRESCRIPTION DRUG PROGRAM

INTRODUCTION

The Prescription Drug Program (the “Drug Plan”) is provided through the Traditional Plan and Healthy Savings Plan (collectively the “Program”) and is a component of the Hormel Foods Corporation Comprehensive Welfare Benefit Plan (the “Plan”). The Program is sponsored and maintained on a self-funded basis by Hormel Foods Corporation (the “Company”). The Company is the Plan Administrator of the Program. Prime Therapeutics LLC (“Prime”) is the Drug Plan Claims Administrator (a/k/a Pharmacy Benefits Administrator) and performs claims processing and other functions in the operation of the Drug Plan.

Please refer to the section of this SPD entitled **General Plan Information**, which is incorporated herein and the terms of that section are specifically made a part hereof.

The Drug Plan provides coverage for the purchase of prescription drugs that are determined to be medically necessary for the care and treatment of the patient covered by the Drug Plan.

Prime has over 60,000 pharmacies nationwide participating in their network. When you obtain services from a participating pharmacy, you will receive the highest level of benefit coverage.

The Drug Plan also provides benefits for covered services you receive from a non-participating pharmacy; however, you will receive a reduced level of coverage when you use a non-participating pharmacy. You will pay a greater portion of your prescription drug expenses when you use a non-participating pharmacy.

IMPORTANT! You can use your Blue Cross identification card at any pharmacy that is part of the pharmacy network. All you have to do is present your card to the pharmacy and they will electronically file your claim with the Drug Plan Claims Administrator.

It is important that you read this summary of the Drug Plan carefully as it explains the Drug Plan, covered expenses, and expenses that are not covered. If you have questions about your coverage, please contact the Drug Plan Claims Administrator.

COVERAGE INFORMATION

COVERED BENEFITS

1. **Prescription products which:**

- (a) Are necessary for the care and treatment of an illness or injury and are prescribed by a duly licensed Prescriber;
- (b) Can be obtained only by Prescription and bear the Legend “Caution, Federal Law Prohibits Dispensing Without A Prescription” (“Legend Drugs”); and
- (c) Are the following Non-Legend Drugs prescribed by a duly licensed Prescriber:
 - 1) Compounded Medications of which at least one ingredient is a Legend Drug; or
 - 2) Any other Medications which due to state law may only be dispensed when prescribed by a duly licensed Prescriber.

2. **Injectable insulin, injectable Glucagon and diabetic supplies** as prescribed by a duly licensed Prescriber.

3. **Preventive drugs.** Coverage is provided for the following products:

- (a) **Contraceptive products.** Coverage is provided without cost sharing requirements (\$0) for evidence-based items that have a U.S. Preventive Services Task Force (USPSTF) ‘A’ or ‘B’ rating. Women with reproductive capacity will have access to all FDA-approved contraceptive methods. This does not include abortifacient drugs.
- (b) **Breast cancer preventive drugs.** Brand name breast cancer preventive drugs are covered without cost sharing requirements (\$0) upon meeting prior authorization criteria as provided by a physician. Criteria can be, but is not limited to, asymptomatic women age 35 or greater without a prior diagnosis of breast cancer who are at increased risk for the disease and at low risk for adverse medication effects.

4. **Vitamins, minerals and hematinics.** Covered products include any vitamin requiring a prescription such as Legend vitamins, multivitamins, fluoride, folic acid, prenatal vitamins and injectable B-12. Other vitamins not requiring a prescription such as minerals, hematinics products and combinations are excluded.
5. **Over-the-counter supplements.** Over-the-counter supplements (aspirin, folic acid, iron, vitamin D, fluoride) will be covered as preventive (\$0 copay) when prescribed and recommended for certain participants based on USPSTF recommendations. Participants must have a prescription and purchase at the pharmacy.
6. **Prescription smoking deterrents.** Covered products include oral Zyban, oral Chantix, Nicotrol Inhaler and Nicotrol Nasal Spray.
7. **Sexual dysfunction products,** including injectables, suppositories and oral tablets.

The coverage of certain prescription drugs may be reduced, increased or eliminated to assist in controlling drug costs.

PLAN OPTIONS - BENEFIT OVERVIEW

This section lists covered benefits provided by the Drug Plan. All benefit payments are based on the allowed amount. Coverage is subject to all other terms and conditions of the Summary Plan Description (SPD). The Drug Plan will pay for covered benefits incurred for the dispensing of prescription products for you and your eligible dependents.

Use of a Non-Participating Pharmacy will require you to make a cash payment and submit a completed reimbursement form with a receipt to the Drug Plan Claims Administrator for reimbursement. Reimbursement for covered prescription products will be determined by the lowest contracted rate of a Participating Pharmacy.

TRADITIONAL PLAN (LOW DEDUCTIBLE)

If you enroll in the Traditional Plan, the following will apply to your prescription drug coverage. The amount you pay for your prescription depends on whether the drug you receive is generic or brand name, and whether it is on the Drug Plan's Preferred Products List. The Drug Plan design rewards those who receive prescription drugs from the Preferred Products List by allowing them to pay less for their prescriptions.

Deductible

There is no deductible under this Drug Plan if you are enrolled in the Traditional Plan. Your out-of-pocket prescription drug expenses for covered benefits **DO NOT** count towards your annual medical deductible or medical out-of-pocket costs.

Copayments

Copayments are made to the pharmacy at the time the prescription is filled. Certain preventive drugs and other medications have a \$0 copayment. Please refer to the *Covered Benefits* section for more information on these drugs. Copayments for various other types of prescription drugs under the Traditional Plan are as follows:

If your Rx is:	You will pay:
Generic on the Preferred Products List	10% of the prescription cost (\$5.00 minimum)
Brand name on the Preferred Products List	20% of the prescription cost (\$5.00 minimum)
Excluded from the Preferred Products List	35% of the prescription cost (\$5.00 minimum)
Specialty drugs through Specialty Pharmacy*	20% of the prescription cost (\$5.00 minimum)

*Specialty drugs must be filled through an in-network Specialty Pharmacy that can be found within the Pharmacy Match Program. Please see *Special Features of the Drug Plan* section below.

Out-of-Pocket Maximums

Under the Traditional Plan, you have a separate out-of-pocket maximum for prescription drug expenses, in addition to the out-of-pocket maximum for your medical plan expenses. The maximum out-of-pocket cost is \$2,500 for covered benefits, per calendar year, per person and \$5,000 per calendar year for family (you and

your eligible dependents). When you have reached your prescription drug out-of-pocket maximum, the Drug Plan will pay 100% of your eligible prescription drug expenses.

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.

Please Note: *If a brand name drug is dispensed when a generic alternative is available, you will pay the difference in cost between the brand name drug and the generic in addition to any copayment you may owe. 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.*

Preferred Products List

The Preferred Products List, also known as a Formulary, is a list of recommended prescription medications that is created, reviewed and continually updated by the Drug Plan Claims Administrator. All available drugs on the market are evaluated to ensure that a wide range of medications are available on the Preferred Products List.

The Drug Plan's use of the Preferred Products List or Formulary does not prevent anyone from receiving a specific prescribed drug, but it encourages participants to select a prescription from the Preferred Products List.

The Preferred Products are selected based upon guidance by the Drug Plan Claims Administrator's Pharmacy and Therapeutics Committee ("**Committee**"). The Committee reviews products and assesses potential for formulary status based upon all recent clinical evidence around both safety and efficacy. Based upon the guidance of this Committee, decisions may be made around:

- Placement of products on the Preferred Products List or removal of products from the Preferred Products List.
- Inclusion or removal of products from Prior Authorization.
- Categorizing certain Non-Legend Products (over-the-counter products) as an eligible expense.

Actions by the Committee take place quarterly, as medical technology evolves, as indications or FDA guidelines change.

The Drug Plan Claims Administrator will inform you of the actions taken by the Committee as appropriate.

The Traditional Plan provides the following insulin benefit - Retail/Mail/ESN preferred insulin and insulin-combo products (tiers 1 & 3) charge members a max of \$25 per 30-day supply. A 90-day supply fill through Mail or ESN will charge members a max of \$75. Members will be charged the lesser of the plan level cost share or \$25/\$75.

HEALTHY SAVINGS PLAN (HIGH DEDUCTIBLE)

If you enroll in the Healthy Savings Plan, the following will apply to your prescription drug coverage.

The amount you pay for your prescription depends on whether the drug you receive is generic or brand name.

Deductible

Your prescription drug coverage is subject to your individual or family deductible under the Healthy Savings Plan. There is no separate deductible or out-of-pocket maximum for prescription drug coverage. The deductibles are listed in the *Health Plan* section of this SPD.

Copayments

When you have met your combined medical and prescription drug deductible, you will pay 20% copayments to the pharmacy at the time the prescription is filled.

Your copayments go towards your combined medical and prescription drug out-of-pocket maximum. Copayments for the difference between the cost of the brand name products and its generic equivalent do not count toward the deductible or out-of-pocket maximum.

Certain preventive drugs and other medications have a \$0 copayment. Refer to the *Covered Benefits* section for more information on these drugs. Copayments for various other types of prescriptions are as follows:

If your Rx is:	You will pay:
Generic drug	20% of the prescription cost after deductible
Brand name drug	20% of the prescription cost after deductible
Specialty drugs through Specialty Pharmacy*	20% of the prescription cost after deductible

*Specialty drugs must be filled through an in-network Specialty Pharmacy that can be found within the Pharmacy Match Program. Please see *Special Features of the Drug Plan* section below.

Out-of-Pocket Maximum

Your out-of-pocket maximum amounts are listed in the *Health Plan* section of this SPD and in the chart in this section. Once you have reached your combined medical and prescription drug out-of-pocket maximum, the Drug Plan will pay 100% of your eligible prescription drug expenses. 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, and you will continue to owe this amount after the out-of-pocket maximum has been met.

Please Note: If a brand name drug is dispensed when a generic alternative is available, you will pay the difference in cost between the brand name drug and the generic in addition to any deductible or copayment you may owe. This difference in cost does not apply toward the deductible or out-of-pocket maximum.

SPECIAL FEATURES OF THE DRUG PLAN

SPECIALTY PHARMACY BENEFIT

The Drug Plan Claims Administrator provides specialized care services for oral and self-injected drug therapies. Specialty Pharmacy programs provide affordable, high-quality care for complex conditions such as multiple sclerosis, rheumatoid arthritis, cancer and many other complex conditions. This clinically based program provides therapy-specific care so you get the most benefit from your treatment.

The Drug Plan reserves the right not to apply manufacturer or provider cost share assistance program payments (e.g., manufacturer cost share assistance, manufacturer discount plans, and/or manufacturer coupons) to the Deductible or Out-of-Pocket maximums.

ADVOCATE+ PHARMACY MATCH

Advocate+Pharmacy Match provides access to high-quality and cost-efficient experiences through an expanded specialty pharmacy network. Advocate+ Pharmacy Match connects you with an approved specialty pharmacy that will then call you to schedule your medication delivery. This solution uses advocates that support members, eliminating barriers and paving a shorter path to treatment with advance prior authorization (PA) support. They also proactively identify financial assistance opportunities for you.

If you have questions about which specialty pharmacy will best fit your needs, please log into your MyPrime portal for more information. If you receive a letter that your specialty pharmacy will be changing, please call the Advocate+ Pharmacy Match line at 1-833-950-3858.

MAIL ORDER PHARMACY PROGRAM

The Drug Plan will pay for covered benefits incurred by a Member for prescription products dispensed through the Mail Order Pharmacy Program identified by the Drug Plan Claims Administrator. Prescription products may be ordered by mail with a copayment from the Member for each prescription or refill. Mail order drugs are subject to the same copayment schedule as drugs purchased from your local pharmacy. You can obtain up to a 90-day supply of maintenance medications when mail order is used.

By law, prescription products cannot be mailed into, or outside of, the United States.

To obtain information about the Mail Order Pharmacy Program or to request forms, you should contact Prime at 1-855-457-0002 or download a form from www.myprimemail.com.

VACCINE NETWORK PROGRAM

The Drug Plan will pay for certain vaccinations offered at a Participating Pharmacy at no cost to you. Vaccines in the program include the following:

- Bacterial vaccine combinations
- Diphtheria-Tetanus combinations (toxoids)
- Flu
- Haemophilus Influenzae Type B (HIB)
- Hepatitis A and B
- Hepatitis combinations
- Human Papillomavirus (HPV)
- Measles, Mumps, and Rubella virus (MMR)
- Meningitis
- Pneumonia
- Polio
- Rabies
- Rotavirus
- Shingles
- Tetanus
- Varicella (Chickenpox)

The shingles vaccine is limited to Members who are age 50 and over, consistent with FDA-approved dosing for the shingles vaccine.

To obtain information about the Vaccine Network Program or inquire on a Participating Pharmacy, you should contact Prime at 1-855-457-0002 or log in to MyPrime.com and click Find Pharmacies.

EXTENDED SUPPLY NETWORK PROGRAM

Extended Supply Network at Your Local Retail Pharmacy

You have the option of obtaining up to a 90-day supply of maintenance medications through a participating Extended Supply Network pharmacy. The Extended Supply Network Program can save you both time and money. Your specific prescription and whether your medication is generic or brand name will determine the amount you pay.

What is a Maintenance Medication?

Maintenance medications are medications that are taken daily for an extended period of time. For example, medications to control blood pressure are taken daily and once the dosage has been stabilized, a person will remain on the same dose for many months. Other examples include: cholesterol-lowering medications, antidepressants, diabetes medications, etc. Ask your doctor or pharmacist if the medications you are taking would qualify.

How to Purchase a Maintenance Medication at a Retail Pharmacy

First locate a participating Extended Supply Network pharmacy by calling the number on the back of your prescription drug ID card. Ask your pharmacist if you need a new prescription to purchase a 90-day supply of your maintenance medications at the participating retail pharmacy and if so, if he or she will contact your doctor.

UTILIZATION MANAGEMENT

For certain prescription drugs, there are additional requirements for coverage or limits on coverage. These requirements and limits ensure that Members use these drugs in the most cost-effective way and also help control Drug Plan costs. The Drug Plan Claims Administrator's Committee developed these requirements and limits for the Drug Plan to help us provide quality coverage to you and your family members. The coverage of certain prescription drugs may be reduced, increased or eliminated to assist in controlling drug costs.

These requirements and limits are listed in this section. The Drug Plan Claims Administrator may have other utilization management procedures, such as drug utilization reviews. These requirements and limits may be found on Prime's website under Find Medicine or by calling Prime's customer service at 1-855-457-0002.

Quantity Limit Restrictions

For certain drugs, the Drug Plan limits the amount of the drug that it will cover per prescription or for a defined period of time. The intent of quantity limit restrictions is to encourage appropriate prescribing quantities as recommended by FDA approved product labeling or as otherwise clinically appropriate.

New to Therapy Program

Oral Oncology Split Fill: Patients who are new to therapy will be provided a partial fill of the medication for a pre-determined length (1-3 months) at a prorated copay based on the day's supply.

Opioid IR (Immediate Release) NTT Split Fill: Patients who are new to Opioid IR therapy will be allowed to fill for a maximum of a 7-day supply and 50 morphine milligram equivalents (MME) per day dosing. Patients

treated in the past 120 days with an Opioid ER medication, oncology medication, or Opioid IR medication are exempt from the 7-day initial fill limit and MME dosing limit.

Step Therapy Program

The Step Therapy Program is a program where the Member must try one or more prerequisite Medications before the Step Therapy Medication will be covered under the Drug Plan. Under the Step Therapy Program, benefit levels for certain Medications identified by the Committee will be adjusted on an individual basis. Under the Traditional Plan, Prescribed Medications may be paid at the Preferred Product level for those individuals who meet program criteria.

Some examples of program(s) available under Step Therapy include: COX-2 Inhibitors, Proton Pump Inhibitors, Hereditary Angioedema, Insomnia and Statin. **Please note:** This list is subject to change based on clinical recommendations from the Drug Plan Claims Administrator's Committee. If you have a question relating to whether a specific drug is included in a Step Therapy Program, you can contact Prime Therapeutics customer service at 1-855-457-0002 or review program information on Prime's website.

Brand Name Drug Management Program

This program excludes brand name drugs where the dominant effective treatment can be provided by generic or over-the counter drug treatments. Brand name drugs in the following categories shall be excluded from coverage:

- Proton Pump Inhibitors
- H2 Antagonists
- Nasal Steroids
- Non-Sedating Antihistamines
- Acne with OTC Alternatives
- Other OTC Alternatives

Prior Authorization Information for Prescription Medications

If the Prescriber believes that you need a Prescription Medication that is on the Prior Authorization List, or is not covered for other reasons, the Prescriber can contact the Drug Plan Claims Administrator to request the Drug Plan's review of the situation. The Prescriber will give the Drug Plan Claims Administrator required information on your medical condition so the Drug Plan can properly evaluate your need for the requested Medication.

Upon review by a licensed Pharmacist, the Drug Plan Claims Administrator may do one of the following:

- Approve the Prescriber's request and authorize coverage of this Medication for a certain period of time at the appropriate copayment.
- Recommend an alternate Medication for consideration by the Prescriber.
- Deny the request to cover the requested Medication if it is determined that the requested Medication is deemed not Medically Necessary or has not been approved by the FDA for its intended use.

If the Prescription Medication that you need requires prior authorization, but you cannot wait for the prior authorization review to take place, you can ask your Prescriber if a drug sample is available, or your pharmacy may provide you with a short-term supply (such as a 5-day supply) while the prior authorization review is taking place. You will be responsible for the full cash copayment at this time.

Prior Authorization List

The physicians and pharmacists who serve on the Drug Plan Claims Administrator's Committee are responsible for reviewing all new medications as they come to market. With each agent, they consider whether a medication should be covered under the Covered Benefits. In addition, they may recommend quantity limits and prior authorization to ensure appropriate use.

When making a recommendation, the Committee focuses on the medication's overall health benefit as well as the cost. The Committee will consider FDA recommendations, manufacturer package labeling instructions, and published clinical recommendations, such as the Journal of the American Medical Association (JAMA).

Below are some examples of products that may appear on the Prior Authorization List:

Adcirca/Revatio	Multiple Sclerosis Medications
Amitiza	Oral Oncology
Ampyra	Peginterferon

Arcalyst / Ilaris	Provigil/Nuvigil
Aromatase Inhibitors	RA/Psoriasis Biologics
ESA (Erythropoiesis Stimulating Agents)	Relistor
Fentanyl Oral	Synagis
Forteo	Xolair
Growth Hormones	Xyrem

Please note this list is subject to change based on clinical recommendations from the Drug Plan Claims Administrator's Committee.

For more information concerning the Prior Authorization List, or to obtain an updated list of those products that appear on the Prior Authorization List, please contact the Drug Plan Claims Administrator at 1-855-457-0002 or visit their website at www.myprime.com.

CLAIM PROCEDURES

The Drug Plan Claims Administrator, Prime Therapeutics, shall make all determinations as to the benefits to be paid when a claim is filed. Any denial of a claim for benefits under the Drug Plan shall be in writing and mailed to you setting forth the specific reason for the denial of benefits.

If you have a question relating to the denial of a claim or any other aspect of administration of the Drug Plan, you can contact Prime Therapeutics customer service at 1-855-457-0002. A customer service representative will assist you in determining whether your benefits were administered correctly and will also document your call. If you still believe your benefits were not administered correctly, you may submit a written appeal.

NOTE: If the Drug Plan is not the primary payer for your dependents' prescription drug coverage, your prescription drug identification card should not be used. You should first submit the claim to the primary payer for processing and then submit it to Prime for processing as the secondary payer.

You should complete a prescription drug reimbursement form and attach a copy of the receipt from the pharmacy and the Explanation of Benefits from the primary payer. You will need to complete a separate claim form for each dependent for which you are requesting reimbursement. These claim forms can be obtained by calling Prime at 1-855-457-0002 or visiting their website at www.myprime.com.

CLAIM REVIEW DEADLINES AND PROCEDURES

A "claim" is any request for a Drug Plan benefit made in accordance with these claim procedures. You become a "claimant" when you make a request for a Drug Plan benefit in accordance with these claim procedures. A communication regarding benefits that is not made in accordance with the procedures listed below will not be treated as a claim.

APPEAL INFORMATION

The Member must exhaust the following internal procedures before any outside action is taken. You must file an appeal within 180 days following the date you received the Explanation of Benefits ("EOB") form from the Drug Plan showing that your claim was denied. You may review the claim file, present evidence and testimony, and submit written comments, documents, records, and other information relating to your claim. We will consider all submissions in making our decision.

We may use internal and external rules and guidelines to review your appeal. You have the right to ask for any relevant documents, records, or other information used to process your claim. You may ask for the scientific or clinical judgment used if your claim was denied because it was determined to be investigative or not medically necessary. We will send you this information free of charge upon request.

To obtain an External Review Request Form, contact Prime Therapeutics customer service at 1-855-457-0002.

FURTHER APPEALS

You may be eligible for a further review of your appeal. The outcome notification letter will describe how to pursue your further appeal rights. **Please note:** a filing fee may apply.

TIME PERIOD FOR MAKING DECISIONS ON APPEALS

After reviewing a claim that has been appealed, the Drug Plan will notify you of its decision within a reasonable period of time but no later than 60 calendar days after the Drug Plan receives your request for review.

This timeline applies only to the mandatory appeal level, further appeals are not subject to specific timelines.

Upon exhaustion of the complaint/appeal process, members of group plans subject to the Employee Retirement Income Security Act (ERISA) have the right to file suit under section 502(a) of ERISA.

For additional information about the diagnosis and treatment codes submitted by your provider, contact Prime's customer service.

ADDITIONAL PROVISIONS

AUTHORIZED REPRESENTATIVE

An authorized representative may act on your behalf with respect to any aspect of a claim or appeal. An Authorized Representative form must be received by the Drug Plan in order for a person to be recognized as your authorized representative. Such forms are available by calling the Drug Plan Claims Administrator's customer service at 1-855-457-0002.

Once an authorized representative is recognized, the Drug Plan will direct all information, notification, etc. regarding the claim or appeal to the authorized representative, unless you provide specific written direction otherwise. You can authorize only one person as your authorized representative at a time, and you can revoke the authorized representative at any time.

No authorization is required for your treating physician or pharmacist to make a claim or appeal on your behalf.

LEGAL ACTIONS FOLLOWING APPEALS

After completing all mandatory appeal levels through this Drug Plan, you have the right to further appeal adverse benefit determinations by bringing a civil action under the Employee Retirement Income Security Act ("ERISA"). Please refer to the section entitled "*ERISA Statement of Rights*" located in the *Notices* section of this SPD. No such action may be filed against the Drug Plan after three (3) years from the date the Drug Plan gives you a final determination on your appeal.

EXCLUSIONS

The following exclusions preempt medical necessity unless explicitly stated below:

1. All vitamins, minerals, and hematinics unless otherwise noted within the Covered Benefits section.
2. Cosmetic drugs, except for acne treatment.
3. Anorectics or any other products, whether prescribed or over-the-counter, used for the purpose of weight control.
4. Growth hormones, unless determined Medically Necessary by the Drug Plan.
5. Hair growth medications.
6. Any product available over-the-counter that does not require a Prescription order by federal or state law and any Medication that is equivalent to an over-the-counter Medication.
7. Charges associated with the administration or injection of any drug (may be eligible for payment under the Health Plan).
8. Drugs received without cost to the employee or covered dependent and without coverage by the Drug Plan.
9. Drugs provided for under another section of the Medical Program.
10. Refill of covered prescription drugs in excess of the number specified by the Prescriber, or any refill dispensed after one year from the date of the Prescriber's last order.

11. Drugs dispensed prior to the effective date of coverage under the Drug Plan or after the date coverage terminated.
12. Charges which are in excess of the Contracted Amount.
13. Therapeutic devices or appliances, including hypodermic needles, syringes (except as stated in the Covered Benefits section), support garments and other nonmedical substances, without regard to their intended use.
14. Immunization agents, biological sera, blood or blood plasma.
15. Products labeled: "Caution-Limited by Federal Law to Investigational Use", or Experimental drugs even though a charge is made to the Member. Approved prescription products that are prescribed for Investigational or Experimental purposes or in Investigational or Experimental dosages.
16. Any charge for the administration of Prescription Legend products.
17. Any Medication, Legend or Non-Legend, which is taken or administered at the place where it is dispensed. Any Medication which is meant to be taken by or administered to the Member, in whole or in part, while the Member is treated at a hospital, a physician's office or extended care facility (but is instead self-administered or administered elsewhere), unless expressly designated by the Drug Plan Claims Administrator.
18. Prescription products which are not dispensed by a licensed Pharmacist or Prescriber.
19. Prescription products that may be received without charge under local, state or federal programs, including Workers' Compensation.
20. Approved Prescription products with no approved Food and Drug Administration (FDA) indications for the purpose for which prescribed.
21. Replacement Prescription products resulting from loss, theft, or damage.
22. Anabolic steroids.
23. All illegal Medications or supplies, even if prescribed by a duly licensed Prescriber.
24. The difference in cost between a generic product and a brand name produce, regardless of circumstances.

PLEASE NOTE: If your requested Medication or supply is not covered, in whole or in part, you still have a right to purchase that product, however, the entire cost of the product will be your responsibility.

COORDINATION OF BENEFITS

Members of a family are frequently covered under more than one group plan providing benefits or services for health care. In other instances, medical and prescription drug claims are paid as a result of other insurance provisions.

For example:

When a husband and wife are working for two (2) different companies, the family might be covered under the medical and prescription drug plan of both companies, or as a result of an automobile accident, medical and prescription drug claims resulting from the accident are paid under the provisions of an automobile policy. In such instances, double coverage results in a family receiving more dollars in benefits than it incurs in medical and prescription drug expenses. Double payments tend to increase the overall cost of medical and prescription drug expenses to the employee, his/her fellow employees, the Company and the public.

To avoid costly duplication of benefits, a Coordination of Benefits provision was added to our Health Care Plan Options. This provision coordinates the benefits payable under the Plan with benefits payable under other group medical plans, automobile policies, homeowner's policies and property insurance policies. Total benefits paid from two (2) or more plans will not exceed 100 percent of the allowable health care expenses incurred by the employee and/or his/her dependents for any one illness or injury. One of the plans is considered "primary" and pays first. The other plan is "secondary" and its benefits will usually be the difference between the benefits paid by the "primary" plan and the total allowable expenses under either plan. If you or your dependents are eligible for prescription drug benefits under this Drug Plan Option and under another prescription drug plan,

benefits will be coordinated so that no more than 100 percent of the “Allowable Charges” is paid jointly by the plans. “Allowable Charges”, as defined above, are determined prior to calculating all percentages, deductibles and benefit maximums. If the other plan does not have a Coordination of Benefits provision, that plan will always be considered “primary” and our Drug Plan Option “secondary”.

The earliest birthday (month and day) in the calendar year determines whether a father’s or mother’s group insurance plan is primary for a dependent child’s medical and prescription drug claims. If both parents have the same birthday, the benefits of the plan that covered the parent longer are considered to be primary. When the parents are divorced or separated, the policy of the parent with custody pays first and the policy of the parent without custody pays second. If the parent with custody has remarried, the policy of the parent with custody pays first, the policy of the stepparent pays second and the policy of the parent without custody pays third. If there is a court decree that states that one of the parents is responsible for the child’s health care, that order will control.

When the order of benefits is not determined by the above, the benefits of the plan covering the person as an employee who is neither laid off nor retired, or as that employee’s dependent, are determined before those of a plan covering a person who is laid off or retired (or as that employee’s dependent). If the other plan does not have this provision, and, as a result, the plans do not agree on the above order of benefits, this provision is ignored.

If none of the above provisions determine the order of benefits, the benefits of the plan which covered a person longer are determined primary.

In the event of duplicate payments, the Company will require reimbursement for any benefits that were paid in excess of what should have been paid as secondary carrier.

NOTE: If the Drug Plan Option is not the primary payer for your dependents’ prescription drug coverage, your prescription drug identification card should not be used. You should first submit the claim to the primary payer for processing and then submit it to Prime for processing as the secondary payer.

You should complete a prescription drug reimbursement form and attach a copy of the receipt from the pharmacy and the Explanation of Benefits from the primary payer. You will need to complete a separate claim form for each dependent for which you are requesting reimbursement. These claim forms can be obtained by calling Prime at 1-855-457-0002, or visiting their website at www.myprime.com.

DEFINITIONS

Brand-Name Product - A Brand name or trademark name, typically the originator of the product and is defined by First Data Bank or any other industry source when assigned a brand status. Brand status may change depending on the cost of the product as issued by the manufacturer.

Claims Administrator/Drug Plan Claims Administrator - An organization that manages payment for Prescriptions and services under the Drug Plan. Also referred to as the Pharmacy Benefits Administrator.

Close Relative - Yourself, spouse, child, sibling, or parent of yourself or your spouse.

Compounded Medications - A prescription where two (2) or more drugs/medications are mixed together. All of these drugs/medications must be FDA-approved. The end product must not be available in an equivalent commercial form. A prescription will not be considered a compound prescription if it is reconstituted or if, to the active ingredient, only water or sodium chloride solution are added. The compound must also be FDA-approved for use in the condition being treated and in the dosage form being dispensed.

Contracted Amount - The discounted amount negotiated by the Drug Plan Claims Administrator with the Drug Plan that is providing the prescription benefit. This amount may include applicable sales tax and pharmacy dispensing fees associated with the dispensing of any prescription.

Copayment - The percentage of a charge a Member is required to pay for certain services eligible under the Drug Plan (may be collected upon receipt of services or billed to you later).

Deductible - The amount you must pay for eligible expenses each year before the Drug Plan begins to pay benefits. There is no deductible for the Traditional Plan. The deductible is a combined deductible for the Healthy Savings Plan. The deductibles are listed in the Benefit Chart.

Doctor - A physician or surgeon who is duly licensed to practice medicine or perform surgery in the state where he or she practices.

Generic Product - A non-Brand name product which is a pharmaceutical equivalent to a Brand name product, but is typically sold at a lower cost and is defined by First Data Bank or any other industry source, when assigned a generic status. Generic status often changes depending on the cost of the product as issued by the manufacturer

Investigative/Experimental - A procedure, technology, treatment, facility, equipment, drug or device which is used mainly for research purposes, as determined by the Drug Plan Medical Director, including techniques or services that have been confined largely to laboratory and/or animal research or have progressed to limited human application but lack wide recognition as proven and effective measures in clinical medicine.

Legend Drugs - A drug that is required to bear one of two statements "Caution Federal Law Prohibits Dispensing Without Prescription" or "RX Only", approved by the Federal Drug and Cosmetic Act.

Medically Necessary - Services, treatment, technology, prescription drugs or supplies ("services") that meet the following criteria:

1. Consistent with generally acceptable principles of medical practice for the diagnosis and treatment of the Member's medical condition;
2. Performed in the most cost-effective manner (in terms of treatment method, setting, frequency and intensity), taking into consideration the Member's medical condition;
3. Required for reasons other than the convenience of the Member or his/her Physician, or solely for custodial, comfort, convenience, appearance, educational, recreational or vocational reasons; and
4. Not otherwise excluded from the Drug Plan.

If a particular service meets all of the above criteria except No. 2, but is safe and effective, the Drug Plan may cover that part of the cost which does not exceed that of an eligible service that would have been sufficient to safely and adequately diagnose or treat the Member's medical condition.

Not all services prescribed or recommended are necessarily covered under the Drug Plan.

Medicine or Medication - A substance or preparation that alleviates or treats a sickness, disease, or injury and may be available by prescription only or over-the-counter. Medicine includes only substances and preparations that qualify as a medical expense under the Internal Revenue Code §213. Medicines or Medications (as defined by the Drug Plan) are not cosmetic in nature, nor merely beneficial to a person's general health.

Member - An employee or family member who enrolls in the Drug Plan through the Health Plan, but only while coverage under the Drug Plan is in effect.

Non-Legend Drugs - An over-the-counter (OTC) Medication or supply normally purchased without a prescription and which are prepackaged for use by the consumer and labeled in accordance with the requirements and statutes and regulations of any state and the federal government.

Non-Participating Pharmacy - Describes services received from a pharmacy who does not participate in the network.

Out-of-Pocket Maximum - A designated dollar amount of eligible expenses which are paid by the employee. When the employee has paid this amount of eligible expenses, the Drug Plan will pay 100 percent of eligible expenses according to the terms of the Drug Plan. Ineligible expenses are not applied toward the out-of-pocket maximum.

Participating Pharmacy - Describes services received from a pharmacy participating in the network.

Pharmacy and Therapeutics Committee A committee comprised of independent physicians and pharmacists, organized by the Drug Plan Claims Administrator that meets on a quarterly basis to review Medications and supplies.

Pharmacist - A person who is legally licensed to dispense prescription legend drugs under the laws of the state in which he/she practices.

Plan Administrator - The individual in the Hormel Foods Corporation management who is ultimately responsible for the day-to-day functions and management of the Drug Plan, and who may employ or contract with persons or firms to process claims and perform other Drug Plan -connected services.

Preferred Products List - A list of products that have been determined by the Pharmacy and Therapeutics Committee to be clinically appropriate for reimbursement at the "Preferred" level of benefits. The Pharmacy and

Therapeutic Committee will review and modify this list periodically, as new information becomes available. The Drug Plan Claims Administrator will make available a copy of the Preferred Products List to the Drug Plan, Participating Providers, Members and pharmacists.

Prescriber - Any person licensed under the medical professional laws of any state to prescribe and administer Medications and supplies.

Prescription - Any written order signed by a Prescriber for a Legend or Non-Legend product that could be a Medication or supply for the person for whom prescribed. The Prescription must be compliant with all applicable laws and regulations and identify the name of the Prescriber and the name of the person for whom prescribed. It must also identify the name, strength, quantity and the directions for use of the Medication or supply prescribed.

Prescription Drug Plan - The plan of benefits established by the Plan Administrator.

Prior Authorization List - A list of prescription products that are FDA approved for a specific diagnosis or as second line therapy, identified by the Pharmacy and Therapeutics Committee for which the Drug Plan Claims Administrator requires medical information from the Prescriber to determine the appropriate level of coverage. The Pharmacy and Therapeutics Committee or Drug Plan Claims Administrator will review and modify this list periodically, as new information becomes available.

Quantity Limits - Limiting the dispensing quantities applied to Medications that are appropriate for acute uses and are designed to provide sufficient amounts for the treatment of one or more acute episodes, based on the FDA guidelines, clinical recommendations published in peer review journals, as well as manufacturer packaging and labeling instructions. Some Quantity Limits are based on the number of units per dispensing while others are specified as a per month limit. The Pharmacy and Therapeutics Committee or the Drug Plan Claims Administrator will review and modify this list periodically, as new information becomes available.

DENTAL PLAN

INTRODUCTION

This Dental Plan contains a summary of the dental coverage offered through the Dental and Vision Program (the “Program”) and is a component of the Hormel Foods Corporation Comprehensive Welfare Benefit Plan (the “Plan”) for benefits effective January 1, 2026. The Program is sponsored and maintained on a self-funded basis by Hormel Foods Corporation (the “Company”). The Company is the Plan Administrator of the Program. Delta Dental of Minnesota (“Delta Dental”) is the Dental Claims Administrator and performs claims processing and other functions in the operation of the Dental Plan.

All coverage for dependents and all references to dependents in this SPD are inapplicable for employee-only coverage.

IMPORTANT! When receiving care, present your identification (ID) card to the provider who is rendering the services. If you have questions about your coverage, please contact the Dental Claims Administrator.

If you have any questions on your Dental Plan benefits, please contact customer service at the telephone number listed on the back of your member ID card.

COVERAGE INFORMATION

Under this Dental Plan, **YOU MAY GO TO THE DENTIST OF YOUR CHOICE**. You may have additional out-of-pocket costs if your dentist is not a Delta Dental PPO™ or Delta Dental Premier® dentist with the Dental Plan. There may also be a difference in the payment amount if your dentist is not a participating dentist with Delta Dental. This payment difference could result in some financial liability to you. The amount is dependent on the nonparticipating dentist's charges in relation to the amount determined by Delta Dental.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN THE DELTA DENTAL PREMIER® AND DELTA DENTAL PPO™ NETWORKS PRIOR TO RECEIVING DENTAL CARE.

NETWORK

PARTICIPATING DENTIST NETWORK

If your dentist does not participate in the network, you may continue to use that dentist, although you will share more of the cost of your care and could be responsible for dental charges up to the dentist's full billed amount.

How to Find a Participating Dentist

You can find a real-time listing of local participating dentists online at <http://www.DeltaDentalMN.org/find-a-dentist> by entering your zip code, city or state. Please use the web site for the most accurate network information. You can also search by dentist or clinic name. The web site also allows you to print out a map directing you to the dental office you select. To search for and verify the status of participating providers, select “Find A Dentist” on the www.DeltaDentalMN.org home page. Select the product or network in the drop-down menu, and search by city and state, zip code or provider or clinic name.

Alternatively, you can call Delta Dental's Customer Service Center at: (800) 448-3815. Customer Service hours are 7 a.m. to 7 p.m., Monday through Friday, Central Standard Time.

When you call to make a dental appointment, always verify the dentist is a participating dentist. Be sure to specifically state that your employer is providing the Dental program.

Delta Dental Premier® Dentist

A Delta Dental Premier® dentist is a dentist who has signed a Delta Dental Premier® membership agreement with his/her local Delta Dental plan. The dentist has agreed to accept Delta Dental's Maximum Amount Payable as payment in full for covered dental care. Delta Dental's Maximum Amount Payable is a schedule of fixed dollar maximums established solely by Delta Dental for dental services provided by a licensed dentist who is a

participating dentist. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental Premier® dentist has agreed not to bill more than Delta Dental's allowable charge. A Delta Dental Premier® dentist has also agreed to file the claim directly with Delta Dental.

Delta Dental PPO™ Network Dentist

A Delta Dental PPO™ network dentist is a dentist who has signed a Delta Dental PPO™ membership agreement with his/her local Delta Dental Plan. The dentist has agreed to accept the Delta Dental PPO™ Maximum Amount Payable as payment in full for covered dental care. You will be responsible for any applicable deductible and coinsurance amounts listed in the Summary of Dental Benefits section. A Delta Dental PPO™ dentist has agreed not to bill more than the Delta Dental PPO™ Maximum Amount Payable. A Delta Dental PPO™ dentist has also agreed to file the claim directly with Delta Dental.

CLAIM PAYMENTS

Payments are made by the Dental Plan only when the covered dental procedures have been completed. The dental plan may require additional information from you or your provider before a claim can be considered complete and ready for processing. In order to properly process a claim, the dental plan may be required to add an administrative policy line to the claim. Duplicate claims previously processed will be denied.

Any benefits payable under this Dental Plan are not assignable by any Covered Person or any eligible dependent of any Covered Person, unless benefits are authorized by the Covered Person to be paid directly to the provider and required by applicable state law.

DELTA DENTAL PREMIER® DENTISTS

Claim payments are based on the Dental Plan's Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental Premier® dentist to a Delta Dental covered patient. The Dental Plan Payment Obligation for Delta Dental Premier® dentists is the lesser of: (1) The Maximum Amount Payable as determined by Delta Dental; or (2) The fee charged or accepted as payment in full by the Delta Dental Premier® dentist regardless of the amount charged. All Dental Plan Payment Obligations are determined prior to the calculation of any patient copayments and deductibles as provided under the patient's Delta Dental program.

DELTA DENTAL PPO™ DENTISTS

Claim payments are based on the Dental Plan's Payment Obligation which is the highest fee amount Delta Dental approves for dental services provided by a Delta Dental PPO™ dentist to a Delta Dental covered patient. The Dental Plan Payment Obligation for Delta Dental PPO™ dentists is the lesser of: (1) The Delta Dental PPO™ Maximum Amount Payable as determined by Delta Dental; or (2) The fee charged or accepted as payment in full by the Delta Dental PPO™ dentist regardless of the amount charged. All Dental Plan Payment Obligations are determined prior to the calculation of any patient copayments and deductibles as provided under the patient's Delta Dental program.

NONPARTICIPATING DENTISTS (OUT OF NETWORK)

Claim payments are based on the Dental Plan's Payment Obligation, which for nonparticipating dentists is the treating dentist's submitted charge or the amount established solely by Delta Dental, whichever is less. Claim payments are sent directly to the Covered Person, unless benefit is authorized by the Covered Person to be paid directly to the provider and required by applicable state law.

SUMMARY OF DENTAL BENEFITS

DEDUCTIBLES

There is a \$50 deductible per Covered Person each Coverage Year up to \$150 maximum for family coverage. The deductible does not apply to diagnostic, preventive and orthodontic services.

	Delta Dental PPO™	Delta Dental Premier®	Nonparticipating ¹
Deductible (does not apply to diagnostic, preventive or orthodontic)	\$50 individual \$150 family	\$50 individual \$150 family	\$50 individual \$150 family

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

COINSURANCE

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

	Delta Dental PPO™	Delta Dental Premier®	Nonparticipating ¹
Diagnostic & Preventive	100%	100%	100%
Basic Services	80%	80%	80%
Oral Surgery	80%	80%	80%
Endodontics	80%	80%	80%
Periodontics	80%	80%	80%
Major Restorative	80%	80%	80%
Prosthetic Repairs and Adjustments	80%	80%	80%
Prosthetics	80%	80%	80%
Orthodontics	50%	50%	50%

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

BENEFIT MAXIMUMS

Annual Plan Maximum

Delta Dental PPO™ Dentists - The Dental Plan pays up to a maximum of \$3,000 for each Covered Person per Coverage Year subject to the coverage percentages identified above. Benefit Maximums may not be carried over to future Coverage Years.

Delta Dental Premier® Dentists - The Dental Plan pays up to a maximum of \$3,000 for each Covered Person per Coverage Year subject to the coverage percentages identified above. Benefit Maximums may not be carried over to future Coverage Years.

Nonparticipating Dentists - The Dental Plan pays up to a maximum of \$3,000 for each Covered Person per Coverage Year subject to the coverage percentages identified above. Benefit Maximums may not be carried over to future Coverage Years. You may be responsible for additional out-of-pocket expenses if charges are above the Table of Allowance amount.

	Delta Dental PPO™	Delta Dental Premier®	Nonparticipating ¹
Annual Maximum	\$3,000	\$3,000	\$3,000

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

Lifetime Plan Maximums

TMJ Lifetime Maximum - There is a separate lifetime maximum of \$1,500 for each Covered Person for TMJ services.

Orthodontic Lifetime Maximum - The orthodontics lifetime maximum includes orthodontic benefits paid per Covered Person under all dental programs sponsored by the Company. The orthodontic maximum differs depending on which provider you choose.

- **Delta Dental PPO™ Dentists** - Orthodontics is subject to a separate lifetime maximum of 50% up to \$3,000 per Covered Person for Delta Dental PPO™ dentists. Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. The Covered Person must remain eligible under the Dental Plan in order to receive continued benefit payments.
- **Delta Dental Premier® Dentists** - Orthodontics is subject to a separate lifetime maximum of 50% up to \$2,500 per Covered Person for Delta Dental Premier® dentists. Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. The Covered Person must remain eligible under the Dental Plan in order to receive continued benefit payments.
- **Nonparticipating Dentists** - Orthodontics is subject to a separate lifetime maximum of 50% up to \$2,500 per Covered Person for nonparticipating dentists. Because orthodontic treatment normally

occurs over a long period of time, benefit payments are made over the course of treatment. The Covered Person must remain eligible under the Dental Plan in order to receive continued benefit payments.

	Delta Dental PPO™	Delta Dental Premier®	Nonparticipating¹
TMJ Lifetime Maximum	\$1,500	\$1,500	\$1,500
Orthodontics Lifetime Maximum	50% up to \$3,000	50% up to \$2,500	50% up to \$2,500

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

DESCRIPTION OF COVERED PROCEDURES

The Dental Plan covers the dental procedures listed in this summary when they are performed by a licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice. The benefits under this Dental Plan shall be provided whether the dental procedures are performed by a duly licensed physician or a duly licensed dentist, if otherwise covered under this Dental Plan, provided that such dental procedures can be lawfully performed within the scope of a duly licensed dentist.

As a condition precedent to the approval of claim payments, the Dental Plan shall be entitled to request and receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist's care is provided, such information and records relating to a Covered Person as may be required to pay claims. Also, the Dental Plan may require that a Covered Person be examined by a dental consultant retained by the Dental Plan in or near the Covered Person's place of residence. The Dental Plan shall hold such information and records confidential.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER NETWORK PARTICIPATION STATUS WITHIN YOUR DELTA DENTAL PPO™ AND DELTA DENTAL PREMIER® NETWORKS PRIOR TO RECEIVING DENTAL CARE.

Delta Dental of Minnesota performs dental necessity reviews to determine whether a service submitted for payment or benefit under this Dental Plan is a dental procedure that is dentally necessary to treat a specific condition or restore dentition for an individual. It is Delta Dental of Minnesota's policy that a licensed dentist reviews claims where a dental necessity determination is made, and denies the oral health service where dental necessity has not been demonstrated. Denials based solely on coverage specifications, limitations, and exclusions under the enrollee's contract are not considered utilization review and not evaluated for dental necessity. Delta Dental evaluates dental procedures submitted to determine if the procedure is a covered benefit under your Dental Plan. Your Dental Plan includes a preset schedule of dental services that are eligible for benefit by the Dental Plan. Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Dental Plan. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your Dental Plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that are not covered by the Dental Plan or exceed the frequency of the Dental Plan benefits do not imply that the service is or is not dentally necessary to treat your specific dental condition. You are responsible for dental services that are not covered or benefited by the Dental Plan. The decision as to what dental care treatment is best for you is solely between you and your dentist.

ONLY those services listed below are covered. Deductibles and maximums are listed under the Summary of Dental Benefits. Services covered are subject to the limitations within the Benefits, Exclusions and Limitations sections. For estimates of covered services, please see the Pretreatment Estimate section.

PREVENTIVE CARE (DIAGNOSTIC AND PREVENTIVE SERVICES)

Oral Evaluations - Any type of evaluation (checkup or exam) is covered two (2) times per Coverage Year.

Radiographs (X-rays)

- **Bitewings** - Covered at one (1) series of bitewings per 12-month period.
- **Full Mouth (Complete Series) or Panoramic** - Covered one (1) time per 36-month period.

- **Periapical(s)** - Single X-rays.

Occlusal - Covered at one (1) series per 12-month period.

Dental Cleaning

Prophylaxis or Periodontal Maintenance - Any combination of these procedures is covered two (2) times per Coverage Year.

Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Periodontal Maintenance is a procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Fluoride Treatment (Topical application of fluoride) - Covered two (2) times per calendar year for dependent children through the age of 18.

Oral Hygiene Instructions - Instructions which include tooth-brushing techniques, flossing and use of oral hygiene aids are covered one (1) time per lifetime.

Space Maintainers - Covered one (1) time per lifetime on eligible dependent children through the end of the month in which the child reaches the age of 17 for extracted primary posterior (back) teeth.

LIMITATION: Repair or replacement of lost/broken appliances is not a covered benefit.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered one (1) time per lifetime for permanent first and second molars of eligible dependent children through the age of 17.

BASIC SERVICES

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- **Anterior (front) Teeth** - Treatment to restore decayed or fractured permanent or primary anterior teeth.
- **Posterior (back) Teeth** - This service is not covered under Basic Services. Refer to the section entitled *Complex or Major Restorative Services*.

LIMITATION: Coverage for amalgam or composite restorations will be limited to only one (1) service per tooth surface per 24-month period.

OTHER BASIC SERVICES

Restorative Cast Post and Core Build-up, including Pins and Posts - See benefit coverage description under the section entitled *Complex or Major Restorative Services*.

Pre-fabricated or Stainless Steel Crown - Covered one (1) time per 24-month period for eligible dependent children through the age of 18.

ADJUNCTIVE GENERAL SERVICES

Intravenous Conscious Sedation and IV Sedation - Covered when performed in conjunction with complex surgical service.

LIMITATION: Intravenous conscious sedation and IV sedation will not be covered when performed with non-surgical dental care.

EXCLUSIONS - Coverage is NOT provided for:

1. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for non-surgical or surgical dental care.
2. Case presentation and office visits.
3. Athletic mouth guard, enamel microabrasion and odontoplasty.
4. Services or supplies that have the primary purpose of improving the appearance of the teeth. This includes, but is not limited to, whitening agents, tooth bonding and veneers.

5. Placement or removal of sedative filling, base or liner used under a restoration.
6. Pulp vitality tests.
7. Diagnostic casts.
8. Adjunctive diagnostic tests.
9. Restorations placed for preventive or cosmetic purposes.
10. Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

BASIC ENDODONTIC SERVICES (NERVE OR PULP TREATMENT)

Endodontic Therapy on Primary Teeth

- Pulpal Therapy
- Therapeutic Pulpotomy

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Apicoectomy
- Root Amputation on posterior (back) teeth

Complex or other Endodontic Services

- Apexification - For dependent children through the age of 16.
- Retrograde filling
- Hemisection, includes root removal

LIMITATION: All of the above procedures are covered one (1) time per tooth per lifetime.

EXCLUSIONS - Coverage is NOT provided for:

1. Retreatment of endodontic services that have been previously benefited under the Dental Plan.
2. Removal of pulpal debridement, pulp cap, post(s), pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
3. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
4. Intentional reimplantation.
5. Pulp vitality tests.
6. Incomplete root canals.

PERIODONTICS (GUM AND BONE TREATMENT)

Basic Non-Surgical Periodontal Care - Treatment for diseases for the gingival (gums) and bone supporting the teeth.

- **Periodontal scaling & root planing** - Covered one (1) time per 24-month period.
- **Full mouth debridement** - Covered one (1) time per lifetime.

Complex Surgical Periodontal Care - Surgical treatment for diseases for the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this Dental Plan:

- Gingivectomy/gingivoplasty
- Gingival flap
- Apically positioned flap
- Osseous surgery
- Bone replacement graft
- Pedicle soft tissue graft
- Soft tissue graft
- Subepithelial connective tissue graft
- Soft tissue allograft
- Distal/proximal wedge
- Combined connective tissue and double pedicle graft

LIMITATION: Only one (1) complex surgical periodontal service is a benefit covered one (1) time per 36-month period per single tooth or multiple teeth in the same quadrant.

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Bacteriologic tests for determination of periodontal disease or pathologic agents.
3. The controlled release of therapeutic agents or biologic materials used to aid in soft tissue and osseous tissue regeneration.
4. Provisional splinting, temporary procedures or interim stabilization of teeth.
5. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide or therapeutic drug injections, drugs or medicines for non-surgical and surgical periodontal care, regardless of the method of administration.

ORAL SURGERY (TOOTH, TISSUE OR BONE REMOVAL)

Basic Extractions

- Removal of Coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Other Complex Surgical Procedures

- Oroantral fistula closure
- Tooth reimplantation - accidentally evulsed or displaced tooth
- Surgical exposure of impacted or unerupted tooth to aid eruption
- Biopsy of oral tissue
- Transseptal fiberotomy
- Alveoloplasty
- Vestibuloplasty
- Excision of lesion or tumor
- Removal of nonodontogenic or odontogenic cyst or tumor
- Removal of exostosis
- Partial ostectomy
- Incision & drainage of abscess
- Frenulectomy (frenectomy or frenotomy)

TEMPOROMANDIBULAR JOINT DISORDER (TMJ)

Dental treatment that is considered surgical and non-surgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder, including splints, is subject to the coordination of benefits. A Pre-treatment Estimate of Benefits is recommended.

NOTE: A claim for TMJ must first be submitted to the Dental Plan. Any remaining costs after consideration under the Dental Plan may be submitted to your Medical Program (if enrolled) for further consideration and/or benefit (see Coordination of Benefits). You must submit a copy of the Dental Explanation of Benefits (EOB) along with your claim when making a claim to the Medical Program.

If you or your covered dependents are not eligible for TMJ benefits under another insurance program, either medical or dental, dental services for TMJ will be covered under this Dental Plan the noted Dental Plan limitations, maximums, deductibles and payment percentages of treatment costs.

LIMITATIONS:

1. Reconstructive surgery benefits shall be provided for reconstructive surgery when such dental procedures are incidental to or follows surgery resulting from injury, illness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician, however, that such procedures are dental reconstructive surgical procedures.

2. Inpatient or outpatient dental expenses arising from dental treatment up to age 18, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate.

For programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this Dental Plan shall be primary and the other policy or contract shall be secondary.

EXCLUSIONS - Coverage is NOT provided for:

1. Intravenous conscious sedation and IV sedation when performed with non-surgical dental care.
2. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration.
3. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
4. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
5. Surgical exposure of impacted or unerupted tooth for orthodontic reasons.
6. Surgical repositioning of teeth.
7. Inpatient or outpatient hospital expenses.
8. Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.

COMPLEX OR MAJOR RESTORATIVE SERVICES (SERVICES PERFORMED TO RESTORE LOST TOOTH STRUCTURE AS A RESULT OF DECAY OR FRACTURE)

Posterior (back) Teeth Composite (white) Resin Restorations

- If the posterior (back) tooth requires a restoration due to decay or fracture;
- If no other posterior (back) composite (white) resin restoration for the same or additional tooth surface(s) was performed within the last 24 months.

Gold Foil Restorations – Benefit shall equal an amalgam (silver) restoration equal to the same number of surfaces and allowances. The patient must pay the difference in cost between the Dental Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

Inlays - Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION: If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Dental Plan's Payment Obligation for the covered benefit and the dentist's submitted fee for the optional treatment, plus any coinsurance for the covered benefit.

Onlays - Covered one (1) time per five (5) year period per tooth.

Permanent Crowns - Covered one (1) time per five (5) year period per tooth.

Implant Crowns - See section entitled *Prosthetic Services*.

Crown Repair - Covered one (1) time per 12-month period per tooth.

Restorative Cast Post and Core Build-up, including one (1) Post per Tooth and one (1) Pin per Surface - Covered one (1) time per five (5) year period when done in conjunction with covered services.

Occlusal Guard – Covered and the benefit is applied against the TMJ lifetime maximum.

Canal Prep and Fitting of Preformed Dowel and Post

EXCLUSIONS - Coverage is NOT provided for:

1. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
2. Procedures designed to alter, restore or maintain occlusion, including but not limited to, increasing vertical

dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

3. Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes, but is not limited to, tooth whitening agents or tooth bonding and veneer covering of the teeth.
4. Placement or removal of sedative filling, base or liner used under a restoration.
5. Temporary, provisional or interim crown.
6. Occlusal procedures including adjustments.
7. Inlays, onlays or crowns placed for preventive or cosmetic purposes.
8. Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

PROSTHETIC SERVICES (DENTURES, PARTIALS, BRIDGES AND IMPLANTS)

Reline, Rebase, Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered when:

- the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after six (6) months following initial placement of the prosthetic appliance (denture, partial or bridge).

Adjustments - Covered two (2) times per 12-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- only after six (6) months following initial placement of the prosthetic appliance (denture, partial or bridge).

Removable Prosthetic Services (Dentures and Partials) - Covered one (1) time per five (5) year period:

- for Covered Persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth; and
- if five (5) years have elapsed since the last benefited removable prosthetic appliance (denture or partial) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) - Covered one (1) time per five (5) year period:

- for Covered Persons age 16 or older;
- for the replacement of extracted (removed) permanent teeth;
- if none of the individual units of the bridge has been benefited previously as a crown or cast restoration in the last five (5) years; and
- if five (5) years have elapsed since the last benefited removable prosthetic appliance (bridge) and the existing appliance needs replacement because it cannot be repaired or adjusted.

Single Tooth Implant Body, Abutment and Crown - Covered one (1) time per five (5) year period for Covered Persons age 16 and over. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a Pretreatment Estimate be requested to estimate the amount of payment prior to beginning treatment.

Restorative Cast Post and Core Build-up, including Pins and Posts - Covered one (1) time per five (5) year period when done in conjunction with covered fixed prosthetic services.

EXCLUSIONS - Coverage is NOT provided for:

1. The replacement of an existing partial denture with a bridge.
2. Initial installation of implants, full or partial dentures or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a Covered Person under this Dental Plan. EXCEPTION: This exclusion shall not apply for any person who has been continuously covered under this Dental Plan for more than 24 months.

3. Interim removable or fixed prosthetic appliances (dentures, partials or bridges).
4. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
5. Additional, elective or enhanced prosthodontic procedures including, but not limited to: connector bar(s), stress breakers, and precision attachments.
6. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
7. Procedures designed to alter, restore or maintain occlusion, including but not limited to, increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
8. Services or supplies that have the primary purpose of improving the appearance of your teeth.
9. Placement or removal of sedative filling, base or liner used under a restoration.
10. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
11. Coverage shall be limited to the least expensive professionally acceptable treatment.

ORTHODONTICS (TREATMENT NECESSARY FOR THE PREVENTION AND CORRECTION OF MALOCCLUSION OF TEETH AND ASSOCIATED DENTAL AND FACIAL DISHARMONIES)

Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.

Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.

Comprehensive (complete) Treatment - Full treatment includes all records, appliances and visits.

Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.

Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.

Other Complex Surgical Procedures

- Surgical exposure of impacted or unerupted tooth for orthodontic reasons
- Surgical repositioning of teeth

LIMITATION: Treatment in progress (appliances placed prior to eligibility under this Dental Plan) will be benefited on a pro-rated basis.

EXCLUSIONS - Coverage is NOT provided for:

1. Monthly treatment visits that are inclusive of treatment cost.
2. Repair or replacement of lost/broken/stolen appliances.
3. Orthodontic retention/retainer as a separate service.
4. Retreatment and/or services for any treatment due to relapse.
5. Inpatient or outpatient hospital expenses.
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments - Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. The Covered Person must have continuous eligibility under the Dental Plan in order to receive ongoing orthodontic benefit payments.

Benefit payments are made in equal amounts:

1. When treatment begins (appliances are installed); and
2. At six (6) month intervals thereafter, until treatment is completed or until the lifetime maximum benefits are exhausted (see section entitled *Benefit Maximums* in this Dental Plan Summary).

Before treatment begins, the treating dentist should submit a Pretreatment Estimate. An Estimate of Benefits form will be sent to you and your dentist indicating the estimated Dental Plan payment amount. This form serves as a claim form when treatment begins.

When treatment begins, the dentist should submit the Estimate of Benefit form with the date of placement and his/her signature. After benefit and eligibility verification by the Dental Plan, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be issued to you and your dentist. This again will serve as the claim form to be submitted six (6) months from the date of appliance placement.

NOTIFICATION REQUIREMENTS

PRETREATMENT ESTIMATE OF BENEFITS

IT IS A GOOD IDEA TO GET A PRETREATMENT ESTIMATE FOR YOUR DENTAL CARE THAT INVOLVES MAJOR RESTORATIVE, PERIODONTIC, PROSTHODONTIC, OR ORTHODONTIC CARE. THE PRETREATMENT ESTIMATE IS RECOMMENDED, BUT NOT REQUIRED FOR YOU TO RECEIVE BENEFITS FOR COVERED DENTAL CARE. THE PRETREATMENT ESTIMATE IS A VALUABLE TOOL FOR BOTH THE DENTIST AND YOU. SUBMISSION OF A PRETREATMENT ESTIMATE ALLOWS THE DENTIST AND YOU KNOW WHAT BENEFITS ARE YOU HAVE AND IF THE TREATMENT IS COVERED. THE PRETREATMENT ESTIMATE OUTLINES WHAT YOU HAVE TO PAY TO THE DENTIST, SUCH AS COPAYMENTS AND DEDUCTIBLES. IT ALLOWS THE DENTIST AND YOU TO MAKE ANY NECESSARY FINANCIAL ARRANGEMENT BEFORE YOUR TREATMENT BEGINS. THIS PROCESS DOES NOT PRIOR AUTHORIZE THE TREATMENT NOR DETERMINE ITS DENTAL OR MEDICAL NECESSITY. THE ESTIMATED PAYMENT IS BASED ON YOUR CURRENT ELIGIBILITY AND CONTRACT BENEFITS IN EFFECT AT THE TIME OF THE ESTIMATE. THIS IS AN ESTIMATE ONLY. FINAL PAYMENT WILL BE BASED ON THE CLAIM THAT IS SUBMITTED ONCE THE TREATMENT IS COMPLETED. SUBMISSION OF OTHER CLAIMS, A CHANGE IN ELIGIBILITY, A CHANGE IN YOUR COVERAGE OR OTHER COVERAGE YOU HAVE MAY ALTER THE PAYMENT.

After the exam, your dentist will tell you the dental treatment that should be given. If the dental treatment involves major restorative, periodontics, prosthetics or orthodontic care, the dentist should submit a claim form to the Dental Plan for the proposed treatment. The Plan will review and determine if the treatment is covered and estimate the amount of payment.

A Pretreatment Estimate of Benefits statement will be sent to you and your dentist. You will be responsible to pay for any deductibles and coinsurance amounts. You will also be responsible to pay for any dental treatment that is not considered a covered service under the Dental Plan.

CLAIM AND APPEAL PROCEDURES

The Dental Claims Administrator, Delta Dental, shall make all determinations as to the benefits to be paid when a claim is filed. Any denial of a claim for benefits under the Dental Plan shall be in writing and mailed to you setting forth the specific reason for the denial of benefits.

If you have a question relating to the denial of a claim or any other aspect of administration of the Dental Plan, you can contact Delta Dental Customer Service at 1-800-448-3815. A customer service representative will assist you in determining whether your benefits were administered correctly and will also document your call. If you still believe your benefits were not administered correctly, you may submit a written appeal.

CLAIM REVIEW DEADLINES AND PROCEDURES

A "claim" is any request for a Dental Plan benefit made in accordance with these claim procedures. You become a "claimant" when you make a request for a Dental Plan benefit in accordance with these claim procedures. There are two types of claims, each with different claim and appeal rules. A communication regarding benefits that is not made in accordance with the procedures listed below will not be treated as a claim.

Concurrent Care Claims

If the Dental Plan reduces or terminates coverage before the end of the course of treatment, it will notify you far enough in advance of the termination or reduction in coverage to allow you to appeal the Dental Plan's decision.

Definition: A Concurrent Care Claim is a claim involving an ongoing course of treatment to be provided over a period of time and for which the Dental Plan is reducing or terminating the coverage before the

end of the scheduled treatment.

Post-Service Claims

If the Dental Plan denies coverage for a dental claim, it will do so within 30 days of the Dental Plan's receipt of the claim from you or your provider. In certain situations, the Dental Plan may extend this by an additional 15 days; if it does, it will notify you of the extension within the original 30 days and will tell you the reasons for the extension and when the Dental Plan expects to make a decision on your claim. If the extension is needed because you failed to submit the necessary information to the Dental Plan, the Dental Plan will tell you of the information it needs and will give you 45 days to provide the needed information to the Dental Plan.

Definition: A Post-Service Care Claim is a claim submitted for payment after health services and treatment have been obtained.

NOTIFICATION OF INITIAL BENEFIT DECISION

If your claim is denied, the Dental Plan will notify you within the time frames stated above. The Dental Plan will also:

1. Tell you the specific reasons your claim was denied;
2. Reference the specific Dental Plan provision(s) on which the determination was based;
3. Describe any additional materials or information for you to complete the claim and an explanation of why the material or information is necessary;
4. Describe the Dental Plan review procedures and the time limits for these procedures (which are also stated below), plus a statement concerning your rights under federal law if your claim is denied;
5. If an internal rule was relied upon by the Dental Plan in making the decision, provide you either a description of the rule or a notice that you can request a copy of the rule from the Dental Plan; and
6. If the claim decision was based on a medical or dental necessity or experimental treatment exclusion, either an explanation of the scientific or clinical judgment for the determination or a statement that the explanation will be provided to you upon your request.

Appeals of Adverse Benefit Determinations

Appeal Procedures

If all or part of your claim is denied after the Dental Plan has received all necessary claim information, you have the right to appeal the decision and request a review of the claim. The procedures for appealing a claim decision are:

1. Compose a written claim appeal, which explains why you believe your claim should be reviewed.
2. Attach any additional information you think will help a favorable decision to be made on your claim.
3. Send your completed appeal, along with any additional information you are submitting, to the Dental Claims Administrator:

Delta Dental of Minnesota
Attn: Professional Services Appeals and Grievances
P.O. Box 30416
Lansing, MI 48909

Your claim appeal must be filed in writing at the Dental Claims Administrator's office within 180 days of the date the claim denial was mailed to you.

When appealing a claim, you have certain rights under federal law. These include:

- You will have the opportunity to submit written comments, documents, records and other information relating to the claim.
- You will be provided upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
- The review by the Dental Plan will take into account all comments, documents, records, and other

information submitted by you relating to your claim, whether or not the information was submitted or considered in the initial benefit determination.

Time Frames for Deciding Claim Appeals

Post-Service Claims

The Dental Plan will review your appeal within 60 days. If special circumstances require, such as the need to hold a hearing, the review of your appeal may be delayed. If this extension is required, the Dental Plan will notify you of the extension and of the special circumstances requiring the extension. After a decision is made concerning your appeal, you will be notified of the decision by the Dental Plan within five (5) days of the decision being made.

Dental appeals will be reviewed by someone different than the original decision-makers and without deference to any prior decision. Because all benefit determinations are based on a preset schedule of dental services eligible under the Dental Plan, claims are not reviewed to determine dental necessity or appropriateness. In all cases, where professional judgment is required to determine if a procedure is covered under the Dental Plan's schedule of benefits, the Dental Claims Administrator will consult with a dental professional who has appropriate training and experience. In such a case, this professional will not be the same individual whose advice was obtained in connection with the initial adverse benefit determination.

The final decision will include the reasons for the decision with specific reference to pertinent plan provision(s) upon which the decision is based.

ADDITIONAL PROVISIONS

Authorized Representative

An authorized representative may act on your behalf with respect to any aspect of a claim or appeal. No authorization is required for your treating dental provider to make a claim or appeal on your behalf. An Authorized Representative form must be received by the Dental Plan in order for a person to be recognized as your authorized representative. Such forms are available by calling the Dental Claims Administrator's Customer Service Department at 1-800-448-3815.

Once an authorized representative is recognized, the Dental Plan will direct all information, notification, etc. regarding the claim or appeal to the authorized representative, unless you provide specific written direction otherwise. You can revoke the authorized representative at any time, and you can authorize only one (1) person as your authorized representative at a time.

Legal Actions Following Appeals

After completing the appeal levels through this Dental Plan, you have the right to further appeal adverse benefit determinations by bringing a civil action under the Employee Retirement Income Security Act ("ERISA").

Please refer to the section entitled "*ERISA Statement of Rights*" located in the section of this booklet entitled **Notices**. No such action may be filed against the Dental Plan after three (3) years from the date the Dental Plan gives you a final determination on your appeal.

EXCLUSIONS

Coverage is **NOT** provided for:

1. Dental services which a Covered Person would be entitled to receive for a nominal charge or without charge if the Plan Sponsor's dental plan contract were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a Covered Person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under the Plan Sponsor's dental plan contract will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving Medical Assistance pursuant to Minnesota Statute Section 62A.045.
2. Dental services or health care services not specifically covered under the Plan Sponsor's dental plan contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).
3. New, experimental or investigational dental techniques or services may be denied until there is, to the satisfaction of the Plan, an established scientific basis for recommendation.

4. Dental services performed for elective or cosmetic purposes. NOTE: Dental services may be subject to pre-payment clinical review of dental records. If services are found to not be dentally necessary, the Dental Plan reserves the right to deny such services and the Covered Member is responsible for the full charge. Dental services are subject to post-payment clinical review of dental records. If services are found not to be dentally necessary, the Dental Plan reserves the right to collect any payment and the Covered Member is responsible for the full charge.
5. Dental services completed prior to the date the Covered Person became eligible for coverage.
6. Services of anesthesiologists.
7. Anesthesia Services, except by a Dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.
8. Deep sedation/general anesthesia, analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care, regardless of the method of administration. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
9. Dental services performed other than by a licensed dentist, licensed physician, his or her employees.
10. Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
11. Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
12. Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
13. Orthodontic treatment services, unless specified in this Dental Benefit Plan Summary as a covered dental service benefit.
14. Case presentations, office visits and consultations.
15. Incomplete, interim or temporary services.
16. Athletic mouth guards, enamel microabrasion and odontoplasty.
17. Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.
18. Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
19. Bacteriologic tests.
20. Cytology sample collection.
21. Separate services billed when they are an inherent component of a Dental Service where the benefit is reimbursed at an Allowed Amount.
22. Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
23. Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).
24. The replacement of an existing partial denture with a bridge.
25. Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
26. Provisional splinting, temporary procedures or interim stabilization.
27. Placement or removal of sedative filling, base or liner used under a restoration.
28. Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
29. Occlusal procedures including adjustments.

30. Pulp vitality tests
31. Adjunctive diagnostic tests.
32. Diagnostic casts.
33. Incomplete root canals.
34. Cone beam images.
35. Anatomical crown exposure.
36. Temporary anchorage devices.
37. Sinus augmentation.
38. Brush biopsy and the accession of a brush biopsy.
39. Restorations placed for preventive or cosmetic purposes.
40. Inlays, onlays and crowns placed for preventive or cosmetic purposes.
41. Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.

LIMITATIONS

OPTIONAL TREATMENT PLANS

In all cases in which there are alternative treatment plans carrying different costs, the decision as to which course of treatment to be followed shall be solely that of the Covered Person and the dentist; however, the benefits payable hereunder will be made only for the applicable percentage of the least costly, commonly performed course of treatment, with the balance of the treatment cost remaining the payment responsibility of the Covered Person.

RECONSTRUCTIVE SURGERY

Benefits shall be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician; to the extent as required by MN Statute 62A.25 provided, however, that such services are dental reconstructive surgical services.

INPATIENT/OUTPATIENT EXPENSES

Benefits for inpatient or outpatient expenses arising from dental services up to age 18, including orthodontic and oral surgery services, involved in the management of birth defects known as cleft lip and cleft palate, as required by MN Statute 62A.042. For programs with orthodontic coverage: If coverage for the treatment of cleft lip or cleft palate is available under any other policy or contract of insurance, this Dental Plan shall be primary and the other policy or contract shall be secondary.

POST PAYMENT REVIEW

Dental services are evaluated after treatment is rendered for accuracy of payment, benefit coverage and potential fraud or abuse as defined in the Health Insurance Portability and Accountability Act of 1996 - Public Law 102-191. Any payments for dental services completed solely for cosmetic purposes or payments for services not performed as billed are subject to recovery. The Dental Claims Administrator's right to conduct post payment review and its right of recovery exists even if a Pretreatment Estimate was submitted for the service.

GENERAL EXCLUSIONS AND LIMITATIONS

For other dental procedure exclusions and limitations, refer to the section entitled *Description of Covered Procedures*.

DEFINITIONS

Maximum Amount Payable	A schedule of fixed dollar maximums established solely by the Dental Claims Administrator for dental services provided by a licensed dentist who is a participating dentist.
PPO Maximum Amount Payable	A schedule of fixed dollar maximums established solely by the Dental Claims Administrator for dental services provided by a licensed dentist who is a Delta Dental PPO™ participating dentist.
Claims Administrator/Dental Claims Administrator	Delta Dental of Minnesota
Copayment/ Coinsurance	The percentage of a charge a Covered Person is required to pay for certain services eligible under the Dental Plan (may be collected upon receipt of services or billed to you later).
Covered Person	An employee or family member who enrolls in the Dental Plan through the Dental and Vision Program, but only while coverage under the Dental Plan is in effect.
Coverage Year	A Coverage Year is a 12-month period in which deductibles and benefit maximums apply. Your Coverage Year is January 1 through December 31.
Deductible	A designated dollar amount of eligible expenses that each Covered Person must pay before the Dental Plan will make any payment toward further eligible expenses (ineligible expenses are not applied toward the deductible).
Dental Plan Dentist	The plan of dental benefits established by the Plan Administrator. A Doctor of Dentistry who is duly licensed to provide dental care in the state where he or she practices and operates within the scope of such license.
Doctor	A physician or surgeon who is duly licensed to practice medicine or perform surgery in the state where he or she practices.
Eligible Provider	An individual or facility duly licensed to provide health care services in the state where care is rendered and who is acting within the scope of that license (except as defined by other definitions).
Emergency & Emergency Conditions	A condition requiring medically necessary care which is immediately necessary to preserve life, prevent serious impairment to bodily functions, organs, or parts to prevent placing the physical or mental health of the person in serious jeopardy.
Member	See "Covered Person".
Nonparticipating Dentist	A dentist who does not participate in the Delta Dental networks.
Participating Dentist	A dentist who participates in the Delta Dental PPO™ or Delta Dental Premier® network.

Plan Administrator

The individual in Hormel Foods Corporation management who is ultimately responsible for the day-to-day functions and management of the Program, and who may employ or contract with persons or firms to process claims and perform other Dental Plan connected services.

Table of Allowance

A list of covered services with an assigned dollar amount that represents the total obligation of the Dental Plan with respect to payment for such service, but does not necessarily represent the dental professional's full fee for that service.

GENERAL INFORMATION

DENTAL PLAN ISSUER INVOLVEMENT

The benefits under the Dental Plan are not guaranteed by Delta Dental under the Plan Sponsor's dental plan contract. As Dental Claims Administrator, Delta Dental pays or denies the claims on behalf of the Dental Plan and reviews requests for review of claims as described in the section entitled *Claim and Appeal Procedures*.

PRIVACY NOTICE

Delta Dental will not disclose non-public personal financial or health information concerning persons covered under the Dental Plan to non-affiliated third parties except as permitted by law or required to adjudicate claims submitted for dental services provided to persons covered under the Dental Plan.

USING YOUR DENTAL PLAN

Dentists who participate with Delta Dental under this Dental Plan are independent contractors. The relationship between you and the participating dentist you select to provide your dental services is strictly that of provider and patient. Delta Dental cannot and does not make any representations as to the quality of treatment outcomes of individual dentists, nor recommends that a particular dentist be consulted for professional care.

All claims should be submitted within 12 months of the date of service. If your dentist is a participating dentist, the claim form will be available at the dentist's office. If your dentist is nonparticipating, claim forms are available by calling the Dental Claims Administrator's Customer Service at 1-800-448-3815. The Dental Plan also accepts the standard American Dental Association (ADA) claim form used by most dentists.

The dental office will file the claim form with the Dental Plan; however, you may be required to assist in completing the patient information portion on the form (Items 1 through 14).

During your first dental appointment, it is very important to advise your dentist of the following information:

- YOUR DELTA GROUP NUMBER
- YOUR EMPLOYER (GROUP NAME)
- YOUR IDENTIFICATION NUMBER (your dependents must use **YOUR** Identification number)
- YOUR BIRTHDAY AND THE BIRTH DATES OF YOUR SPOUSE AND DEPENDENT CHILDREN

CANCELLATION AND RENEWAL

The Dental Plan may be canceled only on an anniversary date of the Plan Sponsor's dental plan contract, or at any time the Plan Sponsor fails to make the required payments or meet the terms of the Contract.

Upon cancellation of the Dental Plan, Covered Persons have no right to continue coverage under the Dental Plan or convert to an individual dental coverage contract.

VISION PLAN

INTRODUCTION

This Vision Plan contains a summary of the vision coverage offered through the Dental and Vision Program (the “Program”) and is a component of the Hormel Foods Corporation Comprehensive Welfare Benefit Plan (the “Plan”) for benefits effective January 1, 2026. The Program is sponsored and maintained on a self-funded basis by Hormel Foods Corporation (the “Company”). The Company is the Plan Administrator for the Program. Vision Service Plan (“VSP”) is the Vision Claims Administrator and performs claims processing and other functions in the operation of the Vision Plan.

All coverage for dependents and all references to dependents in this SPD are inapplicable for employee-only coverage.

VSP has the nation’s largest network of eyecare doctors, with thousands of doctors located in metropolitan as well as rural areas. The Vision Plan provides benefits for covered services from VSP Network eligible vision care doctors

The Vision Plan also provides benefits for covered services you receive from other providers; however, you may receive a reduced level of coverage when you use these providers.

IMPORTANT! When you make your appointment with a VSP Network doctor, advise them that you are a VSP member. Your vision care provider and VSP will handle the rest by verifying your benefits and eligibility for services prior to your scheduled appointment. The VSP doctor will bill VSP directly for your services. You are responsible for services or overages that are not covered by the Vision Plan.

It is important that you read this summary of the Vision Plan carefully as it explains the Vision Plan, eligibility, covered expenses, and expenses that are not covered. If you have questions about your coverage, please contact VSP at the address or phone number listed on the following page.

If you have any questions on your Vision Plan benefits, please contact customer service at 1-800-877-7195

NETWORK

CHOOSING A VISION CARE PROVIDER

Through VSP’s Open Access you and your covered dependents have the freedom to choose any vision provider. VSP’s plan includes a generous reimbursement schedule for services obtained from other providers – including any local or national chains.

LOCATING A VSP NETWORK DOCTOR

You can find a VSP Network doctor by calling the VSP automated member service system via a toll-free number, 1-800-877-7195. You can view a list of participating VSP doctors by logging in to your personal account at www.vsp.com. Select the link *Find a Doctor* and enter your zip code, address provider office location or by Doctor’s name.

NETWORK DOCTORS

1. Call a VSP Network doctor for an appointment.
2. Identify yourself as a VSP member and schedule an appointment.
3. The provider will need the last four digits of your social security number, covered employee’s name, employer name and the patient’s name and date of birth.
4. The provider will contact VSP to verify eligibility, vision coverage and obtain authorization of services/materials. The provider will inform you prior to your visit if you are not eligible for benefits.

VSP providers will automatically file your claim for you.

COVERAGE WITH OTHER PROVIDERS

If you wish to receive services from an out of network provider, VSP will reimburse you up to the amount allowed in the Benefit Chart. Be aware that your reimbursement rate does not guarantee full payment, and VSP cannot guarantee patient satisfaction when services are received from out of network providers. Claims must be filed within 12 months of the date of service,

If you receive services from an out of network provider, the following information is needed for claim submission.

- The provider's invoice, receipt or statement containing the name, address and phone number of the provider, name of patient, date of service and a complete description and amount paid for each service.
- Attached to the provider's bill, please include:
 - ◆ A completed VSP Reimbursement form. This form is located on VSP's website www.vsp.com after logging in to your benefits. You can either submit the claim form and receipt online, or you can print it and attach the itemized receipt and mail it to VSP. If you do not have access to the Internet, you can call VSP's customer service at 1-800-877-7195 or the Horizon Solution Center at 1-866-449-7712 to request the form.

Please keep a copy for your records and send the originals to:

VSP
PO Box 495918
Cincinnati, OH 45249-5918

BENEFIT CHART

This section lists covered services and the benefits the Vision Plan pays. All benefit payments are based on the allowed amount. Coverage is subject to all other terms and conditions of this SPD. For more information on coverage please log in to your account online at www.vsp.com.

The Vision Plan will pay charges incurred by you and your eligible dependents for services performed by an optometrist or ophthalmologist and eye wear prescribed by them, but not to exceed the amount as indicated in the following Benefit Coverage and Schedule:

BENEFIT COVERAGE AND SCHEDULE

BENEFIT	FREQUENCY	Plan Pays In-Network	Your Out-of-Network Reimbursement
Vision Examination	Every Calendar Year	Covered 100% after \$10 copay	Reimbursed up to \$60 after \$10 copay
Retinal Screening	Every Calendar Year	Covered 100% after \$39 copay \$0 copay for members with diabetes	\$0
Essential Medical Eye Care	Available as needed	100% after \$20 copay per exam for routine care to treat pink eye to sudden changes in vision or to monitor dry eye, diabetic eye disease, glaucoma and more	\$0
Frame ¹	Every other calendar year	\$150 allowance after \$20 copay for either lenses or frame (but not both when purchased at the same time) Additional \$20 allowance for featured frame brands. 20% discount on amount over allowance. \$80 allowance at Walmart/Sam's Club/Costco	Reimbursed up to \$70 after \$20 copay for lenses or frame

Prescription Lenses	Every Calendar Year	Covered 100% after \$20 materials copay for either lenses or frame (but not both when purchased at the same time) Included in prescription glasses Polycarbonate lenses: plan pays 100% for dependent children and adults (\$33 copay for adults)	Reimbursed up to: • \$60 single vision • \$89 lined bifocal • \$100 lined trifocal • \$100 progressive • \$160 lenticular after \$20 copay for lenses or frame
Medically Necessary Contact Lenses ^{2, 3}	Every Calendar Year	Covered 100% after \$20 copay	Reimbursed up to \$244 after \$20 copay
Elective Contact Lenses ² (instead of glasses)	Every Calendar Year	\$150 allowance for contact lenses and exam 15% discount on contact lens exam (fitting and evaluation)	Reimbursed up to \$105
Laser Vision Correction ⁴	Once per Lifetime	Allowance of \$200 per eye lifetime maximum ⁴	Reimbursed up to \$200 per eye lifetime maximum ⁴

NOTES:

¹ You may choose a frame outside the Vision Plan coverage and pay the difference in cost.

² Patients choosing contacts instead of prescription glasses use their eligibility for a frame and lenses.

³ Medically Necessary Contact Lenses are a plan benefit when specific benefit criteria are satisfied and when prescribed by a Covered Person's doctor.

⁴ Contact VSP Customer Service or log in to your personal account at www.vsp.com to learn more.

SPECIAL LIMITATIONS

1. For each Covered Person, coverage is limited to either one pair of lenses for glasses or contact lenses per calendar year, not both, and one frame every other calendar year.
2. Medically Necessary Contact Lenses are a Vision Plan Benefit when specific benefit criteria are satisfied and when prescribed by the Covered Person's Network Doctor or Other Provider. Prior review and approval by VSP are not required for the Covered Person to be eligible for Necessary Contact Lenses.

SPECIAL FEATURES

ADDITIONAL DISCOUNTS FROM VSP DOCTOR

Non-Covered Glasses

You can receive 30% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or you can get 20% savings from a VSP provider within 12 months of your last WellVision Exam.

Contact Lens Exam

You will receive a 15% savings on contact lens exam (fitting and evaluation) when purchasing all prescription contact lenses at doctor's usual and customary fees. This benefit is available in conjunction with the VSP contact lens allowance or can be used to purchase contacts in addition to eyeglasses.

Eyeconic

Shop VSP's online store for glasses, contacts and sunglasses and receive 20% off additional eyewear, plus an extra \$20 to spend on select brands. The site offers free shipping and returns, virtual try-on tool, verification of your prescriptions and all-inclusive pricing on glasses and lenses. HSA and FSA are accepted. Go to vsp.com/offers for current value-added benefits and offers.

EXCLUSIONS

1. Care not listed in the Schedule of Care Provided.
2. Sunglasses, plain or prescription.
3. Cosmetic Options.
Examples of cosmetic options include blended lenses, oversized lenses, progressive multifocal lenses, photochromic lenses, tinted lenses, coating of the lens or lenses, laminating of the lens or lenses, cosmetic lenses, UV-protected lenses, corrective vision services, treatments of an experimental nature
4. Orthoptic or vision training and any associated supplemental testing.
5. Non-prescription lenses.
6. Two pairs of glasses in lieu of bifocals.
7. Medical or surgical treatment of the eyes with the exception of limited coverage for Laser Vision Correction.
8. Any eye exam or corrective eyewear required by an employer as a condition of employment.
9. Lost or broken lenses or frame, unless the member has reached his or her normal interval for service when seeking replacements.,

VSP COMPLAINTS AND GRIEVANCES PROCESS

If you have a question or problem, your first step is to call VSP's Customer Service Department at 1-800-877-7195. The Customer Service Department will make every effort to answer your question and/or resolve the matter informally. If a matter is not initially resolved to your satisfaction, you may communicate a complaint or grievance to VSP, orally or in writing, by using the complaint form that may be obtained upon request from the VSP Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. You also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to you to indicate VSP's expected resolution date. Upon final resolution, you will be notified of the outcome in writing.

Claim Payments and Denials

1. **Initial Determination:** VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from you or your authorized representative. In the event that a claim cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.
2. **Request for Appeals:** If your claim for benefits is denied by VSP in whole or in part, VSP will notify you in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, you may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify whom a claim for benefits was denied, including the name of the Enrollee, Member Identification Number of the Enrollee, your name and date of birth, the name of the provider of services and the claim number. You may state the reasons you believe the claim denial was in error. You may also provide any pertinent documents to be reviewed. VSP will review the claim and give you the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. You or your authorized representative should submit all requests for appeals to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
1-800-877-7195

VSP's determination, including specific reasons for the decision, shall be provided and communicated to you within thirty (30) calendar days after receipt of a request for appeal from you or your authorized representative.

If you disagree with VSP's determination, you may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar

days.

When you have completed all appeals mandated by the Employee Retirement Income Security Act of 1974 ("ERISA"), additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. You should contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], you have the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and you disagree with the outcome.

DEFINITIONS

Claims Administrator/Vision Claims Administrator - VSP

Copayment - The percentage of a charge a Covered Person is required to pay for certain services eligible under the Vision Plan (may be collected upon receipt of services or billed to you later).

Cosmetic Contacts - Contact lenses provided in lieu of regular eyeglasses when the contact lenses would not qualify because of cataract surgery or the 20/70 rule described in the section entitled Special Limitations.

Covered Person - An employee or family member who enrolls in the Vision Plan through the Dental and Vision Program, but only while coverage under the Vision Plan is in effect.

Eligible Provider - An individual or facility duly licensed to provide health care services in the state where care is rendered and who is acting within the scope of that license (except as defined by other definitions).

In-Network - Describes services received from a VSP network doctor.

Medically Necessary - Services, treatment, technology, prescription drugs or supplies ("services") that meet the following criteria as determined by the Vision Plan Medical Director:

1. Consistent with generally acceptable principles of medical practice for the diagnosis and treatment of the Covered Person's medical condition;
2. Performed in the most cost-effective manner (in terms of treatment method, setting, frequency and intensity), taking into consideration the Covered Person's medical condition;
3. Required for reasons other than the convenience of the Covered Person or his/her physician, or solely for custodial, comfort, convenience, appearance, educational, recreational or vocational reasons; and
4. Not otherwise excluded from the Vision Plan.

If a particular service meets all of the above criteria except No. 2, but is safe and effective, the Vision Plan may cover that part of the cost which does not exceed that of an eligible service that would have been sufficient to safely and adequately diagnose or treat the Covered Person's medical condition. Not all services prescribed or recommended by In-Network providers are necessarily covered under the Vision Plan.

Member - See "Covered Person".

Network Doctor - A vision care provider who participates in VSP's network of eligible providers.

Ophthalmologist - A person duly licensed to practice ophthalmology in the state where vision care is given and operating within the scope of his/her license.

Optometrist - A person duly licensed to practice optometry in the state where the vision care is given and operating within the scope of his/her license.

Other Providers - Providers who are not members of the VSP network.

Plan Administrator - The individual in Hormel Foods Corporation management who is ultimately responsible for the day-to-day functions and management of the Plan, and who may employ or contract with persons or firms to process claims and perform other Plan-connected services.

Vision Plan - The plan of vision benefits established by the Plan Administrator.

PARTICIPATING EMPLOYERS

Participating Employers for this Summary Plan Description are listed below.

Participating Employers	Eligible Employee Classifications	Contribution rate schedule
Hormel Foods Corporation	Salaried and office hourly	Based on earnings
Hormel Financial Services Corporation	All eligible employee classifications	Based on earnings
Hormel Foods Corporate Services, LLC	All eligible employee classifications	Based on earnings
Hormel Foods International Corporation	All eligible employee classifications	Based on earnings
Hormel Foods Sales, LLC	All eligible employee classifications	Based on earnings
Alma Foods, LLC	All eligible employee classifications	Fixed rate
Applegate Farms, LLC	Salaried and office hourly	Based on earnings
Burke Marketing Corporation	All eligible employee classifications	Fixed rate
Century Foods International, LLC	All eligible employee classifications	Fixed rate
Columbus Manufacturing, Inc.	All eligible employee classifications	Fixed rate
Creative Contract Packaging, LLC	All eligible employee classifications	Fixed rate
Dan's Prize, Inc.	All eligible employee classifications	Fixed rate
Dold Foods, LLC	Office hourly	Based on earnings
Dold Foods, LLC	Plant hourly	Fixed rate
Fontanini Foods, LLC	Office hourly and plant hourly	Fixed rate
Hormel Foods Operations, LLC	All eligible employee classifications and including bargaining unit employees at Suffolk, VA (excluding bargaining unit at the Fresno plant)	Fixed rate
Jennie-O Turkey Store, Inc.	Office hourly, plant hourly and farm salaried	Fixed rate
Lloyd's Barbeque Company, LLC	Office hourly	Based on earnings
Lloyd's Barbeque Company, LLC	Plant hourly	Fixed rate
Logistic Service, LLC	Office hourly	Fixed rate
Osceola Food, LLC	All eligible employee classifications	Fixed rate
Progressive Processing, LLC	All eligible employee classifications	Fixed rate
Provena Foods, Inc. (d/b/a Swiss American Sausage Co.)	Salaried and office hourly	Fixed rate
Rochelle Foods, LLC	Office hourly	Fixed rate
Sadler's Smokehouse, LLC	All eligible employee classifications	Fixed rate
Skippy Foods, LLC	All eligible employee classifications	Fixed rate
Rochelle Foods, LLC	Office hourly	Fixed rate
Sadler's Smokehouse, LLC	All eligible employee classifications	Fixed rate
Skippy Foods, LLC	All eligible employee classifications	Fixed rate