J.R. Simplot Company

Group Health and Welfare Plan

Summary Plan Description

Effective January 1, 2026

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 60 for more details.

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INTRODUCTION

THIS SUMMARY PLAN DESCRIPTION BOOKLET SUPERSEDES ALL PREVIOUSLY PUBLISHED BOOKLETS AND OTHER PLAN COMMUNICATIONS.

This Summary Plan Description booklet describes the programs of the J.R. Simplot Company Group Health & Welfare Plan (the Plan) and the Dependent Care Reimbursement Account and Health Savings Account features of the J.R. Simplot Company Flex Plan (the Flex Plan) for U.S. Employees. It also describes the pre-tax premium payment features of the Flex Plan as related to the Plan programs described in this booklet.

This Summary Plan Description booklet describes the following programs. Some programs are not available to Employees in all classifications or locations. See the **Plan Participation** section for more details.

- Hawaii Kaiser Health Maintenance Organization (HMO) Program*
- Hawaii Medical Assurance Association (HMAA) Program*
- International Welfare Benefits Program*
- Medical Program
- Dental Program
- Vision Program
- Employee Assistance Program (EAP)*
- Health Savings Account (a feature of the J.R. Simplot Company Flex Plan)
- Dependent Care Reimbursement Account (a feature of the J.R. Simplot Company Flex Plan)
- Basic Life and Accidental Death & Dismemberment (AD&D) Insurance Program*
- Long Term Disability Program*
- Voluntary Long Term Disability Program*
- Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance Program*

*This program is insured.

Your coverage is limited to the particular program(s) for which you are eligible and in which you are enrolled.

This Summary Plan Description booklet, together with the accompanying Program Documents, insurance policies and certificates, Benefit Information Reference Sheets, and Plan Document are the documents that govern the Plan. They are intended to help you understand your benefits. Please read them carefully and keep them for future reference. Capitalized terms are very important, and have unique meanings found in the **Definitions** section. You may want to begin your review of this Summary Plan Description booklet by reading that section.

J.R. Simplot Company, as Plan Administrator, has complete discretion to construe or interpret the provisions of this Plan, to determine eligibility for Plan programs, and to determine the type and extent of benefits, if any, to be provided by this Plan. J.R. Simplot Company has delegated claims review fiduciary authority to the applicable insurance company for each of the insured programs under the Plan. As a claims review fiduciary, each such insurance company has sole discretionary authority to determine the availability of benefits under the portion of the Plan that it insures and to interpret, construe and administer the applicable terms of the Plan and any governing insurance policy. The decisions of the Plan Administrator and its designated representatives in such matters shall be controlling, binding, and final.

As Plan Sponsor, J.R. Simplot Company also reserves the right to change or terminate the Plan at any time. If the Plan or any program is amended or terminated, you will be subject to the changes and your rights will be changed accordingly, as of the date of amendment or termination. You do not have ongoing rights to any benefit other than payment of covered expenses incurred before the amendment or termination.

This Summary Plan Description booklet as well as other booklets, pamphlets and documents such as the Program Documents, Benefit Information Reference Sheets and Certificates of Coverage can be accessed through the online benefits system. You can access this system for reference booklets, or to enroll or change enrollments. You can also ask a question by calling the Simplot Benefits Service Center at (800) 254-3252.

If You Have Questions

This Summary Plan Description booklet contains a summary in English of your rights and benefits under the J.R. Simplot Company Group Health & Welfare Plan. If you have difficulty understanding any part of this Summary Plan Description, contact the Human Resources Representative at your location or the Simplot Benefits Service Center by phone Monday through Friday at (800) 254-3252.

Si Tiene Usted Preguntas

Este folleto de Descripción del Plan Sumario contiene un resumen en inglés de sus derechos y beneficios bajo el Plan Grupal de Salud y Bienestar de la compañia de J.R. Simplot. Si tiene alguna dificultad entendiendo parte de esta Descripción del Plan Sumario, por favor llame a su departamento de Recursos Humanos en su localidad o el Centro de Servicios Beneficios al teléfono (800) 254-3252de lunes a viernes.

PLAN PARTICIPATION

Employee Eligibility

All classifications of Employees, other than ACA Seasonal Employees, Turnaround Employees, Contingent Employees, and Externs, are eligible upon hire to participate in the Plan, with coverage effective on the first of the month following your date of hire, except where otherwise indicated. Certain programs are offered based on length of service, pay class, location or collective bargaining unit.

ACA Seasonal Employees, Turnaround Employees, Contingent Employees, and Externs are not eligible to participate in the Plan. For the definitions of these classifications, see definitions on page 56.

The following chart describes the Plan's Employee program eligibility requirements and program offerings, by eligible classification or hourly work location. All programs except the Long-Term Disability Programs begin coverage the first of the month following date of hire. The Long-Term Disability Programs begin coverage the first of the month following six (6) months of employment, for those eligible.

Program of the J.R. Simplot Company Group Health & Welfare Plan or Flex Plan	Eligible classification or Hourly Work location
Medical Program	All Employees except those working in Hawaii
Dental Program	All Employees except those working in Hawaii
Vision Program	All Employees except those working in Hawaii
International Welfare Benefits Program	U.S. based Salaried Employees working at a location outside of the U.S.
Hawaii Kaiser HMO Program	All Employees working in Maui or Kona, Hawaii
HMAA Program	All Employees working in Oahu, Hawaii
Employee Assistance Program	All Employees
Health Savings Account	All Employees except those working in Hawaii
Dependent Care Reimbursement Account	All Employees
Life and AD&D Programs (Basic and Voluntary	All Employees
Long-Term Disability Programs (Basic and Voluntary)	All Employees except those classified as Seasonal, Casual*, Intern or Temporary

*Effective February 3, 2020, as a part of the global implementation of MySimplot, employees previously referred to as "contingent" are now referred to as "casual" employees.

If you are hired in an ineligible classification with J.R. Simplot Company, and later become eligible, you are eligible to participate in the Plan on the first of the month following the date you transferred into an eligible classification. Your eligibility Waiting Period for Long Term Disability Programs only will be calculated from your most recent date of hire.

If you transfer from one classification or location to another and the programs for which you are eligible in the new classification/location are different, you will be able to participate in the new programs on the first day of the month following your transfer date.

Dependent Eligibility

If you meet the Employee eligibility requirements and are participating in the Plan, you are eligible to enroll your Dependent(s) in the programs listed below, provided the program is available to you.

- Hawaii Kaiser HMO Program
- Hawaii Medical Assurance Association Program
- International Welfare Benefits Program
- Medical Program
- Dental Program (unique eligibility rules apply to orthodontic benefits of the Dental Program. See the Dental Program Document for details).
- Vision Program
- Employee Assistance Program
- Voluntary Life and Accidental Death & Dismemberment Insurance Program

Your Dependent(s) become eligible on the later of:

- The date you are eligible as an Employee; or
- The date a qualifying event occurs as outlined in the in Changing Your Elections section (coverage will be effective the first of the month following the date the Dependent is enrolled, except that coverage related to newborns and adopted children will be effective as of the date of birth or adoption provided you enroll the Dependent in a timely manner).

Note: Dependent eligibility provisions may be more restrictive or otherwise different in any insured program under the Plan, such as the HMAA Program, the Hawaii Programs and the Voluntary Life and Accidental Death & Dismemberment Insurance Program. **Please carefully read the Certificate of Coverage and any other written coverage material from the applicable insurance company for complete eligibility provisions.**

Dependent

This means:

- Your Spouse; and
- Your natural or adopted children, including children Placed for Adoption, under 26 years of age; and
- Your stepchildren, foster children, or children of whom you have legal guardianship, under 26 years of age; and
- A child who otherwise qualifies as a Dependent under one of the above provisions except is 26 years of age or older and is Disabled. A child who first becomes Disabled after reaching the age of 26 or is not enrolled as a Dependent prior to reaching the age of 26 is not an eligible Dependent. **You are required to apply for this continuation of coverage due to Disability within 31 days after the child reaches the maximum coverage age of 26**.

For the definition of Dependent for purposes of the Dependent Care Reimbursement Account, see the Dependent Care Reimbursement Account section.

Dependent Documentation

You are required to submit documentation demonstrating your Dependent's eligibility within 75 days inclusive of the date your dependent becomes eligible for coverage under the Plan. Documentation related to newborns and adopted children must be submitted within 120 days.

See the Dependent and Change Documentation section for more information. If you do not submit acceptable documentation within the required amount of time, your Dependent will be considered ineligible.

No Duplicate Coverage

You and your eligible Dependent(s) may not be covered more than once under any of the programs of the Plan. If you (or one of your Dependents) would otherwise be eligible more than once, for example, as an Employee and a Dependent, or as the Dependent of two Employees, etc., you may elect only one of the coverages. Duplicate coverage is not available except that you (or your Spouse) may have coverage as both an Employee and as a Spouse for purposes of the Voluntary Life and Accidental Death & Dismemberment Insurance Program.

Qualified Medical Child Support Order (QMCSO)

The Plan will comply with the requirements of a Qualified Medical Child Support Order (QMCSO) in accordance with applicable law and the Plan's procedures governing QMCSO's.

A QMCSO requires a Plan Participant to provide health coverage to a Dependent child, known as an "alternate recipient," in accordance with the order in situations where the parents are divorced or separated. To be "qualified," the order is required to provide the alternate recipient's name, last known mailing address, and the specific type and duration of coverage to be provided. Once an order has been approved, the alternate recipient's date of birth will also need to be provided in order to complete enrollment. A copy of the procedures governing Qualified Medical Child Support Orders (QMCSO) can be obtained from the Plan Administrator without charge.

Initial Enrollment and Effective Date of Coverage

To request initial coverage for each program of the Plan, you are required to complete enrollment with J.R. Simplot Company.

International Welfare Benefits, Medical Program, Dental Program, Vision Program, and Dependent Care Reimbursement Account

If you complete enrollment within 31 days inclusive of the date you become eligible, coverage for you and your enrolled Dependent(s) will normally take effect as of the first of the month following the date you became eligible. You will be responsible for paying applicable contributions or premiums retroactive to the effective date of coverage.

If enrollment is not completed within 31 days inclusive of the date you became eligible, you will not be allowed to enroll for coverage until the next Annual Enrollment period, unless you qualify for one of the limited exceptions described below under Changing Your Elections.

Except as described in the following paragraph, newly acquired Dependents have to be enrolled within 31 days inclusive of the date they became eligible, e.g., for a new Spouse, within 31 days inclusive of the marriage date. If properly enrolled, their coverage will take effect:

- For a birth or adoption, as of the date of the event.
- For all other events, as of the first of the month following the date you Initiate the Enrollment for the Dependent

If you have a newborn Dependent child while you are enrolled in the Medical Program, Dental Program and/or Vision Program, he or she will be covered under the Program(s) from the moment of birth, provided the child meets the definition of a Dependent. However, claims for the new child will not be reimbursed by the Plan until you have completed enrollment for the child and paid any required contributions retroactive to the first day of coverage. For addition of a newborn child, you will need to enroll the child within 90 days inclusive of the event and submit any contributions in order to have claims applied on a retroactive basis. If you add the newborn during Annual Enrollment, the child's effective date of coverage will be the following January 1st. (This paragraph does not apply to any other programs, including the HMAA Program and the HMO Program; for the governing Dependent eligibility provisions of the HMAA Program or HMO Program, please refer to the applicable Certificate of Coverage.)

Hawaii Kaiser HMO and HMAA

Hawaii State law requires that eligible Employees are automatically enrolled upon meeting Plan eligibility requirements. Therefore, if you do not complete the enrollment process, you will be automatically enrolled in Employee-only coverage beginning on the first of the month following the date you become eligible for the appropriate program based on your work location. There are limited situations, specified by state law that would allow you to waive enrollment. See Waiving Hawaii State Mandated Coverage, below.

If you complete enrollment of yourself and your Dependent(s) within 31 days inclusive of the date you become eligible, coverage for you and your enrolled Dependent(s) will take effect as of the first of the month following your eligibility date. You will be responsible for paying applicable contributions or premiums retroactive to the effective date of coverage.

If enrollment is not completed within 31 days inclusive of the date you became eligible, you will not be allowed to enroll Dependent(s) for coverage until the next Annual Enrollment period, unless you qualify for one of the limited exceptions described below under Changing Your Elections.

Newly acquired Dependents have to be enrolled within 31 days inclusive of the date they became eligible, e.g., for a new Spouse within 31 days inclusive of the marriage date. If properly enrolled, their coverage will take effect:

- For a birth or adoption, as of the date of the event.
- For all other events, as of the first of the month following the date you Initiate the Enrollment for the Dependent

Waiving Hawaii State Mandated Coverage

If you are a Hawaii Employee, you may waive coverage if you meet one of the following conditions:

- You are covered by a federally established health insurance or prepaid health care plan, such as Medicare, Medicaid or medical care benefits provided for military dependents or military retirees and their dependents;
- You are covered as a dependent under a qualified health care plan;
- You are a recipient of public assistance or covered by a State-legislated health care plan governing medical assistance; or
- You are a follower of a religious group who depends upon prayer or other spiritual means for healing.

To waive coverage, you must complete an Employee Notification to Employer (Form HC-5). **The waiver of coverage must be done each calendar year. Failure to complete and/or receive approval for the waiver will result in being enrolled in the Employee-only coverage for the appropriate program based on location.** If you wish to waive coverage, please contact HR Solutions at (208) 780-7500 or HRSolutions@simplot.com. Once received, HR Solutions will process the form in accordance with Hawaii State law before removing the enrollment.

Employee Assistance Program

You are automatically enrolled in this program the first of the month following the date you become eligible.

Basic Life and Accidental Death & Dismemberment Program

Subject to the actively-at-work requirement described in the Certificate of Coverage, you are automatically enrolled in this program the first of the month following the date you become eligible.

Voluntary Life and Accidental Death & Dismemberment Insurance Program

If you complete enrollment within 31 days inclusive of your eligibility date, your coverage will take effect the first of the month following your eligibility date. If you enroll initially or request an increase in coverage outside of your initial 31-day enrollment window, you will be subject to evidence of insurability and your coverage will not take effect unless, and until, the first of the month following receipt of the insurance company approval. In addition, no initial or increased coverage will take effect if you are not actively at work on the date coverage would otherwise begin. Such coverage will not take effect until the day you return to active employment. For complete eligibility and enrollment provisions, see the Certificate of Coverage.

Long-Term Disability Program

Subject to the actively-at-work requirement described in the Certificate of Coverage, you are automatically enrolled in this program the first of the month following completion of the Waiting Period.

Voluntary Long-Term Disability Program

If you complete enrollment within 31 days inclusive of your eligibility date, your coverage will take effect the first of the month following completion of the Waiting Period. If you enroll outside of your initial 31-day enrollment window, you will be subject to evidence of insurability and your coverage will not take effect unless, and until, the first of the month following receipt of the insurance company approval. In addition, no coverage will take effect if you are not actively at work due to Disability on the date coverage would otherwise begin. Such coverage will not take effect until the day you return to active employment. For complete eligibility and enrollment provisions, see the Certificate of Coverage.

Annual Enrollment

During the last quarter of the calendar year, J.R. Simplot Company designates an Annual Enrollment period during which you may change certain Plan enrollments by completing the Annual Enrollment process. If completed timely, permitted changes in Plan enrollments will become effective the following January 1st.

During Annual Enrollment:

- Employees who did not enroll when first eligible may enroll in the Plan, subject to evidence of insurability where applicable,

- Current Plan Participants may change health programs (if available),
- Current Plan Participants may waive coverage in the Medical Program, the Hawaii Kaiser HMO Program, the HMAA Program, Dental Program or Vision Program;
- Current Plan Participants may add or drop Dependents from coverage; and
- Employees may make changes to or initially elect coverage in other programs, such as the Dependent Care Reimbursement Account.

Pre-Tax Payment of Health Premiums and Other Contributions

The Premium Payment Program of the J.R. Simplot Company Flex Plan allows you to pay your contributions for certain health care programs (Medical, Hawaii Kaiser HMO, HMAA, Dental and Vision)* with pre-tax dollars. The deductions are automatically taken from your paycheck on a pre-tax basis when you sign up for these specific programs.

Contributions for the Dependent Care Reimbursement Account (DCRA) and Health Savings Account (HSA) features of the Flex Plan are also made on a pre-tax basis. You elect whether and how much to contribute to these features as described in the Health Savings Account and DCRA sections later.

Contributions for the Voluntary Long Term Disability Program* and the Voluntary Life and AD&D Insurance Program* are made on an after-tax basis.

*No Employee contribution is required for the Employee Assistance Program, the International Welfare Benefits Program, the Long-Term Disability Program and the Basic Life and AD&D Program.

Changing Your Elections

Please choose your program participation carefully, because in most cases your choices will remain in effect until the end of the calendar year. Because your elections are taken from your pay on a pre-tax basis, federal law limits your ability to make changes mid-year to certain circumstances. Election changes under any program are only permitted if the Flex Plan and applicable law permits the change. Subject to the limitations described in each applicable section below, you may change your elections (including your contribution election for the Dependent Care Reimbursement Account) during the year under the following limited circumstances. Changes to your Health Savings Account may be made prospectively at any time, as described in the Heath Savings Account section later.

Change in Status

A Change in Status means any of the following events (as well as any other events that the Plan Administrator determines, in its sole discretion, are permitted under IRS regulations):

- Legal Marital Status: A change in your legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment.
- Number of Dependents: Events that change your number of eligible Dependent children, including birth, death, adoption, and placement for adoption.
- Change in Employment Status: Any change in employment status of you, or your eligible Dependent that affects eligibility under the Plan or a benefit plan of your Dependent's employer, which may include:
    - Termination or commencement of employment;
    - Strike or lockout;
    - Commencement of or return from an unpaid leave of absence, including an approved Military Leave of Absence;

  - Change in work site;
  - Switching from salaried to hourly-paid or union to nonunion or vice versa;
  - Incurring a reduction or increase in hours of employment; or
  - Any other similar change which makes you or your Dependent become (or cease to be) eligible for a particular Employee benefit.
- Dependent Eligibility Requirements: An event that causes your Dependent to satisfy or cease to satisfy the Dependent eligibility requirements of the Plan, such as turning 26 years old.
- Change in Residence: A change in your, or your Dependent's, place of residence which results in a change in eligibility, e.g., moving out of the service area of an HMO Program.

If you experience a Change in Status **and you or a Dependent gain(s) or lose(s) eligibility as a result of the change**, you will have a period of 31 days inclusive of the date of the event to make new coverage elections that are "consistent" with the Change in Status. This "consistency" requirement means that the requested change to your coverage must be made on account of, and correspond with, the Change in Status. The "consistency" requirement is established by federal tax law under a complex set of regulations. The Plan Administrator, in its sole discretion, will determine whether a requested change in coverage satisfies the consistency requirement. If you do not complete a coverage change enrollment within the 31-day period for a Change in Status, you will not be allowed to make changes until the next Annual Enrollment period. If you properly enroll within 31 days inclusive of the date of the event, the election(s) will become effective:

- For a birth or adoption, as of the date of the event.
- For all other events, as of the first of the month following the date you Initiate the Enrollment of the Dependent.

Certain Judgments, Decrees, or Orders

If a judgment, decree, or order resulting from a divorce, legal separation or annulment results in a change in legal custody of a Dependent child, you may make a corresponding change in your Health Coverage elections. If you receive a judgment, decree, or order changing legal custody of a Dependent child, you will have a period of 31 days inclusive of the date of the event to notify the Simplot Benefits Service Center. For additional information, refer to "Qualified Medical Child Support Order (QMCSO)" in the **Plan Participation** section.

Health Insurance Portability and Accountability Act (HIPAA) Special Enrollment Rights

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan provides special enrollment rights during the year in the Medical Program, International Welfare Benefits Program and the HMO Program in the following four circumstances:

- If you or an eligible Dependent declined medical coverage under the Plan because of other health plan coverage, and subsequently lose the other coverage, you or your eligible Dependent, as applicable, will be allowed to enroll in the applicable coverage, but only if you or the eligible Dependent, as applicable, enroll within 31 days inclusive of the date of the loss of other coverage and: a) were under a COBRA continuation provision in the other coverage and the COBRA continuation coverage was exhausted; or b) lost the other coverage as a result of loss of eligibility or because employer contributions toward such coverage were terminated, or because you reached the lifetime limits of available benefits under the other coverage. You or your eligible Dependent will not be eligible for special enrollment in the Plan if the loss of the other coverage was due to nonpayment of premium

or for cause (misconduct). If you or your eligible Dependent satisfy these requirements and properly enroll within 31 days inclusive of the date of the loss of other coverage, your coverage under the applicable program will begin on the first day of the month following the date you complete the enrollment.

- If you acquire a new eligible Dependent as a result of marriage, birth, adoption or Placement for Adoption, you will be allowed to enroll yourself and eligible Dependent(s) in the applicable program(s) of the Plan if you apply for coverage within 31 days inclusive of the date of the marriage, or within 90 days inclusive of the date of birth, adoption or Placement for Adoption. If you properly enroll within the timeframe stated in the prior sentence, coverage under the applicable health program will become effective:
    - For a birth or adoption, as of the date of the event.
    - For all other events, as of the first of the month following the date you Initiate the Enrollment of the Dependent.
- If you or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility and you/they are eligible for Plan coverage, you will be allowed to enroll the individuals who lost Medicaid or CHIP coverage in the applicable program(s) of the Plan if you apply for coverage within 61 days inclusive of the date of the termination. If you properly enroll within 61 days inclusive of the date of the termination, coverage under the applicable program(s) will begin on the first day of the month following the date you enroll yourself or a Dependent.
- If you or your Dependent(s) become eligible for a premium assistance subsidy under Medicaid or CHIP and you/they are eligible for Plan coverage, you will be allowed to enroll the individuals who became eligible for assistance in the applicable program(s) of the Plan if you apply for coverage within 61 days inclusive of the date the individual(s) were determined to be eligible for premium assistance. If you properly enroll within 61 days inclusive of the date of the event, coverage under the applicable program(s) will begin on the first day of the month following the date you enroll yourself or a Dependent.

The above special enrollment rights only apply to enrollment in the specific programs listed, and only under the specific circumstances described.

To request special enrollment or obtain more information, contact the Simplot Benefits Service Center by phone at **(800) 254-3252**. You may also make changes through the online benefits system.

Entitlement to Medicare, Medicaid or Other Government Sponsored Medical Programs

If you or your Dependent become entitled to Medicare or Medicaid, or if you or your Dependent lose entitlement to Medicare or Medicaid, you may make a corresponding change in your election for Health Coverage. You must request applicable election changes within 31 days inclusive of the date of the government notification to you of the change to Medicare, Medicaid or other government-sponsored health programs unless you are entitled to a 61-day special enrollment period, as described in the preceding section.

Change in Cost

If the Plan Administrator notifies you that the cost of coverage under a health program will significantly increase during the year, you may choose either to make an increase in your contributions or revoke your election and receive coverage under another health program that provides similar coverage, if available. For slight increases or decreases, the Plan Administrator will automatically adjust your premium contributions to reflect the minor change in cost.

If your current dependent care provider changes the cost of the care, you may make a corresponding change in your Dependent Care Reimbursement Account. You may also make a corresponding change in your Dependent Care Reimbursement Account if you experience a change in cost due to a change in your dependent care provider and the new provider charges a different rate or because your child begins attending school, thereby reducing the number of hours needed for care. Also, you may terminate your Dependent Care Reimbursement Account because someone (e.g., a relative) becomes available to care for your child at no charge.

You must request applicable election changes within 31 days inclusive of the date of the change in cost.

Change in Coverage under the Plan

If the Plan Administrator notifies you that your coverage under a program of the Plan is significantly reduced, you may revoke your election and elect coverage under another program that provides similar coverage, if available. Also, if during the year the Plan Administrator adds or eliminates a program coverage option, you may elect the newly-added option or elect another option when a program option has been eliminated. You must request applicable election changes within 31 days inclusive of the date of the change in coverage.

Change in Coverage under Another Employer's Plan

You may make a prospective election change that is on account of and corresponds with a change in coverage under the cafeteria or qualified benefit plan of your Dependent's employer if: (i) the other employer's plan permits participants to make elections as allowed under applicable IRS regulations; or (ii) such plan's period of coverage (typically, the plan year) is different from this Plan's period of coverage. For example, if your Spouse elects during his/her open enrollment to drop coverage with his/her employer, then you may add your Spouse to your coverage under the Plan. The Plan Administrator, in its sole discretion, will decide whether a requested change is on account of and corresponds with a change made under another employer's plan, in accordance with prevailing IRS guidance. You must request applicable election changes within 31 days inclusive of the date of the change in coverage under the other employer's plan. The requested election change will become effective on the first of the month following the date you Initiate the Enrollment.

Loss/Gain of Coverage Required by Federal Law

You may otherwise make a prospective election change that is on account of and corresponds with a loss or gain of Health Coverage under additional circumstances to the full extent allowed or required by federal law.

When Employee Coverage Ends

The effective date of the termination of your coverage under this Plan and the Flex Plan varies by program and the particular reason for the termination. For a description of the different termination events and timetables, please refer to the *Benefit Information Reference Sheets* accompanying this Summary Plan Description booklet (see Appendix C on page 65) copies of which are also available on the online benefits system, from HR Solutions, or by request at HRSolutions@simplot.com.

Your coverage under the Plan also may be terminated (including retroactive termination of coverage) if the Plan Administrator determines, in its sole discretion, that you have participated in a fraudulent or intentional material misrepresentation to the Plan or its representatives, including such misrepresentations in connection with eligibility, enrollment or claims for Plan

benefits. Continuing ineligible Dependent(s) on the Plan is considered fraud or material misrepresentation.

When Dependent Coverage Ends

Coverage for your Dependent(s) will cease on the earliest of:

- The date your Employee coverage ends;
- The end of the calendar month in which you fail to make any required contribution for your Dependent coverage;
- The end of the calendar month in which he or she ceases to meet the Dependent eligibility requirements of the Plan;
- The date of the Dependent's death;
- The date Dependent coverage is removed from a program or the Plan, as applicable;
- Upon a determination by the Plan Administrator, in its sole discretion, that the Dependent participated in a fraudulent or intentional material misrepresentation to the Plan or its representatives, including such misrepresentations in connection with eligibility, enrollment or claims for Plan benefits; or
- If the Dependent gains coverage elsewhere and you are removing Dependent Coverage under a Change in Status Event, the Dependent's coverage will end at the end of the month in which you Initiate the Enrollment changes in either the online benefits system or via phone with the Simplot Benefits Service Center.

When your Dependent is no longer eligible for coverage, it is your responsibility to make the change through the online benefits system or by phone via the Simplot Benefits Service Center. The enrollment change must occur within 60 days inclusive of the date of the event to ensure eligibility for COBRA continuation. If you do not make this notification, you will be liable in full for any claims paid after the date your dependent's coverage would have otherwise ended. Reimbursement of any contributions made for this period will be reduced by the amount of such claims paid and will be contingent upon your providing any supporting documentation requested.

Continuation of Coverage

Death

If you die while eligible for and participating in the Plan, your enrolled Dependent's Medical Program, Dental Program and Vision Program coverage will be continued until the earliest of:

- The date the particular health program or Plan terminates; or
- The end of the month of your death plus three additional calendar months.

The additional three months of coverage are available to your family at no cost and will not count against any subsequent period of COBRA continuation coverage.

If you die while covered by the Hawaii HMAA Program or the Hawaii Kaiser HMO Program, your enrolled Dependent's coverage will end on your date of death, subject to COBRA continuation rights described below.

COBRA Continuation

You and your Dependent's Health Coverage may be continued under COBRA following certain events, as described in the **COBRA Continuation** section of this Summary Plan Description booklet.

USERRA

For Employees on an approved Military Leave of Absence, the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) provides for special Health Coverage continuation rights in addition to COBRA. For the first three months of USERRA Health Coverage continuation, you may choose to continue coverage at active Employee contribution rates. Following these first three months, USERRA allows continuation of coverage for up to another 21 months (for a total of 24 months or the period of uniformed service leave, whichever is shorter). The required contribution for this period will not exceed 102% of the cost of the coverage. This time period runs concurrently with COBRA.

Contribution payments for continued coverage are due on a monthly basis, on the first of each month for which coverage is sought, subject to a 30-day grace period. Failure to fully pay the applicable contribution within 30 days of the established due date will result in permanent cancellation of the applicable USERRA continuation coverage.

Whether or not you elect continuation coverage under USERRA, coverage will be reinstated on the first day you return to employment with J.R. Simplot Company if you return to employment within the applicable period set forth in the **J.R. Simplot Company Leave Policy**. This reinstatement right may not apply if you are not released under honorable conditions.

When coverage under this Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous under the Plan. This does not provide coverage for any sickness or injury caused or aggravated by your military service, as determined by the Veterans Administration. For more information regarding your rights under the Uniformed Services Employment and Reemployment Rights Act, **please refer to the J.R. Simplot Company Leave Policy** (available on *The Pulse* at pulse.simplot.com or by request at HRSolutions@simplot.com, or contact your local Human Resources Representative).

FMLA and Other Leaves

You also have a right to continue certain programs as if you were actively employed while on an approved leave of absence qualifying under the Family Medical Leave Act (FMLA). During paid FMLA leave, your contributions will continue through normal salary reductions. During unpaid FMLA leave, J.R. Simplot Company will fund your coverage, and you will be required to reimburse J.R. Simplot Company upon your return to work. Any programs that you choose not to continue during an FMLA leave will be reinstated upon your return to work. For more details on FMLA, and for information regarding program continuation while on other leaves, please refer to the *Benefit Information Reference Sheets* (Appendix C on page 65), copies of which are available on the online benefits system, from HR Solutions, or by request at HRSolutions@simplot.com.

Reinstatement

In certain circumstances, your terminated coverage may be reinstated. For a description of these reinstatement events and timetables, please refer to the *Benefit Information Reference Sheets*, copies of which are also available on the online benefits system, from HR Solutions, or by request at HRSolutions@simplot.com.

Additional Information on Insured Programs

Additional eligibility, enrollment, effective date and other provisions apply to the insured programs of the Plan. **Please refer to the applicable Certificate of Coverage for complete**

details regarding eligibility and coverage. In some cases, the provisions of the Certificate may differ from those generally described in this **Plan Participation** section. If that happens, the terms of the Certificate of Coverage are controlling.

DEPENDENT AND CHANGE DOCUMENTATION

Documentation Requirements

Documentation is required for the following:

- Adding a Dependent upon initial enrollment in the Plan
- Adding a new Dependent during Annual Enrollment
- Making a change mid-year under the provisions found in the Plan Participation section, even if not adding a Dependent

Employees will have 75 days to submit the documentation, inclusive of the date of the event for either a new enrollment or a change. Documentation for newborns and adopted children must be submitted within 120 days. The enrollment system will offer an opportunity to immediately upload documentation as a part of the enrollment process. Employees will also receive an email (if the Employee has a Simplot email address) and a letter as a reminder to submit the documentation at a later time, if preferred. Documentation will need to be uploaded to the system in accordance with the instructions provided in the enrollment system.

If acceptable documentation is not received by the Simplot Benefits Service Center by the deadline, the enrollment or change will be rejected. In addition, failure to submit acceptable documents within the required time for a requested action may be considered fraud or intentional misrepresentation.

All dependent coverage will be pended until documentation is received. In addition, any change made mid-year will be pended until documentation is received, even if a dependent is not added. If acceptable documentation is received by the deadline, coverage will be effective the first of the month following the date you Initiated the Enrollment. In addition, any change in contributions required will be applied retroactive to the effective date of coverage and deducted from the Employees' upcoming check(s).

Acceptable Documentation

You will need to submit documentation acceptable to the Plan Administrator.

The following documents are acceptable to prove Dependent eligibility:

Dependents	Supporting Documentation
Spouse*	Government issued Marriage Certificate
Child / Birth	Government Issued Birth Certificate
Disabled Child	1) Government Issued Birth Certificate 2) You will need to complete the Disabled Dependent Certification form and return it to Blue Cross of Idaho. To obtain the form, call Blue Cross at (855) 216-6850 or download it from the member log-in at www.bcidaho.com
Adopted Child	Placement for Adoption Agreement and/or Adoption Certificate signed by Judge
Foster Child	Official signed legal document placing the child under your foster care

DEPENDENT AND CHANGE DOCUMENTATION

Step-Child	1) Government Issued Birth Certificate **and** 2) Marriage Certificate for Employee and Child's Natural or Adoptive Parent
Legal Dependent Child	Copy of Legal Guardianship

* In jurisdictions where common law spouses are legally recognized, please contact the Simplot Benefits Service Center to discuss documentation to show a common-law marriage.

The following documents are acceptable to prove a change in status:

Change in status event	Supporting Documentation
Marriage*	Government Issued Marriage Certificate
Birth	Government Issued Birth Certificate
Adoption	Placement for Adoption and/or Adoption Decree signed by Judge
Fostering a Child	Official signed legal document placing the child under your foster care
Acquisition of a Legal Dependent	Copy of Legal Guardianship
Divorce/Annulment	Court Issued Divorce Decree or legal Annulment
Legal Separation	Legal Separation Agreement
Employee, Spouse or Dependent Gains Other Coverage	Letter verifying other coverage from insurance company
Employee, Spouse or Dependent Loses Other Coverage	1) Letter from previous employer with coverage end date, or 2) Letter from previous insurance verifying loss of coverage, or 3) COBRA notification with coverage end date
Loss or Gain of CHIP or Medicaid Coverage	Letter verifying loss or gain of CHIP or Medicaid coverage from state agency or carrier
Death of Spouse or Dependent	Death Certificate

* In jurisdictions where common law spouses are legally recognized, please contact the Simplot Benefits Service Center to discuss documentation to show a common-law marriage

The Plan Administrator, in its sole discretion, may accept alternate documents. If you would like to discuss an alternate document, please contact the Simplot Benefits Service Center at (800) 254-3252.

INTERNATIONAL WELFARE BENEFITS PROGRAM

United States Employees on international assignment outside the U.S. and Canada have the opportunity to participate in the International Welfare Benefits Program.

Please refer to the Certificate of Coverage provided by GeoBlue for important coverage information about your medical, prescription drug, dental and vision benefits. Because it describes key features for these benefits, the Certificate of Coverage is considered part of this Summary Plan Description booklet and is incorporated herein by this reference. You may also obtain a copy from Simplot Total Rewards at:

J.R. Simplot Company
Attn: Total Rewards
P.O. Box 27
Boise, ID 83707-0027

Please be sure to carefully read the Certificate of Coverage and any other written coverage material from GeoBlue. It is important to remember that the coverage and rules for these benefits may be different from those provided for other benefits under the J.R. Simplot Company Group Health & Welfare Plan.

Because coverage under the International Welfare Benefits Program is provided through a policy of insurance, GeoBlue is solely responsible for the payment of medical, prescription drug, vision, and dental benefits and all determinations of eligibility and coverage for such benefits under the Plan.

HAWAII KAISER HMO PROGRAM

Eligible Employees working at the Maui and Kona, Hawaii locations will be provided medical, prescription drug, dental and vision benefits through a Kaiser Health Maintenance Organization (HMO) Program.

If you are enrolled in the HMO, please refer to that program's Certificate of Coverage for important coverage information about your medical, prescription drug, dental and vision benefits.

Because it describes key Plan features for the HMO Program, the Certificate of Coverage is considered part of this Summary Plan Description booklet and is incorporated herein by this reference. You may also obtain a copy from Simplot Total Rewards at:

J.R. Simplot Company
Attn: Total Rewards
P.O. Box 27
Boise, ID 83707-0027

Please be sure to carefully read the Certificate of Coverage and any other written coverage material from the HMO Program. It is important to remember that the coverage and rules for the HMO Program may be different from those provided for the Medical Program and that HMO Program coverage is governed by these other written coverage materials.

Because coverage under the HMO Program is provided through a policy of insurance issued by the HMO Program insurer, the HMO Program insurer is solely responsible for the payment of medical, prescription drug, dental and vision benefits and all determinations of eligibility and coverage for such benefits under the Plan.

HAWAII MEDICAL ASSURANCE ASSOCIATION (HMAA) PROGRAM

Eligible Employees working at the Oahu, Hawaii location will be provided medical, prescription drug, dental and vision benefits through the Hawaii Medical Assurance Association (HMAA) Program.

If you are enrolled in the HMAA Program, please refer to that program's Certificate of Coverage for important coverage information about your medical, prescription drug, dental and vision benefits.

Because it describes key Plan features for the HMAA Program, the Certificate of Coverage is considered part of this Summary Plan Description booklet and is incorporated herein by this reference. You may also obtain a copy from Simplot Total Rewards at:

J.R. Simplot Company
Attn: Total Rewards
P.O. Box 27
Boise, ID 83707-0027

Please be sure to carefully read the Certificate of Coverage and any other written coverage material from the HMAA Program. It is important to remember that the coverage and rules for the HMAA Program may be different from those provided for the Medical Program and that HMAA Program coverage is governed by these other written coverage materials.

Because coverage under the HMAA Program is provided through a policy of insurance issued by the HMAA Program insurer, the HMAA Program insurer is solely responsible for the payment of medical, prescription drug, dental and vision benefits and all determinations of eligibility and coverage for such benefits under the Plan.

MEDICAL

About this Section

This section describes the Medical Program. It does not describe medical benefits under the International Welfare Benefits Program, the Hawaii Medical Assurance Association Program, or the Hawaii Kaiser Health Maintenance Organization (HMO) Program. Please refer to the applicable Certificate of Coverage for information about those medical programs.

The Medical Program provides medical and prescription benefits. You may participate in the Medical Program whether or not you participate in other programs.

Detailed Coverage Information

For detailed coverage information for benefits described in this section, as well as the applicable claims and appeals procedures, please refer to the Medical Program Document maintained by Blue Cross of Idaho, which is part of this Summary Plan Description booklet and is incorporated herein by this reference. The Medical Program Document is also available without charge on the online benefits system, or by requesting it from Blue Cross of Idaho at:

Blue Cross of Idaho
PO Box 7408
Boise, ID 83707
(855) 216-6850

Please read and review the Medical Program Document carefully, as it is the official document for determining benefits for this program.

Contribution Discount

The contribution discount is available to all Employees and applies if you do not use tobacco or vaping products. You will be asked to verify this status each year during Annual Enrollment. Please remember that your coverage under the Plan may be terminated (including retroactive termination) if you participate in fraudulent or intentional material misrepresentation to the Plan. If you are unable to meet the criteria for not using tobacco or vaping products, you may contact the Simplot Benefits Service Center at 800-254-3252, and we will work with you (and your physician if you wish) to find an opportunity to earn the same discount by different means.

Contact Information

Medical Claims Administrator: Blue Cross of Idaho

Customer Service: (855) 216-6850 or (208) 286-3813

Prior Authorization – Advanced Imaging and Sleep Studies:

Contact AIM Specialty Health at (866) 714-1105

Prior Authorization (all other services): (800) 743-1871 or (208) 331-7535

Website: www.bcidaho.com

Prescription Drug Claims Administrator: Carelon

Phone: (855) 839-5205

Mail Order: (855) 839-5205

Specialty Rx: (833) 419-0528

Website: members.bcidaho.com for formulary and mail order

Tools and Resources

The Medical Program offers a variety of tools and resources to assist you to manage your health.

Teledoc

Teledoc offers the following services:

- Virtual Care: Convenient, high-quality virtual medical care for non-emergency conditions available 24/7. You have the choice of an on-demand or scheduled visit with a U.S. board-certified clinician via phone or video. Appointments with dermatologists, registered dieticians, and mental health providers (board-certified psychiatrists, psychologists, or licensed therapists) are also available. Appointments for these services must be scheduled in advance. Fees for virtual care vary and are subject to deductible and coinsurance. Visit Simplotbenefits.com for more information.
- Tobacco Cessation: Teladoc offers a tobacco and vape cessation program with trained tobacco cessation coaches. Teladoc physicians can prescribe FDA-approved drugs as necessary, and you have access to additional health content and support resources. To enroll in tobacco cessation, register for Teladoc via Teladoc.com, the Teladoc Health App, or by phone, 1-800-TELADOC (registration code = SIMPLOT), and then contact Simplot HR Solutions for further instruction. Visit simplotbenefits.com for more information.
- Weight Management: Teladoc weight management focuses on lifestyle behavior changes. The program is completely online, so you can access it wherever you have internet connectivity. You get one on one coaching from expert coaches along with online meetups for support and accountability. Components of the program include food logging and fitness tracking, health challenges, learning content, and more. Visit Simplotbenefits.com for more information.

- Chronic Condition Management: Teladoc chronic condition management focuses on diabetes management, prediabetes management, and hypertension (high blood pressure) management. You are provided access to connected health-monitoring devices, certified health coaches and support from physicians and mental health specialists. Visit Simplotbenefits.com for more information.

To enroll, register for Teladoc via Teladoc.com, the Teladoc Health App, or by phone, 1-800-TELADOC (registration code = SIMPLOT).

Blue Cross of Idaho

Blue Cross of Idaho offers the following services:

- Care Management: additional support when dealing with a complex health condition or hospitalization.
- Personal Health Support: access to a nurse or health coach to support you in your health goals.

For more information, or to enroll into one of these programs, please contact Blue Cross of Idaho at 1-855-216-6850.

Find Care

This health care cost estimator tool helps you compare providers, facilities or services based on cost. Access the tool on the Blue Cross of Idaho website, www.bcidaho.com.

Maven

Maven is a digital health platform that provides support throughout the reproductive and family health journey. The virtual support helps those navigating pregnancy, adoption, surrogacy, fertility preservation and treatments — including egg freezing, IVF and IUI — postpartum, parenting and menopause. Visit Simplotbenefits.com for more information.

To enroll, visit www.mavenclinic.com/join/simplot or search Maven Clinic in the App Store (iOS and Android).

Hinge Health

Hinge Health provides access to a digital exercise therapy program designed to help with back, joint, or muscle issues/pain. In addition, there is a women's pelvic health program available. If you meet certain eligibility requirements, you will have access to:

- Personalized program of exercises and stretches designed for you by your physical therapist accessible through your mobile device.
- One on one support from a physical therapist and coach.
- Therapy sessions you can do anytime and anywhere.

To determine if you are eligible for the program, contact Hinge Health at www.HingeHealth.com/Simplot or call (855) 902-2777.

AccessHope

AccessHope provides support to people on a cancer journey, along with their treating oncologists, and those caring for someone with a cancer diagnosis. If you or a family member have been diagnosed with cancer, contact AccessHope to access services, including:

- Cancer Support Team: You and your family can call to get support and advice from experienced oncology nurses.
- Expert Advisory Review: You may request a remote review of your cancer diagnosis and a treatment plan from AccessHope's world-class specialists.

Visit Simplotbenefits.com for more information. For support, contact AccessHope at myaccesshope.org/simplot or call 844-520-0922.

DENTAL

About this Section

This section describes the Dental Program. If eligible, you may participate in the Dental Program whether or not you participate in other programs.

Detailed Coverage Information

For detailed coverage information for benefits described in this section, as well as the applicable claims and appeals procedures, please refer to the Dental Program Document maintained by Blue Cross of Idaho, which is part of this Summary Plan Description booklet and is incorporated herein by this reference. The Dental Program Document is also available without charge on the online benefits system, or by requesting it from Blue Cross of Idaho at:

Blue Cross of Idaho
PO Box 7408
Boise, ID 83707
(855) 216-6850

Please read and review the Dental Program Document carefully, as it is the official document for determining coverage for this benefit.

Contact Information

Blue Cross of Idaho

Phone: (855) 216-6850 or (208) 286-3813

Website: www.bcidaho.com

VISION

About this Section

This section describes the Vision Program. If eligible, you may participate in the Vision Program whether or not you participate in other programs.

Detailed Coverage Information

For detailed coverage information for benefits described in this section, as well as the applicable claims and appeals procedures, please refer to the Vision Program Document maintained by Blue Cross of Idaho, which is part of this Summary Plan Description booklet and is incorporated herein by this reference. The Vision Program Document is also available without charge on the online benefits system, or by requesting it from Blue Cross of Idaho at:

Blue Cross of Idaho
PO Box 7408
Boise, ID 83707
(855) 216-6850

Please read and review the Vision Program Document carefully, as it is the official document for determining coverage for this benefit.

Contact Information

VSP Customer Service

Phone: (800) 877-7195

Website: www.vsp.com

EMPLOYEE ASSISTANCE PROGRAM (EAP)

About this Section

This section describes the Employee Assistance Program (EAP) benefits available under the Plan.

Detailed Coverage Information

For detailed coverage information for benefits described in this section, as well as the applicable claims and appeals procedures, please refer to the combined Plan Document and Summary Plan Description maintained by Spring Health, which is part of this Summary Plan Description booklet and is incorporated herein by this reference. The combined Plan Document and Summary Plan Description is also available without charge on the online benefits system, or by requesting it from Simplot HR Solutions at:

Simplot HR Solutions
1099 W. Front St.
Boise, ID 83702
(208) 780-7500

Please read and review the combined Plan Document and Summary Plan Description carefully, as it is the official document for determining coverage for this benefit.

Contact Information

Spring Health

Phone: (855) 629-0554

Website: Simplot.springhealth.com

PLAN PARTICIPATION CLAIMS AND APPEALS PROCEDURES

About this Section

This section describes the applicable claims and appeals procedures for determinations regarding Plan participation, for example, determinations regarding your eligibility for, or enrollment in, Plan programs. It does NOT describe the procedures regarding claims for benefits under any program of the Plan. Please refer to the applicable section of this document (for example, the **Health Savings Account** section or the **Dependent Care Reimbursement Account** section), the Medical Program Document, the Dental Program Document, the Vision Program Document, or, for an insured program, the applicable Certificate of Coverage, for information about the claims and appeals procedures governing benefit claims under those programs. If your claim relates to the denial of payment for medical or other services actually rendered, you must file that claim under the applicable program procedures as a claim for benefits, and not as a Plan participation claim, even if the claim was denied based on eligibility or enrollment.

Overview

In the course of administering the eligibility and enrollment provisions of the Plan, the Plan Administrator makes determinations regarding your participation in the Plan. Examples of these determinations include, but are not limited to, decisions regarding: your eligibility, the timeliness of enrollment, re-enrollment elections, the payment of contributions or premiums, mid-year election changes, eligibility for COBRA, and dependent eligibility (i.e. common-law marriage, disabled child, Qualified Medical Child Support Orders, etc.).

The Plan Administrator will follow administrative processes and safeguards designed to ensure and to verify that these determinations regarding Plan participation are made in accordance with governing Plan documents and that the Plan's provisions have been applied consistently with respect to similarly situated Employees and Participants.

General Plan Inquiries

Oral or written (including e-mail) inquiries seeking general information about Plan participation will not be considered a Plan participation claim. The implementation of Plan administrative procedures and administrative protocols by the Plan Administrator or its representatives will not be considered an Adverse Benefit Determination. If you have questions about Plan participation, or how to enroll or make enrollment changes, you are encouraged to speak with the Simplot Benefits Service Center at (855) 270-1549 prior to filing a Plan participation claim.

How to File a Plan Participation Claim

If you have requested enrollment in the Plan for yourself or a Dependent and have been denied enrollment or have been informed that you or your Dependent is not eligible, or if you believe your enrollment was processed incorrectly, you may file a Plan participation claim. If your claim relates to the denial of payment for medical or other services actually rendered (or the denial of a pre-service claim for benefits under the Medical Program), you must file that claim under the applicable program procedures as a claim for benefits, and not as a Plan participation claim. In order to make a Plan participation claim, you or your Authorized Representative must file a written request for determination at:

J.R. Simplot Company
ATTN: Plan Participation Claim – Health & Welfare Benefits
P. O. Box 27
Boise, ID 83707

You may also file the written request by e-mailing HRSolutions@simplot.com with the notation that your correspondence is a Plan participation claim.

Plan participation claims must be filed within 30 days of becoming aware of the cause of the claim.

Notification of Plan Participation Determinations - General

The Plan's representatives will notify you or your Authorized Representative of their determination in writing within a reasonable period of time, but not later than 30 days after receipt of the claim.

If your claim is denied, you will receive a notification that includes:

- the specific reason(s) for the denial;
- reference to the specific Plan provisions on which the denial was based;
- a description of any additional information or material needed from you to complete the claim and an explanation of why it is necessary; and
- a description of the Plan's review or appeal procedures, including applicable time limits and, if applicable, a statement of your right to bring suit under ERISA §502(a) with respect to any claim denied after an appeal.

Notification of Plan Participation Determinations – Disability Related Participation

If your Plan participation claim relates to disability (specifically, the continuation of coverage under the Plan during a Dependent's period of Disability as described under "Dependent" earlier in this SPD), and you are contesting the determination of whether the Dependent is Disabled for purposes of continued eligibility under the Plan, then your claim is considered a disability claim and the additional requirements described in this section apply. The Plan's representatives will review a disability claim according to the terms and conditions of the Plan and respond in writing within 45 days after receiving the claim. The Plan may extend this 45-day period for up to two additional periods of 30 days each for reasons beyond the control of the Plan by notifying you in writing before the end of the current response period. The extension notice will indicate the special circumstances requiring the extension and the date by which the claims administrator expects to render its decision on the claim.

If your claim is denied, you will receive a written notice of denial, which will include:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a discussion of the decision including an explanation of the basis for disagreeing with or not following (i) the views presented by you of health care professionals treating the Dependent and vocational professionals who evaluated the Dependent, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit

determination, and (iii) a disability determination regarding the Dependent made by the Social Security Administration;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan which were relied upon in making the denial or a statement that such information does not exist;
- a description of any additional material or information necessary for you to perfect the claim, and an explanation of why such material or information is necessary; and
- a statement that you are entitled to receive, upon reasonable request and at no charge, reasonable access to and copies of all documents, records and information relevant to the claim; and
- a description of the Plan's participation appeal procedure (and the time limits applicable thereto), including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse determination on appeal.

The claims administrator's written decision shall be final and binding on all parties unless you appeal within the time limits explained in Deadline for Filing Appeals below.

Appeals: General Information

If your Plan participation claim is denied, in whole or in part, you have a right to have the Plan review and reconsider your claim. You or your Authorized Representative may file this appeal.

The Plan's representatives will conduct a full and fair review of all Plan participation appeals, independently from the individual(s) who made the initial denial or anyone who reports to such individual(s) and without affording deference to the initial denial. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. A document, record or other information will be considered "relevant" to your claim if such document, record or other information:

- was relied upon by the Plan in reaching its decision on the claim);
- was submitted, considered or generated in the course of deciding the claim, without regard to whether the document, record or other information was relied upon in reaching the decision on the claim;
- demonstrates compliance with the administrative processes and safeguards required under Department of Labor regulations in making the benefit determination;
- or would otherwise be considered relevant to the claim under applicable regulations or other guidance issued by the United States Department of Labor.

You or your Authorized Representative will also have the opportunity to submit to the Plan written comments, documents, records and other information relating to your claim for benefits. The Plan's representatives will take into account all this information regardless of whether it was submitted or considered in the initial denial. If your claim relates to a Dependent's Disability claim, the Plan may also hold a hearing or otherwise ascertain such facts as it deems necessary in order to render a decision.

How to File an Appeal

All requests for a review of a denied Plan participation claim are required to be in writing and should include a copy of the initial denial and any other pertinent information, including documents, records, or comments, that you wish the Plan to review in conjunction with your appeal. Send all information to:

J.R. Simplot Company
ATTN: Plan Participation Appeal – Health & Welfare Benefits
P. O. Box 27
Boise, ID 83707

You may also file the written request by e-mailing HRSolutions@simplot.com with the notation that your correspondence is a Plan participation appeal.

Deadline for Filing Appeals

You or your Authorized Representative are required to file any appeal of an initial denial within 60 days after receiving notification of the initial denial, or, if the claim relates to a Dependent's Disability, within 180 days after receiving notice of the initial denial.

Requests for appeal which do not comply with the above requirements will not be considered.

Time Period for Deciding Appeals

Appeals will be decided by the Plan Administrator or its delegated representative within a reasonable period of time, but not later than 60 days after receipt of the appeal. The decision will be provided to you in writing.

Notification of Appeal Denials – General

If your appeal is denied, the Plan's written notification will include:

- the specific reason(s) for the denial;
- reference to the specific Plan provisions on which the denial was based;
- a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information that are relevant to the claim; and a statement of your right to bring suit under ERISA §502(a).

This mandatory appeal must be completed before filing a civil action or pursuing any other legal remedies.

Notification of Appeal Denials – Disability

Prior to rendering an adverse decision, the Plan will provide you with any new or additional evidence considered, relied upon, or generated by or at the direction of the Plan in connection with the claim, or any new or additional rationale upon which the decision is based. Such evidence and/or rationale will be provided at no charge and sufficiently in advance of the date upon which the decision is required under the following paragraph to give you a reasonable opportunity to respond. The Plan will make its decision with respect to any appeal, and notify you in writing of such decision, within 45 days after receipt of the written appeal; provided that the 45-day period can be extended for up to an additional 45 days if the Plan determines that special circumstances require an extension of time to process the appeal and the Plan notifies you in writing of the extension prior to the termination of the initial 45-day period. The extension notice shall indicate the special circumstances requiring the extension and the date by which the Plan expects to render its decision on the appeal.

If the appeal is denied, the written denial will include:

- the specific reason or reasons for the denial;
- references to the specific Plan provisions on which the denial is based;
- a discussion of the decision including an explanation of the basis for disagreeing with or not following (i) the views presented by you of health care professionals treating the Dependent and vocational professionals who evaluated the Dependent, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the appeal, without regard to whether the advice was relied upon in making the benefit determination, and (iii) a disability determination made by the Social Security Administration;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan which were relied upon in making the denial or a statement that such information does not exist;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant (as described below) to your claim;
- a statement of your right to bring a civil action under Section 502(a) of ERISA, and the limitations period for bringing such action, as well as the calendar date upon which the limitations period will expire.

This mandatory appeal must be completed before filing a civil action or pursuing any other legal remedies.

However, you are deemed to have exhausted the appeal procedure (and may bring an action under Section 502(a) of ERISA or otherwise) with respect to a Dependent Disability Plan participant claim if the Plan fails to strictly adhere to the claims procedures described above, provided that this deemed exhaustion will not apply if the Plan's failure consists of de minimis violations that do not cause and are not likely to cause prejudice or harm, as long as the Plan demonstrates that the violation was for good cause or due to matters beyond the Plan's control, and the violation occurred in the context of an ongoing, good faith exchange of information between you and the Plan, and so long as the violation is not part of a pattern or practice of violations by the Plan. You may request a written explanation of a violation from the Plan, and the Plan's representative shall provide the explanation within 10 calendar days after receiving your request, including a specific description of the bases for asserting that the violation should not cause the deemed exhaustion of the administration procedure. If a court rejects your request for immediate review on the basis that the Plan met the standard for exception for de minimis violations under this paragraph, the appeal shall be considered re-filed as of the date of the Plan's receipt of the court's decision, and the Plan shall notify you of the resubmission within a reasonable time.

Appeals for Rescission of Coverage

If you appeal an initial denial that involves a Rescission of Coverage under the Medical Program, and the Plan denies your appeal, you may have the right to an independent external review. The independent reviewer will have no affiliation with the Plan, J.R. Simplot Company, or the Claims Administrator and its decision will be final and binding on the Plan.

To be eligible for an independent external review, you must exhaust the Plan Participation claims and appeal process above and your appeal must be for a Rescission of Coverage. Other

types of Plan Participation claims are not eligible.

A Rescission of Coverage is the retroactive termination of health coverage, which is prohibited except in the case of fraud or the intentional misrepresentation of a material fact. Retroactive termination for non-payment of medical program contributions, including COBRA contributions, is not a Rescission of Coverage.

To request an independent external review for Rescission of Coverage after you have completed the Plan Participation claims and appeal process above, you may submit a written request to:

Idaho Department of Insurance
ATTN: External Review
700 W. State Street, 3rd Floor
Boise, ID 83720-0043

You must submit your request for an external review within four months of the notice that the Plan has denied your appeal.

COBRA CONTINUATION

About This Section

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage is continuation of the Plan's Health Coverage when it would otherwise end because of certain Qualifying Events, described below. After a Qualifying Event, COBRA coverage will be offered to each person who is a Qualified Beneficiary. You, your Spouse, and your Dependent children could become Qualified Beneficiaries if Health Coverage under the Plan is lost because of a Qualifying Event. This section is intended to inform you, in summary fashion, of your COBRA rights and obligations.

COBRA Administrator

The Plan Administrator has selected a COBRA Administrator to perform certain COBRA-related responsibilities and functions on its behalf. The COBRA Administrator for the Plan is Blue Cross of Idaho. They can be contacted at:

Blue Cross of Idaho

Phone: (855) 216-6850 or (208) 286-3813

Website: www.bcidaho.com

Qualified Beneficiary

Only certain individuals are eligible for COBRA continuation coverage. A person that meets the following two conditions must be offered COBRA continuation coverage if he or she experiences a Qualifying Event that results in a loss of coverage:

- This person is a covered Employee, the Spouse of a covered Employee, or the Dependent child of a covered Employee; and
- The person was covered by the Plan's Health Coverage immediately before the Qualifying Event.

Although a child born or adopted during a period of continuation coverage was not covered by the Plan immediately before the Qualifying Event, under a special rule, such a child is a Qualified Beneficiary entitled to elect COBRA coverage.

Qualifying Events

As an Employee, you will become a Qualified Beneficiary if you lose Health Coverage under the Plan because of any of the following Qualifying Events:

- You fail to meet eligibility requirements while remaining employed; or
- Your employment ends for any reason other than for gross misconduct.

Your Spouse will become a Qualified Beneficiary if your Spouse loses Health Coverage under the Plan because of any of the following Qualifying Events:

- You die;

- You fail to meet eligibility requirements while remaining employed;
- Your employment ends for any reason other than for gross misconduct;
- You become entitled to Medicare benefits after enrolling in COBRA continuation coverage (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your Dependent children will become Qualified Beneficiaries if they lose Health Coverage under the Plan because of any of the following Qualifying Events:

- You die;
- You fail to meet eligibility requirements while remaining employed;
- Your employment ends for any reason other than for gross misconduct;
- You become entitled to Medicare benefits after enrolling in COBRA continuation coverage (under Part A, Part B, or both);
- You become divorced or legally separated from your Spouse; or
- Your child stops being eligible for Dependent coverage under the Plan.

Important Notification Requirements

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred.

When the Qualifying Event is the end of employment, failing to meet eligibility requirements while remaining employed, death of the Employee, or the Employee's becoming entitled to Medicare benefits after enrolling in COBRA continuation coverage, J.R. Simplot Company is required to notify the Plan Administrator of the Qualifying Event.

For the other Qualifying Events (divorce or legal separation or a Dependent child's loss of Dependent eligibility), you or the applicable Dependent are required to notify the Plan Administrator within 60 days after the Qualifying Event occurs, or if later, within 60 days after Health Coverage for the applicable Dependent ends. You or your Dependent(s) are required to provide this notice, in writing, to the COBRA Administrator with the notation that your correspondence involves a Qualifying Event. The written notice must include your/their name, the type of Qualifying Event, and the date of the Qualifying Event.

If you or your Dependent(s) fail to provide this notification within 60 days following the Qualifying Event, you/they will lose the right to elect COBRA coverage.

To protect your COBRA rights, you must notify the Plan Administrator in writing of any address changes for you or Dependents. Retain copies of any notices sent to the Plan Administrator.

Electing COBRA Coverage

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries through a notice of right to elect COBRA coverage, which will contain the necessary election forms. Each Qualified Beneficiary will have an independent right to elect COBRA coverage. Covered Employees may elect COBRA coverage on behalf of their Spouses, and parents may elect COBRA coverage on behalf of their children.

Each Qualified Beneficiary is required to elect COBRA coverage within 60 days after the later of:

- the date that Health Coverage would otherwise end, or
- the date of the COBRA election notice provided to the Qualified Beneficiary.

If you and/or your Dependent Qualified Beneficiaries do not elect COBRA continuation coverage by completing and returning the election forms within this 60-day election period, you/they will lose the right to elect COBRA coverage.

Type of Coverage

The COBRA continuation coverage offered to you and each Qualified Beneficiary will be the same Health Coverage you were enrolled in on the day before the Qualifying Event. Any changes in the terms, conditions, or availability of the Health Coverage benefits will apply to you in the same way such changes apply to similarly situated active Employees and Dependents who have not experienced a Qualifying Event.

COBRA Premiums

The premium for COBRA coverage is usually the total cost of coverage, both employer- and Employee-paid portions, plus a two percent administrative fee. Because J.R. Simplot Company subsidizes the cost of coverage for active Employees, this COBRA premium is substantially more than you pay for coverage as an active Employee.

If you leave J.R. Simplot Company, or if coverage under the Plan ends, under certain circumstances described in the Benefit Information Reference Sheets (see Appendix C on page 65), J.R. Simplot Company will help pay your monthly COBRA premiums for a period of time.

Premiums are applied from the first day of COBRA coverage, which is typically the first day of the next calendar month beginning after the Qualifying Event (the date the Qualified Beneficiary would otherwise lose coverage). Payment of an initial premium for COBRA coverage is due no later than 45 days after the Qualified Beneficiary elects COBRA coverage. The initial premium is the total COBRA premium for any month(s) that end on or before the 45th day after the Qualified Beneficiary elects COBRA coverage. The premium for the month in which the 45th day falls is due by the end of that month. Subsequent premium payments are due on a monthly basis, on the first of each month for which coverage is sought, subject to a 30-day grace period. Failure to fully pay the initial premium within 45 days after electing COBRA coverage or any subsequent monthly premium within 30 days of the established due date will result in permanent cancellation of the applicable COBRA coverage.

Maximum Coverage Periods

The maximum period for which you and/or your Dependent Qualified Beneficiaries may continue coverage will begin on the date the Qualified Beneficiary would otherwise lose coverage, which is typically the first day of the next calendar month after the Qualifying Event. The maximum coverage period will end as set forth below, based on the type of Qualifying Event. Remember that COBRA coverage can end before the maximum coverage period expires in certain situations described below in the “When COBRA Coverage Ends” subsection.

1. **36 Months**. If your Dependent loses Health Coverage because of your death, divorce, legal separation, your becoming entitled to Medicare benefits, or your child’s losing status as a Dependent under the Plan, the maximum coverage period (for your Spouse and Dependent child) is 36 months.

Coordination with Special Continuation Period if You Die

If you die, your covered Dependents may continue their active coverage until the end of the month in which you die plus an additional three months (except in Hawaii). J.R. Simplot Company will pay in full for this additional three months of active coverage for Dependents enrolled at the time of your death in Health Coverage under the Plan. COBRA coverage, if elected, begins after this period ends.

2. **18 Months.** If you or your Dependent loses Health Coverage because you fail to meet eligibility requirements while remaining employed, or your employment is terminated (other than for gross misconduct), the maximum coverage period for each Qualified Beneficiary is 18 months.
3. **Disability Extension from 18 to 29 months**. If you or another Qualified Beneficiary in your family becomes disabled as described below, then coverage for you or your covered Dependents may be extended from 18 months to 29 months.

   To qualify for the disability extension:

   1) The Qualified Beneficiary must have become disabled prior to the 60th day of COBRA coverage as either:

      - Certified by a physician; or
      - Determined by the Social Security Administration; and

   2) The COBRA Administrator must be notified in writing within 60 days after the latest of:

      - The date of the Qualifying Event;
      - The date of disability determination by the Social Security Administration (the notice must include the Qualified Beneficiary's name, the date of disability, and a copy of the certification/determination);
      - The date the Qualified Beneficiary would otherwise lose Health Coverage as a result of a Qualifying Event; or
      - The date the Qualified Beneficiary is first informed of the notice obligation; and

   3) Application for the disability extension must be submitted before the end of the 18-month continuation period (unless, with respect to a Social Security Administration disability determination, the Social Security Administration appeal process reverses a denial of disabled status received by them before the 18-month continuation period expires).
4. **Second Qualifying Event extension from 18 to 36 months.** If a second Qualifying Event subject to a 36-month maximum coverage period for your Dependent(s) (for example, you die or become divorced) occurs within an 18-month or 29-month maximum coverage period, the maximum coverage period for your Dependent Qualified Beneficiaries becomes 36 months from the date the Qualified Beneficiary would have otherwise initially lost coverage, which is typically the first day of the next calendar month after the first Qualifying Event. An event is not a second Qualifying Event unless it would have resulted in a loss of coverage for the applicable Qualified Beneficiaries had the first Qualifying Event not occurred.

   Note: this 36-month extended maximum coverage period will not apply if the COBRA Administrator is not provided written notice of the second Qualifying Event within 60 days of the event after the later of (1) the date of the second Qualifying Event; and 2) the date on which the Qualified Beneficiary would lose coverage under the terms of the Plan as a result of the second Qualifying Event (had the first Qualifying Event not occurred). The notice must include the name of the Qualified Beneficiary(ies), the type of second Qualifying Event and the date of the second Qualifying Event.

5. **36 months from Medicare Entitlement.** If a Qualifying Event occurs within 18 months after you become entitled to Medicare, the maximum coverage period for your Dependent Qualified Beneficiaries becomes 36 months from the date you became entitled to Medicare.

Notice of Unavailability of COBRA Coverage

If the COBRA Administrator receives notice of a Qualifying Event, a second Qualifying Event, or a determination of disability regarding you or one of your Dependents, and determines that the individual is not entitled to COBRA coverage, an explanation as to why the individual is not entitled to COBRA coverage or extended COBRA coverage will be provided within the same time frame that notice of right to elect COBRA coverage would have been provided.

When COBRA Coverage Ends

COBRA continuation coverage for any person ends on the earliest of:

- The date the COBRA maximum coverage period expires;
- The last day of the month for which a required premium was fully paid on a timely basis if a regular premium payment for COBRA coverage is not fully paid by the applicable due date;
- The date the Qualified Beneficiary becomes entitled to coverage under Medicare which, for Medicare eligibility based on age, is the first of the month the individual turns 65 (does not apply if the Qualified Beneficiary was already entitled to Medicare when electing continuation coverage);
- The date the Qualified Beneficiary becomes covered by another group health plan (does not apply if the Qualified Beneficiary was already covered by the other group health plan when electing continuation coverage);
- The date that the applicable Health Coverage under this Plan is terminated, unless the coverage is immediately replaced by another plan or coverage providing similar coverage sponsored by J.R. Simplot Company;
- For a Qualified Beneficiary who was entitled to a 29-month maximum coverage period for disability, the first day of the month that begins more than 30 days after the final determination by the Social Security Administration that the formerly disabled Qualified Beneficiary is no longer disabled. You or your Dependent Qualified Beneficiary is required to notify COBRA Administrator immediately upon receipt of the determination from the Social Security Administration.

Notice of Termination Before Maximum Coverage Period Expires

If COBRA continuation coverage for a Qualified Beneficiary terminates before the expiration of the maximum coverage period, the COBRA Administrator will provide notice to the Qualified Beneficiary of the reason that the continuation coverage terminated, the date of termination, and any rights that the Qualified Beneficiary may have under the Plan or applicable law to elect an alternative group coverage. The notice will be provided as soon as practicable following the Plan Administrator's determination regarding termination of the continuation coverage.

Children Born or Adopted During COBRA Coverage

A child who was born to, adopted by, or Placed for Adoption with you during a period of COBRA coverage will be eligible to become a Qualified Beneficiary provided, in the case of adoption or Placement of Adoption, that the child is under age 26. You may elect COBRA coverage for the child, provided you notify the COBRA Administrator within 90 days inclusive of the date of the birth, adoption or Placement for Adoption for a newborn, and within 31 days inclusive of the date of the event for children other than newborns or adoptions/placements for adoption. COBRA continuation coverage for the child will continue for as long as COBRA continues for your other

eligible Dependents. **If you fail to notify the COBRA Administrator within 31 or 90 days inclusive of the event, as applicable, you will not be allowed to elect COBRA continuation coverage for the child.**

HEALTH SAVINGS ACCOUNTS

About this Section

This section describes the Health Savings Account Program of the J.R. Simplot Company Flex Plan. The Health Savings Account Program is not an employer-sponsored plan, is not an employee welfare benefit plan or part of an employee welfare benefit plan under ERISA and is not subject to ERISA.

Overview

The Health Savings Account (HSA) is not part of the Medical Program, although you must be enrolled in the Medical Program to participate in the Health Savings Account. Participation in the Health Savings Account is voluntary and allows you to set aside funds to pay for qualified medical expenses on an untaxed basis. The account is 100% owned by you, although both you and J.R. Simplot Company may contribute to the account.

J.R. Simplot Company's responsibility with respect to the Health Savings Account Program is limited to determining whether you are enrolled in the Medical Program, making employer contributions for eligible Participants as described below, and paying the monthly administration fees charged by HealthEquity, Inc. (the Health Savings Account administrator) for active Participant accounts. You are responsible for all other aspects of participation in the Program, including determining eligibility, contributions and limits, and expense eligibility, as well as determining any investments for your account. You are also responsible for any additional fees charged based on the transactions or investments in your individual account. You should consult a tax advisor with any questions.

You may contribute to your Health Savings Account on a pre-tax basis by payroll deduction through the Flex Plan. You may also make post-tax contributions directly to the Health Savings Account for which you may receive a tax credit on your tax return. Contribution to the Health Savings Account through payroll deduction will reduce the amount of your taxable compensation. Accordingly, there could be a slight decrease in your Social Security benefits.

Administration and Contact Information

The HSA program is administered by HealthEquity, Inc. For general information or contributions and processing information, contact the HSA provider:

HealthEquity, Inc.

Address: 15 West Scenic Pointe Drive, Suite 100
Draper, UT 84020

Phone: 877-629-8234

Email: memberservices@healthequity.com

Website: HealthEquity.com/Simplot

Eligibility and Enrollment

To be eligible for the employer contributions, you must enroll in the Medical Program (which qualifies as a "high deductible health plan" for Health Saving Account purposes) and elect a HealthEquity Health Savings Account by electing ongoing payroll deductions through the online

benefits system. Additionally, you must not have other coverage that would disqualify you from meeting Internal Revenue Service (IRS) eligibility requirements for an Health Savings Account. Examples of other coverage include coverage under a spouse's health plan that is not an Health Savings Aaccount-eligible plan, Tricare, Indian Health Services coverage, Medicare, Medicaid and coverage under your spouse's Health Care Flexible Spending Account (except a limited purpose Flexible Spending Account). Please refer to IRS Publication 969 for further information regarding IRS eligibility requirements.

Enrollment is on a prospective basis only. Once eligible, you may enroll at any time. HealthEquity will validate your information as required by the Patriot Act.

Once enrolled, a HealthEquity Health Savings Account is established as an individual account in your name. J.R. Simplot Company will be able to deposit employer contributions into the account on your behalf but has no control over your account.

Employee Contributions

You may elect to contribute into a HealthEquity Health Savings Account through pre-tax payroll contributions. You may start, stop, or change your payroll contribution at any time during the year. To do so, you will need to go to the online benefits system and make your contribution election. Your new or changed contribution election will be taken from or apply to the next paycheck that is administratively feasible. J.R. Simplot Company cannot guarantee that a contribution will apply to a particular paycheck.

The administrative fees charged by HealthEquity to have an open Health Savings Account will be paid by J.R. Simplot Company while you are making active payroll contributions (minimum of $0.04/semi-monthly paycheck). Health Savings Account payroll contributions are deducted from the first two paychecks in a calendar month; they will not be deducted from the third paycheck of the calendar month, if applicable. If you stop making payroll contributions, your account will be unlinked from J.R. Simplot Company, and you will be responsible for any fees charged by HealthEquity.

Employer Contributions

J.R. Simplot Company will make employer contributions into your HealthEquity Health Savings Account if you are an active Employee enrolled in the Medical Program (as an Employee and not as a Dependent), enrolled in and actively contributing to a HealthEquity Health Savings Account (minimum of $0.04/semi-monthly paycheck), and eligible to receive contributions on the date that J.R. Simplot Company or its designee initiates the employer contribution process. J.R. Simplot Company will make the following employer contributions to eligible individuals for the 2026 plan year:

1. $300 on, or as soon as administratively practical, after January 1, 2026, or if you are not eligible for HSA contributions on January 1st, as soon as practical once you become eligible to receive HSA contributions.
2. A matching contribution for each dollar you contribute into your HealthEquity HSA through payroll deduction, up to $250. The matching contribution will be made at the same time your payroll contribution is made into your account.
3. $400 for your completion of the Wellness (HSA) Incentive Course in MySimplot and completion of a qualifying preventive service visit* by October 31, 2026, as reported by Blue Cross of Idaho.

* You may choose from one of the following preventive health service visits (age/gender requirements may apply):

- Annual adult physical exam
- Colorectal cancer screening
- Cervical cancer screening (pap smear or equivalent)
- Breast cancer screening (mammogram)
- Lung cancer screening
- Dental semi-annual preventive cleaning visit (Simplot Dental Program enrollment required)
- Annual exam using Catapult Health VirtualCheckup

Other types of preventive service visits covered under the Simplot Medical Program or Simplot Dental Program do not apply for purposes of earning the employer Health Savings Account contribution.

In no event will J.R. Simplot Company make more than one employer contribution of each type listed above to your HealthEquity Health Savings Account for the same calendar year.

J.R. Simplot Company will not make employer contributions to an account that is held by an institution other than HealthEquity. In addition, J.R. Simplot Company will not contribute to an account if informed by HealthEquity that the account has already reached the IRS contribution limit for the calendar year. Therefore, if you have reached the IRS contribution limit prior to receiving any employer contribution, you become ineligible for that employer contribution.

Limit on Contributions

The total contributions into your HealthEquity Health Savings Account, by you, J.R. Simplot Company, or anyone else on your behalf, are subject to calendar year limits established by the IRS. It is your responsibility to ensure you comply with the limits.

Annual contribution limits are applied for individual coverage or family coverage. An additional $1,000 catch-up contribution is available for Employees over age 55. Coverage limits apply to the individual account holder and not to the dependents. Therefore, if you enroll your family under the Medical Program, they do not need to be eligible to open their own Health Savings Account for you to be eligible for the family coverage contribution limit.

Catch-up contributions apply only to the account holder and cannot be made for a spouse.

If more than one spouse has an Health Savings Account, special rules apply regarding limits. Refer to IRS Publication 969 found at www.irs.gov or contact HealthEquity for assistance.

Proration of Limits

Limits are prorated based on the months in which you are eligible to receive Health Savings Account contributions. In addition, limits are prorated for the type of coverage in which you are enrolled. As a result, the limit is adjusted if you move between family and individual coverage or if you gain or lose Health Savings Account eligibility during the calendar year.

In addition, to be eligible to make/receive contributions for a calendar month, you must be enrolled in the Medical program (or another Health Savings Account qualified high-deductible health plan) on the first day of that calendar month.

Last Month Rule

If you are eligible on the first day of the last month of your tax paying year (December 1 for most tax payers), you can contribute up to the full limit for that year as long as you remain eligible through a testing period of 13 months, beginning with the first day of the last month of your taxpaying year.

Eligible for last month rule (example): Julie becomes eligible on December 1, 2026 and elects to open an HSA with individual coverage. She pays taxes on a calendar year period basis. Because she was eligible on December 1, 2026, she is eligible to contribute the full IRS limit for 2026. However, she must remain eligible to make HSA contributions through December 31, 2027 (13 months from December 1, 2026), or 11 months of her 2026 contribution will be considered an excess contribution (she is still eligible to contribute for December) and she will need to pay taxes and penalties on that amount.

Employees are responsible for monitoring compliance with IRS limits in their Health Savings Account on an annual basis. If the employer contribution will cause an excess contribution, you may request to reduce or waive the employer contribution in order to avoid the excess contribution. To do so, you must notify HR Solutions in writing at least one week prior to the date the employer contribution would normally be sent to HealthEquity. J.R. Simplot Company will not make up a waived or reduced employer contribution at a later date.

Interest and Investing

Interest and investment options for your Health Savings Account are determined by HealthEquity. Refer to the HealthEquity Health Savings Account Custodial Agreement, available on their website, for more information.

HealthEquity determines which mutual funds they offer. J.R. Simplot Company has no fiduciary responsibility for your account, interest rates or investment options.

Payment for Qualified Medical Expenses

You may make tax-free payments for Qualified Medical Expenses for you and your tax dependents from your Health Savings Account. Once your account is opened at HealthEquity, they will mail you a debit card to use for this purpose. You may also use the HealthEquity website to make payments or call and speak to a HealthEquity Member Service Representative at 1-877-629-8234.

The IRS determines what is a Qualified Medical Expense. In general, it is an expense:

- Paid for “medical care” within the meaning of Internal Revenue Code Section 213(d), for which you otherwise have not been and will not be reimbursed;
- Incurred by you, your spouse, or your eligible tax dependent, and
- That is not a pre-tax premium for employer sponsored health plan coverage.

Generally speaking, amounts paid for “medical care” under IRS Code Section 213(d) include items—other than premiums—that you could have claimed as a medical care expense deduction on an itemized federal income tax return. This includes your deductibles and other out-of-pocket expenses. Medical, prescription, dental and vision expenses are included. You are responsible for determining whether an expense is a Qualified Medical Expense. **For a list of eligible expenses, please contact HealthEquity or see IRS Publication 502.**

Claim Procedures

This section applies only to claims related to employer contributions to your HealthEquity Health Savings Account . Claims for payment from your account should be directed to HealthEquity.

Employer contributions to your HealthEquity Health Savings Account will be made automatically. If you believe an employer contribution should have been made and was not, you may file a claim no later than March 15th of the following calendar year by writing to HR Solutions at:

J.R. Simplot Company
Attn: HR Solutions
P.O. Box 27
Boise, ID 83707

You may also submit a claim by e-mail to HRSolutions@simplot.com with the notation that the e-mail is a claim related to employer contributions to your Health Savings Account.

If your claim for a benefit is denied, in whole or in part, J.R. Simplot Company will provide you written notice explaining the denial.

Flex Plan Modification/Termination

J.R. Simplot Company reserves the right to modify or terminate the Flex Plan at any time, including any benefit or program offered under the Flex Plan, such as the Health Savings Account Program and/or employer contributions made under the Health Savings Account Program. It is also possible that future changes in state or federal tax laws may require that the Flex Plan be amended accordingly.

DEPENDENT CARE REIMBURSEMENT ACCOUNT

About this Section

This section describes the Dependent Care Reimbursement Account feature of the J.R. Simplot Company Flex Plan (the "Flex Plan"). The Dependent Care Reimbursement Account feature is not subject to ERISA.

Overview

Participation in the Dependent Care Reimbursement Account (DCRA) enables you to set aside funds to pay for qualified day care and eldercare expenses with pre-tax dollars deducted from your paycheck.

The Dependent Care Reimbursement Account feature is administered by HealthEquity.

Contact Information

For general plan information or claims payment and processing information, contact the Dependent Care Reimbursement Account administrator:

HealthEquity, Inc.

Address: 15 West Scenic Pointe Drive, Suite 100
Draper, UT 84020

Phone: 877-629-8234

Email: memberservices@healthequity.com

Website: HealthEquity.com/Simplot

Eligibility and Enrollment

Your participation in the Dependent Care Reimbursement Account is subject to the same eligibility and enrollment rules described in the **Plan Participation** section, with the exception of a unique definition of "Dependent", as described below. You may have a Dependent Care Reimbursement Account regardless of whether you participate in any other programs of the J.R. Simplot Company Group Health & Welfare Plan or the J.R. Simplot Company Flex Plan. Participation in a Dependent Care Reimbursement Account requires you to enroll each year during Annual Enrollment, specifying the amount you wish to deduct from your pay on a pre-tax basis, in whole or partial dollar amounts. This will typically involve estimating your Eligible Dependent Care Expenses for the upcoming year. In making your elections, keep in mind the IRS forfeit rules described below.

When you become a Participant, your pre-tax contributions will be paid with the portion of gross income you elected to forego through salary reduction. These reductions are taken uniformly throughout the year through semi-monthly payroll deductions. Any portion of compensation that you do not choose to apply toward the purchase of the programs described above, will be paid to you as regular, taxable compensation.

The Plan Administrator reserves the right at any time to restrict, amend or terminate in whole or

in part eligibility to participate in the Dependent Care Reimbursement Account in order to meet discrimination testing requirements or other legal or tax requirements.

Tax Advantages

You could save federal income tax, Social Security (FICA) tax, Medicare tax and state tax (in most areas) by participating in the Dependent Care Reimbursement Account. The following is an example of the tax savings you might experience.

Minimum and Maximum Annual Contributions

The maximum amount you can contribute to the account each year is $7,000 ($3,750 if married and filing taxes separately). This maximum amount is not pro-rated or reduced for mid-year enrollments (i.e., mid-year enrollees may still elect to contribute up to the full $7,500/$3,750). The minimum amount is $1 per each semi-monthly paycheck deduction.

If you participate in the Dependent Care Reimbursement Account and your Spouse participates in a similar account through his or her employer, your combined annual contributions to the accounts may not exceed $7,500. In addition, if you are married, your DCRA contributions may not exceed the annual income of the lower-paid spouse. For example, if you earn $30,000 a year and your Spouse earns $2,800, you cannot contribute more than $2,800 to your DCRA.

If your Spouse does not work outside the home and is physically or mentally unable to care for himself or herself, or if he or she is attending school full-time, the IRS assumes your Spouse's earned income to be:

- $250 a month ($3,000 a year) if you have one dependent
- $500 a month ($6,000 a year) if you have two or more dependents.

Record Keeping

If you elect to participate, an account will be created in your name to record the amounts you have contributed and the reimbursements you have received during the year. The account is for record keeping purposes only—it is not funded and does not bear interest. All the reimbursements are paid from the general assets of J.R. Simplot Company.

Eligible Dependent Care Expenses

Eligible Dependent Care Expenses are amounts:

- Considered to be employment-related expenses under Internal Revenue Code Section 21(b)(2), necessary for you and your Spouse (if you are married) to work, look for work, or go to school full-time;
- For the "care" of your Dependent, which means for his/her well-being and protection. The expenses may not be for food, clothing or primarily for education;
- For which you have not and will not be reimbursed, for example, through a federal Dependent Care Tax Credit; and
- That are incurred by you during the applicable year you participated in the Dependent Care Reimbursement Account.

Your care provider can be anyone other than your Spouse or a person you claim as a

dependent on your federal income tax return. If the services are for a Dependent who is a Spouse or other individual 13 years of age or over and incapable of self-care and are provided outside your home, the applicable Dependent(s) must regularly spend at least 8 hours a day in your home. If the services are provided by a dependent care facility that cares for seven or more individuals at the same time, the facility is required to be licensed. When you file your tax return, you are required to include the care provider's Social Security number or tax payer identification number.

Examples of excluded expenses:

- Care provided by a round-the-clock nursing home;
- Housekeeping expenses not related to Dependent care;
- Expenses for services while you're away from work (other than a short, temporary absence of less than 2 weeks, e.g., for vacation or minor illness, if you are still required to pay your provider during that period);
- Care provided while you and/or your Spouse are doing volunteer work or out for the evening socially;
- Educational expenses for a child in kindergarten, first grade or higher;
- Expenses for overnight stays* (boarding) including overnight camps even if the overnight charges can be separated out; and
- Expenses for food, clothing or transportation of your Dependent (unless transportation is provided by the care provider to or from the place where care if provided).

*However, if your work requires you to be gone from home overnight, associated overnight care may be a covered expense.

Definition of "Dependent"

For purposes of the Dependent Care Reimbursement Account feature only, the IRS defines a Dependent as:

- A child 12 or under whom you can claim as a dependent on your federal income tax return and for whom the Employee is the custodial parent in the case of divorced or separated parents. If your child turned 13 during the year, he or she is an eligible dependent for the part of the year he or she was under age 13;
- Your Spouse who is physically or mentally unable to care for himself or herself and has the same principal place of residence as you for more than half of the year; or
- An individual who is physically or mentally unable to care for himself or herself, whom you can claim as a dependent on your federal income tax return, and who has the same principal place of residence as you for more than half of the year.

Your Dependent may be an elderly parent or other relative or dependent, as long as he or she meets all of the above requirements.

Other Tax Information

You may use the Dependent Care Tax Credit and/or the Dependent Care Reimbursement Account for eligible dependent care expenses. You may not, however, use them both for the same expense. In other words, any contributions to your Dependent Care Reimbursement Account reduce dollar-for-dollar the amount you may claim for a Dependent Care Tax Credit. You should review the instructions for Internal Revenue Service Form 2441 or Schedule 2 for

information on how to calculate your tax savings for the Dependent Care Tax Credit, as compared to the Dependent Care Reimbursement Account. If you choose to participate in the DCRA, you are required to file a Form 2441 with your Form 1040 or Schedule 2 with your Form 1040A.

Participation in the Dependent Care Reimbursement Account will reduce the amount of your taxable compensation. Accordingly, there could be a slight decrease in your Social Security benefits.

Internal Revenue Service (IRS) Forfeit Rules

Because the Dependent Care Reimbursement Account is a tax-favored program, IRS rules apply. As a result, the IRS requires you to forfeit any unused funds in your account at the end of the year. All forfeitures will be used first to offset any Plan losses and then to reduce Plan administrative costs.

All claims incurred during a particular year must be received by HealthEquity no later than March 15th of the following calendar year.

If you terminate participation in the Dependent Care Reimbursement Account during the year, your eligibility to incur expenses under the Dependent Care Reimbursement Account ends. You must submit claims for expenses incurred up to the date of termination no later than 30 days following your termination of coverage. Note, eligible mid-year contribution election changes reducing payroll contributions to $0 will not be considered a termination of participation and will not be subject to the 30-day requirement to submit claims.

Any funds for which you have not timely submitted a claim will be forfeited.

Mid-Year Election Changes

Generally, you cannot change your election during the year after enrolling in the Dependent Care Reimbursement Account. In most instances, you will have to wait for the next Annual Enrollment. The limited circumstances in which you may change or revoke your Dependent Care Reimbursement Account election are described in the **Plan Participation** section under the “Changing Your Elections” subsection. If you are allowed to make a mid-year election change under one of these limited circumstances, expenses incurred prior to the change in status are subject to the election in place at the time the expense was incurred. In addition, if you terminate your employment with J.R. Simplot Company your election is automatically revoked.

Dependent Care Reimbursement Account Claims for Reimbursement

When you incur an eligible expense, you will need to submit a reimbursement form along with documentation of the expense. A reimbursement form can be obtained from HealthEquity, either online or by contacting them by phone. You are required to submit your completed request and any required documentation to HealthEquity at the address shown on the form, or through HealthEquity’s website or mobile application.

The amount you contribute to a Dependent Care Reimbursement Account in any year can be used only to reimburse Eligible Dependent Care Expenses incurred during that year.

Dependent Care Reimbursement

For the Dependent Care Reimbursement Account, only your current account balance is available for reimbursement. If the Dependent care services exceed your account balance, you will receive no, or a partial, reimbursement. You will receive the unreimbursed portion of the claim as you make additional contributions to your Dependent Care Reimbursement Account.

You are required to provide your care provider's name and address when you file for reimbursement. You are also required to provide a receipt that lists the dates of service, the amount paid, and the Dependent's names. The receipt has to indicate that the services were for dependent care. If the care was provided in a private home, the caregiver is required to either sign the reimbursement form or sign the receipt.

Direct Deposit

HealthEquity will charge a fee for reimbursements made by paper check, which will be deducted from your Dependent Care Reimbursement Account balance. Dependent Care Reimbursement Account reimbursements may be direct deposited into your checking or savings account at no cost to you. You can sign up for direct deposit at any time during the year. The Dependent Care Reimbursement Account Reimbursement Direct Deposit Authorization form can be obtained from HealthEquity, either online or by contacting them by phone. Enrollment in Direct Deposit carries over from one year to the next if you continue participation in the Dependent Care Reimbursement Account.

Claim Denial and Appeals Procedures

If your claim for a benefit is denied, 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. HealthEquity will provide you written notice of any claims that are denied.

You may appeal the denial of a claim by submitting an appeal request in writing to HealthEquity within 180 days of your receipt of the denial. In conjunction with your appeal, you may review pertinent Flex Plan documents and submit issues, comments and added facts in writing.

HealthEquity will provide a full and fair review of the denial. The decision will ordinarily be made within 60 days after the Plan's receipt of the request for appeal. The decision on appeal will be communicated to you in writing and will include specific reasons for the decision.

Flex Plan Modification/Termination

J.R. Simplot Company reserves the right to modify or terminate the Flex Plan at any time, including any benefit or program offered under the Flex Plan, such as the Dependent Care Reimbursement Account. It is also possible that future changes in state or federal tax laws may require that the Flex Plan be amended accordingly.

DISABILITY, LIFE & ACCIDENT COVERAGE

About this Section

This section describes the following programs of the J.R. Simplot Company Group Health & Welfare Plan:

- Long-Term Disability Program;
- Voluntary Long-Term Disability Program;
- Basic Life and Accidental Death & Dismemberment (AD&D) Insurance Program;
- Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance Program

Some of these programs are not available for all employment classifications. Please read and review the **Plan Participation** section of this Summary Plan Description booklet for detailed eligibility information.

Short-Term Disability

Short-term disability benefits are not provided under this Plan; however short-term income replacement (STD pay) may be available for certain disabilities. For a complete description, please see the J.R. Simplot Company Leave Policy and the applicable STD pay guidelines.

Long-Term Disability Program

The Long-Term Disability (LTD) Program provides you financial protection by paying a portion of your income while you are disabled. Program benefits are provided under a group insurance policy with New York Life. There is no Dependent coverage under the Long-Term Disability Program.

For detailed coverage information, as well as the applicable claims and appeals procedures, please refer to the Certificate of Coverage issued by the insurer, which is part of this Summary Plan Description booklet and is incorporated herein by this reference. The certificate is also available without charge on the online benefits system, or by requesting it from New York Life at:

New York Life
Life Insurance Company of North America
PO Box 81070
Cleveland, OH 44181
(888) 842-4462

Please read and review the Certificate of Coverage carefully, as it is the official document for determining eligibility and coverage for this program.

Voluntary Long-Term Disability Program

The Voluntary Long-Term Disability (LTD) Program provides you additional financial protection by paying a higher portion of your income while covered under the Long-Term Disability Program. Program benefits are provided under a group insurance policy with New York Life. There is no Dependent coverage under the Voluntary Long-Term Disability Program.

For detailed coverage information, as well as the applicable claims and appeals procedures, please refer to the Certificate of Coverage issued by the insurer, which is part of this Summary

Plan Description booklet and is incorporated herein by this reference. The certificate is also available without charge on the benefits online system, or by requesting it from New York Life at:

New York Life
Life Insurance Company of North America
PO Box 81070
Cleveland, OH 44181
(888) 842-4462

Please read and review the Certificate of Coverage carefully, as it is the official document for determining eligibility and coverage for this program.

Basic Life and Accidental Death & Dismemberment (AD&D) Insurance

The Basic Life and Accidental Death & Dismemberment (AD&D) Insurance Program provides you and your family with financial assistance in the event of your death or dismemberment. Program benefits are provided under a group insurance policy with New York Life. There is no Dependent coverage under the Basic Life and AD&D Insurance Program. J.R. Simplot Company pays the entire cost of coverage from its general assets. Subject to the actively-at-work requirement, you are automatically enrolled in this program upon meeting Plan eligibility requirements.

The first $50,000 of Basic Life and AD&D Insurance coverage paid for by J.R. Simplot Company is not taxable to you. If the amount of Basic Life and AD&D Insurance coverage exceeds $50,000, the value of the coverage in excess of $50,000 paid for by J.R. Simplot Company is considered income and is taxable to you. In most cases, the benefit paid will not be taxable to the beneficiary.

For detailed coverage information, as well as the applicable claims and appeals procedures, please refer to the Certificate of Coverage issued by New York Life, which is part of this Summary Plan Description booklet and is incorporated herein by this reference. The certificate is also available without charge on the online benefits system, or by requesting it from New York Life at:

New York Life
Life Insurance Company of North America
PO Box 81070
Cleveland, OH 44181
(888) 842-4462
(888) 842-4462

Please read and review the Certificate of Coverage carefully, as it is the official document for determining eligibility and coverage for this program.

Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance Program

The Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance Program is Employee-paid, supplemental Life and AD&D insurance. Program benefits are provided under a group insurance policy with New York Life. Dependent coverage is also available. Participation is voluntary. You may elect whether, and at what level, you wish to participate.

For detailed coverage information, as well as the applicable claims and appeals procedures, please refer to the Certificate of Coverage issued by the insurer which is part of this Summary Plan Description booklet and is incorporated herein by this reference. The certificate is also available without charge on the online benefits system, or by requesting it from New York Life at:

New York Life
Life Insurance Company of North America
PO Box 81070
Cleveland, OH 44181
(888) 842-4462

Please read and review the Certificate of Coverage carefully, as it is the official document for determining eligibility and coverage for this program.

IMPORTANT PLAN INFORMATION

About this Section

This section contains important information about the Plan and its administration and about your rights under the Plan under a federal law known as ERISA. Some of the benefits and programs described or mentioned in this Summary Plan Description are not subject to ERISA. The descriptions of these benefits and programs are provided in this Summary Plan Description solely for your convenience. The following benefits or programs are not subject to ERISA and thus are not subject to the rights described in "Your Rights" below: the Flex Plan, the Health Savings Account (HSA) Program under the Flex Plan, the Dependent Care Reimbursement Account (DCRA) under the Flex Plan, and short-term disability income replacement benefits.

Your Rights

The following statement of ERISA rights is required by federal law and regulation. As a Participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

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 worksites 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 Employee Benefits Security 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 health care coverage for yourself or your 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 for the rules governing your COBRA continuation coverage rights.

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. If your claim for a welfare benefit is denied in whole or in part you will receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

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, if, for example, it finds your claim is frivolous.

Assistance With Your Questions
If you have any questions about your Plan, 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 area 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.

Additional Plan Information

Name of Plan
J.R. Simplot Company Group Health & Welfare Plan.

Type of Plan
The Plan is a welfare benefit plan, providing health (medical, prescription drug, dental, and vision), employee assistance program, disability, life, accidental death and dismemberment (AD&D) and supplemental life benefits.

Plan Funding and Contributions
The Medical, Dental and Vision Programs are "unfunded", which means that J.R. Simplot Company pays the benefits of the program directly from the J.R. Simplot Company's general assets, with contributions from you and J.R. Simplot Company. Your contributions are made through payroll deductions, on a pre-tax basis under the Premium Payment Program of the J.R. Simplot Company Flex Plan.

The Hawaii Kaiser HMO Program is provided through an insurance contract with Kaiser Permanente. Kaiser Permanente pays the applicable Plan benefits, and you and J.R. Simplot

Company pay the required premiums. Your contributions are made through payroll deductions, on a pre-tax basis under the Premium Payment Program of the J.R. Simplot Company Flex Plan.

The Hawaii Medical Assurance Association (HMAA) Program is provided through an insurance contract with the Hawaii Medical Assurance Association (HMAA). HMAA pays the applicable Plan benefits, and you and J.R. Simplot Company pay the required premiums. Your contributions are made through payroll deductions, on a pre-tax basis under the Premium Payment Program of the J.R. Simplot Company Flex Plan.

The following programs are also provided through contracts of insurance with the companies indicated in parentheses. You and/or J.R. Simplot Company, as indicated, pay the required premiums. All Employee contributions, if applicable, are paid through payroll deductions on a post-tax basis unless indicated otherwise. Plan benefits are paid by the insurer.

- International Welfare Benefits Program (GeoBlue) (J.R. Simplot Company paid)
- Employee Assistance Program (Spring Health) (J.R. Simplot Company paid)
- Long Term Disability Program (New York Life) (J.R. Simplot Company paid)
- Voluntary Long Term Disability Program (New York Life) (Employee paid)
- Basic Life and Accidental Death & Dismemberment Insurance Program (New York Life) (J.R. Simplot Company paid)
- Voluntary Life and Accidental Death & Dismemberment Insurance Program (New York Life) (Employee paid)

Plan Sponsor

The Plan is sponsored by J.R. Simplot Company. J.R. Simplot Company's Employer Identification Number (EIN) is: 82-0196611.

Plan Number

The number assigned to the Plan is: 501.

Type of Administration

The Plan Administrator, J.R. Simplot Company, has full discretionary authority to administer and interpret the Plan, and to determine eligibility for participation and benefits under the Plan. This includes the authority to construe the terms of the Plan and resolve possible ambiguities, inconsistencies, or omissions. All determinations of the Plan Administrator with respect to any matter on which it has the authority to act shall be made by it in its sole discretion and shall be conclusive and binding on all persons. The Plan Administrator's contact information is:

J.R. Simplot Company
Senior Vice President of Human Resources
P.O. Box 27
Boise, ID 83707
Telephone: (208) 336-2110

The Plan Administrator may delegate its duties and responsibilities as it deems appropriate to facilitate the day-to-day administration of the Plan and, unless the Plan Administrator expressly provides to the contrary, any such delegation will carry with it the Plan Administrator's full discretionary authority to accomplish the delegation.

Delegation of Claims Review Fiduciary Authority for Insured Programs

For each of the insured programs under the Plan, J.R. Simplot Company, as Plan Administrator, has delegated to the applicable insurance company its discretionary authority with respect to making and reviewing benefit claims determinations. As a claims review fiduciary, each such insurance company has sole discretionary authority to determine the availability of benefits under the portion of the Plan that it insures and to interpret, construe and administer the applicable terms of the Plan and any governing insurance policy. All determinations and interpretations regarding the payment and review of benefit claims made by each insurance company under its discretionary authority are intended to be conclusive and binding, subject to the applicable appeals process for that program.

Delegation of Claims Review Fiduciary Authority for Employee Assistance Program

For the Employee Assistance Program (EAP) under the Plan, J.R. Simplot Company, as Plan Administrator, has delegated to Spring Health its discretionary authority with respect to making and reviewing benefit claims determinations. As a claims review fiduciary, Spring Health has sole discretionary authority to determine the availability of benefits under the EAP and to interpret, construe and administer the applicable terms of the Plan and any governing insurance policy. All determinations and interpretations regarding the payment and review of benefit claims made by Spring Health under its discretionary authority are intended to be conclusive and binding, subject to the applicable appeals process.

Agent for Service of Legal Process

The Plan Administrator.

Plan Year

The Plan year is January 1 through December 31.

DEFINITIONS

About this Section

There are a number of key phrases and words—usually capitalized—that appear throughout this Summary Plan Description booklet and have a special meaning. In order to understand your benefits, you need to know the definitions of these terms. This section describes the meaning of these defined terms. For the Medical, Dental and Vision Programs, if any of these terms conflict with the defined terms in the Program Documents, the terms in the Program Documents will control. For insured programs, if any of these terms conflict with the defined terms in the Certificate of Coverage, the terms in the Certificate of Coverage will control.

ACA Seasonal Employee

An Employee who is:

- Hired for a specific, short term need that occurs based on season and not due to expected business fluctuation due to demand– for example, for calf branding in the spring;
- Hire and layoff typically occur at the same time each year;
- Length of employment is determined based on the short term seasonal event and does not otherwise fluctuate; and
- Total employment in the calendar year does not exceed 6 months.

Adverse Benefit Determination

A denial, reduction, or termination of a claim for benefits, or a failure to provide or make payment for such a claim (in whole or in part) including determinations of a Claimant's eligibility in connection with a claim for benefits, non-approval of a prior authorization, and determinations that an item or service is Experimental and/or Investigational or not Medically Necessary.

Annual Enrollment

The period each year designated by J.R. Simplot Company in which eligible Employees may change their current Plan elections, effective January 1 of the upcoming calendar year, by submitting an appropriate request to J.R. Simplot Company. Refer to the **Plan Participation** section for more details.

Authorized Representative

Someone authorized to act on a Claimant's behalf. To designate an authorized representative a Claimant is required to provide written authorization on a form provided by the Plan and clearly indicate on the form the nature and extent of the authorization.

Benefit Determination

The decision by Spring Health or other EAP representative regarding the acceptance or denial of a claim for benefits under the EAP.

Casual Employee

An Employee hired for intermittent assignments for an indefinite period of time.

Certificate of Coverage

A certificate of coverage, certificate of insurance or other coverage document provided by the applicable insurance company for an insured program of the Plan that outlines the terms and conditions of the applicable coverage.

Claimant
Any Plan Participant or beneficiary making a claim for benefits. Claimants may file claims themselves or may act through an Authorized Representative.

Claims Administrator
The organization designated to perform claims administration services for a particular program or benefit, including Blue Cross of Idaho, Spring Health, HealthEquity (Health Savings Account and Dependent Care Reimbursement Account), and Vision Service Plan (VSP).

Contingent Employee
A worker who is not considered an employee of J.R Simplot Company, with a relationship that is time-bound and non-permanent, dependent on the continued need for a job or project to be completed and is not paid any direct wages or benefits including but not limited to leased employees and independent contractors.

Dental Program Document
A document, maintained by Blue Cross of Idaho, that outlines the terms and conditions of the Dental Program, for which Blue Cross of Idaho is the Claims Administrator.

Dependent
Refer to Dependent in the **Plan Participation** section.

Dependent Care Reimbursement
A type of flexible spending account under the J.R. Simplot Company Flex Plan (the Flex Plan), as further described in the Flex Plan and summarized in the **Dependent Care Reimbursement Account** section.

Disabled/Disability
Substantially unable to be self-sufficient as the result of injury, sickness, accident, congenital defect, mental retardation, cerebral palsy, epilepsy, or other neurological disorder, and diagnosed by a physician as a permanent or long-term continuing condition. The determination as to whether a Dependent is disabled will be made by the Plan Administrator or its delegate, in its sole discretion.

Employee
A common-law employee of J.R. Simplot Company who is on J.R. Simplot Company's W-2 payroll, except that the term "Employee" does not include any individual classified by J.R. Simplot Company as a leased employee, contract worker, independent contractor, Contingent Employee, or Extern whether or not any such person is on J.R. Simplot Company's W-2 payroll.

Extern
A worker who is enrolled in, or recently graduated from, an accredited educational facility and does not receive wages or salary.

Flex Plan
J.R. Simplot Company Flex Plan, which is a Section 125 plan under the Internal Revenue Code and provides benefits some of which may not be subject to ERISA.

Health Coverage
Medical Program, Dental Program, Vision Program, International Welfare Benefits Program, Hawaii Medical Assurance Association (HMAA) Program, Hawaii Kaiser HMO Program, and Employee Assistance Program (EAP).

Health Maintenance Organization (HMO)
A health care organization, composed of medical care providers and affiliated health care institutions, that agree to provide a specified range of medical care for a fixed fee to individuals residing in its geographic service area.

Initiate the Enrollment
The act of beginning the enrollment process in the online benefits system or via phone with the Simplot Benefits Service Center. The date you Initiate the Enrollment will determine when coverage for certain benefits begins or ends.

Intern Employee
An Employee hired under the Company's internship program.

Medical Program Document
A document, maintained by Blue Cross of Idaho, that outlines the terms and conditions of the Medical Program, for which Blue Cross of Idaho is the Claims Administrator.

Military Leave of Absence
Is defined and described in the J.R. Simplot Company Leave Policy, available on *The Pulse* (pulse.simplot.com) from your local Human Resources Representative or HR Solutions, or by request at HRSolutions@simplot.com.

Participant
An Employee who has enrolled and is currently participating in one or more programs of the Plan.

Placement/Placed for Adoption
This means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

Plan
J.R. Simplot Company Group Health & Welfare Plan.

Plan Administrator
J.R. Simplot Company.

Plan Year
The Plan year is January 1 through December 31.

Program Document
A document, maintained by Blue Cross of Idaho, that outlines the terms and conditions of Health Coverage for which Blue Cross of Idaho is the Claims Administrator. See definition for Dental Program Document, Medical Program Document and Vision Program Document in this

section.

Qualified Medical Child Support Order (QMCSO)
This means a written judgment, order or decree by a court of competent jurisdiction that creates or recognizes the right of a Plan Participant's child (known as the alternate recipient) to receive health benefits under the Plan in situations where the parents are divorced or separated. In order to be "qualified", the court order has to provide the alternate recipient's name, last known mailing address, date of birth and the specific type and duration of coverage to be provided. A copy of the procedures governing Qualified Medical Child Support Orders (QMCSO) can be obtained from the Plan Administrator without charge.

Seasonal Employee
An Employee hired for a seasonal business need, but who does not meet the requirements of an ACA Seasonal Employee.

Service(s)
Services, treatments or other care.

Spouse
Your lawful husband or wife under applicable state law.

Temporary Employee
An Employee who is hired for a short term need but does not meet the definition of ACA Seasonal Employee, Seasonal Employee, or Turnaround Employee.

Turnaround Employee
An Employee who is:
- Hired at a single location to facilitate a scheduled plant or mine shutdown (aka turnaround); and
- Employed for 6 weeks or less.

Vision Program Document
A document, maintained by Blue Cross of Idaho, that outlines the terms and conditions of the Vision Program, for which Vision Service Plan (VSP) is the Claims Administrator.

Waiting Period
The period of time that must pass before an otherwise eligible individual who has properly enrolled is covered for benefits under the terms of the Plan.

APPENDIX A – MEDICARE PRESCRIPTION DRUG NOTICE

Important Notice from J.R. Simplot Company About Your Prescription Drug Coverage and Medicare

If you or a family member is eligible for Medicare, please read this notice carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage with J.R. Simplot Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. This notice applies to the Simplot Medical, the Hawaii Kaiser Health Maintenance Organization (HMO), the Hawaii Medical Assurance Association (HMAA) and the GeoBlue International Welfare Benefits programs provided through the J.R. Simplot Company Group Health and Welfare Plan.

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

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

2. J.R. Simplot Company has determined that the prescription drug coverage offered by the Simplot Medical, the Hawaii Kaiser Health Maintenance Organization (HMO), the Hawaii Medical Assurance Association (HMAA) and the GeoBlue International Welfare Benefits programs of the J.R. Simplot Company Group Health and Welfare Plan are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and are considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current J.R. Simplot Company coverage may be affected depending on which program you are enrolled in and whether your company coverage is primary or secondary. If your current J.R. Simplot Company coverage is primary under Medicare rules, then you can continue to participate in the prescription drug benefit under all Simplot medical programs, and the program will coordinate with your Medicare drug plan. If your current coverage is secondary under Medicare rules, then you should be aware that the prescription drug benefit for the Simplot Medical Program does not provide secondary coverage to other prescription drug plans; however, if your coverage is through the Hawaii Kaiser Health Maintenance Organization (HMO), the Hawaii Medical Assurance Association (HMAA) or the GeoBlue International Welfare Benefits programs, you can continue to participate in the prescription drug benefit, and the program will coordinate coverage with your Medicare drug plan. If you do decide to join a Medicare drug plan and drop your current Simplot coverage, be aware that you and your dependents will be able to get this coverage back at annual enrollment or upon occurrence of a qualifying event.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with J.R. Simplot Company and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage:

- Contact Simplot HR Solutions at 208-780-7500.

Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through J.R. Simplot Company changes. You may also request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage:

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.

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

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

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

Date: January 1, 2026 Version
Name of Entity/Sender: J.R. Simplot Company
Contact – Position Office: HR Solutions
Address: 1099 W. Front Street, Boise, ID 83702
Phone Number: 208-780-7500

APPENDIX B – NOTICE REGARDING WELLNESS PROGRAM

Simplot offers a voluntary wellness program available to all employees enrolled in the Medical Program of the J.R. Simplot Group Health and Welfare Plan who are also enrolled in and contributing to a Health Savings Account with HealthEquity. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be offered the opportunity to complete the Wellness (HSA) Incentive course in MySimplot and complete a preventive care service from a list of specified services. See the "Employer Contributions" portion of the Health Savings Account Program section in this document for more details.

You are not required to participate in the wellness program; however, employees who are eligible and choose to participate in the wellness program will receive an employer contribution to the employee's HSA of $400 for completing both the Wellness (HSA) Incentive course in MySimplot and the preventive care visit.

J.R. Simplot Company will not receive or use any information about your Wellness (HSA) Incentive course or your preventive care. J.R. Simplot Company will only be informed whether you have completed the wellness program requirements or not in order to determine whether to fund the employer contribution into your HSA.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. The wellness program will never disclose any of your personal information either publicly or to the employer, except as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program. You will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. The only individual(s) who will receive your personally identifiable health information is the provider from whom you choose to obtain your preventive services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. J.R. Simplot Company has contracted with Blue Cross of Idaho to administer the wellness program and ensure separation of your personal information from company records. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, you will be notified immediately.

You may not be discriminated against in employment as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Simplot HR Solutions at **(208) 780-7500** or **HRSolutions@simplot.com**.

APPENDIX C – BENEFIT INFORMATION REFERENCE SHEETS

This document supplements the terms of your Summary Plan Description (SPD) and should be kept with your other benefit plan materials.

CONTACT INFORMATION

COBRA/USERRA Continuation – Blue Cross of Idaho
If you want to continue your health coverage through COBRA and/or USERRA, return your completed COBRA enrollment form and first monthly payment to Blue Cross of Idaho. If you have other questions regarding the administration of your COBRA/USERRA coverage, call Blue Cross of Idaho at (855) 216-6850. Blue Cross of Idaho provides COBRA/USERRA administration services for the Self-Funded Medical, Dental, and Vision Programs, along with the insured Hawaii Kaiser HMO Program, Hawaii Medical Assurance Association (HMAA) Program, International Welfare Benefits Program, and Employee Assistance Program. **If you and/or your Dependent Qualified Beneficiaries do not elect COBRA/USERRA continuation coverage by completing and returning the election forms within the 60-day election period, you/they will lose the right to elect COBRA/USERRA coverage.**

Life & AD&D Insurance and Long-Term Disability Insurance – New York Life
If you want to port or convert your life insurance or file for extended life insurance coverage due to a disability, contact New York Life toll-free at (888) 842-4462. You must apply to port or convert your life insurance within 31 days after your insurance ends.

If you want to convert your Long-Term Disability insurance, contact New York Life toll-free at (888) 842-4462. You must apply to convert your Long-Term Disability insurance within 62 days after insurance under the policy ends or within 31 days of the date notice is given to apply for a converted policy or certificate, whichever is later.

Retirement Savings Plan - T. Rowe Price
For more information regarding your savings account, please contact T. Rowe Price at (800) 922-9945.

Health Savings Account /DCRA - HealthEquity
For more information regarding your Health Savings Account or Dependent Care Reimbursement Account, please contact HealthEquity at (877) 629-8234.

EAP – Spring Health
For more information, contact Spring Health at Simplot.springhealth.com or call 855-673-1194.

General Questions
If you have any other questions regarding your coverage, please contact the Simplot Benefit Service Center at (800) 254-3252.

This reference sheet is intended to supplement the Summary Plan Description (SPD) booklets for the J. R. Simplot Company Group Health & Welfare Plan. It also provides general information on other benefit programs available to J. R. Simplot Company employees. If there is a difference between this sheet and the applicable SPD or insurance contract(s), the latter will prevail. This sheet may change to align with plan, program, policy, or contract changes. To receive a copy of the most recent document, please contact the Simplot Benefit Service Center. This document effective date is January 1, 2026.

Benefit **Individuals may not be eligible for or enrolled in each program outlined below**	**Event: Death of Employee**
Simplot Medical Program (including prescription), Simplot Dental Program, Simplot Vision Program, EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Date of event for Employee. End of the month plus three additional months for dependents enrolled in Simplot Medical, Dental, and/or Vision (no premium expense for the additional three months).* **CONTINUATION OR CONVERSION:** *COBRA available for spouse and/or dependents as described in Summary Plan Description.*
Hawaii Kaiser HMO Program (medical, prescription, dental and vision), EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Date of event for Employee. EAP services will continue for an additional 30 days for dependents. Account must be active with EAP prior to termination.* **CONTINUATION OR CONVERSION:** *COBRA available for spouse and/or dependents as described in the HMO Group Service Agreement.*
HMAA Program (medical, prescription, dental and vision), EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Date of event for Employee. EAP services will continue for an additional 30 days for dependents. Account must be active with EAP prior to termination.* **CONTINUATION OR CONVERSION:** *COBRA available for spouse and/or dependents as described in the Description of Coverage.*
International Welfare Benefit, EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Date of event for Employee. End of the month plus three additional months for dependents (no premium expense for the additional three months).* **CONTINUATION OR CONVERSION:** *COBRA available for spouse and/or dependents as described in the Group Plan booklet.*
Dependent Care Reimbursement Account	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which event occurs.*
Health Savings Account (HSA)	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Date of event.* **CONTINUATION OR CONVERSION:** *If the Employee's spouse is the designated beneficiary, the HSA passes to the spouse and continues as an individual account (which may be subject to administrative fees). For other beneficiaries, the account stops being an HSA, and the fair market value of the HSA becomes taxable to the beneficiary(ies) in the year of the event.*
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Date of event.*

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Benefit **Individuals may not be eligible for or enrolled in each program outlined below**	**Event: Death of Employee**

Voluntary Life and AD&D Insurance	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Date of event.* **CONTINUATION, CONVERSION, OR PORTABILITY:** *Date of the event. Conversion or portability options may be available a subject to the requirements described in the Certificate of Coverage. Apply within 31 days of the coverage end date with New York Life.*
Disability Pay	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Date of event.*
Long-Term Disability	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Date of event.*
Retirement Savings Plans	**RETIREMENT SAVINGS PLAN:** *If the Employee has an account balance at T. Rowe Price, T. Rowe Price will need a copy of the death certificate. They will then retrieve the beneficiary designation information and set up an account in the beneficiary's name, and a PIN for the Plan Account Line will be generated and mailed. A Beneficiary Distribution Kit will then be mailed to the beneficiary's address of record. This kit will inform the beneficiary of their options with the account balance.*

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Benefit **Individuals may not be eligible for or enrolled in each program outlined below**	**Event: Disability Leave of Absence (Includes Occupational and Non-Occupational Leaves of Absence.** **If applicable, first 12 weeks will run concurrently with FMLA)**
Simplot Medical Program (including prescription), Simplot Dental Program, Simplot Vision Program, EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** T*he earlier of the end of the month in which the 180th day of consecutive disability leave is reached or the end of the month in which you are placed in a leave long term employment status. EAP services will continue for an additional 30 days. Account must be active with EAP prior to termination.* **CONTINUATION OR CONVERSION:** *COBRA available as described in Summary Plan Description. If your active coverage ends due to disability as described above, COBRA, with the exception of EAP, will be paid in part by the J.R. Simplot Company for the first six months. For this six month period, the Employee's contribution will continue to be the active coverage rate, converted to a per-month basis plus 2% administration fee.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Hawaii Kaiser HMO Program (medical, prescription, dental and vision), EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** T*he earlier of the end of the month in which the 180th day of consecutive disability leave is or the end of the month in which you are placed in a leave long term employment status. EAP services will continue for an additional 30 days. Account must be active with EAP prior to termination.* **CONTINUATION OR CONVERSION:** *COBRA available as described in the HMO Group Service Agreement. If your active coverage ends due to disability as described above, COBRA will be paid in part by the J.R. Simplot Company for the first six months. For this six month period, the Employee's contribution will continue to be the active coverage rate, converted to a per-month basis plus 2% administration fee.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
HMAA Program (medical, prescription, dental and vision), EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** T*he earlier of the end of the month in which the 180th day of consecutive disability leave is reached or the end of the month in which you are placed in a leave long term employment status. EAP services will continue for an additional 30 days. Account must be active with EAP prior to termination.* **CONTINUATION OR CONVERSION:** *COBRA available as described in the Description of Coverage. If your active coverage ends due to disability as described above, COBRA will be paid in part by the J.R. Simplot Company for the first six months. For this six month period, the Employee's contribution will continue to be the active coverage rate, converted to a per-month basis plus 2% administration fee.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*

This reference sheet is intended to supplement the Summary Plan Description (SPD) booklets for the J. R. Simplot Company Group Health & Welfare Plan. It also provides general information on other benefit programs available to J. R. Simplot Company employees. If there is a difference between this sheet and the applicable SPD or insurance contract(s), the latter will prevail. This sheet may change to align with plan, program, policy, or contract changes. To receive a copy of the most recent document, please contact the Simplot Benefit Service Center. This document effective date is January 1, 2026.

Benefit **Individuals may not be eligible for or enrolled in each program outlined below**	**Event:** **Disability Leave of Absence** **(Includes Occupational and Non-Occupational Leaves of Absence.** **If applicable, first 12 weeks will run concurrently with FMLA)**
International Welfare Benefit, EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *The earlier of the end of the month in which the 180th day of consecutive disability leave is reached or the end of the month in which you are placed in a leave long term employment status. EAP services will continue for an additional 30 days. Account must be active with EAP prior to termination.* **CONTINUATION OR CONVERSION:** *COBRA available as described in the Group Plan booklet. If your active coverage ends due to disability as described above, COBRA will be paid by the J. R. Simplot Company for the first six months.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Dependent Care Reimbursement Account	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *If FMLA runs concurrently, please refer to the FMLA Benefit Information Reference Sheet. Participation continues through the duration of the leave, the end of the month in which the 180th day of consecutive disability leave is reached, or the end of the month in which you are placed in a leave long term employment status, whichever is earlier. Contributions will be made through normal payroll salary reductions. If not possible, the Employer will fund the Employee's contributions and withhold "catch-up" amounts upon the Employee's return. However, the Employee may choose to waive Dependent Care Reimbursement during the leave. If chosen, coverage will cease at the end of the month in which the Employee waives coverage.* **CONTINUATION OR CONVERSION:** *Not applicable.* **REINSTATEMENT:** *Prior elections will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Health Savings Account	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *If FMLA runs concurrently, please refer to the FMLA Benefit Information Reference Sheet. Participation continues through the duration of the leave, the end of the month in which the 180th day of consecutive disability leave is reached, or the end of the month in which you are placed in a leave long term employment status, whichever is earlier. Contributions will be made through normal payroll salary reductions.* **CONTINUATION OR CONVERSION:** *Participation continues as an individual account and may be subject to administrative fees. If you no longer have coverage under an HSA eligible medical plan, proration of annual contribution limit may apply.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification and is enrolled in the Simplot Medical Program. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*

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Benefit **Individuals may not be eligible for or enrolled in each program outlined below**	**Event: Disability Leave of Absence (Includes Occupational and Non-Occupational Leaves of Absence.** **If applicable, first 12 weeks will run concurrently with FMLA)**
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *The earlier of (a) the date the Employee is determined not to be eligible for a Waiver of Premium, or (b) the date employment terminates.* **CONTINUATION, CONVERSION OR PORTABILITY:** *A totally disabled Employee may apply for an extension of life insurance coverage as described in the Certificate of Coverage. If the extension of life insurance is approved, AD&D coverage ends. If Life coverage ends a conversion option may be available. A portability option may also be available upon termination of employment. Extension, conversion or portability is subject to the requirements described in the Certificate of Coverage. Apply within 31 days of coverage end date with New York Life.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Voluntary Life and AD&D Insurance	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *The earlier of (a) the date the Employee is determined not to be eligible for a Waiver of Premium, or (b) the date employment terminates. Contributions will be made through normal payroll deductions. If not possible, the Employer will fund the Employee's contributions and withhold "catch-up" amounts upon the Employee's return.* **CONTINUATION, CONVERSION OR PORTABILITY:** *A totally disabled Employee may apply for an extension of life insurance coverage as described in the Certificate of Coverage. If the extension of life insurance is approved, AD&D coverage ends. If Life coverage ends, a conversion option may be available. A portability option may also be available upon termination of employment. Extension, conversion or portability is subject to the requirements described in the Certificate of Coverage. Apply within 31 days of coverage end date with New York Life.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Disability Pay	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Not applicable.* **CONTINUATION OR CONVERSION:** *Not applicable.* **REINSTATEMENT:** *Not applicable.*
Long-Term Disability	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Employee may pursue Disability benefit through LTD program. Contributions will be made through normal payroll deductions. If not possible, the Employer will fund the Employee's contributions and withhold "catch-up" amounts upon the Employee's return.* **CONTINUATION OR CONVERSION:** *Not applicable.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*

This reference sheet is intended to supplement the Summary Plan Description (SPD) booklets for the J. R. Simplot Company Group Health & Welfare Plan. It also provides general information on other benefit programs available to J. R. Simplot Company employees. If there is a difference between this sheet and the applicable SPD or insurance contract(s), the latter will prevail. This sheet may change to align with plan, program, policy, or contract changes. To receive a copy of the most recent document, please contact the Simplot Benefit Service Center. This document effective date is January 1, 2026.

Benefit **Individuals may not be eligible for or enrolled in each program outlined below**	**Event:** **Disability Leave of Absence** **(Includes Occupational and Non-Occupational Leaves of Absence.** **If applicable, first 12 weeks will run concurrently with FMLA)**

Retirement Savings Plans	**RETIREMENT SAVINGS PLAN:** *As long as employment continues, deferrals will be deducted from eligible pay. If the Employee has an outstanding loan and a partial loan repayment is deducted due to an insufficient pay check, T. Rowe Price will refund the repayment amount. The Employee is then responsible for making a manual repayment for the full bi-weekly repayment amount. If no pay is being received, the Employee continues to be responsible for the scheduled repayments. If insufficient or no pay is being received, the Employee may be eligible to suspend loan payments for up to 12 months from the date of the event. Contact T. Rowe Price at 1-800-922-9945 to request a Loan Repayment Kit for participants on a Leave of Absence. This kit will explain the Employee's options. Payments must be made by a certified check or money order. For more information regarding this Plan, please contact T. Rowe Price.*

This reference sheet is intended to supplement the Summary Plan Description (SPD) booklets for the J. R. Simplot Company Group Health & Welfare Plan. It also provides general information on other benefit programs available to J. R. Simplot Company employees. If there is a difference between this sheet and the applicable SPD or insurance contract(s), the latter will prevail. This sheet may change to align with plan, program, policy, or contract changes. To receive a copy of the most recent document, please contact the Simplot Benefit Service Center. This document effective date is January 1, 2026.

Benefit **Individuals may not be eligible for or enrolled in each program outlined below**	**Event:** **Family Medical Leave of Absence (FMLA and State) and Other Government Required Leaves** **(To be used in conjunction with other applicable Benefit Information Reference Sheets, for example, Disability and Personal Leaves of Absence)**
Simplot Medical Program (including prescription), Simplot Dental Program, Simplot Vision Program, EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Not applicable.* **CONTINUATION OR CONVERSION:** *Coverage continues for the duration of the leave. Contributions will be made through normal payroll salary reductions. If not possible, the Employer will fund the Employee's contributions and withhold "catch-up" amounts upon the Employee's return.* **REINSTATEMENT:** *Not applicable.*
Hawaii Kaiser HMO Program (medical, prescription, dental, and vision), EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Not applicable.* **CONTINUATION OR CONVERSION:** *Coverage continues for the duration of the leave. Contributions will be made through normal payroll salary reductions. If not possible, the Employer will fund the Employee's contributions and withhold "catch-up" amounts upon the Employee's return.* **REINSTATEMENT:** *Not applicable.*
HMAA Program (medical, prescription, dental, and vision), EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Not applicable.* **CONTINUATION OR CONVERSION:** *Coverage continues for the duration of the leave. Contributions will be made through normal payroll salary reductions. If not possible, the Employer will fund the Employee's contributions and withhold "catch-up" amounts upon the Employee's return.* **REINSTATEMENT:** *Not applicable.*
International Welfare Benefit, EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Not applicable.* **CONTINUATION OR CONVERSION:** *Coverage continues for the duration of the leave.* **REINSTATEMENT:** *Not applicable.*
Dependent Care Reimbursement Account	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Not applicable.* **CONTINUATION OR CONVERSION:** *If you choose to continue this benefit, participation continues for the duration of the leave. Contributions will be made through normal payroll salary reductions. If not possible, the Employer will fund the Employee's contributions until the earlier of Employee's return or the end of the calendar year in which the event occurs and withhold "catch-up" amounts upon the Employee's return. However, the Employee may choose to waive Dependent Care Reimbursement during the leave. If waived, the coverage will cease at the end of the month in which the Employee waives coverage.* **REINSTATEMENT:** *Not applicable. If the Employee chooses to terminate participation during leave, the Employee may enroll effective the first of the month following return to work.*
Health Savings Account	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Not applicable.* **CONTINUATION OR CONVERSION:** *Participation continues for the duration of the leave. Contributions will be made through normal payroll salary reductions.* **REINSTATEMENT:** *Not applicable.*

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Benefit **Individuals may not be eligible for or enrolled in each program outlined below**	**Event:** **Family Medical Leave of Absence (FMLA and State) and Other Government Required Leaves** **(To be used in conjunction with other applicable Benefit Information Reference Sheets, for example, Disability and Personal Leaves of Absence)**

Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Coverage ends at the end of the approved period of leave under FMLA.* **CONTINUATION:** *Coverage continues for the duration of the leave, as provided under the federal Family and Medical Leave Act.* **REINSTATEMENT:** *If coverage ends, it will be reinstated as provided under the federal Family and Medical Leave Act.*
Voluntary Life and AD&D Insurance	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Coverage ends at the end of the approved period of leave under FMLA.* **CONTINUATION:** *Coverage may be continued for the duration of the leave, as provided under the federal Family and Medical Leave Act. Any Employee contributions will be collected upon the Employee's return to work.* **REINSTATEMENT:** *If coverage ends, it will be reinstated as provided under the federal Family and Medical Leave Act.*
Disability Pay	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Not applicable.* **CONTINUATION OR CONVERSION:** *Not applicable.* **REINSTATEMENT:** *Not applicable.*
Long-Term Disability	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Coverage ends at the end of the approved period of leave under FMLA.* **CONTINUATION OR CONVERSION:** *Coverage may be continued for the duration of the leave, as provided under the federal Family and Medical Leave Act. Contributions will be made through normal payroll deductions. If not possible, the Employer will fund the Employee's contributions and withhold "catch-up" amounts upon the Employee's return.* **REINSTATEMENT:** *If coverage ends, it will be reinstated as provided under the federal Family and Medical Leave Act.*
Retirement Savings Plans	**RETIREMENT SAVINGS PLAN:** *As long as employment continues, deferrals will be deducted from eligible pay. If the Employee has an outstanding loan and a partial loan repayment is deducted due to an insufficient paycheck, T. Rowe Price will refund the repayment amount. The Employee is then responsible for making a manual repayment for the full bi-weekly repayment amount. If no pay is being received, the Employee continues to be responsible for the scheduled repayments. Contact T. Rowe Price at 1-800-922-9945 to request a Loan Repayment Kit for participants on a Leave of Absence. This kit will explain the Employee's options. Payments must be made by a certified check or money order. For more information regarding this Plan, please contact T. Rowe Price.*

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Benefit **Individuals may not be eligible for or enrolled in each program outlined below**	**Event: Military Leave of Absence**

Simplot Medical Program (including prescription), Simplot Dental Program, Simplot Vision Program, EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which event occurs, plus three months USERRA coverage if elected. EAP services will continue for an additional 30 days. Account must be active with EAP prior to termination. Contributions will be made through normal payroll salary reductions. If not possible, the Employer will fund the Employee's contributions and withhold "catch-up" amounts upon the Employee's return.* **CONTINUATION OR CONVERSION:** Continued *USERRA/COBRA is available as described in the Summary Plan Description. USERRA coverage runs concurrently with COBRA coverage.* **REINSTATEMENT:** *Coverage will be reinstated immediately upon return to work, provided proper notification is made as outlined in the Simplot Leave Policy.*
Hawaii Kaiser HMO Program (medical, prescription, dental and vision), EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which event occurs plus three months USERRA coverage if elected. EAP services will continue for an additional 30 days. Account must be active with EAP prior to termination. Contributions will be made through normal payroll salary reductions. If not possible, the Employer will fund the Employee's contributions and withhold "catch-up" amounts upon the Employee's return.* **CONTINUATION OR CONVERSION:** Continued *USERRA/COBRA is available as described in the HMO Group Service Agreement. USERRA coverage runs concurrently with COBRA coverage.* **REINSTATEMENT:** *Coverage will be reinstated immediately upon return to work, provided proper notification is made as outlined in the Simplot Leave Policy.*
HMAA Program (medical, prescription, dental and vision), EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which event occurs plus three months USERRA coverage if elected. EAP services will continue for an additional 30 days. Account must be active with EAP prior to termination. Contributions will be made through normal payroll salary reductions. If not possible, the Employer will fund the Employee's contributions and withhold "catch-up" amounts upon the Employee's return.* **CONTINUATION OR CONVERSION:** Continued *USERRA/COBRA is available as described in the Description of Coverage. USERRA coverage runs concurrently with COBRA coverage.* **REINSTATEMENT:** *Coverage will be reinstated immediately upon return to work, provided proper notification is made as outlined in the Simplot Leave Policy.*
International Welfare Benefit, EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which event occurs. EAP services will continue for an additional 30 days. Account must be active with EAP prior to termination.* **CONTINUATION OR CONVERSION:** Continued USERRA/*COBRA is available as described in the Group Plan booklet or Summary Plan Description. USERRA coverage runs concurrently with COBRA coverage.* **REINSTATEMENT:** *Coverage will be reinstated immediately upon return to work, provided proper notification is made as outlined in the Simplot Leave Policy.*

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Benefit **Individuals may not be eligible for or enrolled in each program outlined below**	**Event: Military Leave of Absence**

Dependent Care Reimbursement Account	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which event occurs, plus three months USERRA coverage if elected, or if earlier, end of the calendar year. Contributions will be made through normal payroll salary reductions. If not possible, the Employer will fund the Employee's contributions until the earlier of employee's return or the end of the calendar year in which the event occurs and withhold "catch-up" amounts upon the Employee's return.* **CONTINUATION OR CONVERSION:** *Not applicable.* **REINSTATEMENT:** *If coverage terminates during leave, the Employee may enroll effective the first of the month following return to work.*
Health Savings Account (HSA)	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which event occurs.* **CONTINUATION OR CONVERSION:** *Participation continues as an individual account and may be subject to administrative fees. If you no longer have coverage under an HSA eligible medical plan, proration of annual contribution limit may apply.* **REINSTATEMENT:** *Eligibility will be reinstated immediately upon return to work, provided proper notification is made as outlined in the Simplot Leave Policy and the employee is enrolled in the Simplot Medical Program.*
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which event occurs, plus an additional 3 months.* **CONVERSION:** *Conversion option may be available for Life coverage only, subject to the requirements described in the Certificate of Coverage. Apply within 31 days of coverage end date with New York Life.* **REINSTATEMENT:** *Coverage will be reinstated immediately upon return to work, provided proper notification is made as outlined in the Simplot Leave Policy.*
Voluntary Life and AD&D Insurance	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which event occurs, plus an additional 3 months. Contributions will be made through normal payroll deductions. If not possible, the Employer will fund the Employee's contributions and withhold "catch-up" amounts upon the Employee's return.* **CONVERSION:** *Conversion option may be available for all life insurance for the Employee and Voluntary life insurance for the spouse and children, subject to the requirements described in the Certificate of Coverage. Apply within 31 days of coverage end date with New York Life.* **REINSTATEMENT:** *Coverage will be reinstated immediately upon return to work, provided proper notification is made as outlined in the Simplot Leave Policy.*
Disability Pay	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Date of event.* **CONTINUATION OR CONVERSION:** *Not applicable.* **REINSTATEMENT:** *Coverage will be reinstated immediately upon return to work, provided proper notification is made as outlined in the Simplot Leave Policy.*

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Benefit **Individuals may not be eligible for or enrolled in each program outlined below**	**Event:** **Military Leave of Absence**

Long-Term Disability	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which event occurs plus an additional 3 months if elected. Contributions will be made through normal payroll deductions. If not possible, the Employer will fund the Employee's contributions and withhold "catch-up" amounts upon the Employee's return.* **CONTINUATION OR CONVERSION:** *Conversion option available if Employee has been enrolled for 12 consecutive months. Apply with New York Life within 62 days after coverage ends or within 31 days of the date notice is given to apply for a converted policy or certificate, whichever is later with New York Life.* **REINSTATEMENT:** *Upon return to active work within 9 months, in a benefit eligible classification, coverage may be reinstated; otherwise, initial eligibility requirements apply.*
Retirement Savings Plans	**RETIREMENT SAVINGS PLAN:** *Employee contributions may be made-up upon return to work. Employer matching contributions will also be made up, but only to the extent that eligible Employee contributions are made up. Upon return, the Retirement Contribution provision (RCP), if applicable, will be made up at the appropriate percentage. The compensation used to determine this contribution will be calculated at the rate the Employee would have earned if not on leave. If the Employee has an outstanding loan from the Plan and is receiving supplemental pay while on Military Leave of Absence, the loan repayments will continue to be deducted. If employee is not receiving pay, then loan repayments will be suspended during period of Qualified Military Service. This suspension will not cause the loan to be deemed. When the Employee returns to work, the loan repayments will resume with the first check at the same repayment amount. If the loan was suspended, the loan period will be extended by adding the period of military service to the maturity date of the original loan. Please contact Simplot HR Solutions for more information.*

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Benefit **Individuals may not be eligible for or enrolled in each program outlined below**	**Event: Not Scheduled to Work or Paid Administrative Leave**
Simplot Medical Program (including prescription), Simplot Dental Program, Simplot Vision Program, EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION:** *Coverage continues through the balance of the calendar year for which benefit eligibility has been established or the balance of the approved Administrative Leave period as applicable. Employer will fund the Employee's contribution and withhold "catch up" amounts upon the Employee's return to work if necessary.*
Hawaii Kaiser HMO Program (medical, prescription, dental and vision), EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION:** *Coverage continues through the balance of the calendar year for which benefit eligibility has been established or the balance of the approved Administrative Leave period as applicable. Employer will fund the Employee's contribution and withhold "catch up" amounts upon the Employee's return to work if necessary.*
HMAA Program (medical, prescription, dental and vision), EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION:** *Coverage continues through the balance of the calendar year for which benefit eligibility has been established or the balance of the approved Administrative Leave period as applicable. Employer will fund the Employee's contribution and withhold "catch up" amounts upon the Employee's return to work if necessary.*
International Welfare Benefit, EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION:** *Coverage continues through the balance of the calendar year for which benefit eligibility has been established or the balance of the approved Administrative Leave as applicable. Employer will fund the Employee's contribution and withhold "catch up" amounts upon the Employee's return to work if necessary.*
Dependent Care Reimbursement Account	**ACTIVE EMPLOYEE PARTICIPATION:** *If the Employee chooses to continue this benefit, participation continues through the balance of the calendar year for which benefit eligibility has been established or the balance of the approved Administrative Leave period as applicable. Employer will fund the Employee's contribution and withhold "catch up" amounts upon the Employee's return to work if necessary. The Employee may choose to waive the coverage if the Employee will be off work for more than two consecutive weeks. In this case, the coverage will cease at the end of the month in which the Employee waives the coverage. Upon return to work the Employee may enroll with coverage effective the first of the month following the date you return to work.*
Health Savings Account (HSA)	**ACTIVE EMPLOYEE PARTICIPATION:** *Participation continues through the balance of the calendar year for which benefit eligibility has been established or the balance of the approved Administrative Leave period as applicable. Contributions will be made through normal payroll salary reductions.*

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Benefit **Individuals may not be eligible for or enrolled in each program outlined below**	**Event: Not Scheduled to Work or Paid Administrative Leave**

Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	**ACTIVE EMPLOYEE PARTICIPATION:** *Coverage continues for the balance of the calendar year for which benefit eligibility has been established or the balance of the approved Administrative Leave period as applicable.*
Voluntary Life and AD&D Insurance	**ACTIVE EMPLOYEE PARTICIPATION:** *Coverage continues through the balance of the calendar year for which benefit eligibility has been established or the balance of the approved Administrative Leave period as applicable. Employer will fund the Employee's contribution and withhold "catch up" amounts upon the Employee's return to work if necessary.*
Disability Pay	**ACTIVE EMPLOYEE PARTICIPATION:** Coverage *continues through the balance of the calendar year for which benefit eligibility has been established or the balance of the approved Administrative Leave period as applicable.*
Long-Term Disability	**ACTIVE EMPLOYEE PARTICIPATION:** *Coverage continues through the balance of the calendar year for which benefit eligibility has been established or the balance of the approved Administrative Leave period as applicable. Employer will fund the Employee's contribution and withhold "catch up" amounts upon the employee's return to work if necessary.*
Retirement Savings Plans	**RETIREMENT SAVINGS PLAN:** *As long as employment continues, deferrals will be deducted from eligible pay. If the Employee is eligible for the Retirement Contribution provision (RCP), Company contributions will continue as long as the Employee continues to have eligible earnings. If the Employee has an outstanding loan and a partial loan repayment is deducted due to an insufficient pay check, T. Rowe Price will refund the repayment amount. The Employee is then responsible for making a manual repayment for the full bi-weekly repayment amount. If no pay is being received, the Employee continues to be responsible for the scheduled repayments. Contact T. Rowe Price at 1-800-922-9945 to request a Loan Repayment Kit for participants on a Leave of Absence. This kit will explain the Employee's options. Payments must be made by a certified check or money order. For more information regarding this Plan, please contact T. Rowe Price.*

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Benefit **Individuals may not be eligible for or enrolled in each program outlined below**	**Event: Personal Leave of Absence or Unpaid Administrative Leave**
Simplot Medical Program (including prescription), Simplot Dental Program, Simplot Vision Program, EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *The earlier of (1) the end of the month in which your leave ends (not to exceed 12 weeks), or (2) the end of the month in which termination occurs. EAP services will continue for an additional 30 days. Account must be active with EAP prior to termination. Employer will fund the Employee's contribution and withhold "catch up" amounts upon the Employee's return to work or from final pay in the event of termination.* **CONTINUATION OR CONVERSION:** *COBRA available as described in Summary Plan Description.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Hawaii Kaiser HMO Program (medical, prescription, dental, and vision), EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *The earlier of (1) the end of the month in which your leave ends (not to exceed 12 weeks), or (2) the end of the month in which termination occurs. EAP services will continue for an additional 30 days. Account must be active with EAP prior to termination. Employer will fund the Employee's contribution and withhold "catch up" amounts upon the Employee's return to work or from final pay in the event of termination.* **CONTINUATION OR CONVERSION:** *COBRA available as described in the HMO Group Service Agreement.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
HMAA Program (medical, prescription, dental, and vision), EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *The earlier of (1) the end of the month in which your leave ends (not to exceed 12 weeks), or (2) the end of the month in which termination occurs. EAP services will continue for an additional 30 days. Account must be active with EAP prior to termination. Employer will fund the Employee's contribution and withhold "catch up" amounts upon the Employee's return to work or from final pay in the event of termination.* **CONTINUATION OR CONVERSION:** *COBRA available as described in the Description of Coverage.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*

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Benefit **Individuals may not be eligible for or enrolled in each program outlined below**	**Event: Personal Leave of Absence or Unpaid Administrative Leave**
International Welfare Benefit, EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *The earlier of (1) the end of the month in which your leave ends (not to exceed 12 weeks), or (2) the end of the month in which termination occurs. Employer will fund the Employee's contribution and withhold "catch up" amounts upon the Employee's return to work or from final pay in the event of termination.* **CONTINUATION OR CONVERSION:** *COBRA available as described in the Group Plan booklet.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Dependent Care Reimbursement Account	**ACTIVE EMPLOYEE PARTICIPATION ENDS**: *If employee choses to continue coverage, the earlier of (1) the end of the month in which your leave ends (not to exceed 12 weeks), or (2) the end of the month in which termination occurs. If you choose to continue this benefit, the Employer will fund the Employee's contribution and withhold "catch up" amounts upon the Employee's return to work or from final pay in the event of termination. The Employee may choose to waive Dependent Care Reimbursement during the leave, and if so, coverage will cease at the end of the month in which Employee waives coverage.* **CONTINUATION OR CONVERSION:** *The Employer will fund the Employee's contributions and withhold "catch-up" amounts upon the Employee's return.* **REINSTATEMENT:** *Prior elections will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Health Savings Account (HSA)	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *The earlier of (1) the end of the month in which your leave ends (not to exceed 12 weeks), or (2) the end of the month in which termination occurs.* **CONTINUATION OR CONVERSION:** *Participation continues as an individual account and may be subject to administrative fees. If you no longer have coverage under an HSA eligible medical plan, proration of annual contribution limit may apply.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification an is enrolled in the Simplot Medical Program. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *The earlier of (1) the end of the month in which your leave ends (not to exceed 12 weeks), or (2) the end of the month in which termination occurs. Employer will fund the Employee's contribution and withhold "catch up" amounts upon the Employee's return to work or from final pay in the event of termination.* **CONVERSION:** *Conversion option may be available for Life coverage only, subject to the requirements described in the Certificate of Coverage. Apply within 31 days of coverage end date with New York Life.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*

Benefit **Individuals may not be eligible for or enrolled in each program outlined below**	**Event:** **Personal Leave of Absence or Unpaid Administrative Leave**
Voluntary Life and AD&D Insurance	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *The earlier of (1) the end of the month in which your leave ends (not to exceed 12 weeks), or (2) the end of the month in which termination occurs. Employer will fund the Employee's contribution and withhold "catch up" amounts upon the Employee's return to work or from final pay in the event of termination.* **CONVERSION:** *Conversion option may be available for all life insurance for Employee, spouse and children, subject to the requirements described in the Certificate of Coverage. Apply within 31 days of coverage end date with New York Life.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Disability Pay	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Date of event.* **CONTINUATION OR CONVERSION:** *Not applicable.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Long-Term Disability	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *The earlier of (1) the end of the month in which your leave ends (not to exceed 12 weeks), or (2) the end of the month in which termination occurs. Employer will fund the Employee's contribution and withhold "catch up" amounts upon the Employee's return to work or from final pay in the event of termination.* **CONTINUATION OR CONVERSION:** *Conversion option available if Employee has been enrolled for 12 consecutive months. Apply with New York Life within 62 days after coverage ends or within 31 days of the date notice is given to apply for a converted policy or certificate, whichever is later.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Retirement Savings Plans	**RETIREMENT SAVINGS PLAN:** *If the Employee has an outstanding loan the Employee continues to be responsible for the scheduled repayments. Contact T. Rowe Price at 1-800-922-9945 to request a Loan Repayment Kit for participants on a Leave of Absence. This kit will explain the Employee's options. Payments must be made by a certified check or money order. For more information regarding this Plan, please contact T. Rowe Price.*

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Benefit **Individuals may not be eligible for or enrolled in each program outlined below**	**Event: Voluntary Termination, Involuntary Termination, Transfer to Ineligible Benefit Status, Reduced Hours of Employment, Reduction in Force, Plant Closure, Strike**
Simplot Medical Program (including prescription), Simplot Dental Program, Simplot Vision Program, EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which event occurs. EAP services will continue for an additional 30 days. Account must be active with EAP prior to termination.* **CONTINUATION OR CONVERSION:** *COBRA available as described in Summary Plan Description. If termination results from Reduction in Force or Plant Closure, COBRA will be paid in part by J.R. Simplot Company for the first three months. For this three month period, the Employee's contribution will continue to be the active coverage rate, converted to a per-month basis plus 2% administration fee.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Hawaii Kaiser HMO Program (medical, prescription, dental and vision), EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which event occurs. EAP services will continue for an additional 30 days. Account must be active with EAP prior to termination.* **CONTINUATION OR CONVERSION:** *COBRA available as described in the HMO Group Service Agreement. If termination results from Reduction in Force or Plant Closure, COBRA will be paid in part by J.R. Simplot Company for the first three months. For this three month period, the Employee's contribution will continue to be the active coverage rate, converted to a per-month basis plus 2% administration fee* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
HMAA Program (medical, prescription, dental and vision), EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which event occurs. EAP services will continue for an additional 30 days. Account must be active with EAP prior to termination.* **CONTINUATION OR CONVERSION:** *COBRA available as described in the Description of Coverage. If termination results from Reduction in Force or Plant Closure, COBRA will be paid in part by J.R. Simplot Company for the first three months. For this three month period, the Employee's contribution will continue to be the active coverage rate, converted to a per-month basis plus 2% administration fee* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*

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International Welfare Benefit, EAP Program and associated Premium Payment Program	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which event occurs. EAP services will continue for an additional 30 days. Account must be active with EAP prior to termination.* **CONTINUATION OR CONVERSION:** *COBRA available as described in the Group Plan booklet. If termination results from Reduction in Force or Plant Closure, COBRA will be paid by J. R. Simplot Company for the first three months.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Dependent Care Reimbursement Account	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which the event occurs. Claims for reimbursement must be made no later than 30 days following termination.* **CONTINUATION OR CONVERSION:** *Not applicable.* **REINSTATEMENT:** *Prior elections will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Health Savings Account (HSA)	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which event occurs.* **CONTINUATION OR CONVERSION:** *Participation continues as an individual account and may be subject to administrative fees. If you no longer have coverage under an HSA eligible medical plan, proration of annual contribution limit may apply.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification and is enrolled in the Simplot Medical Program. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which event occurs.* **CONTINUATION, CONVERSION OR PORTABILITY:** *Conversion or portability options may be available, subject to the requirements described in the Certificate of Coverage. Apply within 31 days of coverage end date with New York Life. If termination is due to employee's disability, the employee may apply for an extension of life insurance coverage as described in the Certificate of Coverage.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Voluntary Life and AD&D Insurance	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which event occurs.* **CONTINUATION, CONVERSION OR PORTABILITY:** *Conversion or portability options may be available for the Employee, spouse and children subject to the requirements described in the Certificate of Coverage. Apply within 31 days of coverage end date with New York Life. If termination is due to employee's disability, the employee may apply for an extension of life insurance coverage as described in the Certificate of Coverage.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*

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Benefit **Individuals may not be eligible for or enrolled in each program outlined below**	**Event: Voluntary Termination, Involuntary Termination, Transfer to Ineligible Benefit Status, Reduced Hours of Employment, Reduction in Force, Plant Closure, Strike**
Disability Pay	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *Date of event.* **CONTINUATION OR CONVERSION:** *Not applicable.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Long-Term Disability	**ACTIVE EMPLOYEE PARTICIPATION ENDS:** *End of the month in which event occurs.* **CONTINUATION OR CONVERSION:** *Conversion option available, if Employee has been enrolled for 12 months. Apply with New York Life within 62 days after coverage ends or within 31 days of the date notice is given to apply for a converted policy or certificate, whichever is later.* **REINSTATEMENT:** *Coverage will be reinstated the first of the month following return to active work, provided the Employee returns within 30 days of the date of loss of coverage in a benefit eligible classification. Initial eligibility requirements apply if return to work occurs in excess of 30 days following loss of coverage.*
Retirement Savings Plan	**RETIREMENT SAVINGS PLAN:** *For Transfer to Ineligible Benefit Status, Reduced Hours of Employment and Strike, employees continue active participation in the savings plan. For all other events the Employee's termination date will be sent to T. Rowe Price. If the Employee has a vested account balance, a Termination Kit will be sent to the Employee's address of record. If the account balance is less than $5,000.00, the Employee will be notified that they will need to remove their money within 30 days of the date the termination kit was sent. If the Employee has an outstanding loan, arrangements can be made to continue monthly repayments or to pay off the loan in full. If arrangements are not made regarding the loan, it will go into default and become immediately taxable. The Termination Kit will explain the options that the Employee has with their account balance and outstanding loan, if applicable. For information regarding this Plan, please contact T. Rowe Price at (800) 922-9945.*

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