Ingredion Incorporated
Master Retiree Welfare Plan

Summary Plan Description

July 2019

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Overview of this Summary Plan Description and the Retirement Health Care Spending Accounts (RHCSAs)

Under the Ingredion Incorporated Master Retiree Welfare Plan (the "Plan") you and your eligible spouse and dependents have access to quality health care and can use the Retirement Health Care Spending Accounts, or RHCSAs, that you accrued under the Ingredion Master Welfare and Cafeteria Plan (the "Master Welfare Plan") to help you pay for that health care coverage after you retire.

If you were a full-time salaried employee who was regularly scheduled to work at least 40 hours per week at Ingredion Incorporated (the "Company") and you retired on or after age 55 with 10 or more consecutive years of credited service, you will have two RHCSAs accrued under the Master Welfare Plan for your use—one for your medical and dental coverage up to the date of Medicare eligibility for yourself and one of equal value to use for medical and dental coverage up to the date of Medicare eligibility for your eligible spouse and dependents (as defined by the Plan). As an eligible retiree (a "Retiree"), you will also be eligible to continue Company-provided medical and dental benefits up to age 65 and receive life insurance benefits, as described in this summary.[1]

However, note that the following important changes were made to the Plan effective January 1, 2015:

- If you were not a Retiree prior to January 1, 2015, you will be eligible for retiree medical benefits under the RHCSA when you retire only if as of December 31, 2014 you were an active employee of the Company who had either (1) reached age 55 with at least 10 years of vesting service under the Company's Cash Balance Plan for Salaried Employees (the "Cash Balance Plan") or (2) reached age 45 with 15 years of vesting service under the Cash Balance. All other balances have been eliminated, so if you do not meet the foregoing requirements, you do not have a balance for use under the RHCSA.
- If you continue to be eligible to participate in the Plan per the foregoing requirements, you will not receive any additional spending credits on your account. In addition, the minimum interest credit on balances for use under the RHCSA has been reduced from 5.25% to 3%.
- All retiree life insurance under the Plan has been eliminated for all persons other than persons who retired prior to January 1, 2015.

This booklet, together with the insurance policy or certificate provided by your life insurance provider, is intended to constitute a summary plan description (SPD) under the Employee Retirement Income Security Act of 1974. This booklet summarizes and explains the most important features of the Plan and describes how the Plan works. It is intended to be an easy-to-understand summary of the general features of the Plan.

You probably will want to read this booklet more carefully as you get closer to retirement. But it's a good idea to have a general understanding of your retirement benefits now, even if you're just starting your career.

The Plan also includes as a component plan the "Salaried Retiree Medical Program for Former Employees of National Starch LLC" for the benefit of each eligible former employee of National Starch

[1] Notwithstanding anything in this SPD to the contrary, no person who was hired by National Starch LLC prior to January 1, 2006 and who had attained age 40 as of January 1, 2006 will be eligible to participate in the Plan.

LLC who was hired by National Starch LLC as a salaried employee before January 1, 2006 and was 40 years of age or older as of such date. The terms of such component plan are set forth in a separate SPD entitled the "Salaried Retiree Medical Program for Former Employees of National Starch LLC Component of the Ingredion Incorporated Master Retiree Welfare Plan".

However, any active legacy National Starch employees who met the grandfathered requirements set forth above as of December 31, 2014 transitioned to the RHCSA spending accounts on January 1, 2015 and will no longer be eligible for any benefits under the Salaried Retiree Medical Program for Former Employees of National Starch LLC Component of the RHCSA. If you are a legacy National Starch employee and were actively employed by the Company on December 31, 2014, on January 1, 2015 you were provided with a RHCSA account balance to be used to pay for retiree medical and/or dental coverage when you retire under the circumstances set forth in the RHCSA. Your RHCSA account balance will be determined based on your years of service with both Ingredion and National Starch.

RHCSA participants who retired prior to January 1, 2015 will remain eligible for the retiree benefits they participated in when they retired (*i.e*., participants in the National Starch Retiree Component will remain eligible for that program, and legacy RHCSA participants will remain eligible for benefits under the RHCSA, subject in each case to the applicable plan's terms).

If you have any questions after reading this material, please contact the Company's Human Resources Department.

This booklet is meant to be only a summary of the provisions of the Ingredion Incorporated Master Retiree Welfare Plan. Complete details are included in the official Plan document. If there is a conflict between the information contained in this booklet and the plan document, the Plan document always will govern.

Eligibility

To be eligible for benefits under the Plan, you either (1) must have been a "Retiree" under the terms of the Plan prior to January 1, 2015, or (2) were an active employee of the Company as of December 31, 2014 who had either (A) reached age 55 with at least 10 years of vesting service under the Cash Balance Plan or (B) reached age 45 with 15 years of vesting service under the Cash Balance Plan. All other balances have been eliminated, so if you do not meet the foregoing requirements, you do not have a balance for use under the RHCSA.

You will only be eligible to use your RHCSAs if you retire after reaching age 55 with at least 10 consecutive years of credited service. If you meet these age and service requirements at the time of your retirement and are not yet eligible for Medicare, then you will be eligible to elect coverage which mirrors the coverage under the Medical and Dental Component Plan options available to active employees of the Company (other than medical spending accounts or any pre-tax contribution feature of a "cafeteria plan" under section 125 of the Code and excluding any benefits required to be provided under the Patient Protection and Affordable Care Act by plans other than retiree-only plans) (a "Retiree Plan")) and use your RHCSA to pay for the cost of such coverage until you become eligible for Medicare or the RHCSA is depleted.

If you retired from the Company prior to January 1, 2015, you will also be eligible for retiree life insurance if you participated as an active employee in the Company's basic life insurance plan prior to your retirement; however, effective January 1, 2015 all retiree life insurance under the Plan has been eliminated for all persons other than persons who retired prior to January 1, 2015.

If you are a part-time salaried employee (regularly scheduled to work less than 40 hours per week at the Company), you will not be eligible for accrual of any RHCSA amounts but if you retire at age 55 or older with at least 10 consecutive years of credited service, you will be eligible to elect coverage for yourself and your eligible spouse and dependents under any of the Medical and Dental options which mirror the options available to active employees of the Company until you become eligible for Medicare.

You must elect such coverage within 30 days of your retirement. If you do not elect coverage within 30 days of your retirement, you will forfeit your right to retiree medical and dental coverage and you will not be eligible to elect such coverage at any time in the future.

You can change your election every year during open enrollment. You will not be able to change your coverage at any other time during the year, even if you experience a change in family status as defined by the Internal Revenue Service ("IRS"). If you elect coverage at the time of your retirement, but you drop coverage at a future date, then you will not be able to reenroll.

You will pay the full cost of this coverage with after-tax dollars.

Access to this coverage for retired employees and their dependents will end:

- For you, on the date you become Medicare-eligible,
- For your spouse or dependent, on the date he or she loses eligibility under the plans which mirror the Company's Medical and Dental Component Plans or becomes Medicare-eligible,
- For you, your spouse and dependents, on your death, or
- For you, your spouse and dependents, on the date you fail to pay the required premiums.

Ineligible Employees

You are **not** eligible to participate if you are:

- covered by a collective bargaining agreement,

- considered to be a temporary employee, fee-for-service worker, leased employee or independent contractor,
- not a U.S. citizen or resident alien,
- otherwise not designated on the Company's payroll as a regular employee or
- not, as of December 31, 2014, an active employee of the Company who has either (1) reached age 55 with at least 10 years of vesting service under the Cash Balance Plan or (2) reached age 45 with 15 years of vesting service under the Cash Balance Plan.

Moreover, if you are not treated as a common-law employee by the Company on its payroll, you will not be eligible for any benefits described in this SPD even if a court of law or administrative agency later determines that you are a common-law employee of the Company.

Notwithstanding anything in this SPD to the contrary, no person who was hired by National Starch LLC prior to January 1, 2006 and who had attained age 40 as of January 1, 2006 will be eligible to participate in the Plan. Any National Starch LLC employee (1) who was hired by National Starch LLC on or after January 1, 2006 or (2) who was hired by National Starch LLC prior to January 1, 2006 but who had not yet reached age 40 as of January 1, 2006 may be eligible to participate in the Plan, subject to its terms, but only upon reaching age 40. However, any active legacy National Starch employees who met the grandfathered requirements set forth in the first paragraph above as of December 31, 2014 transitioned to the RHCSA spending accounts on January 1, 2015 and will no longer be eligible for any benefits under the Salaried Retiree Medical Program for Former Employees of National Starch LLC Component of the RHCSA. If you are a legacy National Starch employee and were actively employed by the Company on December 31, 2014, on January 1, 2015 you were provided with a RHCSA account balance to be used to pay for retiree medical and/or dental coverage when you retire under the circumstances set forth in the RHCSA. Your RHCSA account balance will be determined based on your years of service with both Ingredion and National Starch.

RHCSA participants who retired prior to January 1, 2015 will remain eligible for the retiree benefits they participated in when they retired (*i.e*., participants in the National Starch Retiree Component will remain eligible for that program, and legacy RHCSA participants will remain eligible for benefits under the RHCSA, subject in each case to the applicable plan's terms).

Eligible Dependents

If you are a full-time salaried employee and you meet the age and service requirements described above at the time of your retirement from the Company, then your spouse and all dependents who meet the eligibility requirements for coverage under the plans which mirror the Company's Medical and Dental Plans will be eligible for coverage under the Dependent RHCSA. Note that the definition of "Dependent" under the Plan does not include domestic partners. A Dependent RHCSA will be established for you when you retire for your spouse and any and all eligible dependents you have on that date that you identify on the form provided by the Company. If you have no spouse or dependents when you retire, or if you die before retirement, no Dependent RHCSA will be established for you and one cannot be established in the future. Additionally, you may not add new dependents or spouses after your retirement date.

You will also be able to elect coverage for your spouse and eligible dependents under plans which mirror the Medical and Dental Component Plan options available to active employees of the Company and their dependents, and use your Dependent RHCSA to pay for the cost of such coverage, until your spouse or dependent(s) become eligible for Medicare or no longer qualify for coverage under the Medical and Dental Component Plans, or the Dependent RHCSA is depleted and you elect not to pay your premiums. In order to be eligible for such coverage, your dependent must meet the definition of "dependent" under the plans which mirror the Company's Medical and Dental Component Plans.

How the RHCSAs Work
and
How You Receive Medical and Dental Benefits

Using Your RHCSAs

You must begin using your RHCSAs within 30 days of your retirement from the Company, or you will forfeit the funds credited to your RHCSAs. Additionally, you must continue to use your RHCSAs each year after retirement or you will forfeit the funds in your accounts. You are only eligible to use your RHCSAs if you retire after age 55 with 10 consecutive years of credited service.

Using your RHCSAs and Receiving Medical and Dental Coverage Prior to Reaching Medicare Age

If you retire before you are Medicare-eligible (generally age 65), you can use your RHCSA to obtain medical and dental coverage from the Company. You can elect the same type of coverage that is offered to active employees (under programs which mirror the active programs) —and can change your election every year during open enrollment. You must elect such coverage within 30 days of your retirement. You will not be able to change your coverage at any other time during the year, even if you experience a change in family status as defined by the IRS.

Prior to reaching age 65, your RHCSA can be used only to pay the cost of premiums for coverage under the programs which mirror the Company's Medical or Dental program. As such, in order to use the funds in your RHCSA prior to age 65, you must also elect coverage as a retiree under such programs which mirror the Company's Medical or Dental programs. If you do not elect coverage under these medical or dental coverage options, or if you drop such coverage prior to attaining eligibility for Medicare (generally, age 65), then you will not be eligible to use your RHCSA and all amounts in your account will be forfeited.

If you have a spouse or eligible dependents when you retire, you may also use your Dependent RHCSA to obtain medical and dental coverage for them prior to attainment of Medicare eligibility (under coverage which mirrors that which is offered to active employees and their dependents) *if* they meet the eligibility requirements for coverage under such plans (as described in the summary plan description for the Medical and Dental Component Plans). You must elect such coverage within 30 days of your retirement. You will be able to make changes to your election for spousal and dependent medical or dental coverage only during annual open enrollment. Additionally, you may not add new dependents or spouses after your retirement date.

Prior to your spouse's or dependent's reaching age 65, your Dependent RHCSA can be used only to pay for the cost of premiums for coverage under the programs which mirror the Company's Medical or Dental Component Plans. As such, in order to use the funds in your Dependent RHCSA, your spouse and dependents who are under age 65 must also be enrolled in the programs which mirror the Company's Medical or Dental Component Plans. If you do not elect coverage under the programs which mirror the Company's medical or dental coverage options for your spouse or dependent(s), or if you drop such coverage prior to the time that your spouse or covered dependents attain eligibility for Medicare (generally, age 65), then you will not be eligible to use your Dependent RHCSA and all amounts in your account will be forfeited.

You must elect coverage for yourself, your spouse or your dependents under the programs which mirror the Company's Medical and Dental Component Plans within 30 days of your retirement. If you do not elect coverage within 30 days, then you will forfeit your right to retiree medical and dental coverage and you will not be eligible to elect such coverage at any time in the future. Additionally, if you elect coverage at the time of your retirement, but you drop coverage at a future date, then you will not be able

to reenroll. You can elect such medical and dental coverage independently (*i.e.*, you can elect one or both types of coverage), but once you decline or drop either type of coverage you will not be able to enroll in such coverage at any time in the future.

For more information about the benefits available to you under the programs which mirror the Company's Medical and Dental Component Plans, consult the Company's Human Resources Department.

Waiving Coverage or Benefits

You can elect to waive coverage or benefits under the Plan. All amounts credited to both of your RHCSAs will then be forfeited.

Using Your RHCSAs to Purchase Coverage From Another Source Prior to Medicare Eligibility

Before you become eligible under Medicare you may make an election to use amounts in your RHCSA to purchase medical, prescription drug and/or dental coverage from a source other than a plan maintained by the Company. If you want to make such election to purchase coverage outside of a Company plan, you can opt out of Company plan coverage at retirement or during the open enrollment period for such Company plan. If you make the election described in this paragraph, your RHCSA will be reduced by the amount of any approved reimbursement request submitted by you for such eligible coverage up to twice annually with sufficient proof of coverage, until the earlier to occur of (1) the date on which such account has been depleted or (2) you attain age 65. Such election and reimbursement shall be subject to any additional rules prescribed by the Plan Administrator and to requirements of applicable law.

Important Note: If you opt out of Company plan coverage, you will not have access to any Company plan for retiree coverage at any point in the future.

Using your RHCSAs and Receiving Medical Coverage After Reaching Medicare Age

When you become Medicare-eligible (generally age 65), you will no longer be eligible to participate in the Company's medical and dental coverage. However, you can use your RHCSA toward the cost of Medigap policies, Medicare HMO or PPO policies, Medicare Advantage Plans or certain other Medicare supplement health plans (as approved by the Company) if you feel that your Medicare coverage is not sufficient. (When your spouse or dependent becomes Medicare-eligible, the same rules apply and you can use the Dependent RHCSA in the same way.) If you are Medicare-eligible, you may still use your Dependent RHCSA to elect Company-provided medical or dental coverage for your spouse or dependents (who are not eligible for Medicare).

What is Medigap Insurance?

Medigap insurance provides benefits in those areas or "gaps" where the current Medicare program provides no coverage (*e.g.*, deductibles, prescription drugs, etc.).

What is a Medicare HMO or PPO or a Medicare Advantage Plan?

These are health plans run by private companies that are approved by Medicare. You will pay a monthly premium for the cost of these plans. These plans may provide your Medicare Part A and Part B coverage, but may charge different amounts for the services. They may offer additional coverage and prescription drug coverage as well. In most of these plans, you will need to use doctors, hospitals and providers in the plans' network or else you will pay more.

Using Your RHCSAs to Pay for Medical and Dental Coverage

When you retire, you can make a one-time election to use your RHCSAs to cover 100% of medical and dental premium costs up to the date on which you are eligible for Medicare.

Covered Expenses

You can only use your RHCSAs to pay the premiums for medical and dental care coverage up to the date on which you are eligible for Medicare. Reimbursements will not be made for individual medical or dental expenses, or for Medicare Part B or Part D premiums.

Be sure to consider your, your spouse's and your dependents' ages as well as all of your medical and dental care needs when making your decision because **you cannot change your election after it is made.** Your election must be the same for both of your RHCSAs.

Paying for Coverage

If you retire before becoming Medicare-eligible, you can use the balance in your RHCSA toward the cost of your premiums for medical and dental care coverage under the Company's plans. The Company will then reduce the amount credited to your RHCSAs by the amount of such costs. If you have exhausted your RHCSA balances, the Company will then bill you for any remaining cost. You will have 60 days to pay for this remaining cost of your coverage or participation in the Plan will end.

After you (or your spouse or dependents, as applicable) become Medicare eligible, you will pay your premiums(s) to your Medicare supplement health plan carrier (as approved by the Company) directly and then submit a copy of your bill and your canceled check(s) to the Company for reimbursement. You must attach proof of your expenses (which must be a bill, invoice or statement showing the cost of your premium) to your claim form. Please note that canceled checks alone are not considered receipts or proof of payment.

Once you, or your spouse or eligible dependents, become eligible for Medicare, reimbursements from each of your RHCSAs will be limited to a maximum of $1,881 per year. This amount will be indexed for inflation, and will be prorated in the year in which you (or your spouse or dependent, as applicable) become Medicare-eligible. If your annual Medicare supplement health plan premiums exceed $1,881 for either yourself or your spouse or dependents, you must pay that additional amount yourself. If your Medicare supplement health plan premiums are less than $1,881 for yourself or your spouse or dependents, you will be reimbursed for the full cost of these premiums.

Keep in mind:

- You may not transfer funds from your RHCSA to your Dependent RHCSA or vice versa.
- You cannot use amounts credited to your RHCSA to pay premiums for your spouse or dependents, nor can you use amounts credited to your Dependent RHCSA to pay premiums for yourself.
- All remaining amounts credited to your RHCSA will be forfeited upon your death; credited amounts in your Dependent RHCSA will be forfeited when your spouse or last dependent dies.

Depleted Accounts

If you use up all of the credits to your RHCSA, or to your Dependent RHCSA, prior to reaching age 65, you will still be able to access medical and dental care coverage under the Company's plans until you attain Medicare eligibility —the only difference is that you'll have to pay the full cost out of pocket on an after-tax basis.

When You Die

If you die before age 55 or before completing 10 consecutive years of credited service, any amounts credited to your RHCSAs will be deemed to be forfeited.

If you die after your retirement date, any amount credited to your RHCSA will be deemed to be forfeited, but your spouse and dependents may make elections and receive payments from the Plan until the first of the following occurs:

- the amounts credited to your Dependent RHCSA have been used up,

- in the case of your spouse, your spouse dies,
- in the case of your children, your child no longer meets the Medical Plan or Dental Plan's definition of dependent, or
- the Plan is terminated.

Additionally, your spouse and dependents may continue coverage under the Medical or Dental Component Plan until they become Medicare eligible (or, in the case of your dependent children, when they no longer meet the Medical or Dental Component Plan's definition of dependent).

Keeping Track of Your Account

You will receive annual RHCSA statements that will detail all credited activity in your accounts, including regular and interest credits and premium payments.

When Your Participation Ends

Your participation in the RHCSAs and the Company's medical and dental coverage ends if:

- this Plan terminates or, with respect to coverage under the Medical or Dental Component Plan, such plan terminates or is otherwise amended to eliminate your Plan participation,
- you terminate employment with the Company before retirement at age 55 with 10 consecutive years of credited service,
- you, your spouse and all your covered dependents die,
- you become disabled before you reach age 55 with 10 consecutive years of credited service,
- with respect to coverage under the Company's Medical or Dental Component Plan, you (or your spouse or dependent) become eligible for Medicare,
- with respect to your dependent, he or she loses dependent status and is no longer eligible for coverage,
- with respect to your RHCSAs, your balances in both your RHCSAs become zero,
- you have not paid your share of the cost of your or your spouse's or dependents' coverage within the 60-day grace period, or
- you fail to pay the required premiums.

Note that your participation in the RHCSAs has ended if as of December 31, 2014 you were not already a "Retiree" under the terms of the Plan or an active employee of the Company who has either (1) reached age 55 with at least 10 years of vesting service under the Cash Balance Plan or (2) reached age 45 with 15 years of vesting service under the Cash Balance.

Retiree Life Insurance

You are eligible for retiree life benefits in the amount of $5,000 if you retired prior to January 1, 2015.

You may name a beneficiary(ies) to receive your retiree life insurance death benefits by completing a Beneficiary Form and submitting it to the Company's Human Resources Department. You may change your beneficiary at any time by contacting the Company's Human Resources Department and submitting a new Beneficiary Form. **If you die, the most recent beneficiary form on file with Corporate Human Resources will be used to determine who receives the death benefits under the Plan.** You should periodically make sure your beneficiary designation is up-to-date and you should review and, if appropriate, modify your beneficiary designation when you have a life change event.

If your beneficiary is not living at the time of your death or if you have not designated a beneficiary on the proper form with the Company, then benefits will be paid in accordance with the terms of the insurance policy or contract. If the insurance policy or contract does not include a procedure for determining your beneficiary, then benefits will be paid to your estate.

These retiree life insurance benefits are fully insured through an insurance company and the insurance company acts as the claims administrator. The claims administrator is responsible for determining how much the Plan pays and for administering claims. Further information about your retiree life insurance benefits (including information about the claims administrator) can be found in the insurance policy or contract provided by the insurance company, which is incorporated by reference in this SPD.

Notwithstanding anything herein to the contrary, any former National Starch LLC salaried employee who retired from National Starch LLC on or after January 1, 2001 but prior to January 1, 2015 and who either (1) was at least 45 years old with 10 or more years of service as of 12/31/2000, or (2) was at least age 50 with 15 years or more of service as of 12/31/06 (a "National Starch Retiree") shall be eligible for retiree life insurance. The amount of the life insurance is equal to 100% of such National Starch Retiree's annual salary immediately prior to retirement ("Annual Salary") in the first year of his or her retirement, 50% of such National Starch Retiree's Annual Salary in the 2nd year of his or her retirement and 25% of such National Starch Retiree's Annual Salary after the 2nd year of his or her retirement (subject to a maximum of $20,000 after the first 2 years of retirement).

Other Plan Facts

Plan Cost
The RHCSAs are bookkeeping entries and do not represent assets that have been segregated for the benefit of participants or dependents. All benefits are payable from insurance contracts or the general assets of the Company. The RHCSAs are intended to be unfunded benefits, although the Company may, in its discretion, establish a trust to pay certain benefits under the Plan.

Plan Name
The plan name is the Ingredion Incorporated Master Retiree Welfare Plan.

Plan Sponsor and Administrator
The Plan is a welfare plan sponsored and administered by Ingredion Incorporated. The Company's Board of Directors has appointed the Ingredion Benefits Committee (the "Committee") to serve as Plan Administrator. The Committee has the full discretionary authority and power to control and manage all the administrative aspects of the Plan, as well as full discretionary authority and power to determine eligibility for Plan benefits, to interpret and construe the terms and provisions of the Plan, to determine questions of fact and law, to direct disbursements, and to adopt rules for the administration of the Plan as it may deem appropriate in accordance with the terms of the Plan and all applicable laws.

The Committee may allocate or delegate its responsibilities for the administration of the Plan to others (including designating an individual as Plan Administrator or a claims administrator) and employ others to carry out or render advice with respect to its responsibilities under the Plan, including discretionary authority to interpret and construe the terms of the Plan, to direct reimbursements, and to determine eligibility for Plan benefits.

Any interpretation or determination made under the discretionary authority of the Plan Administrator (or its delegate, including a claims administrator) is to be given full force and effect. The Plan Administrator, its delegate or a claims administrator, as the case may be, has discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan will be paid only if the Plan Administrator (or its delegate or a claims administrator) decides in its discretion that the applicant is entitled to such benefits.

Questions should be directed to the Plan Administrator at:

Ingredion Incorporated
5 Westbrook Corporate Center
Westchester, IL 60154
Tele: (708) 551-2600

Employer Identification Number and Plan Number
The Employer Identification Number for Ingredion Incorporated is 22-3514823. The Plan Number for this Plan is 530. Please use these identifying numbers when inquiring about your retiree benefits described in this SPD.

Plan Year
The records of the Plan are kept on a calendar-year basis. Each plan year ends on December 31.

Agent for Service of Legal Process

The Company's General Counsel is designated as the Plan's agent for service of legal process, at the following address:

General Counsel
Ingredion Incorporated
5 Westbrook Corporate Center
Westchester, IL 60154
(708) 551-2600

Legal process may also be served on the Plan Administrator.

Type of Plan

The Plan is a welfare plan offering medical, dental, and life insurance benefits.

Claims Procedures and Appealing a Claim

To receive any type of payment under the Plan, you first must complete an application and file it in accordance with the formal claims procedures. The claims procedures are described in Appendix A. Application forms and information regarding the procedure may be obtained through the Company's Human Resources Department.

Implied Promises

Nothing in this booklet says or implies that participation in this Plan is a guarantee of continued employment with the Company, nor is it a guarantee that plan benefit levels will remain unchanged in future years.

Plan Amendment or Termination

The Company hopes to continue the Plan indefinitely, but reserves the right to amend, modify or terminate all or any part of the Plan, for any reason and without prior notice. The Company's Board of Directors or a properly authorized designee has the power to amend, modify or terminate the Plan. In the event that the Plan is discontinued, you shall no longer be entitled to any benefit under the Plan, other than payment of covered expenses that you incurred before the Plan was discontinued.

Further, the Company reserves the right to change retiree benefit coverage, discontinue offering coverage to retirees or require payments from retirees that are different from those required by active employees. Additionally, the Company reserves the right to change or terminate any of the underlying plans that are extended to retirees at any time.

Time Limits for Legal Actions

Except for actions to which the statute of limitations prescribed by section 413 of ERISA applies, no legal action may be brought later than one year after you or your authorized representative receives a final decision from the Committee in response to a request for review of the denied claim. No other legal or equitable action involving the Plan may be commenced later than two years from the time the person bringing an action knew, or had reason to know, of the circumstances giving rise to the action. This provision shall not bar the Plan or its fiduciaries from recovering overpayments of benefits or other amounts incorrectly paid to any person under the Plan at any time or bringing any legal or equitable action against any party. Any legal action involving or related to the Plan, including but not limited to any legal action to recover any benefit under the Plan, must be brought in the United States District Court for the Northern District of Illinois, and no other federal or state court.

Please consult the insurance policy or certificate for your life insurance coverage, or the Medical or Dental Component Plan with respect to such benefits, to determine whether any other time limits for legal action may apply to claims for such coverage.

Your Rights Under ERISA

As a participant in the Ingredion Incorporated Master Retiree Welfare 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:

- Examine, without charge, at the Company's main office, the office of the Plan Administrator, your local Human Resources office, and other specified locations, all documents governing the Plan, including insurance contracts, plan descriptions 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 of the U.S. Department of Labor.
- Obtain, upon written request to the Company, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. You may be charged a reasonable fee for the copies.
- Receive a summary of the Plan's annual financial report. The Company is required by law to furnish each participant with a copy of this summary annual report.

Concerning group health plan coverage, you shall also be entitled to:

- Continue health care coverage under a group health plan for yourself, your spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents will be required to pay for such coverage. See the SPD for the Company's Medical and Dental Component Plans for more information about your rights with respect to continuation coverage.
- Obtain a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. With evidence of creditable coverage, you may be entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for up to 12 months (18 months for late enrollees) after the date you enroll in your new employer's plan.

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 Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to act prudently and in the interest of participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit under the Plan or from exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a benefit under the Plan is denied or ignored, in whole or in part, you have the 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 as described in Appendix A.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 (or such other amount in effect from time to time) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If your claim

for benefits is denied or ignored, in whole or in part, you may choose to file suit in a state or federal court after you have completed the claims appeal process (as described in Appendix A). In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If a Plan fiduciary misuses the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Company's Human Resources Department or your local Human Resources office. If the Company does not answer your questions, if you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact:

- The nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX A - CLAIMS PROCEDURES

The procedures for filing claims under the Plan are governed by the Employee Retirement Income Security Act of 1974 (ERISA). These procedures are described below.

Formal Claims Procedures

If you believe that you are entitled to benefits under the Plan, then you must submit your claim in writing in accordance with the Plan's claims procedures.

If you have a claim with respect to the accrual of your RHCSA benefits under the Company's Master Welfare and Cafeteria Plan, then you must submit your claim in accordance with the claims procedure for such plan. Consult the summary plan description and plan document for the Company's Master Welfare and Cafeteria Plan for a copy of the applicable claims procedure.

If you have a claim with respect to your benefits under this Plan, then you must follow the claims procedure describe in this Appendix A. The insurance company for your retiree life coverage reviews all claims related such coverage and is referred to as the "claims administrator." With respect to the other Plan benefits, the "claims administrator" is the Committee that acts as Plan Administrator for the Plan.

Claims procedures for your retiree life insurance may also be described in the insurance policy or certificate provided by the insurance company, which is incorporated as part of this SPD. When submitting a claim, you must follow the claims procedures described in such documents, in addition to the claims procedures described below.

In all cases, you must follow the formal claims procedures when submitting a claim and before initiating a lawsuit or any other proceeding with regard to your claim under the Plan.

Initial Claim

If you believe that you are entitled to benefits, then you must submit your claim in writing to the claims administrator. For claims related life insurance coverage, the claims administrator and its address are identified in the applicable insurance policy or certificate. Claims for other benefits under this Plan should be sent to the Committee at the Company's address.

If your claim for benefits is denied, either in full or in part, then the claims administrator will send you a written or electronic notice within a reasonable period of time after receiving your claim, not to exceed 90 days for life insurance benefit claims and not to exceed 30 days relating to other benefits provided under this Plan.

If the claims administrator determines that it requires an extension of time to review your claim due to special circumstances beyond its control, then you will be notified in writing of the required extension within the initial time limit, and the additional extension period will not exceed 90 days for life insurance benefit claims and not to exceed 15 days for the other benefits provided under this Plan. Any notice of extension will describe the circumstances requiring the extension and the expected date by which the claims administrator will make its determination.

Your denial notice will contain the specific reason(s) for the denial, references to the pertinent plan provisions on which the decision is based, and a description of any additional information or material needed to support your claim and why the additional information or material is necessary. The notice will also provide a description of the plan's appeal procedures and the time limits applicable to those

procedures and a statement that you have a right to bring a civil action under section 502(a) of ERISA with respect to your claim (after you have completed the formal claim and appeal process described in this Appendix A).

You may have an authorized representative pursue your benefit claim on your behalf.

Appeal with Claims Administrator

If your claim is denied and you want to pursue your claim further, then you (or your authorized representative) must request a full and fair review of your denied claim by filing a written appeal with the claims administrator (i) within 60 days after you receive a denial notice related to a claim for life insurance benefit or (ii) 180 days after you receive a denial notice related to a claim for other benefits provided under this Plan.

Your appeal may include any additional information to support your claim, including any written comments, documents, records or other information you wish to have considered (regardless of whether such information was submitted in your initial claim) with your written request for review. As part of your appeal, you, your representative or your beneficiary have the right to request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. The claims administrator has full responsibility and authority to review your claims.

You will receive written or electronic notification of the decision on your appeal within a reasonable period of time after the claims administrator receives your request for review of your claim denial, not to exceed 60 days.

If additional time is needed to review your life insurance benefit appeal, you will receive a written or electronic notice (within the initial time period) advising you that additional time is needed, not to exceed 60 days. Extensions will not be available to the claims administrator for appeals for other benefits. Any notice of extension will describe the circumstances requiring the extension and the expected date by which the claims administrator will make its determination. If the reason for the extension of time is your failure to provide necessary information, then the time frame for making a benefit determination is stopped from the date the claims administrator sends you an extension notification until the date you respond to the request for additional information.

If your appeal is denied, either in full or in part, then the notice of denial will contain the specific reason(s) for denial with references to the pertinent plan provisions on which the denial is based and any additional information or material required to appeal the claim further (if an additional appeal is allowed). The notice will also state that (1) you have a right to bring a civil action for benefits under section 502(a) of ERISA (after you have completed the formal claim and appeal process described in this Appendix A) and (2) you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.

Exhaustion of Claims Procedures

You must follow and exhaust the claims and appeals procedures described in this Appendix A (including any claims procedures described in your insurance policy or certificate or claims procedures for the programs which mirror the Medical or Dental Component Plans for active employees) before you can file a lawsuit, seek arbitration or begin any other proceeding with regard to your claim for benefits under the Plan.

State Law Preemption

Nothing in this Appendix A shall be construed to supersede any provision of State insurance laws, except to the extent that such laws prevent the application of the provisions in this Appendix A.