Ingredion Incorporated
Master Welfare and Cafeteria Plan

Summary Plan Description

January 2022

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INTRODUCTION

ABOUT THIS SUMMARY PLAN DESCRIPTION (SPD)

Ingredion Incorporated (the Company) offers you a wide range of welfare benefit plan options. This Summary Plan Description (SPD) is designed to provide you with important information about these benefit plans, including:

- The plans that are offered to you
- Who is eligible for coverage
- When coverage begins and ends
- When you can make changes to your benefits, and
- Your legal rights.

If you have any questions about your benefits as described in this SPD, you can contact the Company's Human Resources Department at (708) 551-2600.

Defined Terms

A few important terms in this SPD are defined in shaded boxes. These defined terms are bolded and italicized when they are used in the SPD.

Summary Plan Description (SPD), Plan Document, and Other Documents

This document, together with the summaries of benefits and coverage, plan booklets, certificates, schedules of benefits, evidences of coverage, insurance policies, or other benefit summaries provided by the insurance companies and third party administrators, constitute a summary plan description under the Employee Retirement Income Security Act of 1974. This is merely a summary of your benefits under the component plans described in this booklet. The component plans described in this SPD are part of the Ingredion Incorporated Master Welfare and Cafeteria Plan (the "Master Welfare Plan"), which is evidenced by a formal written plan document. The Master Welfare Plan document contains more detailed information regarding the Master Welfare Plan and your benefits. If there is any conflict between this SPD and the Master Welfare Plan document, the plan document will control. To obtain a copy of the plan document, please contact the Company's Human Resources Department at (708) 551-2600.

Additionally, the insurance company and third party administrators for your component plans have provided summaries of benefits and coverage, plan booklets, certificates, schedules of benefits, evidences of coverage, insurance policies, or other benefit summaries which contain more detailed information about your benefits and which are incorporated as part of this SPD. You should consult these additional documents (which are detailed in Appendix D) for further information about your benefits. In addition, if you are a union employee who is subject to the terms of a collective bargaining unit agreement that provides for participation in the benefits described in this SPD, please note that the terms of such collective bargaining agreement will also determine the terms of your participation in these benefits.

IMPORTANT NOTE: SUBJECT TO THE TERMS OF ANY COLLECTIVE BARGAINING AGREEMENT APPLICABLE TO YOU, THE COMPANY RESERVES THE RIGHT TO CHANGE OR TERMINATE ANY OF THE BENEFIT PLANS, INCLUDING ANY OF THE COMPONENT PLANS, AT ANY TIME. RECEIPT OF THIS DOCUMENT DOES NOT CONSTITUTE A PROMISE OF FUTURE EMPLOYMENT.

COLLECTIVE BARGAINING AGREEMENT

You are eligible for the benefits described in this document if you are an hourly employee of the Company at one of the Company's facilities who is covered by a Collective Bargaining Agreement

with the Company that provides for participation in such benefits. Note that not all hourly employees are eligible for all of the benefits described in this SPD, so please contact your local human resources representative if you have questions regarding the extent to which the benefits described in this document apply to you.

You may examine or obtain (upon written request) a copy of the Collective Bargaining Agreement that applies to you by contacting the plan administrator or your union representative.

OVERVIEW OF YOUR BENEFIT PLANS

The Company offers you a variety of component plans to suit the needs of you and your family. A list of these component plans can be found in the section entitled "Benefits Overview" and Appendix A to this SPD. Please note that the terms of these component plans may have been altered due to the COVID-19 pandemic. Any such changes are discussed in the section entitled "Benefits Provided Due to COVID-19."

Each of your benefits is administered by a third party administrator or an insurance company, which are often referred to as "claims administrators" throughout this SPD.

Some of your benefits are paid in full by the Company and are provided to you automatically at no cost. Other benefits are optional and you can elect coverage based on your needs.

WHO'S ELIGIBLE

You are eligible for coverage under the benefit plans described in the section entitled "Benefits Overview" and listed in Appendix A, subject to the terms of the applicable provider contract, except for long-term disability coverage and participation in the retiree spending accounts, if (1) you are a full-time, salaried employee who is regularly scheduled to work at least 20 hours per week at the Company or (2) you are a union employee subject to a collective bargaining agreement that provides for such benefits from the Company. You are eligible for long-term disability coverage if you are (1) a full-time, salaried employee who is regularly scheduled to work at least 30 hours per week at the Company, or (2) you are a union employee subject to a collective bargaining agreement that provides for such benefits from the Company. Please see "Retiree Spending Accounts (RHCSAs)" below for a description of eligibility for benefits under the retiree spending accounts. Interns are eligible to participate in only the medical plan component of the Master Welfare Plan.

Participation begins on the first day of the calendar month coincident with or next following your date of hire. If you are not actively at work[1] when you are first eligible to participate in the component plans, your participation begins on the day you return to active work, provided you have properly enrolled.

Employees who are covered by a collective bargaining agreement with the Company that does not provide for participation in Company benefits, part-time employees, temporary employees, individuals who provide services to the Company pursuant to an agreement the Company has with an outsourcing company or a leasing organization, independent contractors, individuals who have waived participation and any other individuals who are not designated on the Company's payroll as regular employees are not eligible for the benefits described in this SPD. 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.

Coverage for Family Members

You may enroll your eligible ***family members*** for coverage under certain component plans. See the next section of this SPD entitled "Benefits Overview" and the chart under the heading "Coverage Levels and Options" in Appendix A

[1] Under the Medical Plan, you will generally be treated as "actively at work" for certain purposes, as required by law, if you are absent from work solely due to a health factor.

for information regarding the benefit coverage that is available to your eligible ***family members***.

In general your eligible "**family members**" include:

- Your spouse.
- Your unmarried child who is under age 23[2] and qualifies as your tax dependent[3].
- Your unmarried child who is mentally or physically handicapped, as determined by the claims administrator (if the child was an eligible, covered dependent prior to age 23).

However, the definition of eligible children for purposes of your Medical, Dental and Vision Plans is slightly different. Your children who are eligible for such coverage include:

- Your child who is under age 26[2].
- Your unmarried child who is mentally or physically handicapped, as determined by the claims administrator (if the child was an eligible, covered dependent prior to age 26).

Your children include:

- Your biological or legally adopted child;
- Your stepchild; and
- Any other child who lives with you in a parent-child relationship.

You may elect coverage for your ***family members*** only if you have elected coverage for yourself. You may be asked to provide an affidavit or other documentation which proves that any individual you intend to cover satisfies the definition of ***family member***.

If your child is eligible to continue receiving benefits after reaching the applicable age limit under the component plan because he or she is mentally or physically disabled, you will need to provide proof of such child's incapacity and financial dependency within 30 days after your child reaches such age. You may also be required to provide periodic proof of continuous disability for your child in order to continue his or her coverage. If your child becomes mentally or physically disabled after reaching the applicable age limit, that child will not be eligible for coverage. Please contact your local Human Resources Department or the applicable claims administrator for more information.

You may also be able to obtain reimbursement for health care and dependent care costs for certain ***family members*** and dependents if you elect to contribute to the Spending Accounts. The definitions of "family member" and "dependent" for purposes of the Spending Accounts may, however, differ slightly from the definition of ***family member*** set forth above. See the section entitled "Spending Accounts" for the definitions of eligible family member and eligible dependents for these purposes.

Please note, you cannot be covered as both an employee and a dependent under any of the component plans. If you and your spouse both work for the Company, you each may elect to be covered as an employee or one of you may elect to be covered as a dependent. Additionally, children may be enrolled by you or your spouse, but not both.

PAYING FOR YOUR BENEFITS

Cost of Your Benefits

The Company pays the full cost for a few of your benefits. For most benefits, however, there is a cost for each component plan that you choose. See Appendix A for further information about which benefits are paid by the Company and which require a contribution by you. The exact cost of each benefit will be provided to you on your rate sheet at the time that you enroll. Generally, the higher the level of coverage that you elect the higher the cost.

[2] Coverage for your dependent child who reaches the Plan's age limit is terminated on the last day of the month in which such child attains such limit.

[3] Special rules regarding the dependency requirement may apply in the case of divorced or separated parents.

Pre-Tax and After-Tax Contributions

Some of your contributions will be made on a pre-tax basis and some on an after-tax basis. Appendix A provides more detailed information regarding which benefits are paid on a pre-tax or after-tax basis.

Please note, you will not pay Social Security taxes on the pre-tax benefit contributions you make. As a result, your Social Security benefits may be slightly reduced. Consult your financial advisor for further information.

Health and Dependent Care Spending Accounts

In addition to paying your share of the costs of certain benefits on a pre-tax basis, you may be able to elect to participate in a Health Care Spending Account and/or Dependent Care Spending Account. You can elect to contribute pre-tax dollars from your paycheck to these accounts and then use the funds to pay for health care and dependent care costs respectively. See the section entitled "Health and Dependent Care Spending Accounts" below for further information about these accounts.

Health Savings Accounts

If you are eligible to participate in the Health Savings Plan you may choose to elect to make contributions to a health savings account made available in connection with the Health Savings Plan (referred to as the "Health Savings Account" or "HSA"). The Health Savings Account will be an account established for you by a written agreement between you and the Health Savings Account's trustee. The type and amount of benefits you will receive under the Health Savings Account, and the conditions and requirements for your benefits thereunder, are determined by the terms and provisions of the Health Savings Plan, your written agreement with the trustee or custodian of the Health Savings Account and by any other related administrative contract. The Company does not have authority or control over the funds deposited in your Health Savings Account.

You are eligible to participate in the Health Savings Account if (i) you are covered under the Health Savings Plan, (ii) you do not participate in the Company's Health Care Spending Account, and (iii) you do not participate in any health plan which is not a high deductible health plan, except for any benefit provided by "permitted insurance" or "permitted coverage" (e.g., dental, vision, preventive care, long-term care insurance, specific disease insurance, accident insurance, a hospital indemnity plan), as described in section 223(c)(2) of the Internal Revenue Code of 1986, as amended (the "Code" or the "Internal Revenue Code").

If you are eligible to participate in the Health Savings Account, you may elect to reduce your compensation by an amount to be credited to your Health Savings Account on a pre-tax basis. If you do not make such an election before the last day of the Company's annual open enrollment period you will be considered to have elected not to contribute to a Health Savings Account. You are allowed to make a prospective election, at least on a monthly basis, to increase, decrease, make or revoke your election to contribute to your Health Savings Account.

The Company may, in its discretion, choose to contribute to a Health Savings Account on your behalf. If you become eligible to participate in the Health Savings Plan and Health Savings Account during the plan year, the Company may, in its discretion, prorate an amount of the contribution made to a Health Savings Account on your behalf. If you chose not to participate in a Health Savings Account, the Company may, in its discretion, establish a Health Savings Account for you and credit your Health Savings Account with employer contributions made by the Company.

The maximum combined amount that both you and the Company can contribute to a Health Savings Account for your benefit for 2022 is $3,650 if you elect employee-only coverage ($7,300 for 2022 if you elect family coverage; plus catch-up contribution of $1,000 in each case if 55 or older), pro-rated by the number of months that you are eligible to participate in the Health Savings Account. You may also elect to

contribute additional "catch up" contributions if you are age 55 or older. The maximum amounts, for both employee-only coverage and family coverage, may be adjusted from time to time as determined by changes in the law or as decided by the Committee, from time to time.

Please contact the Human Resources Department for more information.

Retiree Health Care Spending Accounts (RHCSAs)

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 Plan, you will be eligible for retiree medical, dental or vision benefits under the RHCSA when you retire.[4]

Please note that any active legacy National Starch employees who met the grandfathered requirements set forth above as of December 31, 2014 transitioned to the RHCSAs 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 were actively employed by the Company on December 31, 2014 and a legacy National Starch employee, on January 1, 2015, you will be provided with a RHCSA balance that you may use to pay for retiree medical and/or dental coverage when you retire under the circumstances set forth in the RHCSA. Your RHCSA balance will be determined based on your years of service with both Ingredion and National Starch.[5]

RHCSAs are spending accounts set up in your name that enable you to pay for the cost of medical and/or dental coverage premiums during retirement. If you are eligible for RHCSA benefits as described in the first paragraph of this section, two RHCSAs have been established in your name — your RHCSA and your Dependent RHCSA. You may use these accounts only to pay for medical and/or dental coverage purchased through the Company before you or your spouse or dependents become eligible for Medicare, and for a Medicare supplement policy thereafter.

RHCSAs are bookkeeping entries, and assets are not segregated with respect to RHCSAs. All benefits will be payable from insurance contracts or the general assets of the Company.

At the end of each calendar year after the RHCSA and Dependent RHCSA (if any) have been established, eligible participants receive interest credits on each account. Interest credits are determined by multiplying the January 1 account value of each account by the yield of 5-year U.S. Treasury notes as of the last business day on or before November 30 of the prior calendar year, plus .25%, or 25 basis points, (not to exceed a maximum of 10.0% or a minimum of 3.00%).

At the end of the plan year, no interest credits will be applied to the RHCSAs for that year if participation in the Master Welfare Plan has ended or if the applicable balance(s) is (are) zero.

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

[4] Note that part-time salaried employees (regularly scheduled to work less than 40 hours per week at the Company) are not eligible to participate in the RHCSAs.

[5] Effective January 1, 2015, each person who was entitled to receive benefits under the Salaried Retiree Medical Program for Former Employees of National Starch LLC Component of the Plan as of December 31, 2014 but who had not yet retired as of such date had a RHCSA established for him or her (a "Former National Starch Participant"). Such RHCSA was credited on January 1, 2015 with regular credits and interest credits for each year of credited service, but determining such Former National Starch Participant's years of credited service by taking into account service with National Starch and its affiliates as if such service had been with the Company and affiliates.

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. Note that 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.

If You Become Disabled

If you become disabled after age 55 with 10 consecutive years of credited service, you will be treated as if you were retired and you and your eligible spouse and dependents can use your RHCSAs.

You must elect such coverage within 30 days of the date you become disabled. If you do not elect coverage within 30 days of your disability date, 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 may make changes to your coverage only during open enrollment and if you drop coverage at a future date you will not be allowed to reenroll.

ENROLLMENT AND WHEN COVERAGE BEGINS

New Employees

You may enroll in the various component plans when you are hired by the Company. You must enroll within 31 days of your hire date.

If you fail to make an election within this 31-day period, then you generally will not receive any benefits under the plans and you will not be able to enroll in the Medical, Prescription Drug, Dental or Vision Plans or the Spending Accounts until the next annual open enrollment period or until you have a ***change in family status*** (as later defined) (or, for the Medical Plan, qualify for a special enrollment period, as described below). You will, however, be automatically enrolled in basic life insurance and long-term disability coverage, and you will be able to participate in the Wellness Plan outside of open enrollment.

Please note, evidence of good health requirements may apply when you first enroll for life and accident insurance benefits above a certain coverage level. Additionally, if you do not enroll in life and accident insurance benefits for your, yourself or your eligible ***family members*** within the 31 days of your hire date, then you (or your family member) may have to provide evidence of good health in order to enroll at a future date. Further information about the evidence of good health requirements can be found in the next section of this SPD entitled "Benefits Overview".

Your participation in any component plan will not become effective until the date on which you meet the eligibility requirements as described above, under the heading "Who's Eligible". As noted above, participation for a new hire begins on the first day of the calendar month coincident with or next following your hire date. If you are currently an employee, but are newly eligible for benefits (because, for example, your hours increased), then your coverage for benefits will become effective on the first day of the calendar month coincident with or next following the date you became eligible for benefits.

Once you are enrolled in the Medical, Prescription Drug, Dental or Vision Plans or Spending Accounts, you cannot change your election until the next annual open enrollment period or until you have a ***change in family status***.

Please note, some of the benefit plans may have an "actively at work" requirement, which means that you must be actively at work in order for your coverage to begin. If you are not actively at work when you are first eligible to participate, your participation begins on the day you return to

active work, provided you have properly enrolled. You will, however, generally be treated as "actively at work" under the Medical Plan for certain purposes, as required by law, if you are absent from work solely due to a health factor. The "actively at work" requirements are further described in the summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary for the applicable component plan.

Please note that interns are eligible to participate in only the Medical Plan component of the Master Welfare Plan.

Annual Open Enrollment

Each Fall, the Company will have an annual open enrollment period, at which time you can elect for the next plan year to enroll in a new component plan, cancel coverage under a component plan, change your amount of coverage or add or drop eligible dependents under a component plan. Your elections will become effective on the first day of the next plan year (which is January 1). **Once the annual open enrollment period for a plan year closes, you will not be able to change your elections under the Medical, Prescription Drug, Dental or Vision Plans or Spending Accounts for the plan year unless you experience a *change in family status* (or, under the Medical Plan, qualify for a special enrollment period**).

If you fail to make any elections during the annual open enrollment period, then your existing coverage elections for the current plan year will automatically continue for the next plan year. If, however, you fail to re-enroll in the Spending Accounts, then you will be deemed to have elected to make no contribution to these accounts. **In other words, you *must* make an affirmative election to enroll in a Spending Account during the annual open enrollment period if you want to contribute to the Spending Account during the upcoming plan year**. You may be allowed to participate in the Health Care Spending Account to the extent that you are permitted to carry over money contributed to such account from the prior plan year, but you will not be permitted to make any additional contributions to the Health Care Spending Account. Please see the section entitled "Health Care Spending Account" for more information.

If you elect to add or increase life or accident insurance coverage for yourself or your eligible ***family member*** during an annual open enrollment period, then you (or your eligible ***family member***) may be required to provide evidence of good health, as further described in the next section entitled "Benefits Overview". In such case, your new elections will not take effect until your change has been approved by the insurance company.

If you would like to make changes to your benefit elections under the Life and Accident Insurance Component Plan during the plan year outside of an annual open enrollment period, then you should contact the Company's Human Resources Department.

Rehired Employees

If you leave the Company and are rehired within 30 days, the benefit elections you had in place immediately before you left the Company will be automatically reinstated (provided you still meet the eligibility requirements). If you leave the Company and are rehired more than 30 days after you left, you will be eligible to make new benefit elections as if you were a new employee (provided you still meet the eligibility requirements).

Change in Family Status

You may change or cancel your benefit elections outside of an annual open enrollment period if you have a ***change in family status***.

A **"change in family status"** includes:

- Your marriage, divorce or legal separation
- Death of a ***family member***
- Dependent is no longer eligible for coverage
- Addition of a dependent (such as birth or adoption of a child)
- You or your ***family member gains or*** loses coverage (under this plan or another employer plan) due to a change in employment status (such as termination or commencement of employment and commencement of or return from a leave of absence)
- You or a ***family member*** lose other coverage under another employer plan
- Your ***family member*** enrolls in another employer plan
- With respect to your Dependent Care Spending Account, you experience a change in your dependent care costs

For a complete list of ***change in family status*** events consult the formal plan document for the Ingredion Incorporated Master Welfare and Cafeteria Plan or call the Company's Human Resources Department.

If you have a ***change in family status***, you can add or drop a benefit plan or coverage for your ***family members*** or dependents (as defined by the respective benefit plan) if your coverage change is consistent with your ***change in family status***. For example, if your ***family member*** loses eligibility for coverage under a plan, you can drop coverage for such ***family member*** under the plan, but you cannot drop coverage for you or any other covered ***family members***.

Important Note: If you have a ***change in family status***, you must log into the online benefits administration system to declare this life event and then must furnish proof of such life event by the deadline indicated in the notice received from the dependent verification vendor to support your ***change in family status***, as required by the Plan Administrator. If you do not provide sufficient documentation by the deadline specified, then your changes will not go through and you will be required to wait until the next annual open enrollment period or you have another ***change in family status*** before you can make any changes to your medical, dental, vision or spending account benefit elections.

If you elect coverage during the plan year due to a ***change in family status***, coverage will begin as of the date the ***change in family status*** occurred (except that (1) coverage under the Spending Accounts will begin on the first day of the next month and (2) coverage for a newly eligible employee will begin on the first day of the calendar month coincident with or next following the date such employee became eligible for benefits), provided you have properly notified the Company's Human Resources Department and submitted the necessary forms and documentation within 30 days of the ***change in family status*** event. If, however, evidence of good health is required, then coverage will not become effective until your change has been approved by the insurance company.

Special Enrollment Periods

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides you and your ***family members*** with certain special enrollment rights which allow you to elect coverage under the Medical Plan during the plan year, outside of an annual open enrollment period.

Specifically, if you decline medical coverage for yourself or your ***family members*** because of other health insurance coverage, then under certain circumstances, you or your eligible ***family members*** may be able to enroll in the Medical Plan in the future if you or they lose such other coverage (or if the employer stops contributing towards the cost of your or your ***family member's*** other coverage). Also, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to elect coverage for yourself and your eligible ***family members*** under the Medical Plan. To enroll in coverage, you must request enrollment within 30 days of the event which triggers the special enrollment rights described in this

paragraph. Coverage will be effective as of the date the event occurred.

Additionally, you may be able to elect coverage under the Medical Plan if you or your dependent (1) is enrolled in a Medicaid plan or a state child health plan (CHIP), and such coverage is terminated due to loss of eligibility for coverage or (2) become eligible for premium assistance (pursuant to a Medicaid or CHIP plan) with respect to coverage under the Medical Plan. You must request enrollment within 60 days of the event which triggers the special enrollment rights described in this paragraph. Coverage will be effective as of the date the event occurred.

To request special enrollment or to obtain more information, contact the Company's Human Resources Department.

Qualified Medical Child Support Orders

You may also be eligible to enroll your child for coverage under the Medical, Dental or Vision Plans pursuant to the terms of a qualified medical child support order (QMCSO). As provided under the Omnibus Budget Reconciliation Act of 1993, a QMCSO is a judgment, decree or order (including approval of a settlement agreement) issued by a state court or through an administrative process under state law that creates or recognizes the right of a child to receive benefits under a group health plan.

The Company determines whether a court order is a QMCSO within the meaning of federal law. Once the Company determines that an order meets the requirements for a QMCSO, coverage will be provided in accordance with federal and applicable state law. If the Company receives a QMCSO, you and the affected child will be notified by the Company before benefits are assigned pursuant to the order. If you are not enrolled in the Medical Plan, Dental Plan or Vision Plan (as applicable) at the time the Company receives a QMCSO, then the Company may automatically enroll you in the plan in order to provide coverage for your child as required by the QMCSO.

For further information about QMCSOs or a copy of the Company's QMCSO procedures, please contact the Company's Human Resources Department.

WHEN YOUR COVERAGE ENDS

Your coverage (and the coverage of your ***family members***) under the component plans ends on the earliest of the following dates:

- The date the Master Welfare Plan or a particular component plan is discontinued or terminated;
- The last day of the month in which you cease to be eligible for coverage (except coverage under the Long-term Disability Plan ends on the date you lose eligibility);
- In the case of one of your eligible ***family members***, the date the ***family member*** is no longer eligible for coverage;[6]
- The date through which you paid your required premiums (if any) for coverage; or
- The last day of the month in which your employment with the Company terminates (except coverage under the Long-term Disability Plan ends on your last day of work).

Continuation Coverage

When coverage under the Medical, Dental or Vision Plans or Health Care Spending Account ends, you or your covered ***family members*** may be able to apply for continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Please see Appendix B of this SPD entitled "COBRA Continuation Coverage" for more information.

[6] Coverage for your dependent children who reach the plan's applicable age limit is terminated on the last day of the month in which such child attains such age.

Coverage During Leaves of Absence

Coverage During FMLA Leave

If you meet certain service requirements, you may be entitled to take a maximum of 12 weeks of unpaid leave in a 12-month period for certain specified family and medical reasons under the Family and Medical Leave Act of 1993 (FMLA). If you take leave under the FMLA, you will generally be entitled during your leave to continue your benefits at the same coverage level in effect at the time of your leave. If you elect to continue coverage, you will be responsible for your share of the premiums (if any) while you are on FMLA leave. Contact the Company's Human Resources Department for more information.

Coverage During Other Leaves of Absence

You may also continue most of your benefits while you are on any other approved leave of absence. Contact the Company's Human Resources Department for more information.

Making Changes to Your Benefits During Your Leave

If your benefits are continued during your leave of absence and you experience a ***change in family status*** during such leave, you will be able to make election changes consistent with your ***change in family status***, as described earlier in this SPD. Additionally, you will be able to make election changes during any annual open enrollment that occurs during your leave.

If you are eligible for benefits during your leave of absence, you will also be eligible for coverage under any new component plans that are offered under the Master Welfare Plan during your leave (subject to applicable eligibility requirements). Your coverage will also be affected by any changes that the Company makes to the component plans during your leave. If the costs for providing new or changed component plans increase during your leave, your contributions may change accordingly.

When you return from your leave, your coverage elections that are in effect as of the day you return from your leave will continue in effect. You will be able to make new coverage elections only during an annual open enrollment or if you have a ***change in family status***.

Paying for Your Benefits During Your Leave

You will be responsible for paying your portion of the cost of coverage at active employee rates while you are on any type of leave of absence, including FMLA leave. If you are on paid leave, the cost of your benefits will be deducted from your pay. If you are on unpaid leave, you will be required to pay your contributions for your benefits with after-tax dollars in the manner required by the Company. Contact the Company's Human Resources Department for more information.

HOW TO OBTAIN MORE INFORMATION ABOUT YOUR BENEFITS

More detailed information about each of your benefit plans is contained in the summaries of benefits and coverage, plan booklets, certificates, schedules of benefits, evidences of coverage, insurance policies, or other benefit summaries that are available for each benefit plan and are incorporated by reference as a part of this SPD. Further information about these documents is found in Appendix D.

Additionally, when you have any questions or need further information about your benefits, several resources are available to you. You can contact the Company's Human Resources Department at (708) 551-2600. Also, Appendix A highlights the contact information for the administrators of each of the plans who are available to answer questions about the plan benefits.

BENEFITS OVERVIEW

MEDICAL, PRESCRIPTION DRUG, DENTAL AND VISION BENEFITS

The Company's Medical Plan, including a prescription drug component, has several options for medical coverage for you and your eligible ***family members***. These various options are described in Appendix A.

The Company's Dental Plan also has multiple options for dental coverage for you and your eligible ***family members***. These various options are described in Appendix A.

The Company's Vision Plan also has multiple options for vision coverage for you and your eligible ***family members***. These various options are described in Appendix A.

The insurance company for the Medical Plan component acts as claims administrator for these benefits. The claims administrator is responsible for determining how much the plan pays and for administering claims. Information about the claims administrators for your Medical, Dental and Vision Plans can be found in Appendix A.

If the Medical, Dental or Vision Plan option which you select has a network of providers, a list of such network providers is automatically available to you, free of charge. You can contact the third party administrator or insurance company for your plan option to obtain a list of network providers or to inquire as to whether a particular provider is in your network.

Coverage details about your medical, dental and vision benefits under the Master Welfare Plan can be found in the summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary that has been prepared by the third party administrator or insurance company for your plan option. These documents are referenced in Appendix D to this SPD.

The decisions about how and when you receive medical, dental or vision care are up to you and your physician or dentist, not the Medical, Dental or Vision Plans. However, some expenses will not be eligible for reimbursement, even if recommended by your medical, dental or vision care provider. To use the Medical, Dental and Vision Plans to your advantage and to receive maximum benefits, please review your summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary to understand how your plan works, how much you pay for your benefits and what benefits are covered under the plan.

ID Card

No matter which medical plan option you have, you should receive a Member ID card. You and your covered ***family members*** should carry an ID card at all times. You will need to present this card when you receive medical care, services or supplies. Additionally, this ID card should contain information regarding how to contact the claims administrator. You can print out your dental and vision card online if you wish.

Women's Cancer Rights

Pursuant to the Women's Health and Cancer Rights Act of 1998 (WHCRA), the Medical Plan provides certain benefits in connection with a mastectomy. You will be able to receive coverage, in a manner determined in consultation with the participant and the attending physician, for the following:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.

- Treatment of physical complications resulting from a mastectomy, including lymphedemas.

These benefits will be subject to the same deductibles and coinsurance amounts that are applicable to other benefits under the Medical Plan. If you have any questions about these benefits, you can contact the Company's Human Resources Department or the claims administrator.

Hospital Stay Rules for Mothers and Newborns

The Medical Plan will not restrict benefits for any hospital length of stay in connection with childbirth for a mother or newborn child to less than 48 hours following a vaginal delivery and 96 hours following delivery by cesarean section, in accordance with federal law. Under federal law, authorization is not required for a hospital stay for a mother or her newborn child in connection with the birth of the child if the hospital stay does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). If the mother needs to remain hospitalized longer than 48 hours (or 96 hours, as applicable), or if the newborn infant needs to be hospitalized for additional days beyond the covered mother's stay, the mother may be required to notify the claims administrator for the required authorization. Your medical provider may do this for you automatically, but it is your responsibility to make sure the extended stay has been approved.

Please note, the state where you live may impose additional or different requirements regarding hospital stays for mothers and newborns that may be applicable to any fully insured medical plan options. Please consult your summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary for information regarding any such state laws which may be applicable to your coverage.

WELLNESS PROGRAM

The Company sponsors a wellness program for all U.S. salaried and North Kansas City, MO union employees and their eligible spouses or domestic partners. The long-term goal of this free benefit program is to reduce the incidence of serious, preventable illness or disease in the Company's employee population and offer ways for its employees to make healthier lifestyle choices.

LIFE AND ACCIDENT BENEFITS

The Company automatically provides you with basic life insurance benefits, except in the case of certain union employees who must affirmatively elect basic life insurance benefits. Additionally, the Company provides you with an opportunity to elect various supplemental benefits under the Life and Accident Insurance Plan. You may elect from among various life insurance and accidental death and dismemberment (AD&D) coverage options for both yourself and your eligible ***family members***. In order for your ***family members*** to be eligible for certain life and AD&D coverage, you (the employee) must first be enrolled in such coverage. Your benefit options under these plans are described in Appendix A.

These 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. Information about the claims administrator for these benefits can be found in Appendix A to this SPD.

Coverage details about your life and AD&D benefits can be found in the summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary that has been provided by the insurance company for your benefits or, if applicable, the Collective Bargaining Agreement that applies to you. These documents are referenced in Appendix D to this SPD.

Evidence of Good Health

If you (or your eligible ***family members***) elect life insurance coverage above a certain amount, then you may be required to provide evidence of good health. Additionally, if you (or your eligible ***family members***) do not enroll in life insurance coverage within 31 days of your eligibility date, then you may be required to provide evidence of good health before you can add these benefits. Further, if you (or your eligible ***family members***) elect to increase your life insurance coverage amount at a future date, you may be required to provide evidence of good health.

For information about obtaining evidence of good health, contact the Company's Human Resources Department or the insurance company. If evidence of good health is required, then your elections will not take effect until your election has been approved by the insurance company.

Further information about the evidence of good health requirements can be found in the applicable Collective Bargaining Agreement, summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary (as detailed in Appendix D).

Beneficiary Form

You may name a beneficiary(ies) to receive your death benefits under the Life and Accident Insurance Plan if you die by completing a Beneficiary Form. Beneficiary designations will be maintained online via www.ingredionbenefits.com. You may change your beneficiary online at any time or by contacting the Company's Human Resources Department and submitting a new Beneficiary Form. **If you die, the most recent Beneficiary Form online or on file with the Company's Human Resources Department will be used to determine who receives the death benefits under the Life and Accident Insurance Plan.** You should periodically make sure your beneficiary designation is up-to-date by going to www.ingredionbenefits.com and you should review and, if appropriate, modify your beneficiary designation when you have a ***change in family status***.

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 certificate or policy.

For further information about naming a beneficiary under the Life and Accident Insurance Plan, please go online to www.ingredionbenefits.com consult the summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary for the Life and Accident Insurance Plan or contact the Company's Human Resources Department.

Taxation of Life Insurance Benefits

Under current tax law, you may be taxed on the amount of your life insurance coverage carried by your employer that exceeds $50,000. Therefore, your life insurance coverage may result in taxable income. This tax liability is called "imputed income" and will be reported as income on your IRS Form W-2. The amount of your imputed income will be determined in accordance with guidelines established by the IRS.

LONG-TERM DISABILITY BENEFITS

The Company automatically provides you with benefits under the Long-term Disability (LTD) Plan. These 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. Information about the claims administrators can be found in Appendix A to this SPD.

Coverage details about your LTD benefits can be found in the summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary that have been provided by the

applicable insurance company. These documents are referenced in Appendix D to this SPD.

Paying for Coverage in the LTD Plan and Taxation of LTD Benefits

The Company will pay the premiums for your coverage under the LTD plan and you will have imputed income on the cost of such premiums.

Coordination with Family and Medical Leave Act

Your disability may qualify you for an authorized leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA). Please note, however, that if you qualify for FMLA leave, then your FMLA leave will run concurrently with any period during which you are receiving disability benefits or workers' compensation benefits.

SPENDING ACCOUNTS

You may also be eligible to elect to participate in a Health Care Spending Account and/or a Dependent Care Spending Account. Further information about Spending Accounts can be found in the next section of this SPD entitled "Health and Dependent Care Spending Accounts".

HEALTH SAVINGS ACCOUNT

If you are eligible to participate in the Health Savings Plan, you may also elect to contribute to an HSA. Further information about the HSA can be found on p. 4 of this SPD.

SEVERANCE COMPONENT PLANS

Please note that the Ingredion Incorporated Employee Severance Plan for Salaried Employees and the Ingredion Incorporated Special Severance Plan are also components of the Ingredion Incorporated Master Welfare and Cafeteria Plan but are described in separate summary plan descriptions. Please contact the Human Resources Department to find out if you are eligible to participate in these component plans and would like a copy of these summary plan descriptions.

CLAIMS ADMINISTRATOR

Each of your benefit plans is administered by a claims administrator, as outlined above and detailed in Appendix A. The claims administrator has full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of coverage under the applicable plan.

HEALTH AND DEPENDENT CARE SPENDING ACCOUNTS

HOW YOUR HEALTH AND DEPENDENT CARE SPENDING ACCOUNTS WORK

Health and Dependent Care Spending Accounts can help you save money if you incur covered health care or dependent care expenses during the year. The Spending Accounts are designed to help you pay for eligible health care and dependent care expenses with pre-tax dollars.

The Health Care Spending Account helps pay for health care expenses not covered by your or your spouse's health care plans. The Dependent Care Spending Account helps you pay someone to care for young children or dependent adults while you work.

Note that if you participate in the HSA described on p. 4, you are not eligible to participate in a Health Care Spending Account.

The Spending Accounts are voluntary – you elect whether or not to contribute to either or both type of accounts each year. The Spending Accounts work much like bank accounts. First, you make deposits into your Spending Accounts with pre-tax dollars through payroll deductions (which reduce your taxable income). During the year, as you pay out-of-pocket expenses for health care and dependent care, you file a claim for reimbursement from your Spending Accounts for the eligible out-of-pocket health care and dependent care expenses which you incurred, respectively. The reimbursements you receive are tax-free.

TAX CONSIDERATIONS AND SPENDING ACCOUNT RULES

The IRS has certain guidelines for the operation of Spending Accounts. This section highlights some of these guidelines.

The tax effects related to your Spending Accounts can be complex. You may wish to consult your tax advisor before deciding to contribute to a Spending Account.

"Use It or Lose It" Rule

One of the rules imposed by the IRS is the "use it or lose it" rule. Under this rule, you must decide how much you want to contribute to each Spending Account before the beginning of the calendar year, usually during annual open enrollment or when you first enroll in the Spending Accounts. You will then make contributions to your account for the entire calendar year. In general, you may be reimbursed with those contributions only for expenses which you incur during that calendar year, and you must submit a claim for those expenses by March 30 of the following year. The IRS requires that you forfeit any money which remains in either of your Spending Accounts after March 30 following the end of the calendar year in which the money was contributed, except as otherwise provided below. In other words, you must "use it or lose it."

Because of the "use it or lose it" rule, you should estimate your expenses carefully before deciding how much to contribute to a Spending Account.

However, if any amount remains unused in your Health Care Spending Account at the end of a plan year, your Health Care Spending Account will receive carryover credit of up to $550 (as increased in the future as allowed per regulations) of any such remaining amount as of the first day of the immediately following plan year; provided, however, that if you have elected to participate in a Health Savings Account and the Health Savings Plan (HSP) for such immediately following plan year, you will be deemed to have waived the carryover of such unused amounts, and such unused amounts shall be forfeited as described above. Any carryover credit will be available in your Health Care Spending Account until March 30 of the following plan year, which is the run out period for prior year claims.

Other Tax Considerations

The following are some other tax considerations which you should know about before electing to participate in a Spending Account:

- You may not claim any expenses reimbursed from either Spending Account as a deduction or credit on your federal income tax return.

- If your taxable income – after deducting your contributions to your Spending Accounts – is less than the Social Security wage base, this could make your future Social Security benefits slightly smaller. This result occurs because the money you deposit in your Spending Accounts "reduces" your pay for tax purposes, and the Company reports a smaller earnings amount to Social Security for that year.

Other Spending Account Rules

The following are some additional rules that apply to your Spending Accounts:

- If you do not elect to contribute to one or both of the Spending Accounts for the coming year, you may not file any claims against such account(s) during that year, except to the extent that you are allowed to carry over money in your Health Care Spending Account to such year.

- Deposits to your Spending Accounts stop if one of the events described under the heading "When Your Coverage Ends" in the "Introduction" section occurs, such as when you terminate your employment with the Company or are no longer eligible. You may be reimbursed from the balance remaining in your Health Care Spending Account for any eligible expenses you incurred before that event occurred and from the balance remaining in your Dependent Care Spending Account for any eligible expenses incurred through the end of the calendar year.

- You may not use money designated for health care expenses to pay for dependent care expenses, and vice versa. Also, you may not transfer money from one Spending Account to another.

- The entire amount that you elect to contribute to your Health Care Spending Account for the year will be available for reimbursement on the first day of the plan year (January 1). Thus, you may submit a claim for ***eligible expenses*** regardless of the current balance in your Health Care Spending Account at that time, as long as the total amount of claims submitted for the plan year does not exceed the amount you elected to contribute to your Health Care Spending Account for the plan year. You will be reimbursed for expenses only if, when combined with any previously paid expenses, they do not exceed the amount you elected to contribute to your Health Care Spending Account for the year.

- Any claim for eligible dependent care expenses that exceeds the current balance in your Dependent Care Spending Account will be reimbursed only up to an amount that is equal to the balance in your Dependent Care Spending Account at that time.

- If you enroll in a Spending Account mid- year because you are a new hire or because of a ***change in family status***, only eligible expenses incurred after your participation date may be reimbursed under the account. Likewise, if you change the amount of your deferral election during the year due to a ***change in family status***, any additional amounts you contribute can be used only toward eligible expenses incurred after the date of the ***change in family status***. Also, if you change elections pursuant to a ***change in family status***, you may not submit expenses for any new ***family members*** that were incurred prior to such ***change in family status***.

- Your Spending Account elections do not roll over from year to year. **You must reenroll in the Spending Accounts each year.** If you do not reenroll during the annual open enrollment period, you will not be able to participate in the Spending Accounts for the following plan year (unless you experience a

qualified ***change in family status*** which would enable you to enroll in a Spending Account during the plan year), except to the extent that you are allowed to carry over money in your Health Care Spending Account to the following year.

THE CLAIMS ADMINISTRATOR

The Company has hired a third party to administer the Spending Accounts. This administrator also acts as claims administrator for the Spending Accounts. The claims administrator has full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of coverage under the Spending Accounts. The name and contact information for this third party administrator can be found in Appendix A.

HEALTH CARE SPENDING ACCOUNT

Contribution Amounts

The maximum amount you may contribute to your Health Care Spending Account is $2,750 and the minimum amount is $100 for 2021. However, if you are considered a "highly compensated employee" or "key employee" under the Internal Revenue Code, the amount of money you may contribute to your Health Care Spending Account may be limited. You will be notified if this situation applies to you.

Eligible Expenses

You can use your Health Care Spending Account to pay for eligible, unreimbursed health care services that you and/or your eligible ***family members*** incur.

An eligible "**family member**" for purposes of the Health Care Spending Account is:

- Your spouse,
- Your children under the age of 26,
- Your unmarried children who can be claimed as a dependent on your federal income tax return, or
- Any individual who can be claimed as a dependent on your federal income tax return.

Your ***family members*** do not have to be enrolled in any benefit plans sponsored by the Company in order for expenses to be eligible for reimbursement under your Health Care Spending Account.

In general, you may be reimbursed for any out-of-pocket medical, dental or vision care expenses that are not reimbursed by any other coverage and that would otherwise qualify as a deduction on your federal income tax return (under section 213 of the Internal Revenue Code). You may also be reimbursed for any health care expense which has been determined by the IRS to qualify for reimbursement under a health care spending account.

For a detailed list of eligible and ineligible expenses and services, please see IRS Publication 502. Further information on eligible health care expenses is available on the third party administrator's website.

Determining Your Contributions and "Use It or Lose It" Rule

To determine how much to contribute to your Health Care Spending Account, you should consider the type of health care services you and your eligible ***family members*** will need in the coming year. Then, estimate how much these services may cost. Be sure to estimate carefully. In order for expenses to be eligible for reimbursement under your Health Care Spending Account in a particular calendar year, expenses for services must generally be incurred during that calendar year and be submitted by March 30 of the following year. Generally, expenses are

deemed to be incurred at the time that the related health care services are provided (and not at the time that such expenses are actually paid), with a few limited exceptions. If you have any questions about expenses that are covered or coverage with regard to pre-paid medical, dental or vision expenses, you may contact the third party administrator.

In general, any amounts remaining in your Health Care Spending Account after March 30 will be forfeited under the IRS "use it or lose it" rule. However, if any amount remains unused in your Health Care Spending Account at the end of a plan year, your Health Care Spending Account will receive carryover credit of up to $550 of any such remaining amount as of the first day of the immediately following plan year; *provided*, *however*, that if you have elected to participate in a Health Savings Account for such immediately following plan year, you will be deemed to have waived the carryover of such unused amounts, and such unused amounts shall be forfeited as described above. Any carryover credit will be available in your account after March 30 of the following plan year, which is the run out period for prior year claims.

Continuation Coverage

When coverage under the Health Care Spending Account ends, you or your covered ***family members*** may be able to apply for continuation coverage pursuant to COBRA. Please see Appendix B entitled "COBRA Continuation Coverage" for more information. If you do not elect COBRA continuation coverage for your Health Care Spending Account, you will be able to submit expenses for eligible services incurred only up to the date that your coverage ends due to termination or any other event.

DEPENDENT CARE SPENDING ACCOUNT

Contribution Amounts

The minimum annual contribution amount is $100. If you are single or you are married and file a joint tax return, you may generally elect to contribute a maximum of $5,000 to your Dependent Care Spending Account each year. If you and your spouse both contribute to accounts, you are limited to a combined total of $5,000 ($2,500 per person) each year. Additionally, if you are married and you and your spouse file separate tax returns, you may generally elect to contribute a maximum of $2,500 to your Dependent Care Spending Account. However, your tax situation or your annual income can limit your maximum contribution, as follows:

- If you or your spouse have an annual income less than $5,000, your maximum contribution to a Dependent Care Spending Account is equal to the lower annual income.

- Generally, if your spouse does not have any annual income and is not looking for work or attending school on a full-time basis, you may not contribute to a Dependent Care Spending Account. However, if your spouse is a full-time student for at least five months of the year or is mentally or physically disabled, he or she will be "credited" with income of $250 per month if you have one ***eligible dependent*** and $500 per month if you have 2 or more ***eligible dependents*** for each month he or she is a student or disabled.

In addition, if you are considered a "highly compensated employee" or "key employee" under the Internal Revenue Code, the amount of money you can contribute to your Dependent Care Spending Account may be limited. You will be notified if this situation applies to you.

Eligible Expenses

You can use your Dependent Care Spending Account to pay certain costs for the care of your ***eligible dependents***. The care must be needed so you and your spouse can work, or to allow you to work if your spouse is a full-time student or unable to care for himself or herself.

An "**eligible dependent**" is a person who has the same principal place of residence as you for more than half the year and is:

- your child younger than age 13 who you can claim as a dependent on your federal income tax return;
- your spouse who is mentally or physically disabled; or
- your dependent who is mentally or physically disabled (and who you can claim as a dependent on your federal income tax return).[7]

Generally, "**eligible expenses**" include charges for home or day care for your ***eligible dependents***. See below for further information and restrictions.

Eligible expenses include expenses related to day care provided outside your home for your ***eligible dependents*** who are mentally or physically disabled and unable to care for themselves only if such dependents regularly spend at least eight hours a day in your home.

You can use the money in your Dependent Care Spending Account to be reimbursed for ***eligible expenses*** you incur for day care for your ***eligible dependents*** that is provided by any of the following:

- Individuals (including relatives unless they are your spouse, your or your spouse's tax dependent, or your child under the age of 19) who are responsible for providing care for your eligible dependents – either in your home or theirs.
- Day care centers.
- Day camps (but not overnight camps).
- Nursery schools (or preschools) which provide care for your eligible dependents.

If a day care or school serves six (6) or more children, it must be licensed and comply with state and local laws.

Please note that you must provide the name, address, Social Security number or other tax identification number of the individual, day care center or other entity providing the dependent care in order to receive reimbursements.

In addition, you must be working during the time that your ***eligible dependents*** are receiving care. If you are married, your spouse must be:

- Working or seeking work;
- A full-time student at least five months during the year; or
- Mentally or physically disabled and unable to care for himself or herself.

If you are divorced or legally separated, you may use your Dependent Care Spending Account for child care expenses if you have custody of your child during more of the year than the child's other parent.

Further information on eligible dependent care expenses is available on the third party administrator's website.

Ineligible Expenses

You may not use your Dependent Care Spending Account to pay for certain expenses such as (but not limited to) amounts paid for:

- Expenses incurred for days you are not working or days when you do not meet eligibility requirements (unless due to a short, temporary absence, such as a sick day or vacation day).
- Care for your dependents who are not ***eligible dependents***.

[7] Certain limited provisions in the Internal Revenue Code's definition of dependent (including the gross income limitation) are disregarded when determining whether an individual is a dependent for purposes of your Dependent Care Spending Account. You should consult your tax advisor for further information.

- Any child care services provided by your spouse or by a parent of your child who is not your spouse.

- Any child care services provided by individuals (i) that you or your spouse can claim as dependents on your federal income tax return or (ii) who are your children and are younger than age 19 at the end of the year.

- Expenses for food or clothing for an ***eligible dependent*** (unless they are an inseparable part of the care for such dependent).

- Expenses for an overnight camp.

- Costs for kindergarten or a higher grade. (If the cost can be separated between education and after-school care, however, a portion of expenses for after-school care may be eligible).

- Expenses incurred before your participation date.

- Expenses incurred after you stop contributing or participating.

- Services that are paid for by another organization or provided without cost.

- Expenses you claim as deductions or credits on a federal or state income tax return.

Please note that the lists of eligible expenses and ineligible expenses are subject to change. Please contact the third party administrator if you have a questions regarding whether a particular expense is eligible.

Determining Your Contributions and "Use It or Lose It" Rule

To determine how much to contribute to your Dependent Care Spending Account, you should consider the type of dependent care services you will need in the coming year. Then, estimate how much these services may cost. Be sure to estimate carefully. In order for expenses to be eligible for reimbursement under your Dependent Care Spending Account in a particular calendar year, expenses must be incurred during that calendar year and submitted by March 30 of the following year. Generally, expenses are deemed to be incurred at the time that the dependent care services are provided (and not at the time that such expenses are actually paid).

In general, any amounts remaining in your Dependent Care Spending Account after March 30 will be forfeited under the IRS "use it or lose it" rule.

Dependent Care Spending Account vs. Tax Credit

Keep in mind that, under current IRS regulations, you may be eligible to receive a tax credit for dependent care expenses. You may claim the credit when you file your income tax return. However, you may not claim the tax credit for any expenses reimbursed from your Dependent Care Spending Account. You may want to talk to a tax specialist to help you determine which approach is best for you – using a Dependent Care Spending Account, the tax credit, or a combination of the two.

FILING A CLAIM

Manually submitting claims

Once you incur an eligible medical or dental expense you may submit the claim either online, via fax or mail. The submission must include a completed claim form with supporting documentation (generally the date of service including year, amount, provider name and type of service). Requests for reimbursement received online will be processed once corresponding receipts are submitted. Requests for reimbursement received via fax will be processed the later of two business days after receipt of the claim or prior to the next scheduled claim reimbursement date. Claims received via mail may require one additional day for processing.

The third party administrator will notify you of any missing information or ineligible expenses. This notification will be in the form of a reimbursement statement similar to an explanation of benefits (EOB) or a letter.

Reimbursement requests may be submitted after the expense is incurred and during the period of coverage or applicable run-out period (often 90 days, but you may choose differently). Claims submitted after the run-out period will be denied. Reimbursement checks will be mailed to the employee or the reimbursement amount will be deposited directly into the participant's bank account.

Claims

To receive money from your Spending Accounts, complete a flexible spending accounts reimbursement form. Fax or mail the completed form, together with the appropriate supporting documentation (including your itemized, paid receipts), to the address reflected on the claim form. You can obtain a copy of the form on the third party administrator's website or from the Company's Human Resources Department. You may also file a claim online with the third party administrator.

In order to be reimbursed for expenses under your Spending Accounts, you must submit a receipt.

Further, to be reimbursed for an expense related to medical or dental services, your submission must include the explanation of benefits statement (if any) which you received for the submitted expense.

In order to be reimbursed for expenses under your Dependent Care Spending Account, your receipt must list the caregiver's name, address, Social Security number (or other taxpayer identification number), and dates of service.

By seeking reimbursement for any expense under your Health Care Spending Account, you certify that such expense was incurred on behalf of yourself or your eligible ***family members***. By seeking reimbursement under either Spending Account, you certify that the expense will not be claimed as a deduction on your personal tax return.

If your claim is approved, the money will be withdrawn from the appropriate Spending Account, and the check will be mailed to you.

Each time you receive a payment, you will receive an explanation of how the payment was calculated and how much money remains in your Spending Account. If no payment is made, you will receive an explanation as to the reason for the non-payment.

For further information about filing a claim under the Spending Accounts, see Appendix C at the end of the SPD.

Taxable Payments

If for any reason you receive a reimbursement for an ineligible expense, or for an amount in excess of the maximum amount permitted by the law, these amounts may be taxable income. You will be responsible for any taxes due on these amounts. If you are unsure whether your expenses are eligible for reimbursement under a Spending Account, contact the Company's Human Resources Department or the third party administrator for the Spending Accounts before submitting your claim.

BENEFITS PROVIDED DUE TO COVID-19

As a result of the COVID-19 pandemic, the Company has provided or will provide certain COVID-19-related benefits. The benefits listed in this section are in addition to, and in some cases are an expansion of, the benefits provided in the section entitled "Benefits Overview."

CHANGES TO DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT ELECTIONS

Losing access to your child care provider during the COVID-19 pandemic is a qualified life event which will allow you to make an election to decrease your Dependent Care Flexible Spending Account during 2020.

CHANGES TO HEALTHCARE FLEXIBLE SPENDING ACCOUNT ELECTIONS

If you made a Healthcare Flexible Spending Account election for 2020, you were allowed the option to revoke your election, as well as increase or decrease the amount of your election during a special election period from June 22, 2020 to July 3, 2020.

SHORT TERM DISABILITY CLAIMS

The Company's insurance provider will provide for a 14-day approval on short term disability claims if you provide verbal confirmation of symptoms and treatment for COVID-19. In addition, the insurance provider is including COVID-19 claims as part of its standard short term disability claims process, which provides for fast-tracking of claims.

TELEHEALTH

If you and your family members were covered under the Medical Plan, including if you were covered under the HSP but had not yet satisfied your deductible, you were provided free access to telehealth services provided through MDLIVE and other in-network providers through September 30, 2020.

COVID TESTING AND IMMUNIZATION

Participants covered under the Medical plan will pay no cost for testing or testing-related visits with in-network providers to diagnose COVID-19. Once available, a COVID-19 immunization will be free to all Medical Plan participants the same as any covered in-network preventative treatment.

ERISA AND ADMINISTRATIVE INFORMATION

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

This document, together with the summaries of benefits and coverage, applicable Collective Bargaining Agreement, plan booklets, certificates, schedules of benefits, evidences of coverage, insurance policies, or other benefit summaries provided by the insurance companies or third party administrators, is intended to constitute a summary plan description of the employee benefit plans as required by the Employee Retirement Income Security Act of 1974 ("ERISA"). The benefit plans described in this SPD are part of the Ingredion Incorporated Master Welfare and Cafeteria Plan, which is evidenced by a formal written plan document (part of which constitutes a "cafeteria plan" with the meaning of section 125 of the Internal Revenue Code). If there is any conflict between this SPD and the Master Welfare Plan document, the Master Welfare Plan document will control. Please contact the Company's Human Resources Department if you would like a copy of any of these other documents or the most recent annual report for the Master Welfare Plan.

ERISA REQUIREMENTS

A description of the Dependent Care Spending Account is contained in this SPD in order to communicate this benefit to you. However, the Dependent Care Spending Account is not governed by ERISA.

All other benefit plans described in this SPD are considered welfare benefit plans under ERISA and thus are governed by ERISA. The information about these plans contained in this SPD is provided to you pursuant to the requirements of ERISA.

AMENDMENT OR TERMINATION OF A PLAN

Subject to the terms of any applicable Collective Bargaining Agreement, the Company reserves the right to amend, modify or discontinue all or any part of its benefit plans, including the Master Welfare Plan and any component plans relating thereto, at any time, for any reason and without prior notice. In the event that a component plan is discontinued, you shall no longer be entitled to any benefit under the component plan, other than payment of covered expenses that you incurred before the component plan was discontinued.

GENERAL ADMINISTRATIVE INFORMATION

Plan Name

All of the component plans described in this summary are part of one formal plan entitled the "Ingredion Incorporated Master Welfare and Cafeteria Plan". Additionally, the benefits described in this document are governed by a written plan document entitled the "Ingredion Incorporated Master Welfare and Cafeteria Plan."

Plan Sponsor

Ingredion Incorporated is the Plan Sponsor of your benefit plans. The address and telephone number of the Plan Sponsor is:

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

A complete list of the employers participating in the Master Welfare Plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator and is available for examination by participants and beneficiaries.

Plan Administrator

The general administration of the Master Welfare Plan is performed by a Committee that is appointed by and serves at the will of the Board of Directors of the Company. The Committee can be contacted at:

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

The Plan Administrator has discretionary authority to interpret the terms of the Master Welfare Plan and each component plan, and to determine eligibility and entitlement to plan benefits in accordance with those terms. The Plan Administrator makes decisions and resolves conflicts regarding claims for benefits, the operation of the plans and the interpretation of plan terms. In certain instances, the Plan Administrator has delegated some of these responsibilities and authorities to persons within the Company or to third parties, including the claims administrators.

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 Master Welfare Plan. Benefits under the Master Welfare 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.

Employer Identification Number

The Plan Sponsor's employer identification number is 22-3514823.

Agent for Service of Legal Process

The Company's General Counsel is designated as the Master Welfare 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.

Plan Number

The plan number for the Ingredion Incorporated Master Welfare Plan is 525.

Plan Year

The plan year for the Master Welfare Plan is the calendar year, beginning January 1 and ending December 31. The Master Welfare Plan and all its records are kept on this calendar year basis.

Type of Plan, Plan Benefits and Administrators

The Plan is a welfare plan offering medical, dental, vision, prescription drug, life, disability, accidental death & dismemberment, wellness, critical illness and severance benefits as well as Flexible Spending Accounts.

The types of component benefit plans offered under the Master Welfare Plan as well as the addresses, phone numbers and websites for the insurance carriers and administrators for each component plan can be found in Appendix A at the end of this SPD.

CLAIMS PROCEDURES

If you believe that you are entitled to benefits under any of the component plans described in this SPD, then you must submit your claim in accordance with the claims procedures for the appropriate component plan. The claims procedures are described in Appendix C.

Your claims will be reviewed by the claims administrator for the respective benefit plan. The claims administrators have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of coverage under the respective component plan.

TIME LIMIT 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 claims administrator in response to a request for review of the denied claim. No other legal or equitable action involving the Master Welfare 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 Master Welfare Plan or its fiduciaries from recovering overpayments of benefits or other amounts incorrectly paid to any person under any plan at any time or bringing any legal or equitable action against any party.

Any legal action involving or related to the Master Welfare Plan, including but not limited to any legal action to recover any benefit under the Master Welfare 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 summaries of benefits and coverage, plan booklets, certificates, schedules of benefits, evidences of coverage, insurance policies, or other benefit summaries for the Master Welfare Plan to determine whether any other time limits for legal action may apply to claims under the plan.

LEGAL FEES

To the extent any claim or other legal action involving or related to the Master Welfare Plan is brought against a Plan Party (as defined below), the person or persons bringing such action shall not be entitled to recover any legal fees or expenses from the Master Welfare Plan, the Company, the Benefits Committee, the Plan Administrator, any of their respective affiliates, or any of their respective designees, allocatees, officers, directors, trustees, employees or agents (each, a "Plan Defendant"), or any other person with a right to indemnification from a Plan Defendant (each such person and each such Plan Defendant, a "Plan Party"), (a) including any legal fees or expenses incurred in connection with or otherwise attributable to (i) administrative proceedings under, or legal actions involving, the Master Welfare Plan, and (ii) actions brought under ERISA or any other law, rule or regulation, and (b) regardless of whether or not all or any part of such legal actions are decided in favor of the person bringing such legal action. In addition, no employee or former employee, beneficiary or other person shall be entitled to recover any legal fees or expenses from a Plan Party in connection with any administrative proceedings related to a claim, including if the claim is approved and no legal action is brought in connection with such claim.

PLANS' RIGHTS OF SUBROGATION, RECOVERY AND REIMBURSEMENT

The plans have the right to recover overpayments and payments made for benefits covered by another plan or program, including another group health plan, another disability plan, a governmental program, or a statutory plan such as Workers' Compensation. If you or your covered ***family members*** receive such a payment, the claims administrator may withhold payment on future benefits until these payments have been recovered or deduct such amounts from payments which you receive from the plan.

Additionally, if you or your covered ***family members*** receive certain benefits under the Medical, Dental, Vision or Long-term Disability Plans for injury, sickness or disability that was caused or is payable in whole or in part by a third party (including an insurance company or uninsured motorist coverage) and you have a right to receive payment from the third party (whether or not such payment is designated as payment for medical, dental, vision or disability benefits), then the plan has the right to recover payments for the benefits paid on your behalf under the plan. If you or your covered ***family member*** receive any such payments from third parties, payment of future benefits may be withheld until these payments have been recovered by the plan. Additionally the plan shall have the right to recover such payments by subrogation directly from the responsible third party or its insurer, without regard to whether you are pursuing a claim against such party.

In making a claim for benefits under any of these plans, you and your covered ***family members***

agree that the plan shall be reimbursed and shall recover 100% of such amounts (i) paid by a plan or (ii) which a plan is otherwise obligated to pay and thereafter pays, to the maximum amount you are otherwise entitled to receive in connection with a claim against a third party arising out of an injury, sickness or disability (whether received by judgment, settlement or otherwise). You further agree to offer any assistance necessary to help the plan recover such amounts.

The plan's right to reimbursement and restitution shall apply to the full amount of benefits paid without any deduction for attorney's fees and costs or other expenses incurred by you or any covered ***family member***, without regard to whether you or a covered ***family member*** is fully compensated by the recovery on the claim against the third party (*i.e.*, whether you or your covered ***family member*** is "made whole") and without regard to allocation or designation of the recovery. If the recovery from the third party is less than the benefits paid by the plan, then the plan is entitled to be paid all of the recovery from the third party. The plan shall have an equitable lien against all funds received by you or a ***family member*** and all such funds shall be deemed to be held in constructive trust for the benefit of the plan until such funds are delivered to the plan. This lien and constructive trust shall be imposed against any party who is holding such funds.

This right of recovery, reimbursement and restitution, in contract and in equity, constitutes a first priority and first lien against any settlement, judgment, award or other payment obtained by you or on your behalf, or by your covered ***family member*** or on behalf of your covered ***family member***, for recovery of amounts paid by the pertinent plan.

In addition to the rights of recovery described in this section, your summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary may also contain additional provisions regarding a plan's rights of recovery, subrogation and reimbursement. Please consult these documents (as described in Appendix D) for further information regarding such rights.

By accepting benefits under the benefit plans described in this SPD, you acknowledge and agree to the recovery, subrogation and restitution provisions as described in this section (including provisions in the additional documents described in Appendix D).

NO GUARANTEE OF EMPLOYMENT

Nothing in the Master Welfare Plan, the plans or in this SPD guarantees a right to employment with the Company.

HIPAA PRIVACY AND SECURITY UNDER GROUP HEALTH PLANS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (and regulations thereunder) contains requirements regarding your protected privacy rights with respect to how your health information that is obtained by the health plans will be used and disclosed by the Company and the health plans. There are requirements regarding when and how the health plans may disclose protected health information (including electronic protected health information) to the Company. There are also requirements regarding how and for what purposes the Company may use such information once it is obtained, and who within the Company may have access to such information. Additionally, the Company must make certain certifications before the health plans will disclose any protected health information to the Company. Finally, the Company has set forth certain procedures to ensure that these requirements are met and has appointed a privacy official to administer these privacy policies. The plan document for the Master Welfare Plan as well as outside materials provided by the insurance companies for the health plans contain detailed information regarding these privacy rights. Please contact the Company's Human Resources Department for copies of these documents.

ERISA RIGHTS

As a participant in the component plans which are subject to ERISA, you are entitled to certain rights and protections under ERISA. ERISA

provides that all plan participants shall be entitled to:

- Examine, without charge, at the office of the Plan Administrator and at other specified locations, such as the personnel office, all documents governing the Master Welfare Plan, including insurance contracts, plan descriptions and a copy of the latest annual report (Form 5500 Series) filed by the Master Welfare 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 Plan Administrator, copies of documents governing the operation of the Master Welfare Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary each year of the Master Welfare Plan's annual financial report. The Plan Administrator 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 and/or dependents if there is a loss of coverage under the Master Welfare Plan as a result of a qualifying event. You, your spouse or your dependents will be required to pay for such coverage. See Appendix B of this SPD entitled "COBRA Continuation Coverage" for more information about your rights with respect to continuation coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Master Welfare Plan. The people who operate the plan, called "fiduciaries" of the Master Welfare 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 Master Welfare Plan or from exercising your rights under ERISA.

Enforcement of Your Rights

If your request for a benefit under the Master Welfare 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 have your claim reviewed and reconsidered, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For example, if you request materials from the Master Welfare 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 request for benefits is denied or ignored, in whole or in part, you may choose to file suit in a federal court after you have completed the claims appeal process (as described in Appendix C). 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 Master Welfare 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.

Any suit filed in federal court shall be subject to the restrictions and limitations imposed by the Master Welfare Plan, including, without limitation, the Master Welfare Plan's statute of limitations, venue and legal fees restrictions described herein or in the Master Welfare Plan document.

Assistance With Your Questions

If you have any questions about the Master Welfare Plan, you should contact the Company's Human Resources Department. 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
INFORMATION ABOUT YOUR BENEFITS AND PROVIDERS

GENERAL INFORMATION ABOUT YOUR BENEFITS

If you have any questions about your benefits, you can contact the Company's Human Resources Department at (708) 551-2600 or in writing at:

Ingredion Incorporated
Attn: Human Resources Department
5 Westbrook Corporate Center
Westchester, IL 60154

The following table shows the names, addresses, telephone numbers and websites of the insurance companies and third party administrators for your welfare plans. Each third party administrator and insurance company also acts as the claims administrator for the applicable component plan.

In addition to the information below, please consult your summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, Collective Bargaining Agreement or other benefit summary for each component plan and, if applicable, your Member ID Card for the most up-to-date contact information for the claims administrator.

Component Benefit Plan	Claims Administrator (Insurance Company or Third Party Administrator)
Medical Plans – HRP and HSP; BlueEdge HCA and BlueEdge HSA; Mapleton and NKC Warehouse HSA Union	BlueCross and BlueShield of Illinois 300 East Randolph Street Chicago, IL 60601 1-800-458-6024 / www.bcbsil.com For Appeals: Claim Review Section P.O. Box 2401 Chicago, IL 60690
Health Savings Plan Account (HSA)	Fidelity Investment Services P.O. Box 145429 Cincinnati, OH 45250-5429 1-800-544-3716 www.401k.com
Health Care and Dependent Care Flexible Spending Accounts (HCFSA and DCFSA)	WEX (Discovery Benefits) P.O. Box 2926 Fargo, ND 58108-2926 Customer service: 1-866-451-3399 Claims: 1-866-451-3245 www.discoverybenefits.com; customerservice@discoverybenefits.com

Component Benefit Plan	Claims Administrator (Insurance Company or Third Party Administrator)
Employer Paid Critical Illness (only available to participants enrolled in the HSP or BlueEdge HSA) Voluntary Critical Illness (only available to those not identified above)	Metropolitan Life Insurance Company ("MetLife") 200 Park Avenue New York, NY 10166 1-800-942-0854 www.metlife.com/mybenefits
Medical plan for approved ex-pats only (*i.e.*, U.S. employees on foreign assignment):	For Claims outside the USA: Aetna International P.O. Box 981543 El Paso, TX 79998-1543 1-800-231-7729 www.aetnainternational.com
Prescription Drug	Express Scripts P.O. Box 14711 Lexington, KY 40512 1-866-877-8492 www.express-scripts.com
Dental Plan	BlueCross and BlueShield of Illinois 300 East Randolph Street Chicago, IL 60601 1-800-458-6024 / www.bcbsil.com
Vision	MetLife 200 Park Avenue New York, NY 10166 1-855-638-3931 www.metlife.com/mybenefits
Accident and Hospital Indemnity	MetLife 200 Park Avenue New York, NY 10166 1-800-438-6388 www.metlife.com/mybenefits
Long-Term Disability Plan Life and AD&D Insurance Plan	New York Life (Cigna) 12225 Greenville Ave., Suite 1000 Dallas, TX 75243 Claims: 1-888-842-4462 www.mycigna.com

COVERAGE LEVELS AND OPTIONS

The following table details the various coverage levels and options available to you with respect to your component plans as well as information regarding how benefits are funded. For further details regarding your coverage options, consult your summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary for each plan (as described in Appendix D), Collective Bargaining Agreement or call the Human Resources Department.

Type of Plan	Coverage Levels	Coverage Options	Type of Funding
Medical and Prescription Drug	• Employee only • Employee + spouse/domestic partner • Employee + children • Employee + family members	• Health Savings • Health Reimbursement Plan	Employer and Employee pre-tax contributions Note that certain union groups are not eligible to participate. Please contact the HR department for more information.
Dental	• Employee only • Employee + spouse/domestic partner • Employee + children • Employee + family members	• PPO	Employer and Employee pre-tax contributions Note that certain union groups are not eligible to participate. Please contact the HR department for more information.
Life and AD&D Insurance	For employees: • Employee Basic Life and AD&D • Employee Supplemental Life • Employee Supplemental AD&D • Dependent Supplemental Life • Dependent Supplemental AD&D	• Consult booklet/certificate of coverage for further details about these coverage amounts. Please note: Evidence of good health may be required if you decide to add or change certain coverage more than 31 days after your eligibility date or if you elect coverage in excess of certain amounts. Consult your booklet/certificate to determine when evidence of good health applies.	Employee Basic Life and AD&D: Employer contributions All other coverage: Employee after-tax contributions Note that different contribution requirements apply to certain union employees. Please contact the HR department for more information.

Type of Plan	Coverage Levels	Coverage Options	Type of Funding
Long-Term Disability	• Employee only	• Consult booklet/policy for further details about coverage amounts.	Employer contributions (*i.e.*, fully-employer-paid) but employee pays tax on this amount through imputed income Please see the applicable provider contracts and Collective Bargaining Agreement or call the Human Resources Department for information regarding the various coverage levels and options available to you.
Health Care Spending Account	N/A	• You can elect to contribute from $100 to $2,750 to your account.	Employee pre-tax contributions
Dependent Care Spending Account	N/A	• You can elect to contribute from $100 to $5,000 to your account ($2,500 maximum if married and filing separate tax returns).	Employee pre-tax contributions
Vision	• Employee only • Employee + spouse/domestic partner • Employee + children • Employee + family members		Employer and Employee pre-tax contributions
Critical Illness	• Employee only • Employee + spouse/domestic partner • Employee + children • Employee + family members	Note that Employer-provided coverage is only available to participants who are enrolled in the HSP or BlueEdge HSA. All other participants can	Employer-provided coverage that is taxable to the Employee Employee after-tax contributions for voluntary coverage

Type of Plan	Coverage Levels	Coverage Options	Type of Funding
		purchase coverage on a voluntary basis.	
Accident Hospital Indemnity	Employee only • Employee + spouse/domestic partner • Employee + children • Employee + family members		Employee after-tax contributions

APPENDIX B
COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that provides for continuation of group health coverage in certain situations. Under COBRA, you and your covered ***family members*** who are ***qualified beneficiaries*** may have the right to continue coverage under the Medical Plan, Dental Plan, Vision Plan or Health Care Spending Account[8] (the "group health plans") in certain instances when coverage would otherwise be lost due to a ***qualifying event***.[9]

"**Qualified beneficiaries**" are you and your ***family members*** who are covered under one of the Company's group health plans and lose such coverage due to a ***qualifying event***. Children born to or placed for adoption with a covered employee during a period of COBRA coverage are also ***qualified beneficiaries***.

"**Qualifying event**" means a specific situation, described in the table below under the heading "Qualifying Events", that makes you eligible for COBRA continuation coverage.

The Company has hired a third party to administer COBRA benefits under the group health plans. Information about the administrator can be found in Appendix A. If you have questions about your COBRA rights, you can contact the third party COBRA administrator or the Company's Human Resources Department.

In order to be eligible for continuation coverage, a ***qualified beneficiary*** must be covered under the group health plan when a ***qualifying event*** occurs (except for newborns and adopted children). The continuation coverage available at the time of a ***qualifying event*** is identical to the coverage option that was in effect at the time of the ***qualifying event***, or to similarly situated active employees and their ***family members*** to the extent that such identical coverage option is no longer offered under the Master Welfare Plan.

Qualified beneficiaries do not have to provide proof of good health to purchase continuation coverage. Any ***qualified beneficiary*** who wants continuation coverage must sign up for it within 60 days after the later of the date such ***qualified beneficiary*** is furnished an election notice or the date he or she otherwise loses health care coverage under the group health plan. Each ***qualified beneficiary*** has an individual right to elect continuation coverage. Additionally, you may elect continuation coverage on behalf of your spouse, and you or your spouse may elect coverage on behalf of your children.

[8] Continuation coverage for your Health Care Spending Account will cease at the end of the plan year in which the ***qualifying event*** occurs. Please note, your participation in the Health Care Spending Account terminates upon your termination of employment. Thus, you will be able to seek reimbursement for expenses incurred after your termination of employment *only if* you elect continuation coverage pursuant to COBRA and if, pursuant to such election, you continue to make contributions to your Health Care Spending Account on an *after-tax basis* after your termination of employment.

[9] Certain medical, dental or vision options that are fully insured may also be subject to continuation coverage rules under state insurance laws. You should consult the applicable summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary for your medical, dental or vision benefits to determine if any such state continuation coverage rights apply to you.

QUALIFYING EVENTS

The following table describes ***qualifying events*** and the maximum period of continuation coverage available for each.

Qualifying Event	**Qualified Beneficiaries**	
If coverage stops because:	***You may continue coverage for up to:***	***Your covered family member may continue coverage for up to:***
You stop working for the Company (for reasons other than gross misconduct) or your hours of employment are reduced such that you are no longer eligible for benefits[10]	18 months[11]	18 months
You die	N/A	36 months
You and your ***spouse*** divorce or legally separate	N/A	36 months
Your child loses eligibility for coverage	N/A	36 months
You become entitled to Medicare[12]	N/A	36 months

For further information about your entitlement to continuation coverage under any of these events, please contact the Company's Human Resources Department or the third party COBRA administrator.

To ensure that the Company or the third party COBRA administrator can contact you with respect to any continuation rights to which you may be entitled under this provision, it is important that you and your ***family members*** keep the Company (and the third party COBRA administrator, in the event that continuation coverage is elected) informed at all times of your current address(es).

HOW TO OBTAIN COBRA CONTINUATION COVERAGE

When a Qualified Beneficiary Is Responsible for Notifying the Plan Administrator

If a ***qualified beneficiary*** loses coverage under a group health plan because of any of the following events, then you or the ***qualified beneficiary*** (or a representative of either of you) must notify the Company's Human Resources Department in writing:

- You become divorced or legally separated from your ***spouse***; or
- Your child loses dependent status under the Master Welfare Plan.

[10] See the section entitled "Disabled Qualified Beneficiary" for information regarding a possible extension to 29 months for ***qualified beneficiaries*** who become disabled.

[11] If you take a leave of absence for qualified military service, you (and certain of your dependents) may be entitled to up to 24 months of continuation coverage under the group health plans pursuant to the Uniformed Services Employment and Reemployment Rights Act. Contact the Company's Human Resources Department for further information.

[12] If you become entitled to Medicare before the ***qualifying event***, then the period of coverage for your covered ***family members*** ends on the later of (i) 36 months after you become entitled to Medicare and (ii) 18 months (or 29 months if there is a disability extension) after the ***qualifying event***.

You or the ***qualified beneficiary*** must provide this notice to the Company's Human Resources Department within 60 days of the latest of:

- The date of the ***qualifying event***;
- The date on which coverage would be lost because of the ***qualifying event***; and
- The date on which you or the ***qualified beneficiary*** is notified (either through this document or a general COBRA notice) of the obligation to provide this notice and the procedures for providing such notice.

Additionally, if the **qualifying event** is your divorce or legal separation, then your notification should also include legal documents substantiating such event, such as a court- entered divorce decree.

If the required notice is not provided within the time limits described above, then COBRA continuation coverage will not be available.

You will be provided a COBRA enrollment package within 14 days of the Company's third party COBRA administrator's receipt of the notice.

When the Company Is Responsible for Notifying the Plan Administrator

If you or a ***qualified beneficiary*** loses coverage under a group health plan because of any of the following events, the Company will notify the Plan Administrator within 30 days of the event:

- Your death;
- A reduction in your hours of employment;
- Your termination of employment; or
- You become entitled to Medicare.

After the Company provides such notice to the Plan Administrator, you will receive a COBRA enrollment package within 14 days of the Plan Administrator's receipt of the notice.

Electing Coverage After You Receive a COBRA Enrollment Package

In order for you or a ***qualified beneficiary*** to receive COBRA coverage, you or the ***qualified beneficiary*** must elect such coverage within 60 days of the later of:

- The date coverage would be lost because of a COBRA ***qualifying event***; and
- The date you receive a COBRA enrollment package.

If you or a ***qualified beneficiary*** elects COBRA coverage during this 60-day period, coverage will be provided retroactively from the date that coverage would otherwise have been lost. You will be required to pay for any associated premiums, retroactive to the date of the ***qualifying event***.

If you do not elect COBRA continuation coverage during this 60-day period, then coverage will end retroactively back to the date of the ***qualifying event*** that triggered the loss in coverage and may not be reinstated and you will be able to submit claims for expenses incurred only up to the date of such event.

MULTIPLE QUALIFYING EVENTS

If you and your ***qualified beneficiaries*** are receiving COBRA coverage due to a ***qualifying event*** that provides 18 months of continuation coverage, then each ***qualified beneficiary*** who is receiving COBRA coverage can extend continuation coverage from 18 months to 36 months if, during the first 18 months of COBRA continuation coverage, another ***qualifying event*** occurs. For example, your spouse can extend continuation coverage that he or she is receiving due to a reduction in your hours of employment if you become divorced or legally separated or if you die or become entitled to Medicare during the initial 18-month period. If more than two ***qualifying events*** occur, continuation coverage will be limited to 36 months in total for all events combined.

In order for such ***qualified beneficiary's*** coverage to be extended to 36 months as described above, it is his or her responsibility to notify the Company's Human Resources Department of the second ***qualifying event*** within 60 days after the latest of:

- The date of the second ***qualifying event***;
- The date on which coverage would be lost because of the second ***qualifying event***; and
- The date on which the ***qualified beneficiary*** is notified (either through this document or a general COBRA notice) of his or her obligation to provide this notice and the procedures for providing such notice.

Such notice can be provided by you or the ***qualified beneficiary*** (or a representative of either of you). Additionally, if the ***qualifying event*** is your divorce or legal separation, then your notification should also include legal documents substantiating such event, such as a court-entered divorce decree.

If the required notice is not provided within the time limits described above, then the additional COBRA continuation coverage as described in this section will not be available to the ***qualified beneficiary***.

DISABLED QUALIFIED BENEFICIARY

A ***qualified beneficiary*** who elects COBRA continuation coverage may request an extension of coverage from 18 months to 29 months if the Social Security Administration determines that any ***qualified beneficiary*** was disabled:

- At the time of your termination of employment (for reasons other than gross misconduct) or reduction in your hours of employment; or
- Within the first 60 days of the initial COBRA election period.

To obtain this extension, the Company's Human Resources Department must be notified in writing within 18 months of the ***qualifying event*** and within 60 days after the latest of:

- The date the Social Security Administration determined the ***qualified beneficiary*** was disabled;
- The date of the ***qualifying event***;
- The date on which coverage would be lost because of the ***qualifying event***; and
- The date on which the ***qualified beneficiary*** is notified (either through this document or a general COBRA notice) of the obligation to provide this notice and the procedures for providing such notice.

Note: this option to extend coverage due to a disability applies to all ***qualified beneficiaries*** (not just the disabled beneficiary).

The notice to the Company's Human Resources Department should include the written determination of disability from the Social Security Administration.

If the required notice is not provided within the time limits described above, then the additional COBRA continuation coverage due to the disability determination will not be available.

If a ***qualified beneficiary's*** coverage was extended as explained above, then he or she may be eligible for another coverage extension to a maximum of 36 months (measured from the date of the original ***qualifying event***) if, during the 29-month period described above, a second ***qualifying event*** occurs. However, termination of employment and reduction in hours are not considered second or additional ***qualifying events*** that extend the coverage period beyond 29 months. In order to receive this additional coverage, the ***qualified beneficiary*** (or you or a representative) must provide written notice to the Company's Human Resources Department as described above under the heading above entitled "Multiple Qualifying Events."

Notwithstanding the duration of coverage described above in the event a ***qualified***

beneficiary is determined to be disabled by the Social Security Administration, COBRA coverage for a disabled ***qualified beneficiary*** (and other ***qualified beneficiaries*** who elected continued coverage in respect of the same ***qualifying event***) stops on the later of (i) the first day of the month that is more than 30 days after the Social Security Administration determines that the ***qualified beneficiary*** is no longer disabled (if the initial 18-month period has ended) and (ii) the end of the maximum coverage period that applies without the disability extension. A ***qualified beneficiary*** must notify the Company's Human Resources Department in writing within 30 days after the later of:

- The date that the Social Security Administration makes a final determination that the ***qualified beneficiary*** is no longer disabled; and

- The date on which the ***qualified beneficiary*** is notified (either through this document or a general COBRA notice) of the obligation to provide this notice and the procedures for providing such notice.

MAKING CHANGES IN COBRA COVERAGE

You are subject to the same rules as active employees regarding making changes in levels of coverage if you continue your coverage under COBRA. Therefore, you will be able to make changes in your coverage level only during an annual open enrollment period or if you have a qualifying ***change in family status*** (as defined in the "Introduction" section) and you notify the Company's Human Resources Department within 30 days of the date of the ***change in family status***.

PAYING FOR COBRA COVERAGE

Each ***qualifying beneficiary*** electing continuation coverage must pay the full monthly cost for that coverage plus a 2% administrative fee. "Full cost" means an amount that is not subsidized by the Company. Therefore, your continued coverage under COBRA will be more expensive to you than the portion of the cost of your coverage you paid before the COBRA ***qualifying event***.

When you elect COBRA coverage, you will be required to pay premiums retroactively back to the ***qualifying event*** date. In addition, the initial premium payment must be paid within 45 days of electing COBRA coverage.

After the initial payment, all payments are due the first of each month and are considered delinquent if not paid within 30 days. If payment is not postmarked within the required time period, coverage will be cancelled and cannot be reinstated.

WHEN COBRA CONTINUATION COVERAGE ENDS

Coverage under COBRA generally ends at the end of the maximum 18-month, 29-month or 36-month period. However, COBRA coverage stops sooner if:

- The required contributions are not made on time;

- The ***qualified beneficiary*** becomes covered under another health plan after electing continuation coverage;

- The plan is terminated and the Company provides no other health coverage;

- The ***qualified beneficiary*** becomes entitled to Medicare (under Part A, Part B or both) after electing continuation coverage;

- Disability ceases after 18 months of continuation coverage (with respect to a disability-related extension of COBRA continuation coverage); or

- A ***qualified beneficiary*** engages in conduct that would result in termination of coverage under the plan for a similarly situated individual who is not receiving continuation coverage.

If you or a ***qualified beneficiary*** do not elect or pay for COBRA continuation coverage within the

required time limits, then coverage ends as of the date of the ***qualifying event***.

APPENDIX C
CLAIMS PROCEDURES

The procedures for filing claims under the plans 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 a plan, then you must submit your claim in accordance with the Master Welfare Plan's claims procedures as described in this Appendix C. The insurance company or third party administrator for the applicable plan reviews all claims under a plan and is referred to as the "claims administrator" for your plan.

Claims procedures may also be described in the summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary provided by the insurance company or third party administrator for each benefit plan (which are described in Appendix D). When submitting a claim, you must follow the claims procedures described in such documents, in addition to the claims procedures described below. If there is any conflict between the claims procedures in this SPD and the claims procedures in the applicable summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary, the claims procedures in such benefit summary will govern unless the procedures are contrary to applicable law.

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 a plan.

INITIAL CLAIM

If you believe that you are entitled to benefits, then you must submit your claim in writing (or orally, if your claim is an ***urgent care claim*** under the Medical Plan, Dental Plan or Vision Plan) to the claims administrator at the address provided in Appendix A.

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 the following time limits:

- 72 hours for ***urgent care claims*** under the Medical Plan, Dental Plan or Vision Plan,
- 15 days for ***pre-service claims*** under the Medical Plan, Dental Plan or Vision Plan,
- 30 days for ***post-service claims*** under the Medical Plan, Dental Plan or Vision Plan and claims under the Spending Accounts,
- 45 days for disability benefit claims, or
- 90 days for life and accident benefit claims.

If the claims administrator determines that it requires an extension of time to review your claim due to special circumstances (for life and accident benefit claims) or that an extension of time is necessary due to matters beyond the control of the plan (for medical, dental, vision and disability benefit claims), then you will be notified in writing of the required extension within the initial time limit, and the additional extension period will not exceed the following time periods:

- 15 days for medical, dental, vision or Spending Account claims (and no extension is allowed for ***urgent care claims***),
- two 30-day extensions for disability claims, or
- 90 days for life and accident benefit claims.

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, including the expedited review process for an ***urgent care claim*** 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 C).

Additionally, if the claims administrator makes an adverse benefit determination with respect to a benefit claim under the Medical Plan, Dental Plan, Vision Plan or Health Care Spending Account, then the notice of denial from the claims administrator will provide (1) a reference to any internal rule, guideline, protocol or similar criterion which it relied upon in making an adverse determination (or a statement that such criterion will be provided free of charge upon request) and (2) if the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances (or a statement that such explanation will be provided free of charge upon request). In addition to the above, if the claims administrator makes an adverse benefit determination with respect to a disability benefit claim, then the notice of denial from the claims administrator will also provide (1) a discussion of the decision, including an explanation of the basis for disagreeing with or not following (A) the views presented by you to the plan of health care professionals treating you and vocational professionals who evaluated you, (B) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the decision, and (C) a Social Security Administration determination presented by you to the plan; and (2) a statement that you are entitled to reasonable access to, and copies of, all documents, records and other information relevant to your claim. Such notice will be written in a manner calculated to be understood by you. Notification of the denial of a disability benefits claim will be provided to you in a culturally and linguistically appropriate manner (to the extent required by the regulations under section 503 of ERISA).

You may have an authorized representative pursue your benefit claim on your behalf. If you have an ***urgent care claim*** under the Medical Plan, Dental Plan or Vision Plan, a health care professional with knowledge of your medical condition will also be permitted to act on your behalf with respect to your claim.

Special Procedures Related to Claims Under the Medical Plan, Dental Plan, Vision Plan and Health Care Spending Account

For ***urgent care and pre-service claims***, you will be notified of the claims administrator's determination, regardless of whether the claim is approved or denied. For ***post-service claims***, you will be notified only if your claim is denied. You may be notified orally of the claims administrator's determination of your ***urgent care claim***. A written or electronic notification will be furnished to you within 3 days after the oral notification.

The term "**urgent care claim**" means any claim for medical care or medical treatment which, unless special time periods for making urgent care determinations were applied:

- Could seriously jeopardize your life or health or your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

An individual acting on behalf of the plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, can determine whether the claim is an ***urgent care claim***. However, if a physician with knowledge of your medical condition notifies the claims administrator that any claim is an ***urgent care claim***, then the claim will be treated as an ***urgent care claim***.

The term "**pre-service claim**" means a claim for a benefit with respect to which the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit before a person receives medical care.

The term "**post-service claim**" means any claim that is not a ***pre-service claim*** or ***urgent care claim***. ***Post-service claims*** generally involve only the payment or reimbursement of cost for medical care already provided.

If the claims administrator determines that your ***urgent care claim*** does not contain sufficient information to make a determination, then the claims administrator will notify you as soon as possible, but no later than 24 hours after receipt of your claim, of the specific information necessary to complete your claim. In such case, you will be provided a reasonable amount of time, not less than 48 hours, to provide the necessary information. The claims administrator will provide you with its determination of your ***urgent care claim*** as soon as possible, but no later than 48 hours after the earlier of (i) its receipt of the specified information and (ii) the end of the period given to you to provide the additional required information.

If the claims administrator determines that your ***pre-service claim*** has been improperly filed[13], then the claims administrator will notify you, and will provide you with information about the proper procedures for filing your claim, as soon as possible but no later than 5 days after receipt of your claim (or within 24 hours in the case of a failure to file a claim involving urgent care). This notification may be oral, unless you specifically request a written notification.

If an extension of time is required to review your ***pre-service claim***, ***post-service claim***, or Heath Care Spending Account claim due to the fact that you have not submitted required information, then the notice of extension will describe the additional information that is required and you will be given at least 45 days from receipt of the notice to provide the specified information.

If a plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments, any reduction or termination by the plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall be treated as a claim denial. The claims administrator shall notify you of such determination sufficiently in advance of the reduction or termination to allow you time to appeal the denial and obtain a determination on your appeal before the course of treatment is reduced or terminated.

If you submit a claim that is an ***urgent care claim*** requesting to extend an approved course of treatment beyond the initially prescribed period of time or number of treatments, then the claims administrator will respond to your claim within 24 hours of receipt, provided that the claim is submitted at least 24 hours before the expiration of the originally approved period.

Special Procedures Related to Disability Benefits Claims

If an extension is required to review a claim involving a disability determination (including any claim under the Long-term Disability Plan), the notice of extension will explain the standards on which entitlement to benefit is based, the

[13] This provision only applies to a failure that (1) is a communication by you or an authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters, and (2) is a communication that names you, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

unresolved issues that prevent a decision on your claim and the additional information needed to resolve the issues. In such case, you will be given at least 45 days to provide the specified information.

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 (or oral appeal, if your claim is an ***urgent care claim*** under the Medical Plan, Dental Plan or Vision Plan) with the claims administrator within 60 days after you receive a denial notice (180 days in the case of a claim for medical, dental, vision, disability, or Spending Account benefits). Your appeal should be filed at the address provided for the appropriate claims administrator in Appendix A.

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 the following time limits:

- 72 hours for appeals of ***urgent care claims*** under the Medical Plan, Dental Plan or Vision Plan,
- 30 days for appeals of ***pre-service claims*** under the Medical Plan, Dental Plan or Vision Plan (or 15 days if the claims administrator provides a second level of appeal),
- 60 days for appeals of ***post-service claims*** under the Medical Plan, Dental Plan or Vision Plan (or 30 days if the claims administrator provides a second level of appeal),
- 45 days for disability appeals,
- 60 days for appeals under the Spending Accounts, or
- 60 days for life or accident benefit appeals.

If the claims administrator determines that additional time is needed to review your appeal due to special circumstances, you will receive a written or electronic notice (within the initial time period) advising you that additional time is needed, not to exceed the following time periods:

- 45 days for disability claims or
- 60 days for life and accident benefit claims.

Extensions will not, however, be available to the claims administrator for appeals under the Medical Plan, Dental Plan, Vision Plan or Spending Accounts. 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 C) 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.

Additionally, if the claims administrator denies your appeal under the Medical Plan, Dental Plan, Vision Plan, Long-term Disability Plan or Health Care Spending Account, then the notice of denial from the claims administrator will provide (1) a reference to any internal rule, guideline, protocol or similar criterion which it relied upon in making an adverse determination (or a statement that such criterion will be provided free of charge upon request) and (2) if the claim denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances (or a statement that such explanation will be provided free of charge upon request). In addition to the above, if the claims administrator denies your appeal with respect to a disability benefit claim, then the notice of denial from the claims administrator will also provide (1) a discussion of the decision, including an explanation of the basis for disagreeing with or not following (A) the views presented by you to the plan of health care professionals treating you and vocational professionals who evaluated you, (B) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the decision, and (C) a Social Security Administration determination presented by you to the plan. Such notice will be written in a manner calculated to be understood by you. Notification of the denial of a disability benefits claim will be provided to you in a culturally and linguistically appropriate manner (to the extent required by the regulations under section 503 of ERISA).

Special Procedures Related to Appeals under the Medical Plan, Dental Plan, Vision Plan, and Health Care Spending Account, and Appeals of Disability Benefit Claims

The following procedures will apply to appeals under the Medical Plan, Dental Plan, Vision Plan, and Health Care Spending Account, and to any appeals of disability benefit claims (including under the Long-term Disability Plan):

- Your appeal will be reviewed by someone of the plan who is neither the individual who made the original adverse benefit determination with respect to your claim, nor a subordinate of such individual (the "Reviewer").
- The Reviewer will not give deference to the initial adverse decision on your claim.
- With respect to any benefit determination that is based, in whole or in part, on medical judgment, the Reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither an individual who was consulted in connection with the original adverse benefit determination with respect to your claim, nor a subordinate of such individual.
- Any expert whose advice was obtained in connection with the adverse determination of your benefit claim will be identified, regardless of whether the advice was relied upon in making the determination with respect to your claim.

If an appeal is made with respect to the denial of an ***urgent care claim***, then you may request, either orally or in writing, an expedited review of your appeal. All necessary information (including the benefit determination) will be transmitted to you by telephone, facsimile or other available similarly expeditious method.

ADDITIONAL STANDARDS RELATED TO APPEALS UNDER THE MEDICAL PROGRAM

The following standards apply only to appeals under the Medical Plan for health care benefits only.

As part of your appeal, in addition to the rights described above, (1) you, your representative or your beneficiary also have the right to review the claim file and to present evidence and testimony and (2) the right to receive, free of charge, (A) any new or additional evidence considered, relied upon or generated by the claims administrator in connection with the claim and

(B) any new or additional rationale. Such new or additional evidence or rationale, as possible and sufficiently before the final internal claim denial is due.

If your appeal is denied, either in full or in part, then the notice of denial will contain the following additional information:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
- A description of the reason(s) for the denial, including the denial code and its corresponding meaning, as well as a description of the claim administrator's standard, if any, that was used in denying the claim. In the case of a final internal claim denial, this description will also include a discussion of the decision.
- A description of the available internal appeals and external review procedures, including information on how to initiate an appeal.
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist you with the internal claims and appeals and external review process.

Deemed Exhaustion of Internal Claims and Appeals Process

In the event that the claims administrator does not comply with the internal claims and appeals procedures, as outlined above, you will be deemed to have exhausted the internal claims and appeals process and may immediately initiate an external review (as described below). You will also be entitled to pursue any available remedies under section 502(a) of ERISA or under state law. Notwithstanding the foregoing, the internal claims and appeals process will not be deemed to be exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the claims administrator demonstrates that the violation was for good cause or due to matters beyond the control of the claims administrator and that the violation occurred in the context of an ongoing, good faith exchange of information between you and the claims administrator. This exception is not available if the violation is part of a pattern or practice of violations by the claims administrator. You may request a written explanation of the violation from the claims administrator, and such explanation will be provided to you within ten days and will include a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals procedures to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review on the basis that the program met the above-stated standards for the exception to apply, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten days), the claims administrator will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. The time period for re-filing the claim will begin to run upon your receipt of such notice.

STANDARD EXTERNAL REVIEW PROCESS

The following standards only apply to appeals (other than appeals involving eligibility) under the Medical Plan for health care benefits (1) that involve ***medical judgment***, as determined by an external reviewer, or (2) a ***rescission of coverage***.

The term "**medical judgment**" includes, but is not limited to, determinations based on requirements for medical necessity, appropriateness of care, health care setting, level of care, effectiveness of a covered benefit or determinations as to whether a treatment is experimental or investigational.

The term "**rescission of coverage**" means any retroactive termination of medical care coverage, except where an individual (or a person seeking

coverage on behalf of the individual) either (i) performs an act, practice or omission that constitutes fraud, (ii) makes an intentional misrepresentation of material fact, or (iii) fails to timely pay required premiums or contributions towards the cost of coverage.

Request for External Review

You may file a request for an external review with the claims administrator provided that your request is filed within four months after the date you receive a denial notice. If there is not a corresponding date four months after the date the claims administrator receives your notice, then you must file the request by the first day of the fifth month following the claim administrator's receipt of the notice.

Preliminary Review

Within five business days following the receipt of the external review request, the claims administrator will complete a preliminary review of the request to determine whether (1) you or your beneficiary are (or were) covered under the Medical Plan at the time that the health care item or service was requested or, in the case of a retrospective review, was covered under such program at the time the health care item or service was provided; (2) the claim denial does not relate to your or your ***family member's*** failure to meet the requirements for eligibility under the terms of the Medical Plan, (3) you have exhausted the program's internal appeal process (unless you are not required to do so due to the claims administrator's failure to comply with the internal claims and appeals procedures and such failure did not fall under one of the deemed exhaustion exceptions) and (4) you have provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, you or your representative will be issued a written notification. If your request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If your request is not complete, such notification will describe the information or materials needed to make the request complete and you will be allowed to perfect your request for external review within the four month filing period or within the 48 hour period the following the receipt of the notification, whichever is later.

Referral to an Independent Review Organization

Upon a determination that your request is eligible for external review following the preliminary review, the claims administrator will assign your claim to an accredited internal review organization ("IRO"). The assigned IRO will timely notify you in writing of your request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review.

Within five business days after the date of assignment to the IRO, the claims administrator will provide to the assigned IRO documents and any information considered in denying your claim. Failure by the claims administrator to timely provide the documents and information will not delay the conduct of the external review. If the claims administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse your claim denial. The IRO will notify you within one business day after making the decision.

Upon receipt of any information submitted by you, the assigned IRO will, within one business day, forward the information to the claims administrator. Upon receipt of any such information, the claims administrator may reconsider its denial of your claim that is the subject of the external review. Reconsideration by the claims administrator will not delay the external review. The external review may be terminated as a result of the reconsideration only if the claims administrator decides, upon completion of its reconsideration, to reverse its claim denial and provide you with coverage or payment. Within one business day after making

such a decision, you will be provided written notice and the assigned IRO will terminate the external review.

The IRO will review all information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and will not be bound by any decisions or conclusions reached during the internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by you, the claims administrator, or your treating provider;
- The terms of the Medical Plan to ensure that the IRO's decision is not contrary to the terms of the program, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the claims administrator, unless the criteria are inconsistent with the terms of the Medical Plan or applicable law; and
- The opinion of the IRO's clinical reviewer or reviewers after considering the information described above to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned IRO will provide you with written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date(s) of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or Federal law to either you or the Medical Plan;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

COMPLIANCE WITH INDEPENDENT REVIEW ORGANIZATION DECISION

Upon the IRO's decision to reverse the claim administrator's claim denial, you will promptly receive coverage or payment for that claim.

EXPEDITED EXTERNAL REVIEW PROCESS

Request for Expedited External Review

You may request an expedited external review if you receive:

- A denial of a claim involving a medical condition for which the timeframe for completing an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed an expedited internal appeal request; or

- A final denial of a claim involving (1) a medical condition where the timeframe for completing a standard external review would seriously jeopardize your life or health or your ability to regain maximum function, (2) an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of request for expedited external review, the claims administrator will determine whether the request meets the reviewability requirements as set forth above for standard external review. You will receive a notice regarding the claim administrator's reviewability assessment. This notice will contain the same information that would be provided under a standard external review notice.

Referral to an IRO

Upon a determination that your request is eligible for external review following the preliminary review, the claims administrator will assign your claim to an IRO (using the process set out above for a standard external review).

The claims administrator will provide or transmit all necessary documents and information considered in denying your claim to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The IRO will consider the information or documents listed above under the procedures for standard review, to the extent the information or documents are available. In reaching its decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusion reached during the internal claims and appeals process.

The assigned IRO will provide you with notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide you with written confirmation of the decision. The notice will contain the same information that applies in the context of standard external review.

ADDITIONAL APPEAL WITH CLAIMS ADMINISTRATOR

Some claims administrators have a second level of appeal. Consult the summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary provided by the claims administrators for each benefit plan (described in Appendix D) to determine whether the claims administrator requires a second level of appeal. If a second level of appeal is required, it will follow the same general procedures as outlined above under the heading "Appeal with Claims Administrator."

EXHAUSTION OF CLAIMS PROCEDURES

You must follow and exhaust the claims and appeals procedures described in this Appendix C (including any claims procedures described in your summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary, which are incorporated by reference into this document) before you can file a lawsuit, seek arbitration or begin any other

proceeding with regard to your claim for benefits under any plan described in this SPD.

ARBITRATION OR MEDIATION

Some of the plans may have procedures regarding the submission of your claim to arbitration or mediation after the claims procedures described in this Appendix C are exhausted. Please consult your summary of benefits and coverage, plan booklet, certificate, schedule of benefits, evidence of coverage, insurance policy, or other benefit summary to determine whether arbitration is required or provided under a specific plan.

STATE LAW PREEMPTION

Nothing in this Appendix C 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 C.

APPENDIX D
INSURANCE PROVIDER AND THIRD PARTY ADMINISTRATOR DOCUMENTS

The following table details the summaries of benefits and coverage, plan booklets, certificates, schedules of benefits, evidences of coverage, insurance policies, or other benefit summaries which are incorporated as part of this SPD. The documents have been prepared by the insurance company or third party administrator for each component plan and describe the benefits for the respective component plan in further detail.

Benefit Plan Component	**Documents**	**Provided By**
Medical Plan – Health Reimbursement Plan (HRP)	Coverage Booklet and Summary of Benefits and Coverage	BlueCross BlueShield of Illinois
Medical Plan – Health Savings Plan (HSP)	Coverage Booklet and Summary of Benefits and Coverage	BlueCross BlueShield of Illinois
Medical Plan option for ex-pats only	Certificate	Aetna
Prescription Drug	Summary of Benefits and Coverage	Express Scripts
Critical Illness	Coverage Booklet and Summary of Benefits and Coverage	MetLife
Dental	Plan Booklet, Summary of Benefit and Coverage and/or Other Schedules of Benefits	BlueCross BlueShield of Illinois
Vision	Plan Booklet, Summary of Benefit and Coverage and/or Other Schedules of Benefits	MetLife
Accident Hospital Indemnity	Coverage Booklet	MetLife
Life and AD&D Insurance	Certificate of Insurance/Booklet (including schedule of benefits)	New York Life (Cigna)
Long-Term Disability	Insurance Policy/Booklet (including schedule of benefits)	New York Life (Cigna)

APPENDIX E
YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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

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

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

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

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact your state public health department or the U.S. Department of Labor at the nearest office of the U.S. Department of Labor listed in your telephone directory. Visit www.ingredionbenefits.com for more information about your rights under state and federal law.