NEW HIRE GUIDE

2025-
2026

Ag PARTNERS

HERE'S WHERE TO FIND ...

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Ag Partners Coop appreciates your commitment to our success. We're equally committed to providing you with competitive, affordable health and wellness benefits to help you take care of yourself and your family.

Please read this guide carefully. It has a summary of your plan options and helpful tips for getting the most value from your benefit plans. We understand that you may have questions about annual enrollment, and we'll do our best to help you understand your options and guide you through the process.

This guide is not your only resource, of course. Anytime you have questions about benefits or the enrollment process, you can contact your human resources representative. Although this guide contains an overview of benefits, for complete information about the plans available to you, please see the summary plan description (SPD) provided by your carrier on ADP.

For more information about your benefits, please reach out to Human Resources:

Lacey Dalinghaus, Chief Human Resources Officer
785.294.0397
laceyd@agpartnerscoop.com

ENROLLING IN BENEFITS

If you want health benefits in 2025 and 2026 for yourself or your family, you must enroll in one of the plan options during your initial enrollment period. If you need to add or remove coverage for yourself or your dependents after the enrollment period, you must wait until the next open enrollment period unless you have a qualifying life event as defined by the IRS.

The IRS requires that you make changes to your coverage within 30 days of your qualifying life event. You'll need to provide proof of the event, such as a marriage certificate, divorce decree, birth certificate or loss-of-coverage letter.

Please remember to add your Social Security number and the Social Security numbers of your dependents during enrollment.

Eligibility

All benefit elections made will be effective through June 30, 2026.

Outside your initial benefit enrollment period, you will not have the chance to add, change or remove benefits unless you have a qualifying life event. Otherwise, you will be able to make new elections or change your existing elections during the annual open enrollment period.

ELIGIBLE EMPLOYEES

You may enroll in the benefits program if you are a regular full-time employee. As a benefits-eligible employee, you have the opportunity to enroll in benefit plans as a new hire or during the annual open enrollment period.

If you're enrolling as a new employee, you become eligible for benefits the first of the month following your hire date.

DEPENDENT ELIGIBILITY

As you become eligible for benefits, so do your eligible dependents. In general, eligible dependents include:

- Your legal spouse.
- Your children up to the age of 26. This includes your natural children and those of your spouse, as well as adopted children, stepchildren, or children obtained through court-appointed legal guardianship. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided to and approved by HR. Additionally, children who have been named in a qualified medical child support order are covered by our plan.

QUALIFYING LIFE EVENTS

It is your responsibility to notify human resources within 30 days of the qualifying life event. Failure to do so may result in an inability to change your benefit election(s).

Here are some examples of qualifying life events:

- Birth, legal adoption or placement for adoption
- Marriage, divorce or legal separation
- Dependent child reaches age 26
- Spouse or dependent loses coverage elsewhere
- Death of your spouse or dependent child
- Spouse or dependent becomes eligible or ineligible for Medicare/Medicaid or the state children's health insurance program
- Court-ordered change

MEDICAL

BLUE CROSS AND BLUE SHIELD OF KANSAS | BCBSKS.COM | 800.432.3990

Blue Cross and Blue Shield administers our comprehensive medical plans. Blue Cross's Blue Choice network offers exceptional access to in-network providers and deep discounts on services, resulting in lower costs for our employees and our plan. It is highly recommended you verify that all associated providers are participating in the Blue Choice network. This helps to avoid incurring any unexpected out-of-network charges and ensures cost effective use of your health plan.

Ag Partners Coop is committed to helping you and your dependents maintain health and wellness by providing you with access to the highest levels of care. We offer you a choice of two medical plan option(s) for the 2025-2026 plan year:

- Blue Plan (PPO)
- Red Plan (HDHP)

BASIC MEDICAL TERMS

In-Network Versus Out-of-Network A network is comprised of all contracted providers. Networks request providers to participate in its network, and, in return, providers agree to offer discounted services to their patients. If you pick an out-of-network provider, your claims could cost more because you will not receive the discounts that an in-network provider offers.

Preventive Care Routine healthcare services that can minimize the risk of certain illnesses or chronic conditions. Examples of Preventive Care services include, but are not limited to: physical, mammogram, flu vaccine, prostate test, smoking cessation, etc.

Deductible The amount you owe for covered healthcare services before your plan begins to pay benefits. For example, if your deductible is $3,300, your plan won't pay anything until you've paid the first $3,300 of the bill for your covered healthcare services subject to the deductible. Preventive Care is not subject to the deductible as it is covered 100% by either medical plan option.

Coinsurance Your share of the costs of a covered healthcare service, calculated as a percentage (for example, 20%) of the allowed amount for the service. Your coinsurance will begin after you have met your deductible. For example, if the charge for an office visit is $100, and you have met your deductible, your coinsurance payment of 20% would be $20. Your health insurance pays the rest of the allowed amount.

Copay A copay is a fixed dollar amount you pay for a healthcare service. The amount can vary by the type of service.

Medical and Prescription Drug Plan Summary

Your financial responsibility is based on your provider's network: PPO (Blue Choice) or Traditional (CAP). Maximum benefits are available when services are received from Blue Choice providers.

Blue Choice: Deductible, coinsurance or copay amount (outlined below).
CAP (Non-Blue Choice): Additional 20% non-PPO network coinsurance amount, *deductible, coinsurance or copay amount.
Non-Blue Choice & Non-CAP: The difference between the payment allowance and provider charge, additional 20% non-PPO network coinsurance amount, *deductible, coinsurance or copay amount.

*Non-PPO Coinsurance limited to a combined $2,000 per person, $4,000 two or more persons each benefit period.

Medical	Blue Plan (PPO)	Red Plan (HDHP)
Blue Choice Network	In-network	In-network
Deductible Employee only Family	 $1,500 $3,000	 $3,300 $6,600
Coinsurance (member pays)	20%	0%
Out-of-pocket maximum (includes deductible) Employee only Family	 $6,350 $12,700	 $6,350 $12,700
Preventive care	Plan pays 100%	Plan pays 100%
Primary care visit (includes mental health)	$25 copay	Deductible
Specialist visit	$50 copay	Deductible
Telemedicine (Amwell virtual care)	$0 copay	Deductible
Emergency room	$250 copay then deductible/ coinsurance	Deductible
Urgent care	Up to $50 copay	Deductible
Prescription drugs	**Blue Plan (PPO)**	**Red Plan (HDHP)**
Retail (30-day supply)		
Tier 1 — generics	$10 copay	Deductible then $10 copay
Tier 2 — preferred	$35 copay	Deductible then $35 copay
Tier 3 — nonpreferred	$70 copay	Deductible then $70 copay
Tier 4 — specialty	Preferred: $150 copay Non-preferred: 20% up to $250	Preferred: Deductible then $150 copay Non-preferred: Ded. then 20% up to $250
Mail order (90-day supply)		
Tier 1 — generics	$25 copay	Deductible then $25 copay
Tier 2 — preferred	$87.50 copay	Deductible then $87.50 copay
Tier 3 — nonpreferred	$175 copay	Deductible then $175 copay
Tier 4 — specialty	Preferred: $375 copay Non-preferred: 20% up to $625	Preferred: Deductible then $375 copay Non-preferred: Ded. then 20% up to $625

Prescription drugs — 100% coverage for preventive generics before the deductible applies.

MEDICAL AND PRESCRIPTION CONTRIBUTIONS

EFFECTIVE JULY 1, 2025

2025 rates	Total premium	Ag Partners contribution	Employee contribution (per month)	Employee contribution (per pay period)	Ag Partners HSA contribution (per pay period)
Blue Plan (PPO)					
Employee	$726.62	$624.05	$102.57	$47.34	--
Employee + spouse	$1,499.11	$1,049.38	$449.73	$207.57	--
Employee + child(ren)	$1,415.79	$1,020.69	$395.10	$182.35	--
Family	$2,188.27	$1,531.79	$656.48	$302.99	--
Red Plan (HDHP)					
Employee	$675.83	$650.44	$67.05	$30.95	$19.23
Employee + spouse	$1,396.80	$1,199.02	$281.12	$129.75	$38.46
Employee + child(ren)	$1,314.15	$1,158.12	$239.36	$110.47	$38.46
Family	$2,080.96	$1,760.10	$404.20	$186.55	$38.46

Employees can elect the medical and prescription drug plan without enrolling in the dental or vision plan.

BLUE CROSS OF KANSAS TOOLS

BLUE CROSS AND BLUE SHIELD OF KANSAS | BCBSKS.COM | 800.432.3990

BlueAccess

BlueAccess is Blue Cross of Kansas's gateway to your health information. On the bcbsks.com/blueaccess website, you can quickly and securely:

- Check your claims and view your plan usage.
- Find in-network providers and hospitals.
- Compare quality ratings for doctors.
- Access your virtual ID card.
- Contact customer support.

Registration is quick and simple.

1. Go to bcbsks.com/blueaccess.
2. Click Register for a BlueAccess account.
3. Have your Blue Cross ID card handy and follow the step-by-step instructions.

Once you have registered for a BlueAccess account, download the mobile app to track claims, find doctors and view your plan benefits from anywhere.

Know Your Cost Before You Go

Get the care you need and save money! With Blue Cross's cost transparency tool, you can compare costs before you go to the doctor. Find out how much you could save by:

- Accessing the largest doctor and hospital network in Kansas.
- Getting an estimate for the average cost of a medical service or procedure in your area.
- Comparing doctors' costs, side by side.

Log in to BlueAccess via the bcbsks.com/blueaccess website or mobile app to access the cost transparency tool.

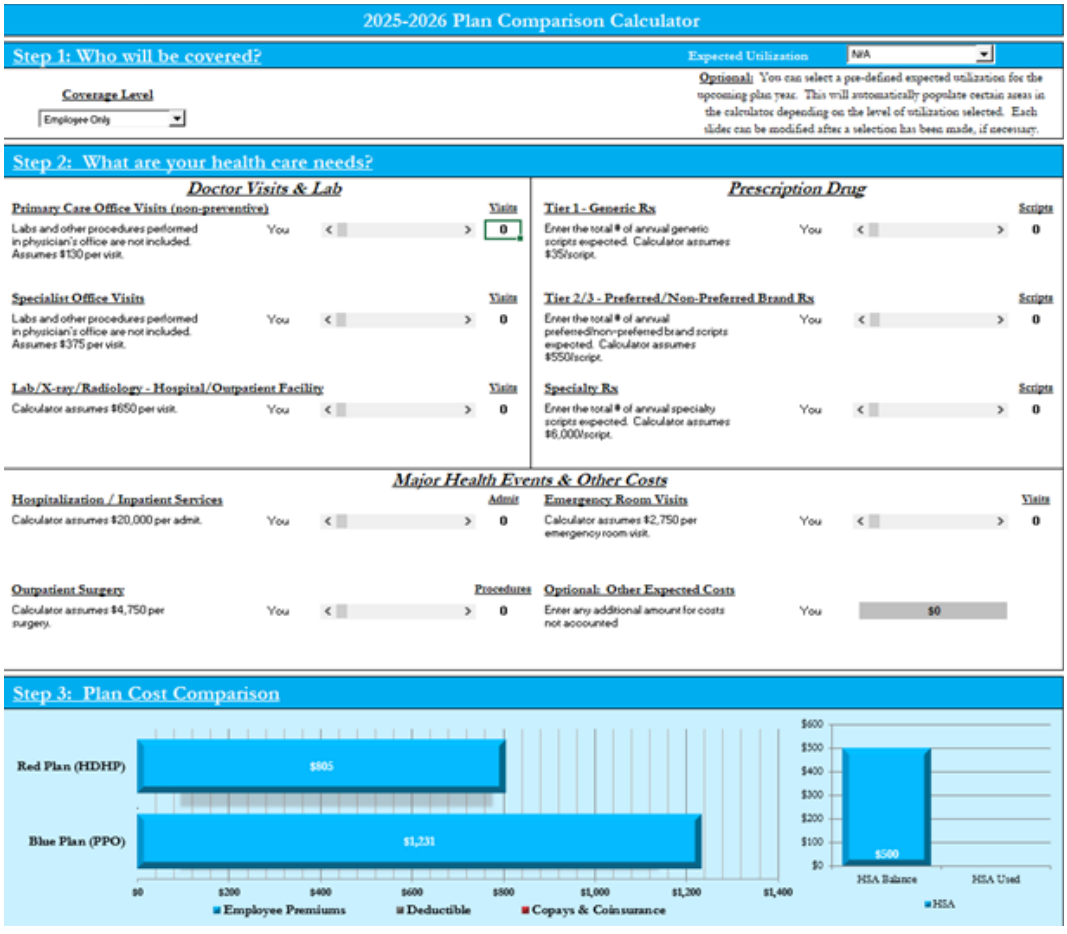
Scan this QR code on your smartphone camera to download the BlueAccess app!

HEALTH PLAN COST CALCULATOR

Make an Informed Decision on Your Medical Plan

To help you make an informed decision on which medical plan option is best for you and your family, we have created a plan cost calculator designed to illustrate your anticipated out-of-pocket expenses. To use the calculator:

- Open the tool by clicking the picture below and downloading the Excel file.
- First, select your coverage level.
- Then, input your expected healthcare needs. If you are unsure about what healthcare you will receive in 2025-26, you can select a predefined utilization from the drop-down menu at the top right of the tool.
- Finally, compare the expected cost between the two plan options. This comparison includes your contributions, deductibles, and copay and coinsurance.



To ensure the plan cost calculator will function, please click the box to "Enable Content" upon opening the file.

If you have questions about using the calculator, please reach out to Human Resources.

TELEMEDICINE

AMWELL | BCBSKS.COM/TELEMED | 844.733.3627

Access to a Doctor – Anytime, Anywhere

With Amwell, you can have a virtual doctor's visit from your smartphone or computer – right when you need it. See a doctor from the comfort of your own home – or anywhere else for that matter. Safe and secure, it's the quality care you need, made easier.

What Is Telemedicine?

Telemedicine is an alternative to in-person visits. It allows healthcare professionals to evaluate, diagnose and treat patients at a distance via secure video/audio connections.

With Blue Cross and Blue Shield of Kansas coverage, you can visit live with a doctor on your computer or mobile device when it's convenient for you.

Virtual visits do not replace your primary care physician. It is a convenient and affordable option for quality care:

- When you need care now and your primary care physician is not available
- If you're considering the ER or urgent care for a nonemergency issue
- When traveling
- For dependent children away at school needing immediate care

HOW TO REGISTER FOR AMWELL

- Download the Amwell app on any mobile device
- Visit bcbsks.com/telemed
- Call toll-free at 844.733.3627

Conditions Commonly Treated Through a Virtual Visit

Doctors can diagnose and treat a wide range of non-emergency medical conditions, including:

- Bladder infection
- Urinary tract infection
- Bronchitis
- Cold/Flu
- Diarrhea
- Fever
- Migraine/ Headaches
- Pink eye
- Rash
- Sinus problems
- Sore throat
- Stomach ache

Behavioral Health Services Through Amwell

Amwell's team of behavioral health professionals are available from 6 a.m.-10 p.m. CT, seven days a week and can help diagnose and treat behavioral health concerns such as:

- Anorexia
- Anxiety and depression
- Bipolar disorder
- Bulimia
- Cognitive disorders
- Insomnia
- OCD and PTSD
- Panic attack

AMBULANCE COVERAGE

MASA | MASAACCESS.COM/MEMBER | 800.643.9023

Ensure you and your family are protected from unexpected costs when you use emergency transportation by adding MASA to your benefits.

MASA's solution is simple — with MASA, there is no "out-of-network." MASA works as a payer, not a provider. You simply call 911 when there is an emergency, and you'll never have to worry about what ambulance provider picks you up. When the ambulance bill arrives, send it to MASA. They will advocate for you to ensure the ambulance charges are accurate and Blue Cross has paid its portion, and then they cover the remaining balance, including your deductibles and copays.

What Does MASA Cover?

MASA's Emergent Plus plan covers each of the following services and much more!

EMERGENCY GROUND AMBULANCE COVERAGE

MASA covers out-of-pocket expenses associated with emergency ground transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

REPATRIATION TO HOSPITAL NEAR HOME TRANSPORT/FACILITY TRANSFER

MASA provides services and covers out-of-pocket expense for the coordination of the insured and the dependents' non-emergency transportation by a medically equipped air ambulance in the event of hospitalization more than 100 miles from the insured's home if the treating physician and MASA's medical director says it is medically appropriate and possible to transfer the insured to a hospital nearer to home for continued care and recuperation.

EMERGENCY AIR AMBULANCE COVERAGE

MASA covers out-of-pocket expenses associated with emergency air transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

HOSPITAL TO HOSPITAL AMBULANCE COVERAGE

MASA will cover out-of-pocket expenses incurred by the insured associated with a medically necessary hospital-to-hospital transfer by a medically equipped ground ambulance, rotary (i.e., helicopter) or fixed-wing aircraft when ordered by the treating physician at the medical facility where the insured is presently admitted to the nearest and most appropriate medical facility capable of providing the necessary, specialized level of care required and that is not available at the sending facility.

Transportation Coordination Services

Access transport services for the following benefits (limited benefits may be available depending on the plan you elect):

- Repatriation near home
- Child, pet, and vehicle return
- Companion transportation
- Hospital visitor transportation
- Patient return transportation
- Sick while away from home expense protection
- Organ retrieval and organ recipient transport
- Mortal remains transportation

When to access: During or immediately following your emergency care treatment.

How to access: Call 800.643.9023. The MASA team is available 24/7/365 to assist and will begin making the necessary arrangements, including working with the Blue Cross of KS team.

Claims

Benefits that you submit claims for include:

- Emergency ground ambulance coverage
- Emergency air ambulance coverage
- Hospital to hospital ambulance coverage
- Post-admission continued care transportation coverage

When to file your claim: When you receive the ambulance bill.

How to file your claim: Online at masaaccess.com/member or email ambulanceclaims@masaglobal.com

View your online benefits at masaaccess.com/member or through the MASA app.

WELLNESS INCENTIVE

Ag Partners cares about our employees' health and wellbeing. We believe physical wellbeing plays a key role in a happy, healthy lifestyle.

For the 2026 calendar year, employees are eligible to receive a **wellness incentive** for completing an annual physical. It is highly important to establish a relationship with a primary care provider, and your annual physical is the best way to do so.

Employees who receive a preventive physical, complete the form, and turn it into HR will receive $500 in AgActive Wellness funds to use on fitness or wellness related items and activities.

Please note: Annual physicals may or may not include lab or blood work. These tests are not always covered at 100%. Before you receive labs or have blood drawn, ask your doctor if these services are preventive or diagnostic.

Preventive or Diagnostic?

You benefit both financially and health-wise when you get annual medical checkups. Preventive care helps you avoid more serious and costly health problems down the road. Plus, it's fully covered in-network. But did you know that, depending on the situation, the same test or service can be considered preventive (100% covered) or diagnostic (you share the cost)?

PREVENTIVE CARE SERVICES:

- Help you stay healthy by checking for disease before you have symptoms or feel sick
- Can include flu shots and other vaccinations, physical exams, lab tests and prescriptions
- 100% covered when delivered by an in-network provider

DIAGNOSTIC SERVICES:

- Check for a disease after you have symptoms or due to a known health issue
- Can also include physical exams, lab tests, and prescriptions
- You pay your share of the cost

If you're unsure why a test was ordered, ask your doctor. And don't forget to schedule your preventive care visits. Many people use a key date like their birthday or anniversary as a reminder to make their appointments each year.

New administrator for 2025-26. All participants will receive a new debit card prior to July 1, 2025.

HEALTH SAVINGS ACCOUNT (HSA)

HEALTHEQUITY | HEALTHEQUITY.COM | 866.346.5800

If you enroll in the HDHP (Red Plan), you will be able to open an HSA through HealthEquity. An HSA is a personal healthcare bank account you can use to pay out-of-pocket medical expenses with pretax dollars. If you enroll in a high-deductible health plan, you can open an HSA.

You own and administer your HSA. You determine how much you contribute to your account, when to use your money to pay for qualified medical expenses, and when to reimburse yourself. Remember, this is a bank account; you must have money in the account before you can spend it.

HSAs offer you the following advantages:

TAX SAVINGS: You contribute pretax dollars to the HSA. Ag Partners will also contribute to your HSA for 2025-26. Interest accumulates tax-free, and funds are withdrawn tax-free to pay for medical expenses.

REDUCED OUT-OF-POCKET COSTS: You can use the money in your HSA to pay for eligible medical, dental and vision expenses and prescriptions. You can use your HSA funds to help you meet your plan's annual deductible.

A LONG-TERM INVESTMENT THAT STAYS WITH YOU: Unused account dollars are yours to keep even if you retire or leave the company. Also, you can invest your HSA funds so your available healthcare dollars can grow over time.

THE OPPORTUNITY FOR LONG-TERM SAVINGS: Save unused HSA funds from year to year. You can use this money to reduce future out-of-pocket health expenses. You can even save HSA dollars to use after you retire.

How Much You Can Deposit Into an HSA in 2025

Ag Partners employer contributions count toward the annual HSA contribution limits, so you need to carefully plan how much you'll contribute annually to avoid excess contributions. These limits apply even for participants entering the plan midyear. Prior-year contributions may be made through April 15 of the following year.

IRS limits subject to change	Under age 55	Age 55 and older (and not enrolled in Medicare)
Individual	$4,300	$5,300 (includes $1,000 "catch-up" contribution)
Family	$8,550	$9,550 (includes $1,000 "catch-up" contribution)

You are eligible to open and fund an HSA if:

- You are not enrolled in any other non-HSA qualified health insurance plan.
- You are not covered by your spouse's health plan (unless it is a qualified HDHP), flexible spending account (FSA) or health reimbursement arrangement (HRA).
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare, TRICARE or TRICARE For Life.
- Care received through the VA in the preceding three calendar months was dental, vision or preventive care or was provided to a veteran who has a disability rating from the VA.

How to Access/Make Contributions to Your HSA

Once your account is open, you can access it via healthequity.com. You'll set up your payroll contributions during open enrollment, but you can make contribution changes at any time during the year through HealthEquity. Note that it may take between one and two payroll periods for an HSA change to be processed.

2025-26 Ag Partners Employer Contributions

Once you open your HSA with HealthEquity, Ag Partners will contribute the following (cash) amounts to your HSA. HSA employer contributions are normally deposited on a per-paycheck basis. **You must be enrolled in the Red Plan to be eligible for the Ag Partners contribution.**

Employer HSA contribution	Bi-weekly	Annually
Employee only	$19.23	$500
Employee + spouse	$38.46	$1,000
Employee + child(ren)	$38.46	$1,000
Employee + family	$38.46	$1,000

Distributions

HSA distributions are tax-free if they are used to pay for qualified medical expenses.

- Qualified medical, dental and vision expenses not covered by insurance
- Qualified long-term care services and long-term care insurance
- Continuation of coverage required by federal law (i.e., COBRA)
- Health insurance for the unemployed
- Medicare expenses (but not Medigap)
- Retiree health expenses for individuals aged 65 or older

Distributions made for any other purpose are subject to income tax and a 20% penalty. The 20% penalty is waived in the case of death or disability. The 20% penalty is also waived for distributions made by individuals aged 65 or older.

For More Information

Access the HealthEquity customer website at healthequity.com. You can contact HealthEquity at 866.346.5800.

FLEXIBLE SPENDING ACCOUNT (FSA)

HEALTHEQUITY | HEALTHEQUITY.COM | 877.924.3967

A great way to plan ahead and save money over the course of a year is to participate in an FSA. An FSA lets you redirect a portion of your salary on a pretax basis into a reimbursement account, saving you money on taxes. Each year that you would like to participate in the FSAs, you must elect the amount you want to contribute.

	Annual contribution limits
Healthcare flexible spending account	$3,300*
Dependent care flexible spending account	$5,000 filed jointly $2,500 filed individually*

*IRS limits subject to change.

Ag Partners offers two types of FSAs that can help you save on a pretax basis for out-of-pocket expenses.

Healthcare Flexible Spending Account

The healthcare FSA can be used to pay for eligible out-of-pocket medical, dental, vision and prescription drug expenses. For a complete listing of qualified healthcare expenses, visit healthequity.com.

Funds in the healthcare FSA are available at the beginning of the plan year and can be used for your expenses and those of your spouse and dependents, even if you and your family aren't covered by our healthcare plan.

CARRYOVER BENEFIT

The maximum contribution in 2025 for the healthcare flexible spending account is $3,300. This is a use-it-or-lose-it account, meaning any funds remaining in the account following the close of the plan year will be forfeited. All services must be incurred from July 1, 2025, through June 30, 2026. Our plan has a carryover feature that allows up to $660 of your unused funds to be carried forward to the following plan year. These carryover dollars can be used for expenses incurred at any point within the new plan year. Any unused amount over $660 will be lost.

If you have extra money in your FSA at the end of the year, visit fsastore.com or the Amazon FSA store to spend down your balance. Remember, FSA dollars are use it or lose it!

TAX-FAVORED ACCOUNT

TAX-FAVORED ACCOUNT

Dependent Care Flexible Spending Account

Dependent care FSAs allow you to set aside money pretax to pay eligible out-of-pocket day care expenses so that you or your spouse can work or attend school full time. You must contribute money through payroll deduction to your dependent care FSA before you can spend it.

During open enrollment, you must decide how much to set aside for this account in 2025. You may contribute up to $5,000, or up to $2,500 if you are married and file separate tax returns.

ELIGIBLE EXPENSES

- Adult day care
- Child day care
- After-school care
- Babysitting (work-related, in your home or someone else's home)
- Babysitting by your relative who is not a tax dependent (work-related)
- Nanny or au pair
- Custodial elder care
- Transportation to and from eligible care (provided by your care provider)

INELIGIBLE EXPENSES

- Babysitting (not work-related, for other purpose)
- Babysitting by your tax dependent (work-related or for other purpose)
- Custodial elder care (not work-related, for other purpose)
- Dance lessons, piano lessons or sports lessons
- Educational, learning or study skills services for child(ren)
- Household services (housekeeper, maid, cook, etc.)

EMPLOYEE ASSISTANCE PROGRAM (EAP)

ACENTRA HEALTH | EAPHELPLINK.COM CODE: KCLEAP5 | 877.239.8783

We all know that life can be challenging at times. Issues like illness, debt and family problems can leave us feeling worried or anxious and not able to be at our best. Your Employee Assistance Program provides counseling sessions at no cost to you, as well as offering a wide variety of services to enhance overall wellbeing and support healthy work/life balance. The program is completely confidential and available to you, your household family members, and your dependents.

Here's what the program offers:

- **EAP:** 5 face-to-face visits with experienced clinicians (per occurrence), without any per-session cost to you.
- **LEGAL RESOURCES:** Free 30-minute telephonic consultations with state-specific attorneys and discounts on additional services.
- **FINANCIAL RESOURCES:** Up to 60 minutes of free consultation with certified financial coaches for each financial issue.

The EAP provides counseling on all aspects of life, including:

- Difficulties in relationships.
- Emotional/psychological issues.
- Stress and anxiety issues with work or family.
- Personal and life improvement.
- Legal or financial issues.
- Depression.
- Child care and elder care issues.
- Grief issues.

Assistance Around the Clock

Whenever you need assistance with a work/life issue, the EAP is there for you, 24 hours a day. Specialists are available for confidential 24/7 assistance and support.

FOR MORE INFORMATION AND RESOURCES:

Call: 877.239.8783
Go online: eaphelplink.com
Your access code: KCLEAP5

DENTAL

DELTA DENTAL OF KS | DELTADENTALKS.COM | 800.234.3375

Although you can choose any dental provider, when you use an in-network dentist, you will generally pay less for treatments because your share of the cost will be based on negotiated discount fees. With out-of-network dentists, the plan will pay the same percentage, but the reimbursement will be based on out-of-network rates. You may be billed for the difference.

Dental exams can tell your doctor a lot about your overall health. It's important to schedule regular exams to help detect significant medical conditions before they become serious.

To find an in-network dentist, please visit deltadental.com/us/en/member/find-a-dentist.html.

	In-network
Deductible	
Employee only	$50
Family	$150
Is the deductible waived for preventive services?	Yes
Annual plan maximum (per individual)	$1,500
Diagnostic and preventive	
Oral exams, X-rays, cleanings, fluoride, space maintainers, sealants	100%
Basic – covered 100% for dependents under age 12	
Oral surgery, fillings, endodontic treatment, periodontic treatment, repairs of dentures and crowns	50%
Major – covered 100% for dependents under age 12	
Crowns, jackets, dentures, bridge implants	50%

DENTAL BI-WEEKLY EMPLOYEE PAYROLL CONTRIBUTIONS

EFFECTIVE JULY. 1, 2025

	Bi-weekly
Employee	$12.79
Employee + spouse	$25.39
Employee + child(ren)	$25.84
Family	$43.53

- You can elect the Delta Dental dental plan regardless of whether you are enrolled in the medical or vision plan.
- You typically do not need to present an ID card when visiting your dentist. To print an ID card, log in to deltadentalks.com.

AMERITAS VISION PLAN

AMERITAS | AMERITAS.COM | 800.659.2223

Ameritas' vision care benefits include coverage for eye exams, standard lenses and frames, and contact lenses. The vision plan is built around a network of eye care providers, with better benefits at a lower cost to you when you use providers who belong to the Ameritas network. When you use an out-of-network provider, you will have to pay more for vision services.

Eye exams can tell your doctor a lot about your overall health. It's important to schedule regular exams to help detect significant medical conditions before they become serious.

	In-network
Plan year	July 1-June 30
Eye exam with dilation as necessary (once per 12 months)	$0 copay
Frames (once per 24 months)	$130 allowance
Single vision lenses (once per 12 months)	Covered in full
Bifocal lenses (once per 12 months)	Covered in full
Trifocal lenses (once per 12 months)	Covered in full
Lenticular lenses (once per 12 months)	Covered in full
Medically necessary contact lenses (once per 12 months)	Covered in full
Elective contact lenses in lieu of glasses (once per 12 months)	$130 allowance

Frequency limitations are based on date of service. Please refer to the full plan summary for out-of-network coverages.

VISION CARE DIRECT PLANS

VISION CARE DIRECT | VISIONCAREDIRECT.COM | 877.488.8900

Vision Care Direct's vision care benefits also include coverage for eye exams, standard lenses and frames, and contact lenses. The vision plan is built around a network of eye care providers, with better benefits at a lower cost to you when you use providers who belong to the Vision Care Direct network. When you use an out-of-network provider, you will have to pay more for vision services.

	Gold – Materials Only 130	Gold – Exam + Materials 130	Silver – Exam + Materials 130
	In-network	In-network	In-network
Plan year	July 1-June 30	July 1-June 30	July 1-June 30
Eye exam with dilation as necessary (once per 12 months)	Not covered	$15 copay	$15 copay
Frames	$130 allowance	$130 allowance	$130 allowance
Frame Frequency	Every 12 months	Every 12 months	Every 24 months
Single vision lenses (once per 12 months)	$15 copay then covered 100%		
Bifocal lenses (once per 12 months)	$15 copay then covered 100%		
Trifocal lenses (once per 12 months)	$15 copay then covered 100%		
Progressive lenses (once per 12 months)	$15 copay plus average above allowance		
Polycarbonate lenses for children	$25 copay, included for children up to age 18		
Medically necessary contact lenses (once per 12 months)	$250 allowance		
Elective contact lenses in lieu of glasses (once per 12 months)	$130 allowance		

VISION BI-WEEKLY EMPLOYEE PAYROLL CONTRIBUTIONS

EFFECTIVE JULY 1, 2025

		Vision Care Direct		
	Ameritas Plan	Gold Materials Only 130	Gold Exam + Materials 130	Silver Exam + Materials 130
Employee	$5.40	$5.10	$6.99	$5.78
Employee + spouse	$8.03	$8.15	$11.18	$9.25
Employee + child(ren)	$13.57	$9.41	$12.90	$10.67
Family	N/A	$16.00	$21.93	$18.15

LIFE AND AD&D

KANSAS CITY LIFE | KCLIFE.COM | 800.247.6875

Ag Partners' comprehensive benefits package includes financial protection for you and your family in the event of an accident or death. Group term life and AD&D coverage are provided automatically at no cost to you upon employment.

In the event of your death, the life insurance policy provides a benefit to the beneficiary you designate. If your death is the result of an accident or if an accident leaves you with a covered debilitating injury, you are covered under the AD&D insurance for the same amount.

Basic Life and AD&D

Group term life and AD&D	100% paid by the employer
Employee	1x annual salary

Age reduction may apply.

Voluntary Life and AD&D

You have the opportunity to purchase voluntary life and AD&D insurance for yourself, your spouse and/or your dependent children. Your cost for this coverage is based on the amount you elect and your age. You must purchase voluntary life and AD&D insurance for yourself in order to purchase spouse and/or dependent child(ren) coverage. If you did not enroll in this coverage when you were first eligible or if you elect an amount in excess of the guaranteed issue amount, you will be subject to medical underwriting.

Coverage	Available benefit	Guaranteed issue amount
Employee $10,000 increments	5x annual salary up to $300,000	$100,000

Please ensure your beneficiary information is up to date in ADP!

Benefit	$10,000	$50,000	$100,000	$150,000	$200,000	$300,000
Under age 29	$0.48	$2.38	$4.75	$7.13	$9.51	$14.26
Age 30-34	$0.62	$3.12	$6.23	$9.35	$12.46	$18.69
Age 35-39	$0.79	$3.95	$7.89	$11.84	$15.78	$23.68
Age 40-44	$1.07	$5.33	$10.66	$15.99	$21.32	$31.98
Age 45-49	$1.50	$7.48	$14.95	$22.43	$29.91	$44.86
Age 50-54	$2.27	$11.33	$22.66	$33.99	$45.32	$67.98
Age 55-59	$3.37	$16.87	$33.74	$50.61	$67.48	$101.22
Age 60-64	$4.80	$24.00	$48.00	$72.00	$96.00	$144.00
Age 65-69	$8.16	$40.80	$81.60	$122.40	$163.20	$244.80
Age 70-74	$13.91	$69.55	$139.11	$208.66	$278.22	$417.32
Age 75+	$50.96	$254.82	$509.63	$764.45	$1,019.26	$1,528.89

SHORT-TERM DISABILITY

WORKPLACE BENEFITS | DREW@WORKPLACEBEN.COM | 785.766.0264

Ag Partners has partnered with Workplace Benefits to provide financial assistance in case you become disabled or unable to work.

Voluntary Short-Term Disability (STD) Plan

STD benefits are designed to replace a portion of your income for a non-work-related short-term injury or illness. STD benefits are paid at 60% of your eligible weekly base pay during the first 13 weeks of injury or illness.

Short-term disability eligibility — full-time employees	100% paid by the employee
Weekly benefit amount	60%
Benefits begin	Same day for injury 7 days following illness
Benefits duration	13 weeks

The STD benefit is available on a voluntary basis. Any income replacement benefits received are taxable.

SHORT-TERM DISABILITY BI-WEEKLY EMPLOYEE PAYROLL CONTRIBUTIONS

EFFECTIVE JULY 1, 2025

Benefit	$100	$200	$300	$400	$500	$600	$700	$800	$900	$1,000
Under age 29	$4.86	$9.72	$14.58	$19.45	$24.29	$29.16	$34.02	$38.89	$43.74	$48.60
Age 30-34	$5.73	$11.47	$17.19	$22.94	$28.66	$34.40	$40.14	$45.86	$51.59	$57.34
Age 35-39	$7.16	$14.33	$21.49	$28.65	$35.82	$42.98	$50.16	$57.33	$64.48	$71.66
Age 40-44	$8.99	$17.97	$26.96	$35.93	$44.92	$53.90	$62.89	$71.87	$80.86	$89.83

VOLUNTARY BENEFITS

WORKPLACE BENEFITS | DREW@WORKPLACEBEN.COM | 785.766.0264

Accident Insurance

The accident insurance through Workplace Benefits is designed to supplement major medical coverage by paying specific cash benefit amounts for expenses resulting from injuries or accidents. For information on all covered accidents, refer to the full marketing materials from Workplace Benefits. Since this plan pays a cash benefit, you are free to use it for whatever purpose you choose!

Policy benefits	Plan 1	Plan 2
Initial hospital confinement (pays once per year)	$1,000	$1,500
Daily hospital confinement (pays each day)	$200	$300
Intensive care benefit (Pays up to 30 days per covered accident)	$1,600	$2,400
Rider benefits		
Ambulance		
Ground	$200	$300
Air	$600	$900
Initial accident treatment		
Doctor's office	$100	$150
Urgent care	$100	$150
ER	$200	$300
X-ray	$200	$300
Dislocation or fracture	Up to $4,000	Up to $6,000
Laceration	$100	$150
Ear injury (once per lifetime)	$200	$300
Eye injury	$200	$300

ACCIDENT BI-WEEKLY EMPLOYEE PAYROLL CONTRIBUTIONS

EFFECTIVE JULY 1, 2025

Accident plan	Plan 1	Plan 2
Employee only	$6.42	$9.00
Employee + spouse	$11.13	$15.59
Employee + child(ren)	$13.00	$17.53
Family	$19.31	$26.17

WELLNESS BENEFIT

The Accident Insurance plans also includes a Wellness Benefit, which pays $50 per day up to 2 times per insured per calendar year, subject to a maximum of four times for all insured persons per calendar year, for the following screenings or exams:

- Blood screening for triglycerides, cholesterol, HDL, LCL, or fasting blood glucose
- Annual physical exam
- Routine eye exam

VOLUNTARY BENEFITS

WORKPLACE BENEFITS | DREW@WORKPLACEBEN.COM | 785.766.0264

Critical Illness Insurance

Critical illness is designed to supplement major medical coverage by paying a lump-sum benefit due to diagnosis of a covered critical illness, condition, or procedure. Benefits paid are subject to maximums as listed on the full marketing materials from Workplace Benefits. Below are a few examples of benefits offered under this plan.

Illness	Payable amount
Heart attack	100%
Coronary artery bypass surgery	50%
Sudden cardiac arrest	50%
Angioplasty	25%
Stroke	100%
Invasive cancer	100%
Non-invasive cancer	50%
Skin cancer	$250 per calendar year
The wellness benefit pays $50 per calendar year per insured person for specific screening services.	

Benefit Amounts over $30,000 require underwriting approval.
Child Benefit is equal to 25% of employee benefit.
Please see full plan summary for rates for your spouse, family, and/or tobacco users.

CRITICAL ILLNESS BI-WEEKLY EMPLOYEE PAYROLL CONTRIBUTIONS

EFFECTIVE JULY 1, 2025

Benefit	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
Age 18-24	$0.92	$1.31	$1.71	$2.10	$2.50	$2.89
Age 25-29	$1.29	$1.91	$2.54	$3.15	$3.78	$4.39
Age 30-34	$1.72	$2.65	$3.59	$4.53	$5.47	$6.42
Age 35-39	$2.52	$4.01	$5.49	$6.98	$8.46	$9.94
Age 40-44	$3.48	$5.63	$7.79	$9.94	$12.10	$14.26
Age 45-49	$4.69	$7.90	$11.14	$14.36	$17.58	$20.80
Age 50-54	$6.22	$10.84	$15.45	$20.07	$24.68	$29.31
Age 55-59	$8.31	$14.94	$21.58	$28.22	$34.84	$41.46
Age 60-64	$9.29	$17.12	$24.97	$32.81	$40.66	$48.50
Age 65-69	$9.48	$17.83	$26.19	$34.53	$42.88	$51.22
Age 70+	$11.98	$22.72	$33.49	$44.25	$55.00	$65.76

The critical illness plan pays a $50 benefit per calendar year per insured person for specified screening services. For a full listing of qualifying screening services, please reach out to Human Resources.

RETIREMENT

UNITED BENEFITS GROUP | UBGRETIRE.COM | 800.816.5535

401(k) Retirement Plan

The Ag Partners 401(k) retirement plan is designed to help you prepare for retirement and attain your financial goals. When you enroll in the plan, a personal account will be established with United Benefits Group in your name, funded by:

- Your contributions (pretax and/or Roth).
- Employer matching contributions.
- Investment earnings on both types of contributions.

Ag Partners adds to your savings through its employer match, matching your contributions dollar for dollar on the first 2% of your contributions. You are eligible to participate in the 401(k) plan after 3 months of service with Ag Partners.

Employee must be 18 years old to be eligible for participation in the 401(k) plan

RetireMint

- Mandatory participation after 1,000 hours of service
- Employee contributes 4% of gross wages
- Ag Partners Coop contributes 3.55% of gross wages

Employee must be 21 years old to be eligible for participation in the RetireMint plan

Retirement Facts

WHAT DO YOU NEED? Studies suggest you need 11.1x your annual income at retirement age (67) to maintain your standard of living throughout retirement.

HOW MUCH DO YOU NEED TO SAVE? The same study says you need to save 16% of every paycheck starting at age 25 to accumulate 11.1x your annual income.

HOW LONG? You would need to save from ages 25-64 (42 years) in order to achieve this goal.

4% Contribution to the Coop Retirement Plan + **3%** Contribution to your 401(k) = **7%** Total contribution instead of 16%

PAID TIME OFF

Paid Time Off

All full-time employees are entitled to the number of PTO days as outlined below.

NON EXEMPT (Hourly): Beginning on the first day of the month, following 30 days of continuous service, an employee will begin accruing the following hours/days per month.

Continuous Employment	Full-Time Accrual
1-4 years	18 workdays (12 hours/month)
5-9 years	21 workdays (14 hours/month)
10+ years	30 workdays (20 hours/month)

PTO can only be used in one-hour increments. Employees may accrue PTO leave up to a maximum of 320 hours or 40 days at any one time. Unpaid time off requires supervisor approval.

EXEMPT (Salary): Unlimited PTO.
There is no set number of days off - as long as time away is approved in advance and responsibilities are covered. This flexible policy reflects our trust in employees to balance time off with performance and team needs.

Holiday Pay

Ag Partners Coop observes the following six (6) paid holidays each year for full-time employees. Part-time and Temporary/Seasonal employees are not eligible for holiday pay.

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

Paid Maternity Leave

- 8 weeks of paid maternity leave will be granted to mothers who give birth.
- This leave begins immediately following birth of a child and is intended to support the mother's physical recovery.
- Eligibility begins at 1 year of employment.

Paid Medical Leave

- Up to 8 weeks of paid medical leave for exempt (salary) employees facing a serious health condition, following 4 weeks of Unlimited PTO
- Eligibility Beings at 1 year of employment.

EMPLOYEE DISCOUNTS

- 5¢ discount/gallon on fuel at cardtrols with a Coop gas card (for personal use only)
- Mr. Tire Service Center in Seneca (for personal use)
  - 15% off of selling price for gloves, batteries, antifreeze and other miscellaneous items
  - Tires: 10% over cost for tires – mounting and balancing included in price
  - Discounts on tire repairs, balancing and rotating tires, oil, filters, and labor

COMPANY UNIFORMS

Employees receive an allowance of $270 per calendar year for Ag Partners branded apparel or boots ordered online through our company clothing website.

QUESTIONS?

Lacey Dalinghaus, Chief Human Resources Officer
Phone: 785.294.0397
Email: laceyd@agpartnerscoop.com

MENTAL HEALTH RESOURCES

988 Suicide & Crisis Lifeline

We can all help prevent suicide. If you or someone you know is in crisis, dial 988 for immediate, free, confidential support from a trained professional. The 988 Suicide & Crisis Lifeline provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week, across the United States. Support also available via text at 988 and chat. Learn how to advocate for suicide prevention.

Visit: 988lifeline.org
Call: 988
Chat: 988lifeline.org/chat

What Happens When I Chat or Text with the 988 Lifeline?

1. First, you'll see a wait-time message while we connect you to a crisis counselor.

2. If demand is high, you can always look at our "Helpful Resources" below, or call the 988 Lifeline at 988.

3. A crisis counselor will answer your chat or text.

4. This person will listen to you, understand how your problem is affecting you, provide support, and share resources that may be helpful.

Your conversations are free and confidential.

For more information on resources or to chat online with Lifeline, visit 988lifeline.org.

CONTACTS

Medical Plan

BLUE CROSS BLUE SHIELD OF KANSAS

Member services: 800.432.3990
Website: bcbsks.com

Telemedicine

AMWELL

Phone: 844.733.6327
Website: amwell.com

FSA & HSA

HEALTHEQUITY

FSA customer service: 877.924.3967
HSA customer service: 866.346.5800
Website: healthequity.com

Employee Assistance Program

ACENTRA HEALTH

Free, confidential support: 877.239.8783
Website: eaphelplink.com
Access Code: KCLEAP5

Dental

DELTA DENTAL OF KANSAS

Customer service: 800.234.3375
Website: deltadentalks.com

Vision

AMERITAS

Customer service: 800.659.2223
Website: ameritas.com

VISION CARE DIRECT

Customer service: 844.488.8900
Website: visioncaredirect.com

Life and AD&D

KANSAS CITY LIFE INSURANCE

Customer service: 800.247.6875
Website: kclife.com

Voluntary Short-Term Disability

WORKPLACE BENEFITS

Customer service: drew@workplaceben.com
Website: 785.766.0264

Accident & Critical Illness Insurance

WORKPLACE BENEFITS

Customer service: drew@workplaceben.com
Website: 785.766.0264

401(k) Retirement

UNITED BENEFITS GROUP

Customer service: 800.816.5535
Website: ubgretire.com

Ag Partners Cooperative, Inc.

HEALTH PLAN NOTICES

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IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Ag Partners Cooperative, Inc. About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE FROM AG PARTNERS COOPERATIVE, INC. ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Ag Partners Cooperative, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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

2. Ag Partners Cooperative, Inc. has determined that the prescription drug coverage offered by the Ag Partners Cooperative, Inc. Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. See the Ag Partners Cooperative, Inc. Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the Ag Partners Cooperative, Inc. Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Ag Partners Cooperative, Inc. Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Ag Partners Cooperative, Inc. prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call 785.336.6153 ext. 216. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Ag Partners Cooperative, Inc. changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date:	May 12, 2025
Name of Entity/Sender:	Lacey Dalinghaus
Contact—Position/Office:	Chief Human Resources Officer
Address:	201 N 6th St Seneca, KS 66538
Phone Number:	785.336.6153 ext. 216

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

AG PARTNERS COOPERATIVE, INC.
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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

This notice is provided to you on behalf of:

Ag Partners Employee Benefit Plan*

* This notice pertains only to healthcare coverage provided under the plan.

For the remainder of this notice, Ag Partners Cooperative, Inc. is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
- Examples of "payment" activities include billing, claims management, and medical necessity reviews.
- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

If protected health information is properly disclosed under the HIPAA Privacy Practices, such information may be subject to redisclosure by the recipient and no longer protected under the HIPAA Privacy Practices.

5. Disclosure for Underwriting Purposes. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities (subject to certain limitation described in paragraph 20 below);
- When required for judicial or administrative proceedings (subject to certain limitation described in paragraph 20 below);
- When required for law enforcement purposes (subject to certain limitation described in paragraph 20 below);
- When required to be given to a coroner or medical examiner or funeral director (subject to certain limitation described in paragraph 20 below);
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its representatives that he or she is acting on your behalf and with your consent. Your spouse might to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected

health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. Reproductive Health Care Privacy: Effective December 23, 2024, a group health plan may not disclose protected health information to: (i) conduct a criminal, civil, or administrative investigation into a person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; (ii) impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; or (iii) identify any person for the purposes described in (i) and (ii).

Reproductive health care means care, services, or supplies related to the reproductive health of the individual.

This prohibition only applies if the reproductive health care is lawful under the law of the state in which the health care was provided and under the circumstances in which it was provided, or if the reproductive health care was protected, required, or authorized by Federal law, including the United States Constitution, regardless of the state in which it is provided. For example, if you receive reproductive health care in a state where such care is lawful even though it is not lawful in the state where you reside, the plan may not disclose this information to conduct an investigation.

A group health plan may not use or disclose protected health information potentially related to reproductive health care for the purposes of uses and disclosures of 1) public health oversight activities, 2) judicial and administrative proceedings, 3) law enforcement purposes, and 4) coroners and medical examiners without obtaining a valid attestation from the person requesting the use or disclosure of such information. A valid attestation under this section must include the following elements:

(i) A description of the information requested that identifies the information in a specific fashion, including one of the following: (A) the name of any individual(s) whose protected health information is sought, if practicable; and (B) if including the name(s) of any individual(s) whose protected health information is sought is not practicable, a description of the class of individuals whose protected health information is sought.

(ii) The name or other specific identification of the person(s), or class of persons, who are requested to make the use or disclosure.

(iii) The name or other specific identification of the person(s), or class of persons, to whom the covered entity is to make the requested use or disclosure.

(iv) A clear statement that the use or disclosure is not for a purpose prohibited by the reproductive health care regulation.

(v) A statement that a person may be subject to criminal penalties if that person knowingly and in violation of HIPAA obtains individually identifiable health information relating to an individual or discloses individually identifiable health information to another person.

(vi) Signature of the person requesting the protected health information, which may be an electronic signature, and date. If the attestation is signed by a representative of the person requesting the information, a description of such representative's authority to act for the person must also be provided.

For example, if you lawfully obtain an abortion and an investigation into the provider is conducted, law enforcement would need to submit an attestation in order to try and obtain the information. The plan would deny the request per HIPAA's prohibition on the disclosure of reproductive health care because such care was lawful.

21. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 24).

22. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

23. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

24. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Lacey Dalinghaus
SVP Human Resources
785.336.6153 ext. 216

Effective Date

The effective date of this notice is: May 12, 2025.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

AG PARTNERS COOPERATIVE, INC. EMPLOYEE HEALTH CARE PLAN

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *30 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within *30 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Lacey Dalinghaus
SVP Human Resources
785.336.6153 ext. 216

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If you believe you are eligible for this extension, contact the Plan Administrator.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Lacey Dalinghaus
SVP Human Resources
201 N 6th St
Seneca, KS 66538
785.336.6153 ext. 216

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

Ag Partners Cooperative, Inc. Employee Health Care Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at 785.336.6153 ext. 216.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Ag Partners Cooperative, Inc. Employee Health Care Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Ag Partners Cooperative, Inc. Employee Health Care Plan at:

Lacey Dalinghaus
SVP Human Resources
785.336.6153 ext. 216

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Ag Partners Cooperative, Inc. Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The Ag Partners Cooperative, Inc. Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

Blue Plan (PPO)	In-Network	Out-of-Network
Individual Deductible	$1,500	$1,500
Family Deductible	$3,000	$3,000
Coinsurance	80%	80%
Red Plan (HDHP)	In-Network	Out-of-Network
Individual Deductible	$3,300	$3,300
Family Deductible	$6,600	$6,600
Coinsurance	100%	100%

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at:

Lacey Dalinghaus
Chief Human Resources Officer
785.336.6153 ext. 216

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.