Plan Document
and
Summary Plan Description

Agropur inc. Prescription Drug Plan

Plan: 510

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Plan Description

Purpose

The Plan Document details the benefits, rights, and privileges of Covered Individuals (as later defined), in a fund established by Agropur inc. (the "Company") and referred to as the "Plan." The Plan Document explains the times when the Plan will pay or reimburse all or a portion of Eligible Expenses.

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Effective Date of Plan	January 1, 2025
Name of Plan	Agropur inc. Prescription Drug Plan Hereafter, known as the "Plan"
Name of Group Health Plan	Agropur inc. Comprehensive Health and Welfare Benefits Plan Hereafter, known as the "Health Plan"
Name and Address of Plan Sponsor	Agropur inc. 3500 East Destination Drive Appleton, WI 54915
Name of Plan Administrator	Agropur inc.
Name and Address of Claims Administrator	Rx Benefits, Inc. 3700 Colonnade Pkwy, Suite 600 Birmingham, AL 35243
Employer I.D. Number	35-1442306
Plan Number	510
Type of Plan	A self-funded group health plan providing prescription drug expense coverage
Agent For Legal Service	Agropur inc.
Funding of the Plan	Agropur inc. and Employee Contributions
Medium For Providing Benefits	The benefits are administered in accordance with the Plan Document by the Claims Administrator.
Plan Year	Begins January 1st and ends December 31st

The Plan Administrator or its delegate has the sole authority and discretion to interpret and construe the terms of the Plan and to determine any and all questions in relation to the administration, interpretation or operation of the Plan, including, but not limited to, eligibility under the Plan, payment of benefits or claims under the Plan and any and all other matters arising under the Plan. The decision of the Plan Administrator will be final and binding on all interested parties.

Plan Document and Summary Plan Description

The legal document according to which this Plan is administered.

Claims Administrator is Not a Fiduciary

A Claims Processor is not a fiduciary under the Plan, as defined by ERISA, by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

Legal Entity

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Contributions to the Plan

The amount of contributions to the Plan is to be made on the following basis:

The Company will from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Company and the amount to be contributed (if any) by each covered Employee. Notwithstanding any other provision of the Plan, the Company's obligation to pay claims otherwise allowable under the terms of the Plan will be limited to its obligation to make contributions to the Plan as set forth in the preceding sentence. Payment of said claims in accordance with these procedures will discharge completely the Company's obligation with respect to such payments. In the event that the Company terminates the Plan, then as of the effective date of termination, the Company and Covered Individuals will have no further obligation to make additional contributions to the Plan.

Plan Modification and Amendments

Subject to any negotiated agreements, the Company may modify, amend, or discontinue the Plan without the consent of Covered Individuals. Any changes made shall be binding on each Employee and on any other Covered Individuals. This right to make amendments shall extend to amending the coverage (if any) granted to retirees covered under the Plan, including the right to terminate such coverage (if any) entirely.

Termination of Plan

The Company reserves the right at any time to terminate the Plan by a written instrument to that effect. All previous contributions by the Company will continue to be issued for the purpose of paying benefits under the provisions of this Plan with respect to claims arising before such termination or will be used for the purpose of providing similar health benefits to Covered Individuals, until all contributions are exhausted.

Plan Is Not a Contract

The Plan Document constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment or give any Employee of the Company the right to be retained in the service of the Company or to interfere with the right of the Company to discharge or otherwise terminate the employment of any Employee.

Claim Procedure

In accordance with Section 503 of ERISA, the Claims Administrator will provide adequate notice in writing to any Covered Individuals whose claim for benefits under this Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the Covered Individuals. Further, the Claims Administrator will afford a reasonable opportunity to any Covered Individuals, whose claim for benefits has been denied, for a full and fair review of the decision denying the claim by the person designated by the Claims Administrator for that purpose.

Protection against Creditors

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same will be void. If the Company finds that such an attempt has been made with respect to any payment due or to become due to any Covered Individual, the Company in its sole discretion may terminate the interest of such Covered Individual or former Covered Individual in such payment, and in such case will apply the amount of such payment to or for the benefit of such Covered Individual or former Covered Individual, his or her spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a Dependent of such Covered Individual or former Covered Individual, as the Company may determine, and any such application will be a complete discharge of all liability with respect to such benefit payment. This Provision does not prohibit a Covered Individual from assigning his or her benefits to an Eligible Provider.

Indemnification of Employees

Except as otherwise provided in ERISA, no director, officer, or Employee of the Company or of the Claims Administrator will incur any personal liability for the breach of any responsibility, obligation, or duty in connection with any act done or omitted to be done in good faith in the administration or management of the Plan and will be indemnified and held harmless by the Company from and against any such personal liability, including all expenses reasonably incurred in his or her defense if the Company fails to provide such defense. The Company and the Plan each may purchase fiduciary liability insurance consistent with applicable law.

Compliance

It is the intent of this Plan to comply with all federal regulations that govern health care including ERISA (Employee Retirement Income Security Act of 1974), TEFRA (Tax Equity Fiscal Responsibility Act of 1982), DEFRA (the Deficit Reduction Act of 1984), COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985), HIPAA (Health Insurance Portability and Accountability Act of 1996), PPACA (Patient Protection and Affordable Care Act of 2010 also referred to as ACA - Affordable Care Act), and any regulations that may become effective.

Plan Summary and Benefits

Eligible Class

Employees enrolled in the Health Plan. All eligibility provisions for employees and dependents are defined by the health plan.

Additional Information

Information regarding extension of benefits, coordination of benefits and subrogation/third party recovery can all be found in the Company sponsored Health Plan.

General provisions including notice of rescission/termination/modification of coverage, GINA, Protected Health Information (PHI) and HIPAA security information can all be found in the Company sponsored Health Plan.

Prescription Schedule of Benefits

BENEFIT PLAN – HDHP 1	
Annual Deductible Per Plan Year: Medical and pharmacy expenses are subject to the same Deductible. • Per Person • Per Family	 $3,300 $6,600
Annual Out-Of-Pocket Maximum Per Plan Year: Medical and pharmacy expenses are subject to the same out-of-pocket maximum. • Per Person • Per Family **Embedded:** When an individual in the family plan meets the individual out-of-pocket maximum, that individual will have the remainder of their eligible prescription drug expenses covered at a $0 copay for the remainder of the benefit year.	 $4,000 $8,000
By Participating Retail Pharmacy 01 – 90 Day Supply Covered Person's Coinsurance Amount PPACA Preventive Care Drugs All Other Formulary Generic Drugs All Other Formulary Brand Drugs	 You pay 20% You pay $0 You pay 20% You pay 20%
By Participating Mail Order Pharmacy 01 – 90 Day Supply • Covered Person's Coinsurance Amount PPACA Preventive Care Drugs All Other Formulary Generic Drugs All Other Formulary Brand Drugs	 You pay 20% You pay $0 You pay 20% You pay 20%

If a brand name drug is purchased when a generic is available, the participant will be responsible for the difference in cost between the name brand and generic drug in addition to the copay.
Medications required as part of PPACA Preventive Care services are covered 100% with no Copay or Deductible required.

BENEFIT PLAN – HDHP 2	
Annual Deductible Per Plan Year: Medical and pharmacy expenses are subject to the same Deductible. • Per Person • Per Family	 $5,000 $10,000
Annual Out-Of-Pocket Maximum Per Plan Year: Medical and pharmacy expenses are subject to the same out-of-pocket maximum. • Per Person • Per Family **Embedded:** When an individual in the family plan meets the individual out-of-pocket maximum, that individual will have the remainder of their eligible prescription drug expenses covered at a $0 copay for the remainder of the benefit year.	 $6,000 $12,000
By Participating Retail Pharmacy 01 – 90 Day Supply • Covered Person's Coinsurance Amount PPACA Preventive Care Drugs All Other Formulary Generic Drugs All Other Formulary Brand Drugs	 You pay 20% You pay $0 You pay 20% You pay 20%
By Participating Mail Order Pharmacy 01 – 90 Day Supply • Covered Person's Coinsurance Amount PPACA Preventive Care Drugs All Other Formulary Generic Drugs All Other Formulary Brand Drugs	 You pay 20% You pay $0 You pay 20% You pay 20%

If a brand name drug is purchased when a generic is available, the participant will be responsible for the difference in cost between the name brand and generic drug in addition to the copay.
Medications required as part of PPACA Preventive Care services are covered 100% with no Copay or Deductible required. This includes the expanded list as allowable under ACA.

BENEFIT PLAN – Copay Plan	
Annual Deductible Per Plan Year: Medical and pharmacy expenses are subject to the same Deductible. • Per Person • Per Family	 $1,500 $3,000
Annual Out-Of-Pocket Maximum Per Plan Year: Medical and pharmacy expenses are subject to the same out-of-pocket maximum. • Per Person • Per Family **Embedded:** When an individual in the family plan meets the individual out-of-pocket maximum, that individual will have the remainder of their eligible prescription drug expenses covered at a $0 copay for the remainder of the benefit year.	 $3,000 $6,000
By Participating Retail Pharmacy 01 – 31 Day Supply • Covered Person's Coinsurance Amount PPACA Preventive Care Drugs All Other Formulary Generic Drugs All Other Formulary Brand Drugs All Other Formulary Non-Preferred Brand Drugs All Other Formulary Specialty Drugs	 20% You pay $0 You pay $10 Copay You pay $35 Copay You pay $70 Copay You pay $150 Copay
By Participating Retail Pharmacy 32 - 90 Day Supply • Covered Person's Coinsurance Amount PPACA Preventive Care Drugs All Other Formulary Generic Drugs All Other Formulary Brand Drugs All Other Formulary Non-Preferred Brand Drugs	 20% You pay $0 You pay $30 Copay You pay $100 Copay You pay $210 Copay
By Participating Mail Order Pharmacy 01 – 90 Day Supply • Covered Person's Coinsurance Amount PPACA Preventive Care Drugs All Other Formulary Generic Drugs All Other Formulary Brand Drugs All Other Formulary Non-Preferred Brand Drugs	 You pay 20% You pay $0 You pay $25 Copay You pay $87.50 Copay You pay $175 Copay

If a brand name drug is purchased when a generic is available, the participant will be responsible for the difference in cost between the name brand and generic drug in addition to the copay.

Medications required as part of PPACA Preventive Care services are covered 100% with no Copay or Deductible required. This includes the expanded list as allowable under ACA.

Definitions

Copayment / Coinsurance means the monetary amount (which may be expressed as either a percentage or a specific dollar amount) that a member is required to pay at the Participating Pharmacy at the time the benefits are provided.

Formulary means a list of preferred and non-preferred Prescription Drugs and supplies and their associated coverage information (e.g. tiers, limits, coverage exclusions, restrictions), developed, published and periodically revised by PBM for the Plan's benefit.

Generic Drug means an FDA-approved prescription drug, identified by its chemical composition, that is therapeutically equivalent and interchangeable with brand name drugs having an identical amount of the same active ingredient(s). The Generic Drug shall be identifiable in the Medi-Span database as having a multisource code of "Y".

Generic Drug Policy applies to a dispense-as-written (DAW) rule. This Plan rule applies if a member requests a brand drug when a generic drug is available. In such cases, the member will be responsible for the applicable cost share plus the difference in cost between the brand drug requested and the generic.

Non-Participating Pharmacy means any retail or mail order Pharmacy that is not contracted by the Pharmacy Benefits Administrator and is excluded from the network of Pharmacies.

Over-the-Counter (OTC) Drugs applies to drugs or devices that are available without a prescription from a prescribing physician. Most OTC Drugs or devices are not covered by the Plan.

Participating Pharmacy means any retail or mail order Pharmacy that is contracted by the Pharmacy Benefits Administrator to be included in a network of Pharmacies at a contracted amount.

Pharmacy means a licensed establishment where Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state in which the pharmacist practices.

Pharmacy Benefits Administrator means an organization that manages payment for Prescriptions and services under the Plan.

Prescription Drug means a pharmaceutical or pharmaceutical compound (i) that is included in the United States Pharmacopeia and that is required to be dispensed pursuant to a prescription and which is required by law to bear the legend, "Caution -- Federal law prohibits dispensing without prescription", or (ii) that is otherwise accepted by Sponsor as a Covered Product for purposes of this Agreement.

Prior Authorization means a rule applicable to certain medications which require members or their prescribing physicians to obtain prior authorization for a drug before it is covered by the Plan.

Specialty Drugs means Prescription Drugs as determined by PBM, that are typically used to treat chronic or complex conditions, and typically have one or more of several key characteristics, including frequent dosing adjustments and intensive clinical monitoring to decrease the potential for

drug toxicity and increase the probability for beneficial treatment outcomes; intensive patient training and compliance assistance to facilitate therapeutic goals; limited or exclusive product availability and distribution (if a drug is only available through limited specialty pharmacy distribution it is always considered a Specialty Drug) or specialized product handling and/or administration requirements. Specialty Drugs may be administered by any route of administration. Specialty Drugs may include biosimilars.

ADDITIONAL PLAN DESIGN INFORMATION

Pharmacy Network Design:

The National Preferred Pharmacy Network includes a network of pharmacies locally and nationwide. Register at http://member.rxbenefits.com to search for an in-network pharmacy or call RxBenefits at 800-334-8134 for assistance.

Mail Service:

Mail Order is designed to fill maintenance medications for chronic conditions that you take on a recurrent basis. Your Mail Service Partner Pharmacy is Express Scripts. For information regarding your Mail Service benefit, register at www.express-scripts.com or call RxBenefits at 800-334-8134 for assistance.

Formulary Design:

The Formulary is a list of preferred Prescription Drugs and supplies and their associated coverage information (e.g. tiers, limits, coverage exclusions, restrictions), developed, published and periodically revised by PBM for the Plan's benefit. For additional information regarding this Formulary, please visit http://member.rxbenefits.com or call RxBenefits at 800-334-8134 for assistance.

Member ID Cards:

Members will receive a Prescription Benefit ID card from the medical benefit administrator. This ID card contains important information the pharmacy needs in order to process prescriptions.

Step Therapy:

Step Therapy is a program intended to ensure that members receive the most cost-effective medications prior to the Plan approving brand medications to treat a particular condition. Your Plan has elected to implement the Step Therapy Program. For more information, please visit http://member.rxbenefits.com or call RxBenefits at 800-334-8134 for assistance.

Refill-Too-Soon Limitations:

A prescription may not be refilled until at least 75% of a 30-day supply (or 60% of a 90-day supply at mail order) has been utilized. For example, 23 days of a 30-day supply must be utilized before the pharmacy is able to process another fill.

COVERED MEDICATIONS

The following drug categories are generally covered by the Plan. Some drugs may require medical review or apply quantity limits. This list is subject to change.

1. Legend Drugs (drugs that require a prescription) Exceptions: See Excluded Drugs/Categories list.
2. Compound medication of which at least one ingredient is a legend drug. (prior authorization required when over $300)
3. Diabetic Care: Insulin/insulin pre-filled syringes, disposable insulin needles/syringes, Agents/Strips for testing, Lancets
4. Contraceptives as required under Healthcare Reform
5. Generic sexual dysfunction drugs
6. Preventive medications as required under Healthcare Reform
7. Migraine medications
8. Sleep agents

DRUGS REQUIRING PRIOR AUTHORIZATION

The following drug categories are subject to prior authorization. Your physician's office may obtain a prior authorization form by calling RxBenefits at 800-334-8134. This list is subject to change.

• Standard drugs more than $1,000 for 1-83 day supply claims and $3,000 for 84+ day supply claims.
• Compounded drugs more than $100
• ADHD / narcolepsy drugs
• Androgens
• Breast cancer chemo-prevention drugs
• HIV Preventatives
• Inhalation / nasal smoking cessation products
• Smoking cessation drugs (for treatment more than 6 months)

EXLUDED DRUGS/CATEGORIES

This list highlights common plan exclusions but is not all-inclusive.
• Non-prescription / non-prenatal vitamins and supplements
• Nutritional diet supplements
• Ostomy supplies
• Over-the-counter (OTC) drugs (except those listed as covered)
• Products for cosmetic indications e.g., anti-wrinkle agents, Botox, and hair growth stimulants
• Brand name sexual dysfunction drugs
• Fertility medications
• Weight loss medications

APPEALS AND CONTACT INFORMATION

A member's rights to appeal an adverse benefit determination under this Plan's Medical Benefit, which are set forth elsewhere in this Plan, will apply equally to the Prescription Drug Benefit. Members wishing to appeal a pharmacy claim may contact RxBenefits at the address below.

Rx Benefits, Inc.
3700 Colonnade Pkwy, Suite 600
Birmingham, AL 35243
Attn: Appeals / External Review

Rights under ERISA

Your Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Right to Examine and Obtain Copies of Plan Documents

Plan participants have the right to examine all documents governing the Plan, including insurance policies, Plan Documents, collective bargaining agreements, and any latest annual reports (Form 5500) filed by the Plan with the United States Department of Labor. The latest annual report can be found at www.efast.dol.gov. The Plan Administrator will tell the Plan participant where the other Plan documents are available for examination. Plan participants may examine any documents without charge.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your ERISA Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a State or Federal court.

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA or HIPAA, 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, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CLAIMS PROCEDURES

A. Filing of Claims

This Section shall apply for any claim for benefits under a Component Benefit Plan unless that plan has a claims procedure that is compliant with ERISA Section 503. If the Component Benefit Plan has a claims procedure that is compliant with ERISA Section 503, the claims procedure of the Component Benefit Plan shall apply.

A request for benefits is a "claim" subject to these procedures only if it is filed by the plan participant or an authorized representative of the plan participant in accordance with these claim filing procedures. Claims must generally be filed in writing with the applicable Component Benefit Plan insurer or administrator. (However, if a claim is an urgent care claim, an oral filing is acceptable.) If a claim is filed and the information is incomplete so as to prevent the claim from being processed, the participant will be given notice and an opportunity to complete the claim and refile.

An inquiry is not considered as a claim filing when it relates to general provisions of a plan (such as eligibility for participation, whether a service will be considered for benefits and prior approval of that service is not a requirement), the inquiry must be directed to the Plan Administrator.

Participants may designate an authorized representative if written notice of such designation is provided to the applicable provider identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of the participant's medical condition may act as an authorized representative with or without prior notice.

B. Timing of Notice of Claim

The Plan Administrator shall notify the plan participant of any adverse benefit determination within a reasonable period of time, but not later than the time frame below, depending on the type of benefit being provided under the Component Benefit Plan under which the claim for benefits arises.

<u>In General</u>
Notice will be provided within 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Plan Administrator both determines that such an

extension is necessary due to matters beyond the control of the Plan and notifies the plan participant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Prescription Drug Benefit Claims

The timeframe for benefit determinations shall be the same as under group health plans and shall be determined as provided under DOL Reg. section 2560.503-1(f)(2). For purposes of this section, group health plan means a group health plan as defined in DOL Reg. section 2560.503-1(m)(6).

C. Content of Notice of Denied Claim

If a claim is wholly or partially denied, the Plan Administrator shall provide the Plan participant with a written notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (4) an explanation of the steps that the Plan participant must take if he wishes to appeal the denial including a statement that the Plan participant may bring a civil action under ERISA.

In addition, if the wholly or partially denied claim is by a Plan providing group health or disability benefits, the following information must also be included in the written notice: (1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Plan participant upon request; or (2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Plan participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of a wholly or partially denied claim involving urgent care (as defined in DOL Reg. section 2560.503-1(m)(1)) under a Plan providing group health benefits, the notice must include a description of the expedited review process applicable to such claims. In addition, the information described in this Section may be provided orally within the timeframe required provided that a written or electronic notification is furnished to the plan participant not later than 3 days after the oral notification.

In the case of a disability claim or a claim involving disability, any adverse benefit determination shall include a discussion of the decision, with the basis for disagreeing with the views or decisions of any treating health care professionals, vocational experts, or other payers of benefit who granted the claimant's similar claims (including disability determinations by the Social Security Administration (SSA)). Any adverse benefit determination shall also include the plan's specific internal rules, guidelines, protocols, standards, or other similar criteria relied upon in making the adverse determination or, alternatively, a statement that such plan rules, guidelines, protocols, standards or other similar criteria do not exist. Any adverse benefit determination shall be provided in a culturally and linguistically appropriate manner.

The claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

D. Appeal of Denied Claim

If a Plan participant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the

claim has been wholly or partially denied (the 180th day for claims involving a group health plan or disability benefits). The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The Plan participant shall lose the right to appeal if the appeal is not timely made.

(1) The Plan participant shall be provided, upon request and free of charge, documents and other information relevant to his claim. A written appeal may also include any comments, statements or documents that the Plan participant may desire to provide. The Plan Administrator shall consider the merits of the Plan participant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances, as the Plan Administrator may deem relevant.

(2) In addition to the requirements of paragraph (A) above, if the claim is under a Component Benefit Plan providing group health or disability benefits, the claims procedures shall be determined in accordance with paragraph (C) and 2560.503-1(h)(4).

The Plan Administrator shall ordinarily rule on an appeal within 60 days. However, if special circumstances require an extension and the Plan Administrator furnishes the Plan participant with a written extension notice during the initial period, the Plan Administrator may take up to 120 days to rule on an appeal. If the denied claim is by a Component Benefit Plan providing group health or disability benefits, the timing of the Plan Administrator's review shall be determined in accordance with DOL Reg. section 2560.503-1(i)(2) and 560.503-1(i)(3).

In the case of a disability claim or a claim involving disability, a claimant may review the claim file and present evidence and testimony as part of the claims and appeals process. Further, the Plan Administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim. Such evidence shall be provided as soon as possible and to the extent possible in advance of the date on which the notice of adverse benefit determination on review is required to give the claimant a reasonable opportunity to respond before that date. Prior to issuing an adverse benefit determination on review based on a new or additional rationale, the plan administrator shall provide the claimant, free of charge, with the rationale. Such rationale shall be provided as soon as possible and to the extent possible in advance of the date on which the notice of adverse benefit determination on review is required to give the claimant a reasonable opportunity to respond before that date.

In the event of any error, a claimant may request a written explanation from the plan, including a specific description of the plan's bases, if any, for asserting that the error is *de minimis* and should not result in the deemed exhaustion of administrative remedies. The Plan shall provide this written explanation, if requested, within 10 days.

E. Denial of Appeal

If an appeal is wholly or partially denied, the Plan Administrator shall provide the Plan participant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Plan participant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Plan participant's claim for benefits, and (4) a statement describing the Plan participant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties. In addition, if the claim is under a Component Benefit Plan providing group health or disability benefits, the denial notice shall include additional information required under DOL Reg. section 2560.503-1(j)(5).

F. Exhaustion of Remedies

Before a suit can be filed in Federal court, claimants must exhaust internal remedies.

G. Additional Claims Processes

Applicability
This Subsection shall apply to the extent (1) the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules and (2) the Plan is not a grandfathered health plan under the Affordable Care Act.

Effective Date
This Subsection shall be effective the later of the first plan year beginning after September 23, 2010 or the date the Plan is no longer a grandfathered health plan under the Affordable Care Act.

Internal Claims Process
The claims requirements above shall apply as the internal claims process except as provided under DOL Reg. 2590.715-2719 and any superseding guidance.

Adverse Benefit Determination
An adverse benefit determination means an adverse benefit determination as defined in DOL Reg. 2560.503-1, as well as any rescission of coverage, as described in DOL Reg. 2590.715-2712(a)(2).

Expedited Urgent Care Determination
The requirements of DOL Reg. section 2560.503-1(f)(2)(i) apply as provided in DOL Reg. 2590.715-2719(b)(2)(ii)(B) and any superseding guidance. Plan participants must be notified of benefit determinations (whether adverse or not) with respect to a claim involving urgent care (as defined in DOL Reg. section 2560.503-1(m)(1)) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim.

Full and Fair Review
A Plan participant must be allowed to review the file and present evidence and testimony as part of the internal appeals process. Plan participants must be provided, free of charge, with any new or additional evidence considered relied upon or generated by the Plan in connection with the claim sufficiently in advance of the final adverse benefit determination to give the Plan participant a reasonable opportunity to respond prior to that date. The Plan must also meet the conflict of interest requirements under DOL Reg. 2590.715-2712(b)(2)(D).

Notice
A description of available internal and external claims processes and information regarding how to initiate an appeal must be provided. Notices of adverse benefit determinations must include the information required under DOL Reg. 2590.715-2719(b)(2)(ii)(E) as applicable. The final notice of internal adverse benefit determination must include a discussion of the decision. Notice must be provided in a linguistically appropriate manner as provided under DOL Reg. 2590.715-2719(e). The Plan must disclose the contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

Deemed Exhaustion of Internal Claims Process
If the Plan fails to adhere to the requirements of DOL Reg. 2590.715-2719(b)(2), except as provided under DOL Reg. 2590.715-2719(b)(2)(ii)(F)(2), the plan participant may initiate an external review

under Section 6.02(b)(2) or may bring an action under section 502(a) of ERISA as provided in DOL Reg. 2590.715-2719(b)(2)(ii)(F) and any superseding guidance.

H. External Claims Process

State Process

To the extent the Plan is required under DOL Reg. section 2590.715-2719(c)(1)(i) or (c)(1)(ii) to comply with a State external claims process that includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the plan or issuer must comply with the state external claims process of DOL Reg. section 2590.715-2719(c).

Federal Process

To the extent the Plan is not required under DOL Reg. section 2590.715-2719(c)(1)(i) or (c)(1)(ii) to comply with the State external claims process, then the plan or issuer must comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d) and any superseding guidance.

Definitions

ACA

See *PPACA*.

Annual

Periodic, based on a Calendar Year.

Brand Name Drug

Prescription drugs marketed with a specific brand name by the company that manufactures it, usually the company which develops and patents it.

Claims Processor

The person or firm employed by the Company to provide consulting services to the Company in connection with the operation of the Plan and any other functions, including the processing and payment of claims.

Copayment (Copay)

Copayment (copay) is the fixed dollar amount you pay each time you receive certain covered services.

DEFRA

The Deficit Reduction Act of 1984, as amended.

Eligible Expense

Any Medically Necessary treatment, services, or supplies that are not specifically excluded from coverage elsewhere in this Plan.

ERISA

The Employee Retirement Income Security Act of 1974, as amended.

Experimental

Any medical procedure, equipment, treatment, or course of treatment, or drug or medicine that is limited to research, not proven in an objective manner to have therapeutic value or benefit, restricted to use at medical facilities capable of carrying out scientific studies, or is of questionable medical effectiveness. To determine whether a procedure is experimental the Company will consider, among other things, commissioned studies, opinions, and references to or by the American Medical Association, the Federal Drug Administration, the Department of Health and Human Services, the National Institute of Health, the Council of Medical Specialty Societies and any other association or federal program or agency that has the authority to approve medical testing or treatment.

Final Internal Adverse Benefit Determination

A final internal adverse benefit determination means an Adverse Benefit Determination that has been upheld by the Plan at the completion of the internal appeals process. Refer to the "Claim Procedure and Appeal Process" in the "General Provisions" section of this document.

Generic Drug

A generic drug is identical, or bioequivalent, to a brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics, and intended use.

HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Illness

A bodily disorder, disease, physical Sickness, Mental Disorder or infirmity, or functional Nervous Disorder of a Covered Individual. Illness shall include pregnancy and any complications of pregnancy.

Injury

The term "Injury" shall mean only accidental bodily Injury caused by an external force. All injuries to one person from one accident shall be considered an "Injury."

Medicare

The medical care benefits provided under Title XVIII of the Social Security Act of 1965, as subsequently amended.

Plan

The term "Plan" means without qualification the Plan outlined herein.

PPACA

The Patient Protection and Affordable Care Act of 2010, as amended from time to time.

Prior authorization

Prior authorization determines whether a proposed treatment is covered by the Plan. An Eligible Provider or a Covered Individual may submit information to the Claims Administrator regarding a proposed service to determine if and at what level the service is covered by the Plan.

Prescription Drug

All drugs that are required under Federal law to bear the label, "Caution: Federal law prohibits dispensing without prescription," or any substitute required label, and injectable insulin (whether or not by prescription), as long as the drug was prescribed by a licensed Physician.

Pronouns

References to *you*, *your*, and *yourself* refer to the eligible Employee and Covered Dependents. References to *he*, *his*, or *him*, where they may still occur, may refer to either gender; these references are not meant to be discriminatory, but to avoid "he or she" type wording, as was custom.

Self-injectable Drug(s)

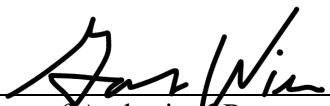
Prescription drugs that are intended to be self administered by injection to a specific part of the body to treat certain chronic medical conditions.

Specialty Drugs

Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia.

Agropur inc. hereby establishes a program of benefits constituting an "Employee Welfare Benefit Plan" under the Employee Retirement Income Security Act of 1976 (ERISA), as amended. By signing below, Agropur inc. agrees to be bound by the terms of the plan.

Agropur inc.

By: 

Signature of Authorized Representative

Garrick Wisner

Print Name

Director Global Compensation

Title

Witnessed

By: Chris Hagen

Signature of Witness

Date:

03 / 05 / 2025

Chris Hagen - Senior Benefits Advisor

Print Name