

Agropur inc. Comprehensive Health and Welfare Benefits Plan

January 1, 2026

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I. Introduction to Agropur inc. Comprehensive Health and Welfare Benefits Plan

A. Legal Entities

This document describes the health and welfare benefit plans sponsored by the following related U.S. legal entities:

- Agropur inc.

This entity (hereinafter “Agropur”) is a wholly-owned subsidiary of Agropur cooperative, a Canadian company.

B. Component Plans Provided

Agropur maintains the Agropur inc. Comprehensive Health and Welfare Benefits Plan (“Plan”) for the exclusive benefit of its eligible employees as well as their spouses and/or dependents. The Plan consists of a variety of components as follows:

- Medical:
 - Anthem BlueCross BlueShield of Wisconsin - (self-insured medical coverage primarily for the benefit of all employees)
- Dental
 - MetLife - (fully-insured dental coverage primarily for the benefit of all employees)
 - Delta Dental - (fully-insured dental coverage primarily for the benefit of all employees)
- Voluntary Vision
 - MetLife - (fully-insured voluntary vision coverage primarily for the benefit of all employees)
- Basic Term Life
 - MetLife - (fully-insured basic life coverage primarily for the benefit of all employees)
- Voluntary Term Life and Voluntary Term Dependent Life
 - MetLife - (fully-insured voluntary life and dependent life coverage primarily for the benefit of all employees)
- Basic Accident (AD&D)
 - MetLife - (fully-insured basic accident coverage primarily for the benefit of all employees)
- Voluntary Accident (AD&D)
 - MetLife - (fully-insured voluntary AD&D coverage primarily for the benefit of all employees)
- Voluntary Accident Insurance
 - MetLife - (fully-insured voluntary accident coverage primarily for the benefit of employees)
- Voluntary Critical Illness Insurance
 - MetLife - (fully-insured voluntary critical illness offered to all benefit eligible employees)
- Voluntary Hospital Indemnity Insurance
 - MetLife - (fully-insured voluntary hospital indemnity offered to all benefit eligible employees)
- Short Term Disability Insurance
 - Administered by MetLife - (self-insured coverage primarily for the benefit of all employees)
- Long Term Disability Insurance
 - MetLife - (fully-insured LTD coverage primarily for the benefit of all employees)
- Employee Assistance Program (EAP)
 - Administered by TELUSHealth (coverage primarily for the benefit of all employees)
- Health FSA
 - Administered by UMB Financial Corporation - (coverage primarily for the benefit of all employees)

- Voluntary Legal
 - Administered by LegalShield. - (coverage primarily for the benefit of all employees)

This document is intended to function as both the plan document and the summary plan description for the Agropur inc. Comprehensive Health and Welfare Benefit Plan. Eligibility for each component part of the Plan may vary based upon an employee's employment classification, and not every employee may be eligible to participate in every benefit identified in this document. (see Eligibility, defined further under Section II). Similarly, COBRA participants may not be eligible to participate in each of the benefits set forth herein.

Some of the component parts of the Plan require you to make an annual election to enroll for coverage. Others require only an initial enrollment. You will be notified of these requirements when you enroll in the individual component parts. Additionally, for those plans requiring an annual enrollment, an announcement will be made as to when open enrollment will take place.

C. Detailed Component Information

In addition to this document, all of the above noted component parts of the Plan are described in more detail in a variety of other documents that are provided separately to participants (in some cases electronically), such as certificate of insurance booklets, plan documents, benefit-specific summary plan descriptions, or other governing documents (hereinafter the "Component Plan Documents"). Such descriptions will typically be prepared and/or issued by one of the following entities: Agropur, an insurance provider, or a third-party administrator. If you have any questions about how to obtain these documents, please contact the Plan Administrator's Designee listed in Section III of this document. This Summary Plan Description is intended to work in conjunction with those documents, and it is recommended that participants attach this document to the Component Plan Documents they may have received for both ease of reference, and to help ensure that they have the most comprehensive benefits information possible. However, where there are conflicts between the documents, such as eligibility, this Summary Plan Description will prevail.

D. Plan Document and Summary Plan Description Requirements

Some or all of the component parts of this plan may be covered by ERISA (which is a Federal law regulating health and welfare benefits plans). To the extent any component part of this Plan is not covered by ERISA, this Plan will in no way change the non-ERISA nature of the component part of the Plan. For those component parts of the Plan that are covered by ERISA, this document, along with the Component Plan Documents, constitute both a written plan document as required by ERISA section 402, and a Summary Plan Description as required by ERISA section 102. The above-referenced documents supersede and replace any prior Summary Plan Descriptions.

E. Assistance in Non-English Language

This document, along with the Component Plan Documents, contains a summary in English of your plan rights and benefits under the Agropur inc. Comprehensive Health and Welfare Benefit Plan. If you have difficulty understanding any part of these documents, contact the Employee Service Center at 866-445-8885.

II. Benefit Plans Offered By Agropur

Component	Employee Eligibility	When participation begins
Medical: Anthem BCBS of Wisconsin	Employees employed by Agropur; And in the following employment categories: - Regular employee employed 30 hours per week, which is met either: - o By qualifying as a “full time employee” under the ACA lookback measurement rule; or - o Being regularly scheduled to work 30 hours per week	First of the month following 1 month of employment
Dental: MetLife	Employees employed by Agropur; And in the following employment categories: - Regular employee employed 30 hours per week, which is met either: - o By qualifying as a “full time employee” under the ACA lookback measurement rule; or - o Being regularly scheduled to work 30 hours per week	First of the month following 1 month of employment
Voluntary Vision: MetLife	Employees employed by Agropur; And in the following employment categories: - Regular employee employed 30 hours per week, which is met either: - o By qualifying as a “full time employee” under the ACA lookback measurement rule; or - o Being regularly scheduled to work 30 hours per week	First of the month following 1 month of employment
Term Life: MetLife	Employees employed by Agropur; And in the following employment categories: - Regular employee employed 30 hours per week, which is met either: - o By qualifying as a “full time employee” under the ACA lookback measurement rule; or - o Being regularly scheduled to work 30 hours per week	First of the month following 1 month of employment
Voluntary Life, Voluntary Dependent Life: MetLife	Employees employed by Agropur; And in the following employment categories: - Regular employee employed 30 hours per week, which is met either: - o By qualifying as a “full time employee” under the ACA lookback measurement rule; or - o Being regularly scheduled to work 30 hours per week	First of the month following 1 month of employment
Term AD&D: MetLife	Employees employed by; And in the following employment categories: - Regular employee employed 30 hours per week, which is met either: - o By qualifying as a “full time employee” under the ACA lookback measurement rule; or - o Being regularly scheduled to work 30 hours per week	First of the month following 1 month of employment

Voluntary AD&D: MetLife	Employees employed by Agropur; And in the following employment categories: - Regular employee employed 30 hours per week, which is met either: - o By qualifying as a “full time employee” under the ACA lookback measurement rule; or - o Being regularly scheduled to work 30 hours per week	First of the month following 1 month of employment
STD: Administered by MetLife	Employees employed by Agropur; And in the following employment categories: - Regular employee employed 30 hours per week, which is met either: - o By qualifying as a “full time employee” under the ACA lookback measurement rule; or - o Being regularly scheduled to work 30 hours per week	First of the month following 1 month of employment
LTD: MetLife	Employees employed by Agropur; And in the following employment categories: - Regular employee employed 30 hours per week, which is met either: - o By qualifying as a “full time employee” under the ACA lookback measurement rule; or - o Being regularly scheduled to work 30 hours per week	First of the month following 1 month of employment
Voluntary Accident Insurance: MetLife	Employees employed by Agropur; and covered under one of the medical plans offered by Agropur; And in the following employment categories: - Regular employee employed 30 hours per week, which is met either: - o By qualifying as a “full time employee” under the ACA lookback measurement rule; or - o Being regularly scheduled to work 30 hours per week	First of the month following 1 month of employment
Voluntary Critical Illness Insurance: MetLife	Employees employed by Agropur; And in the following employment categories: - Regular employee employed 30 hours per week, which is met either: - o By qualifying as a “full time employee” under the ACA lookback measurement rule; or - o Being regularly scheduled to work 30 hours per week	First of the month following 1 month of employment
Voluntary Hospital Indemnity Insurance: MetLife	Employees employed by Agropur; And in the following employment categories: - Regular employee employed 30 hours per week, which is met either: - o By qualifying as a “full time employee” under the ACA lookback measurement rule; or - o Being regularly scheduled to work 30 hours per week	First of the month following 1 month of employment
Employee Assistance Program (EAP): Administered by TELUSHealth	All employees employed by Agropur.	Date of hire.

Health FSA: Administered by UMB Financial Corporation	Employees employed by Agropur; And in the following employment categories: - Regular employee employed 30 hours per week, which is met either: ○ By qualifying as a “full time employee” under the ACA lookback measurement rule; or ○ Being regularly scheduled to work 30 hours per week	First of the month following 1 month of employment.
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The listing of components plan is subject to change, in which case, the participants will be notified, but that in the interim an eliminated program will not be considered part of the plan and any new programs will be considered part of the plan.

Disclaimer: *The above benefits are generally provided pursuant to the provisions of the Component Plan Documents adopted by Agropur (as referenced in Section I, C. above). If any of the terms of this document conflict with the terms of the Component Plan Documents, then the terms of this document will control*

III. Additional Summary Plan Description & Component Plan Information

A. General Plan Information

1. Plan Sponsor and Address

Agropur inc.
3500 East Destination Drive
Appleton, WI 54915
FEIN: 35-1442306

2. Plan Administrator

See paragraph 6 below.

3. Plan Name and Identification Number

Agropur inc. Comprehensive
Health and Welfare Benefits
Plan
Plan Number Assigned by
Employer: 510

4. Type of Plan

Agropur inc. Comprehensive
Health and Welfare Benefits
Plan providing a variety of
benefits (including health
insurance) as set forth in this
document. The plan also
includes flexible benefit plans
(cafeteria plans) under
Internal Revenue Code
Section 125.

5. Other Contacts for Benefit/Claim Information

a. Self-Insured Components

Medical

Anthem BlueCross
BlueShield of WI
20725 Watertown Road
Waukesha, WI 53186

Dental

Metropolitan Life Insurance
Co.
200 Park Avenue
New York, NY 10166

Delta Dental of Wisconsin
Group Dental Benefits
P.O. Box 828
Stevens Point, WI 54481-
0828

Health FSA

UMB Financial Corporation
1010 Grand Blvd.
Kansas City, MO 64106

b. Fully-Insured Components

Life – Basic Term

Metropolitan Life Insurance
Co.
200 Park Avenue
New York, NY 10166

Life – Voluntary & Voluntary Dependent

Metropolitan Life Insurance
Co.
200 Park Avenue
New York, NY 10166

AD&D – Basic

Metropolitan Life Insurance
Co.
200 Park Avenue
New York, NY 10166

AD&D - Voluntary

Metropolitan Life Insurance
Co.
200 Park Avenue
New York, NY 10166

Long Term Disability

Metropolitan Life Insurance
Co.
200 Park Avenue
New York, NY 10166

Short Term Disability Insurance

Metropolitan Life Insurance
Co.
200 Park Avenue
New York, NY 10166

Accident Insurance - Voluntary

Metropolitan Life Insurance
Co.
200 Park Avenue
New York, NY 10166

Critical Illness Insurance - Voluntary

Metropolitan Life Insurance
Co.
200 Park Avenue
New York, NY 10166

Hospital Indemnity Insurance - Voluntary

Metropolitan Life Insurance
Co.
200 Park Avenue
New York, NY 10166

Vision – Voluntary

Metropolitan Life Insurance
Co.
200 Park Avenue
New York, NY 10166

Legal – Voluntary

LegalShield
One Pre-Paid Way – P.O. Box
145
Ada, OK 74820

Employee Assistance Program (EAP):

TELUSHealth
250 Royall St #210w
Canton, MA 02021

6. Plan Administrator / Plan Fiduciary / Agent for Service of Legal Process

Agropur inc. is the Plan Administrator. Agropur inc. is also the Plan Fiduciary and the agent for the service of legal process on the Plan. Agropur has designated the following individual to act on behalf of the Plan Administrator:

Garrick Wisner (hereinafter, “the Plan Administrator’s Designee”)
Agropur inc.
3500 East Destination Drive
Appleton, WI 54915
(920) 944-0990

The Plan Administrator maintains the Plan’s records, manages the operation of the Plan and interprets the Plan’s provisions. In general, it is the duty of the Plan Administrator to see that the Plan is carried out in accordance with its terms, for the exclusive benefit of the persons entitled to participate in the Plan without discrimination among them. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan.

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the plan.

Any interpretation, determination or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

Some component parts under the Plan may be fully-insured, provided by contract with an HMO, or administered by a third-party administrator. In such cases, the insurance company, HMO, or third-party administrator will generally be responsible for determining both:

- i. the amount of benefits payable (if any) under the Plan; and
- ii. The claims procedures to be followed and claims forms to be used by employees and their dependents under the plan. (Detailed claims procedures are contained in the Component Plan Documents).

Employee eligibility for one or more component parts of the plan (in particular, the group health plan) may be determined by the Plan Administrator according to a special measurement method (called the “look-back” method) to determine whether employees have sufficient hours of service to obtain full-time status for purposes of

group health coverage, based on rules adopted by the IRS to comply with the Patient Protection and Affordable Care Act (“ACA”). Under the look-back method, an employee’s hours of service will be calculated over a “measurement period” to determine whether or not the employee will be considered a full-time employee under the ACA during a subsequent “stability period” that is the same length as the measurement period. Details regarding the measurement and stability periods, and the rules for counting hours of service are available upon request to the Plan Administrator. Determination of eligibility and full-time status for each component part of the plan will be made at the sole and absolute discretion of the Plan Administrator and may take into account the definition of “full-time” employee contained in the ACA.

If you have any general questions regarding the Plan or the amount of benefits payable under any component parts of the Plan, contact the appropriate insurance company, HMO, or third-party administrator (as identified in paragraph 5, above). Inquiries may also be directed to the Plan Administrator’s Designee.

7. Plan Year: January 1– December 31

8. Amendment to, Loss of, or Termination of Benefits

Agropur reserves the right to amend or terminate the Plan, any component parts of the Plan, and any employee contribution amounts at any time without the consent of any participant or beneficiary. Likewise, the costs of premiums for benefits may be increased at our discretion, or the discretion of any insurance companies or third-party administrators with whom we have contracted.

Your coverage under this Plan will terminate if:

- A. You no longer meet the eligibility requirements of the Plan (subject to your right to Continuation of Benefits),
- B. You cease to make required employee contributions, or
- C. The Plan terminates.

More detailed information regarding the reasons you or your dependents could lose your eligibility for benefits under the Plan can be found in the Component Plan Documents. The Plan (and any subsequent amendments) may be amended or terminated by a written instrument signed by the individual authorized above to act on behalf of the Plan Administrator or other designee.

9. No Contract of Employment

The Plan is not intended to be, nor shall be construed as, a contract of employment or other arrangement between the employee and Agropur, and shall not have any effect on the right of either the employer or the employee to terminate the employment relationship at any time, with or without notice.

10. Termination of Benefits

Your participation in the Plan (and that of your eligible family members) will terminate immediately upon the occurrence of a “qualifying event” (such as termination or reduction of work hours; please see the COBRA section of this document for examples of additional “qualifying events”). However, the ability of you and/or any of your eligible dependents to continue participating in any of the component parts of the Plan after the occurrence of a “qualifying event” will be

determined by the Component Plan Documents. Please see the Component Plan Documents for each component part of the Plan to determine which termination date will apply.

Additional causes for the termination of coverage in this Plan or any component parts of the Plan include, but may not be limited to, the failure to pay your share of an applicable premium, the reduction of your work hours below any required hourly threshold, and the submission by you of any false claims. For additional details regarding the timelines and circumstances of benefits termination please refer to the Component Plan Documents for each component part of the Plan.

11. Reinstatement of Benefits Following Rehire

A Participant whose employment terminates and who is rehired within 13 weeks into another benefits eligible role is eligible to participate as of the first of the month following the date of rehire.

A Participant whose employment terminates and who is rehired over 13 weeks later into another benefits eligible role is eligible to participate after completion of the standard eligibility waiting period.

12. Restrictions on Receiving Benefits

The benefits available to certain employees of Agropur who are officers, directors, or highly compensated may be restricted in certain circumstances. The Internal Revenue Code sets limitations on the amount and/or percentages of some benefits that may be received by certain classes of employee. If Agropur believes that the limits may be exceeded, Agropur may arbitrarily limit the amount of employee contribution such participants may allocate to nontaxable benefits, so that the limit will not be exceeded.

12. Funding Medium

Contributions and funding for the component parts of the Plan are derived from three primary sources: 1) contributions from the general assets of Agropur; 2) before-tax contributions from employees; and 3) after-tax contributions from employees. These contributions are paid to the plan sponsors, insurers, or third-party administrators for each component part of the Plan (as listed in paragraph 5, above) according to the Component Plan Documents for each component of the Plan.

13. Loss or Recovery of Benefits

The component parts of the Plan may recover overpaid benefits and erroneously paid benefits through its right to subrogation and reimbursement. These rights are described in further detail in the Component Plan Documents for each component part of the Plan.

14. Filing a Claim and Claim Denial

Fully-Insured Plans:

For purposes of determining the amount of, and entitlement to, benefits under a fully-insured component part of the Plan (as identified in paragraph 5, above), the respective insurer or HMO is the named fiduciary under that component part of the Plan, and has the full power to interpret and apply the terms of the component part as they relate to the benefits provided under the applicable insurance or HMO contract.

To obtain benefits under a fully-insured component part of the component part of the Plan, you must follow the claims procedures under the applicable insurance or HMO contract, which may require you to complete, sign and submit a written claim on a specified form. Contact the Plan Administrator for any such forms.

The insurance company or HMO will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company or HMO has the right to secure independent medical advice, and to require such other evidence as it deems necessary in order to decide your claim. If the insurance company or HMO denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company or HMO for a review of the denied claim. The insurance company or HMO will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. If you fail to appeal on in a timely fashion, you may lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing legal action).

For more detailed information regarding claims processing, denials, and appeals, please see the Component Plan Documents for each component part of the Plan.

Self-Funded Plans:

For purposes of determining the amount of, and entitlement to, benefits under a self-funded component part of the Plan, the Plan Administrator's designee is the named fiduciary under the component part of the Plan, with the full power to make factual determinations and to interpret and apply the terms of the self-funded components of the Plan.

However, for some or all of our self-funded component plans, Agropur has contracted with various Third-Party Administrators (TPAs) to process and pay claims. These TPAs have been charged with the responsibility for making factual determinations and interpreting and applying the terms of these self-funded components. The TPAs for each component part of the Plan are identified in paragraph 5, above.

To obtain benefits from a self-funded plan, you must complete, execute and submit to the applicable TPA (or Plan Administrator if no TPA has been identified) a written claim on a form available from or acceptable to the TPA. The TPA will decide your claim in accordance with reasonable claims procedures, as required by ERISA and the PHSA. The TPA has the right to secure independent medical advice, and to require any other such evidence as it deems necessary in order to decide your claim. If the TPA denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the TPA for a review of the denied claim. The TPA will decide your appeal in accordance with its reasonable claims

procedures, as required by ERISA and the PHSA. If you fail to appeal in a timely fashion, you may lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing legal action).

For more detailed information regarding claims processing, denials, and appeals, please see the Component Plan Documents for each component part of the Plan.

B. Government Required Notices

The following ERISA Notice applies to all ERISA-covered plans referenced in this document. The other notices (COBRA, HIPAA, Qualified Medical Child Support Orders, Women's Health Cancer Rights Act, and Rights Under Newborn and Mothers Health Protection Act) apply only to the health plan components of the Plan.

1. ERISA Rights

Your ERISA Rights:

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan or its component parts, including insurance contracts, plan documents, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan or its component parts, including insurance contracts, plan documents, and copies of the latest annual report (Form 5500 Series). The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, 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. For more details, review the COBRA section of this document, as well as any related sections in the Component Plan Documents.

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 health and welfare benefit plans that may be covered by ERISA. The people who operate your plans, who are “fiduciaries” of those plans, 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 Plan benefits or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit under the Plan or one of its component part 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 insurance contracts, plan documents or the latest annual report from the Plan or its component parts and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the claims procedures available to you, you may file suit in a state or Federal court. In addition, if you disagree with the component part of the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan or its component parts, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration, or visit their website: www.dol.gov/ebsa.

2. COBRA Rights

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. 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 to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the component parts of the Plan and under federal law, you should either review the Component Plan Documents for each component part of the Plan, or contact the Plan Administrator's Designee.

Diversified Benefits Services, Inc.(DBS) is responsible for administering COBRA continuation coverage, and is the primary contact for COBRA related matters for all Agropur employees.

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 offered when coverage under a component part of the Plan would otherwise end because of a life event known as 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." A qualified beneficiary is someone who will lose coverage because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under a component part of the Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are involuntarily reduced, or
- (2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you may become a qualified beneficiary if you will lose your coverage under a component part of the Plan because any of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your spouse.
 - a. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

Your dependent children may become qualified beneficiaries if they will lose coverage under a component part of the Plan because any of the following qualifying events happens:

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than his or her gross misconduct,
- (4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child stops being eligible for coverage under the plan as a "dependent child."

Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they lost coverage under a component part of the Plan during the leave. Contact the Plan Administrator's Designee for more information about these special rules.

When is COBRA Coverage Available?

COBRA continuation coverage will be offered to qualified beneficiaries only after the Plan Administrator's Designee has been notified that a qualifying event has occurred. The Plan Administrator's Designee must be notified by the employer of the following qualifying events:

- (1) The end of employment or reduction of hours of employment;
- (2) Death of employee; or
- (3) Employee becoming entitled to Medicare benefits (under Part A, Part B or both)

You Must Give Notice of Some Qualifying Events

For the 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's Designee. The Plan requires you to notify the Plan Administrator's Designee within 60 days after the qualifying event occurs. You must send this notice to the Plan Administrator's Designee, who may be contacted as outlined in Section III, above. The notice must be in writing, indicating the participant affected. If the qualifying event is a divorce, a copy of the divorce decree must be provided.

How is COBRA Coverage Provided?

COBRA continuation coverage is a temporary continuation of coverage. Once the Plan Administrator's Designee receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that component part of the Plan coverage would otherwise have been lost.

If the qualifying event is termination of employment or the reduction of work hours, COBRA continuation coverage will be available for up to 18 months. However, there are a number of scenarios under which employees and/or their dependents may be able to continue COBRA coverage for longer than 18 months.

When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

When the qualifying event is a reduction in work hours due to military leave of more than 30 days, continuation coverage may be available under USERRA for up to 24 months.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under a component part of the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan

Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must be determined 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 continuation coverage. In order to receive this extension, you must provide the Plan Administrator's Designee with a copy of the determination by the Social Security Administration within 60 days of the date of the determination by the Social Security Administration, the date of the qualifying event, or the date that coverage would otherwise be lost under a component part of the Plan as a result of the qualifying event, whichever is later, but in no event later than the end of the original 18 month period of continuation coverage. **Notice must be provided to the Plan Administrator's Designee, who may be contacted as outlined in Section III, above.**

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator's Designee. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under a component part of the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under a component part of the Plan had the first qualifying event not occurred. **In all of these cases, you must make sure that the Plan Administrator's Designee is notified of the second qualifying event within 30 days of the second qualifying event. This notice must be sent to the Plan Administrator's Designee, who may be contacted as outlined in Section III, above.**

State Law

Individual states may have COBRA or health care continuation laws that cover fully-insured health plans (self-funded health plans will not have to comply with these state laws) and permit coverage to continue in a similar manner to COBRA. Some states may provide for a greater continuation benefit, others less. When state law and COBRA are both applicable, the qualified beneficiary is entitled to receive the most liberal benefit.

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, Medicaid, 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.

If You Have Questions

Questions concerning your Plan, or its component parts, or your COBRA continuation coverage should be addressed to the Plan Administrator's Designee. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at 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

In order to protect your family's rights, you should keep the Plan Administrator's Designee informed of 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's Designee. If you have any questions about your COBRA rights, contact Diversified Benefits Services, Inc.

3. HIPAA Notice

Your HIPAA Rights:

The Health Insurance Portability and Accountability Act (HIPAA) provides for a special enrollment right if you, or a spouse and dependent, lose coverage elsewhere or obtain a new dependent through marriage, birth or adoption. The requirements for the special enrollment right are detailed below.

Loss of Coverage:

If you decline enrollment for yourself and your dependents (including your spouse) because of other health insurance coverage, and that coverage terminates due to certain qualifying reasons, you may be entitled to a special enrollment period in one or more component parts of the Plan. The qualifying reasons leading to a special enrollment right for loss of coverage are:

- Exhaustion of COBRA or state law continuation rights;
- Loss of eligibility for other coverage due to legal separation, divorce, death, termination of employment or reduction in hours; or
- Because employer contributions for the other coverage cease.

Should one of the above noted events occur, you must notify the Plan within 30 days to take advantage of this special enrollment right. You must inform the Plan Administrator's Designee in writing at the time you decline coverage that you are declining coverage because of other health insurance coverage in order to be eligible for this special enrollment period.

Marriage, Birth or Adoption:

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse, and your newly acquired dependents, provided that enrollment is requested within in Workday within 30 days after the marriage, birth, adoption, or placement for adoption.

Loss of Medicaid or State Child Health Plan (CHIP) Coverage:

If you and/or your dependents were covered under a Medicaid plan or State Child Health Plan (CHIP) and that coverage is being terminated due to a loss of eligibility, you may be able to enroll yourself and your dependents on the medical components of the Plan, provided you request enrollment in Workday within 60 days after the date that termination of such coverage occurred, and that you meet certain other important conditions described in the Component Plan Documents of each component part of the Plan. Coverage under this Plan will be effective on the date the other coverage ended.

Eligibility for Premium Subsidy Assistance under Medicaid or State Child Health Plan (CHIP):

If you and/or your dependents are determined to be eligible under a state's Medicaid plan or State Child Health Plan (CHIP) for a premium subsidy assistance, you may be able to enroll yourself and your dependents on the medical components of the Plan, provided you request enrollment in Workday within 60 days of the determination of eligibility for premium subsidy assistance for you or your dependents, and that you meet certain other important conditions as described in the Component Plan Documents of each component part of the Plan.

Please note Component Plan Documents may provide for more generous special enrollment rights. Participants should review the Component Plan Documents for specifics of each plan.

4. Qualified Medical Child Support Orders

The component parts of this Plan will comply with Qualified Medical Child Support Orders (QMCSO) as required by ERISA. A QMCSO is a court order typically issued as part of a divorce or a state child support order that requires health plan coverage for the child of a plan participant.

The procedures to comply with a QMCSO are available to employees. Contact the Plan Administrator's Designee for the QMCSO procedures.

5. Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires that all group health plans that provide coverage for mastectomies also provide coverage for breast reconstructive surgery in connection with that mastectomy.

All participants and beneficiaries who receive benefits under the medical components of the Plan with respect to a mastectomy and elect breast reconstruction surgery in connection with that mastectomy are entitled to coverage for that reconstruction in a manner determined in consultation with the attending physician and the patient. Such coverage includes:

- Reconstruction of the breast on which the mastectomy was performed.

- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the medical components of the Plan. If you would like more information on WHCRA benefits, call the Plan Administrator's Designee.

6. Rights Under Newborns and Mothers Health Protection Act

Under the Newborns and Mothers Health Protection Act (NMHPA), group health plans generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 (or 96 hours, as applicable).

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact the Plan Administrator's Designee.