SUMMARY PLAN DESCRIPTION

for the Prescription Drug Benefits

under the:

- Bunge Employee Welfare Benefit Plan
- Bunge Retiree Welfare Benefit Plan

Effective January 1, 2024

Contents

Introduction

Bunge North America, Inc. ("Bunge") provides medical and prescription drug benefits to its eligible employees. Prescription drug benefits are provided to employees, retirees and their dependents who are covered for medical benefits under one of the following plans:

- Bunge Employee Welfare Benefit Plan
- Bunge Retiree Welfare Benefit Plan

These two plans are collectively referred to as the "Plan."

Medical benefits are described in separate summary plan descriptions (SPDs). This summary, together with the documents listed in Appendix A (collectively, "Express Scripts Booklets"), is intended to describe prescription drug benefits. This summary is intended to serve as a summary plan description (SPD), as required by the Employee Retirement Income Security Act (ERISA).

Prescription drug benefits are provided under administrative service only contracts with service providers. All benefits are summarized in this document and in the Express Scripts Booklets**.** A directory of participating pharmacies is provided at no cost to you. You may also access a list of participating pharmacies at www.express-scripts.com or you can contact Express Scripts 1-866-503-8472. For TDD assistance, please call 1-800-759-1089.

For additional information regarding the benefits provided under the Plan, please contact the Plan Administrator identified in the *Administrative Information* section.

Bunge reserves the right to change, amend, suspend, or terminate any or all of the benefits under this Plan, in whole or in part, at any time and for any reason at its sole discretion.

Note that by adopting and maintaining these benefits, Bunge has not entered into an employment contract with any employee. Nothing in the legal Plan documents or in the SPD gives any employee the right to be employed by Bunge or to interfere with Bunge's right to discharge any employee at any time.

Eligibility

Eligible Employees

Generally, you are considered an "eligible employee" or "eligible retiree" and are eligible for prescription drug benefits if you are enrolled in a medical plan option for one of these plans:

- Bunge Employee Welfare Benefit Plan
- Bunge Retiree Welfare Benefit Plan

Specifically excluded are any Part-time Employees, seasonal or temporary Employees, Leased Employees (as defined in Section 414(n) of the Internal Revenue Code), expatriate Employees covered under an expatriate plan that includes prescription drug benefits, Employees covered under a Health Maintenance Organization that that includes prescription drug benefits or Employees subject to collective bargaining, unless such agreement(s) provide for eligibility in this Plan.

Please refer to the SPDs for the Welfare Benefit Plan options for specific eligibility requirements for employees and retirees.

Eligible Dependents

Your dependent is eligible for prescription drug benefits if he or she is enrolled as a dependent in one of the following plan options:

- Bunge Employee Welfare Benefit Plan
- Bunge Retiree Welfare Benefit Plan

Eligible dependents may include:

(1) A covered Employee's Spouse.

The term "Spouse" shall mean a person recognized as married to you by the state, possession, or territory of the United States in which you were married, regardless of where you live. If you were married in a foreign jurisdiction, your spouse means a person recognized as your spouse under the laws of at least one state, possession, or territory of the United States, regardless of where you live. The Plan Administrator may require documentation proving a marital relationship. “Domestic Partners” are not considered legal Spouses.

(2) A covered Employee’s child who is less than 26 years old. An eligible child is your biological child, your stepchild, your adopted child, a child place for your adoption or for whom legal adoption proceedings have been started, a child for whom you are the full (as opposed to temporary or partial) legal guardian or custodian or a child for whom you are required to provide medical coverage under a qualified medical child support order.

(3) An eligible child as described above who reaches age 26 and is Totally Disabled, incapable of self-sustaining employment by reason of mental disability or physical disability, provided such child is or was under the limiting age of dependency at the time of application for coverage in the Plan. If you first become eligible for coverage as an employee after your disabled child is age 26, you may still apply for coverage for the child if the disability occurred prior to the child’s 26th birthday and continued until the date of your application. Subsequent certifications of disabled status may be required.

Please refer to the SPDs for the Bunge Employee Welfare Benefit Plan and the Bunge Retiree Welfare Benefit Plan options for specific eligibility requirements for dependents.

You are required to provide proof of your dependents’ eligibility upon request. False or misrepresented eligibility information may cause both your coverage and your dependents’ coverage to be irrevocably terminated (retroactively to the extent permitted by law), and could be grounds for employee discipline up to and including termination.

Qualified Medical Child Support Orders

The Plan may be required to provide prescription drug coverage for your child due to a Qualified Medical Child Support Order (QMCSO) even if you have not enrolled the child. You may obtain a copy of Bunge's procedures governing QMCSO determinations, free of charge, by contacting Bunge at (314) 292-2000.

A QMCSO is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and that the plan administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your Federal income tax return, and children who don't reside with you. However, children who are not eligible for coverage under the Plan, due to their age for example, cannot be added under a QMCSO.

Enrollment

New Employees

To be covered for prescription drugs, you must enroll in a medical plan option for one of these plans:

- Bunge Employee Welfare Benefit Plan
- Bunge Retiree Welfare Benefit Plan

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Enrollment Requirements of the Plan.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the first day that the Dependent Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met. Newborn children enrolled for coverage on a timely basis will be effective from the moment of birth.

Please refer to the SPDs for the Bunge Employee Welfare Benefit Plan and the Bunge Retiree Welfare Benefit Plan options for enrollment information, including when you can make changes to your coverage during the plan year.

HIPAA Special Enrollment Events

If you decline enrollment for Medical benefits (including prescription drug benefits) for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents (including domestic partners) in the Medical benefits provided under this Plan if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your dependents' other, non-COBRA coverage). However, you must request enrollment within 31 days after your or your eligible dependents' other coverage ends (or after the other employer stops contributing toward the other, non-COBRA coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse, and your new eligible dependent children in the Plan's Medical benefits. However, you must request enrollment within 31 days after the date of the marriage or within 60 days of the date of the birth, adoption, or placement for adoption.

If you request a change due to a special enrollment event within the allowed timeframe, coverage will be effective as of the date of the event.

The Plan recognizes a HIPAA special enrollment window for employees and dependents (including domestic partners) who are eligible but not enrolled if they lose Medicaid or CHIP coverage because they are no longer eligible, or they become eligible for a state's premium assistance program. Employees have 60 days from the date of the Medicaid/CHIP event to request enrollment under the Plan. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

To request special enrollment or obtain more information, contact Bunge at (314) 292-2000.

Coverage During Leave of Absence

The sections below describe benefit continuation for two specific types of leave: Family and Medical Leave of Absence and Active Military Leave of Absence. For more information about other types of leave of absence, refer to your SPDs for the Welfare Benefit Plan or contact Human Resources or your Benefits Representative.

FMLA Leave

The federal Family and Medical Leave Act (FMLA) allows eligible employees to take a specific amount of unpaid leave for serious illness, the birth or adoption of a child, to care for a spouse, child, or parent who has a serious health condition, to care for family members wounded while on active duty in the Armed Forces, or to deal with any qualifying exigency that arises from a family member's active duty in the Armed Forces. This leave is also available for family members of veterans for up to five years after a veteran leaves service if he or she develops a

service-related injury or illness incurred or aggravated while on active duty. See the Human Resources Department for more information about what leave is available under the FMLA.

If you take an FMLA leave, you may continue your medical coverage (including prescription drug coverage) for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave. If you take a paid leave of absence, the cost of the coverage will continue to be deducted from your pay on a pre-tax basis. If you take an unpaid leave of absence that qualifies under FMLA, you may continue your participation as long as you contribute the active employee share of the cost of medical coverage during the leave by, paying for coverage during your leave on a pre-tax basis, to the extent possible, or by catching up with pre-tax contributions upon your return from leave. You also have the option to suspend your medical coverage during the unpaid leave.

If you lose your medical coverage during an FMLA leave (e.g., because you suspended coverage) you may re-enroll when you return from your leave. Your medical coverage will start again on the first day after you return to work and make your required contributions.

If you do not return to work at the end of your FMLA leave you may be entitled to purchase COBRA continuation coverage (see the *COBRA* section).

Military Leave

If you take a military leave, whether for active duty or for training, you are entitled to extend your medical coverage for up to 24 months as long as you give Bunge advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your total leave, when added to any prior periods of military leave from Bunge, cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit — including situations where service members are involuntarily retained beyond their obligated service date; additional required training; federal service as a member of the National Guard; and service under orders during war or national emergencies declared by the President or Congress. Additionally, the maximum time period may be extended due to your hospitalization or convalescence following service-related injuries after your uniformed service ends.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the contributions required for active employees. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (including any amount for dependent coverage) who is not on military leave.

If you take a military leave, but your coverage under the Plan is terminated — for instance, because you do not elect the extended coverage — when you return to work at Bunge, you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to health plan coverages. USERRA permits a health plan to impose an exclusion or waiting period to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during performance of service in the uniformed services.

If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage if you extended benefits for less than 18 months. However, your military leave benefits continuation period runs concurrently with your COBRA coverage period,

subject to the limitation of COBRA. This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible. Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

When Coverage Ends

Your prescription drug coverage will terminate when you are no longer enrolled in a medical plan option for one of these plans:

- Bunge Employee Welfare Benefit Plan
- Bunge Retiree Welfare Benefit Plan

Specific rules regarding when medical (and with it, prescription drug coverage) ends are found in the SPD describing the Welfare Benefit Plan option in which you are enrolled.

Generally, coverage for your spouse and other dependents terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the SPD describing the medical plan option in which they are enrolled.

For children covered pursuant to a QMCSO, coverage will end as of the date that the child is no longer covered under a QMCSO.

Depending on the reason for termination of coverage, you and your covered spouse and dependent child(ren) might have the right to continue health coverage temporarily under COBRA (see COBRA section below) or under a conversion right under a particular benefit plan.

COBRA

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances (called “qualifying events”) when coverage would otherwise end. The right to COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children who lose coverage for certain specified situations. If you elect COBRA for your medical coverage, you will automatically be covered under COBRA for prescription drug coverage. No separate election for prescription drug coverage is required or allowed. The COBRA premium you pay for medical coverage includes prescription drug coverage. For more information on your COBRA rights and obligations, please refer to the COBRA section of the SPD describing the medical plan option in which you are enrolled.

Prescription Drug Benefits

Definitions

Brand-name drug (brand drug): A medication that is available only from its original manufacturer or from another manufacturer that has a licensing agreement to make the drug with the brand-name manufacturer. These medications are marketed under a recognized brand name. A brand-name drug may have a generic equivalent once the manufacturer is required to allow other manufacturers the opportunity to make the medication.

Co-payment/Co-insurance: A portion of the total cost of the claim that must be paid by the member.

Date of Service: Date on which a prescription is filled or dispensed.

Days Supply: The number of days payable by the plan for the dispensed drug.

Direct Claim: A reimbursement process whereby the member pays 100% of the prescription drug cost at the time of purchase and then submits a paper claim for reimbursement.

Federal Legend Drugs: A drug that requires a prescription; these drugs can be identified by the presence of "Federal Legend" on the label.

Formulary: A list of commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings. An independent Pharmacy and Therapeutics committee updates this list regularly based on continuous evaluation of medications. You can contact Express Scripts at 1-888-327-9791 to determine if the brand-name drug you are taking is on the formulary. You can also locate this information at www.express-scripts.com. If a drug you are taking is not on the formulary, you may want to discuss alternatives with your doctor or pharmacist. Using drugs on the formulary will keep your costs and the Plan's costs lower.

Generic drug: A medication that contains the same active ingredient and is manufactured according to the same strict federal regulations as its brand-name counterpart. Medication that is chemically equivalent and therapeutically equivalent to a brand medication, but manufactured at a lower cost. The Food and Drug Administration (FDA) requires generic medications to meet the same standards as Multi Source (brand) medications. Generic medications may differ in color, size, or shape, but the Food and Drug Administration requires that they have the same strength, purity, and quality as their brand-name counterparts. A generic medication can be produced once the manufacturer of the brand-name medication is required to allow other manufacturers the opportunity to produce the medication.

In-Network Retail Claims: Claims processed by pharmacies that participate in the Express Scripts National Network and are included in the member's pharmacy network.

Maintenance Medication: Medications prescribed for long-term use, (i.e., maintenance medication taken for long-term prevention such as: high-blood pressure sufferers or diabetics).

Multi Source (Brand) Drug: Brand Name Drug that has a FDA Approved generic equivalent substitute available.

Network Pharmacy: A retail pharmacy that has an agreement currently in effect with Express Scripts for this Plan to dispense Prescription Drugs to Participants.

Out-Of-Network Claims: Claims processed by pharmacies that do not participate in the Express Script's national pharmacy network.

Out-of-Network Pharmacy: A retail pharmacy that does not currently have an agreement with Express Scripts for this Plan. You will pay 100% of the cost of the prescription if you use one of these pharmacies.

Over-the-Counter (OTC Medication): Medication that does not require a prescription.

Prior Authorization: Process by which a medication or benefit that is not normally covered under the member's plan may be covered on an exception basis with the appropriate medical.

Benefits Highlights

Bunge North America – Anthem Basic HDHP

	Express Scripts Participating Network Retail Pharmacy (up to 30 day supply)	**Non-network pharmacy**
Preventive Drugs (Generic/Preferred/Non-Preferred)	Retail: $10/$20/$30 copay Mail: $20/$40/$60 copay	Not covered
Generic drugs	20% coinsurance after deductible	Not covered
Preferred brand drugs	20% coinsurance after deductible	Not covered
Non-preferred brand drugs	20% coinsurance after deductible	Not covered
Specialty (brand and generic)	$100.00 (Limited to 30-day supply) after deductible	Not covered
Maintenance drugs must be filled 90 days at a time at a Smart90 retail pharmacy or Express Scripts Pharmacy. Prescriptions dispensed in 30-day supplies at a retail pharmacy that are otherwise available in 90-day supplies through a Smart90 retail pharmacy or Express Scripts Pharmacy will have a penalty assessed upon the 4th consecutive 30-day refill (and any subsequent, consecutive refills.) Members will pay 100% of the discounted drug price after courtesy fills.		

Bunge North America – Anthem Core HDHP

	Express Scripts Participating Network Retail Pharmacy (up to 30 day supply)	**Non-network pharmacy**
Preventive Drugs (Generic/Preferred/Non-Preferred)	Retail: $10/$20/$30 copay Mail: $20/$40/$60 copay	Not covered
Generic drugs	20% coinsurance after deductible	Not covered
Preferred brand drugs	20% coinsurance after deductible	Not covered

Non-preferred brand drugs	20% coinsurance after deductible	Not covered
Specialty (brand and generic)	$100.00 (Limited to 30-day supply) after deductible	Not covered
Maintenance drugs must be filled 90 days at a time at a Smart90 retail pharmacy or Express Scripts Pharmacy. Prescriptions dispensed in 30-day supplies at a retail pharmacy that are otherwise available in 90-day supplies through a Smart90 retail pharmacy or Express Scripts Pharmacy will have a penalty assessed upon the 4th consecutive 30-day refill (and any subsequent, consecutive refills.) Members will pay 100% of the discounted drug price after courtesy fills.		

Bunge North America – Anthem Premium PPO

	Express Scripts Participating Network Retail Pharmacy (up to 30 day supply)	**Non-network pharmacy**
Generic drugs	Retail (30 days) - $10.00 Mail (90 days) - $20.00	Not covered
Preferred/Brand drugs	Retail (30 days) - $40.00 Mail (90 days) - $80.00	Not covered
Non-preferred/Brand drugs	Retail (30 days) - $60.00 Mail (90 days) - $120.00	Not covered
Specialty (brand and generic)	$100.00 (Limited to 30-day supply)	Not covered
Maintenance drugs must be filled 90 days at a time at a Smart90 retail pharmacy or Express Scripts Pharmacy. Prescriptions dispensed in 30-day supplies at a retail pharmacy that are otherwise available in 90-day supplies through a Smart90 retail pharmacy or Express Scripts Pharmacy will have a penalty assessed upon the 4th consecutive 30-day refill (and any subsequent, consecutive refills.) Members will pay 100% of the discounted drug price after courtesy fills.		

Bunge North America Decatur, IN – Anthem Premium PPO

	Express Scripts Participating Network Retail Pharmacy (up to 30 day supply)	**Non-network pharmacy**
Generic drugs	Retail (30 days) - $10.00 Mail (90 days) - $20.00	Not covered
Preferred/Brand drugs	Retail (30 days) - $40.00 Mail (90 days) - $80.00	Not covered
Non-preferred/Brand drugs	Retail (30 days) - $60.00 Mail (90 days) - $120.00	Not covered
Specialty (brand and generic)	$100.00 (Limited to 30-day supply)	Not covered

Maintenance drugs must be filled 90 days at a time at a Smart90 retail pharmacy or Express Scripts Pharmacy. Prescriptions dispensed in 30-day supplies at a retail pharmacy that are otherwise available in 90-day supplies through a Smart90 retail pharmacy or Express Scripts Pharmacy will have a penalty assessed upon the 4th consecutive 30-day refill (and any subsequent, consecutive refills.) Members will pay 100% of the discounted drug price after courtesy fills.

Member Services

Visit Express Scripts website, www.express-scripts.com, to view your plan design and co-payment information, search for details on prescription medications, locate a participating pharmacy near you, and manage your home delivery prescriptions. For additional plan inquiries, you may call Express Scripts directly at 1-888-327-9791. For future reference, this number is listed on the back of your Express Scripts ID card.

Covered Expenses

The Plan's prescription benefit covers a wide variety of prescription drugs, including generic drugs and brand-name drugs. The Plan also maintains a formulary, which is a list of preferred drugs that members can obtain for lower copays and to help save them money.

An expert panel of physicians and pharmacists carefully reviews the drugs on the formulary for safety, quality, effectiveness and cost. The formulary and conditions of drug coverage under the Plan is subject to change. To find out whether a particular medicine is included on the formulary or covered under the Plan, and what conditions of coverage (if any) may apply, go to express-scripts.com or call Express Scripts Member Services. A pharmacist can also check whether a medication is on the formulary or covered at any time.

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medications of which at least one ingredient is a legend drug and as long as all ingredients of the Compounded Medication are covered under the Plan
- Insulin
- OTC and Legend Diabetic Supplies/Insulin Needles, Syringes
- OTC and Legend Insulin Pumps and Accessories
- OTC and Legend Needles and Syringes
- Pre-Packaged oral Contraceptives, up to a 91-day supply
- Depo-Provera/Depo-SubQProvera, up to a 90-day supply
- Contraceptives
- Card and Direct: Plan B, through age 16
- Card and Direct: Emergency Contraceptives
- Fertility Agents
- Progesterone In Oil
- Drugs to Treat Impotency Except Yohimbine, for males only age 18 and over
- Card and Direct: Relenza/Tamiflu
- Synagis / Respigam
- Antihemophilia Agents

- Androgenic Agents
- Thalomid, up to a 28-day supply (SPS=504)

Medications

Generic Medications

Generic drugs may have unfamiliar names, but they are safe and effective. Be assured that generic drugs and their brand-name counterparts:

- Have the same active ingredients
- Are manufactured according to the same strict federal regulations

Generic drugs may differ in color, size, or shape, but the U.S. Food and Drug Administration requires that the active ingredients have the same strength, purity, and quality as the brand-name alternatives.

Prescriptions filled with generic drugs often have a lower co-payment. Therefore, you may be able to get the same health benefits at a lower cost. You should ask your doctor or pharmacist whether a generic drug would be right for you. You may be able to receive the same high-quality medication but reduce your expenses.

Generic medications contain the same active ingredients as brand-name counterparts, are just as safe and effective, and meet the same U.S. Food and Drug Administration standards for quality, strength and purity. However, generic drugs normally cost substantially less than their brand name counterparts. Therefore, generic drugs offer a simple and safe alternative to help reduce your medication costs. Ask your doctor to see if a generic drug could treat your condition.

Formulary and Non-Formulary Medications

The Formulary is a guide for you and your doctor to refer to when filling out your prescriptions. If there is no generic medication available for your condition, there may be more than one brand name for you and your doctor to consider. Express Scripts provides a list of formulary brand name medications to help you and your doctor decide medications that are clinically appropriate and cost effective.

If a drug you are taking is not on the formulary, you may want to discuss alternatives with your doctor or pharmacist. Using drugs on the formulary will keep your costs and the Plan’s costs lower.

A current drug list is available online or upon request by calling Member Services. To avoid paying higher co-payments associated with non-preferred drugs, please take this list with you when you visit your doctor so he or she can refer to it when prescribing medications for you and your eligible family participants.

Coverage limits

Your plan may have certain coverage limits. For example, prescription drugs used for cosmetic purposes may not be covered, or a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period.

If you submit a prescription for a drug that has coverage limits, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your

doctor a toll-free number to call. If you use the Express Scripts Pharmacy, your doctor will be contacted directly.

When a coverage limit is triggered, more information is needed to determine whether your use of the medication meets your plan's coverage conditions. We will notify you and your doctor in writing of the decision. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal.

Benefit ID Cards

Express Scripts will provide an initial benefit ID card upon enrollment in the plan. Present your ID card when filling a prescription at the pharmacy. Should you need additional or replacement ID cards, please contact Member Services or visit www.express-scripts.com to either request a new card or print a temporary card.

Retail Pharmacies

Network Retail Pharmacies

The Express Scripts Pharmacy Network is a national network many retail pharmacies, including independent community pharmacies. The network includes most major chains, discount, grocery and independent pharmacies, so there is a good chance that your local pharmacy is a participating member of the network. Use one of these pharmacies to fill prescriptions for short-term medications, such as antibiotics. To find a local pharmacy, visit www.express-scripts.com or contact Express Scripts Customer Care at 1-888-327-9791.

Mail Order Pharmacy

The Express Scripts Mail Order Pharmacy Program

The Express Scripts Pharmacy Program is designed for plan participants taking maintenance medications, or those medications taken on a regular basis, for the treatment of long-term conditions such as diabetes, arthritis or heart conditions. The program provides up to a 90-day supply of medication, delivered directly to your home or other requested location, postage paid.

In order to fill your prescription through the Express Scripts Pharmacy Program, mail your prescription, order form and payment in the envelope provided. You may also ask your doctor to call 1-888-327-9791 for further instruction. Your medication will usually be delivered within 8 days of Express Scripts receiving your order.

To order refills, call the automated refill system at 1-888-327-9791, or visit www.express-scripts.com. Refills are normally delivered within 3 to 5 days.

If you are a first-time visitor to the site, please take a moment to register have your member ID and a prescription number available.

To ensure timely delivery, please place your orders at least two weeks in advance to allow for mail delays and other circumstances beyond our control. If you have any questions concerning your order, or if you do not receive your medication within the designated timeframe, please contact Member Services.

If a new medication has been prescribed for you to take immediately, please ask your doctor to issue two prescriptions; one prescription should be written and filled at your local pharmacy and the second should be written for up to a 90-day supply and mailed to the Express Scripts Pharmacy.

As you manage your prescriptions, please be aware that each and every prescription is filled and checked by highly qualified registered pharmacists to ensure that quantity, quality and strength are accurate. A patient profile is maintained on file to ensure that there are no adverse reactions with other prescriptions you are receiving from retail and/or mail order pharmacies. If any questions arise regarding potential drug interactions or other adverse reactions, Express Scripts' pharmacists will contact either you or your doctor prior to dispensing the medication.

Expenses Not Covered

If any expense not covered is contrary to any law to which the plan is subject, the provision is hereby automatically changed to meet the law's minimum requirement. No payment will be made under any portion of the plan for

- Non-Federal Legend Drugs
- Federal Legend Non-Drugs
- Non Federal Legend Non-Drugs
- Investigational Drugs
- Glucowatch Products
- Nutritional Supplements and Combo Nutritional Products
- Ostomy Supplies

Categories that are excluded from coverage but not listed here:

- Respiratory Therapy Supplies (RX)
- Vitamins (RX, INJ)
- IVIG (Specialty BP/BTA) (RX, INJ)
- Botulinum Toxins (Non-Cosmetic/Essential)

Benefit Determinations

Determinations on prescription drug benefits will be made by Express Scripts in accordance with the Plan.

You may request coverage beyond your plan's standard benefit offering, or if you are dissatisfied with a benefit determination made by Express Scripts, you may appeal the determination in writing.

Claims Process

Filing a Claim

Any participant or beneficiary under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the Claims Administrators. When the Claims Administrator receives

your claim, it will be responsible for reviewing the claim and determining how to pay it on behalf of the Plan.

In general, when you need to file a claim use the addresses listed on the applicable claims form, or below. When your claim is received by the Claims Administrator, it will be reviewed and the Claims Administrator will determine how to pay your claim on behalf of the Plan. Claims forms are available from the Claims Administrator.

This section provides general information about the claims and appeals procedure applicable to the Plan under ERISA. The Plan will comply with additional claim and appeal rules if required under Health Care Reform. You will be notified if any of these new rules impact your claim.

Claim-Related Definitions

Claim

Any request for plan benefits made in accordance with the plan's claims-filing procedures, including any request for a service that must be pre-approved.

The Plan recognizes four categories of health benefit claims:

Urgent Care Claims

"Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. The Plan must defer to an attending provider to determine if a claim for Medical benefits is urgent.

Pre-service Claims

"Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

Post-Service Claims

"Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.

Concurrent Care Claims

"Concurrent care claims" are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim," "pre-service claim," or "post-service claim," depending on when during the course of your care you file the claim. However, the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

Adverse Benefit Determination

If the Plan does not fully agree with your claim, you will receive an "adverse benefit determination" — a denial, reduction, or termination of a benefit, or failure to provide or pay for

(in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate; and
- A concurrent care decision.

An adverse benefit determination includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not in connection with the rescission there is an adverse effect on any particular benefit at that time. However, if the plan retroactively cancels coverage for failure to pay required contributions, that is not an adverse benefit determination.

Initial Claim Determination

For each of the Plan options, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue.

The timeframes on the following pages apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan's review procedures and the time limits applicable to such procedures;
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.
- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; and
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

The notice will also include information sufficient to identify the claim involved. This includes:

- The date of service, the health care provider, and the claim amount, if applicable;
- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;

- A description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- In addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

Appeals

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review within 180 days from receipt of notice of the initial adverse benefit determination. The request must be made in writing and should be filed with the Claims Administrator. If you don't appeal on time, you lose your right to later object to the decision.

Coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the Plan will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests must be sent to: Express Scripts Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. Fax 1 877- 852-4070.

Administrative appeal requests must be sent to: Express Scripts Attn: Administrative Appeals Department, PO Box 66587 St Louis, MO 63166-6587. Fax 1 877- 328-9660.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and

copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record or other information is relevant to the claim will be determined in accordance with the applicable Department of Labor (DOL) regulations. You are also entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

The Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

Before making a benefit determination on review, the Claims Administrator must provide you 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 Medical claim. This evidence will be provided at no cost to you, and will be given before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

If the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your Medical benefit claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review and you may ask the Plan to explain why the error is minor and why it meets this exception.

Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment under the Medical benefit plan, you may begin an expedited external review before the Plan's internal appeals process has been completed.

The Claims Administrator will provide you with written notification of the Plan's determination on review. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review;
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures;
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request;
- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);
- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- A description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- In addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

Second Level Appeal

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. To initiate a second level appeal, you or your authorized representative (such as your physician), must provide in writing, your name, member ID, phone number, the prescription drug for which benefit coverage has been denied and any additional information that may be relevant to your appeal. This information should be mailed to Express Scripts at the address above. A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for appeal. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. The decision made on your second level appeal is final and binding.

If you are not satisfied with the decision of the second level appeal, you also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if your second level appeal is denied.

In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. An urgent care claim is any claim for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately

managed. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim, of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information.

You have the right to request an urgent appeal of an adverse determination if you request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or your physician may call or send a written request to Express Scripts. In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to bring a civil action under section 502(a) of ERISA if your final appeal is denied.

If the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your Medical benefit claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimis, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review and you may ask the Plan to explain why the error is minor and why it meets this exception.

Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment under the Medical benefit plan, you may begin an expedited external review before the Plan's internal appeals process has been completed.

External Review

You may have the right to request an external review of a claim involving medical judgment, as determined by the external reviewer, or a coverage rescission. You must request the external review within 4 months of the date you receive an adverse benefit determination. If your request for an external review is determined eligible for such a review, an independent organization will review the Claims Administrator's decision and provide you with a written determination.

The external review decision is binding on you and the Plans, except to the extent other remedies are available under federal law. The external review process does not apply to an adverse benefit determination or final internal adverse benefit determination that is not related to medical judgment or coverage rescission.

Legal Action

Before pursuing legal action for benefits under the Plan, you must first exhaust the Plan's claim, review and appeals procedures. Additionally, any lawsuit you bring for Plan benefits must be filed within 36 months of the date on which your claim is incurred under the Plan, and must be filed in the U.S. District Court for the Eastern District of Missouri.

Coordination of Benefits

The Plan will coordinate benefits with any other health plan that covers you or your eligible dependents. Refer to the SPD describing the plan option in which you are enrolled for the Plan's

rules regarding coordination of benefits, order of benefit determination, disagreement on benefit coordination and facility of payment.

Acts of Third Parties

When you or your covered dependent are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible prescription drug expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. Refer to the SPD describing the plan option in which you are enrolled for the Plan's procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made on your behalf by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

- Has an equitable lien on any and all monies paid to (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid to (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and
- May bring an action on its own behalf or on the covered person's behalf, or intervene in any pending lawsuit, against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses. Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;
- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Provide proof, if requested by the Claims Administrator and in the form requested by the Claims Administrator, that you have not and will not discharge or release a claim against a third party without the written consent of the Claims Administrator;
- Execute a written agreement assigning your rights against a third party to the Plan and/or authorizing the Plan to sue, compromise or settle a cause of action against a third party, if requested by the Claims Administrator;
- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including instituting a formal proceeding against a third party and/or setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this Summary;
- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness; and
- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

The Plan may terminate your Plan participation and/or offset your future benefits in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan. If the Plan must institute proceedings against you for not honoring the Plan's recovery rights under this section, you will be responsible for the costs of collection, including reasonable attorney's fees.

If the "Acts of Third Party" provisions in this SPD conflict with provisions in a Benefit Booklet governing insured benefits, the Benefit Booklet will govern. If the Benefit Booklet for any self-insured benefit contains subrogation, reimbursement or recovery provisions, those provisions and the "Acts of Third Party" provisions in this SPD will both apply, so that the Plan has the maximum subrogation, reimbursement, and recovery rights.

Recovery of Overpayment

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you,

the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

Non-assignment of Benefits

Plan participants cannot assign, sell, transfer, pledge, borrow against, or otherwise promise any benefit payable under the Plan or the right to assert legal rights, including an administrative claim or lawsuit against any of the following: the Plan, the Plan Administrator, a Claims Administrator, or any Plan fiduciary, or the Company and any Participating Employers, or their officers, shareholders, or employees. For example, Plan participants may not assign their right to receive Plan benefits and legal rights relating to the Plan to any health care provider—such assignment is not permitted and is void. The Plan Administrator or Claims Administrator may make payment directly to the Plan participant or, at its discretion, make payment directly to a doctor, hospital, or other provider of care. When payment is made directly to a doctor, hospital or other provider of health care, such direct payments are solely at the discretion of the Plan Administrator or Claims Administrator—such payments do not create any enforceable assignment of benefits or the right to assert any legal rights or to bring any administrative claim or lawsuit by any doctor, hospital, or other provider of care against the Plan (or the Plan Administrator, Claims Administrator, or any Plan fiduciary, or the Company and Participating Employers, or officers, shareholders or employees thereof).

The Plan will, when required by law or applicable guidance, recognize an assignment of benefits to a state Medicaid program.

Misstatements and Misrepresentations

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

If you or your dependent(s) receive benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation, you may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. If you make any intentional misrepresentation or use fraudulent means concerning eligibility for coverage, changing your existent coverage, or benefits under the Plan, your coverage (and your dependents' coverage) may be terminated irrevocably (retroactively to the extent permitted by law), and could be grounds for discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

Administrative Information

Below is key information you need to know about your benefit plans:

Plan Name	▪ Bunge Employee Welfare Benefit Plan ▪ Bunge Retiree Welfare Benefit Plan
Plan Number	▪ 501: Bunge Employee Welfare Benefit Plan ▪ 550: Bunge Retiree Welfare Benefit Plan
Plan Sponsor	Bunge North America, Inc. 1391 Timberlake Manor Parkway Chesterfield, MO 63017 (314) 292-2000
Employer Identification Number	13-4977260
Plan Administrator	Bunge North America, Inc. 1391 Timberlake Manor Parkway Chesterfield, MO 63017 (314) 292-2000
Agent for Service of Legal Process	Bunge North America, Inc. 1391 Timberlake Manor Parkway Chesterfield, MO 63017 (314) 292-2000
Plan Year	January 1 – December 31
Plan Type	Welfare benefit plan providing prescriptions drug benefits.
Source of Contributions	The cost of medical coverage (including prescription drug coverage) is shared by Bunge and its enrolled employees. Bunge contributes the difference between the amount employees contribute and the amount required to pay benefits under the Plan. The Plan Administrator will notify employees annually as to what the employee contribution rates will be. Bunge in its sole and absolute discretion, shall determine the amount of any required contributions under the Plan and may increase or decrease the amount of the required contribution at any time. Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be applied first to reimburse Bunge for their contributions, unless otherwise provided in that group insurance contract or required by applicable law.

Plan Document

This document is intended merely as a summary of the official Plan document(s). In the event of any disagreement between this summary and the official Plan document(s), as they may be amended from time to time, the provisions of the Plan document(s) will govern.

Plan Amendment and Termination

Bunge reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time. For example, Bunge reserves the right to amend or terminate benefits, covered expenses, benefit copays, lifetime maximums, and reserves the right to amend the Plan to require or increase employee contributions. Bunge also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by Bunge will be done in accordance with Bunge's normal operating procedures. Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of Bunge, the Plan shall terminate unless the Plan is continued by a successor to Bunge.

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to Bunge to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document.

Plan Administration

Bunge is responsible for the general administration of the Plan, and will be the fiduciary to the extent not otherwise specified in this SPD or the Plan document. Bunge has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions. Such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and Bunge will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Plan Administrator, nor Bunge will be liable in any manner for any determination made in good faith.

Bunge may designate other organizations or persons to carry out specific fiduciary responsibilities for Bunge in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping,
- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan, and

- The responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

Bunge will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

Questions

If you have general questions regarding your medical coverage, please contact the Plan Administrator. However, if you have specific questions concerning your prescription drug coverage, such as what's covered or excluded, please Contact Express Scripts. You may also use the contact information on the back of your Express Scripts ID card.

ERISA

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 you, and all other participants, shall be entitled to:

Receive Information about Your Plan and Benefits

You can:

- Review at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, insurance contracts and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. There is no charge for this review.
- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any is required to be prepared by ERISA. The Plan Administrator is required by law to furnish each participant with a copy of any required summary annual report (SAR).

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse and/or dependent child(ren) if there is a loss of coverage under the Plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description for the medical plan option in which you are enrolled and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on 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 Rights

If your claim for a 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If 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, 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 (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or:

Office of Outreach, Education, and Assistance
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.

Appendix A — Express Scripts Booklets

This summary should be read in combination with the SPDs for the medical option in which you are enrolled.

Please also see the Express Scripts Booklets for details of Plan benefits.

Coverage	Evidence of Coverage Name
Prescription Drugs	Summary of Benefits and Coverage for the Basic HDHP, Core HDHP, and Premium PPO medical plan options under the Plan SPDs for the Bunge Employee Welfare Benefit Plan and the Bunge Retiree Welfare Benefit Plan ESI Benefit Booklet for Bunge North America, Inc.

ESI Benefit Booklet for Bunge North America, Inc.

Prescription plan FAQs

What is covered?

The Plan's prescription benefit covers a wide variety of prescription drugs, including generic drugs and brand-name drugs. The Plan also maintains a formulary, which is a list of preferred drugs that members can obtain for lower copays and to help save them money.

An expert panel of physicians and pharmacists carefully reviews the drugs on the formulary for safety, quality, effectiveness and cost. The formulary and conditions of drug coverage under the Plan are subject to change. To find out whether a particular medicine is included on the formulary or covered under the Plan, and what conditions of coverage (if any) may apply, go to express-scripts.com or call Express Scripts Member Services. A pharmacist can also check whether a medication is on the formulary or covered at any time.

What is not covered?

Some drugs are not covered, or excluded, from the prescription drug benefit, which means there are no alternatives to try or exceptions to coverage. Benefit exclusions and other drugs excluded from the formulary are noted elsewhere in the Summary Plan Description. To check whether a medication is excluded, go to express-scripts.com or call Express Scripts Member Services.

What is the difference between generic and brand-name drugs?

Generic drugs have the same active ingredients in the same dosage form and strength as their brand-name counterparts. The color and shape may differ between the generic and the brand drug; however, the active ingredients must be the same for both. The U.S. Food and Drug Administration (FDA) approves both brand and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand-name drugs. These requirements assure that generic drugs are as safe and effective as brand drugs. The formulary (the list of preferred drugs) chosen by the Plan contains only FDA-approved generic medications.

Preferred brand drugs, also known as formulary drugs, are medications that have been reviewed and approved by a group of physicians and pharmacists, and have been added to the Express Scripts formulary selected by the Plan based on their proven clinical and cost effectiveness.

Non preferred brand drugs, or non-formulary drugs, are medications that the same team of physicians and pharmacists have not approved for the Express Scripts formulary selected by the Plan. This happens when the team determines that a clinically equivalent and more cost-effective alternative generic or preferred brand drug is available.

The formulary changes from time to time as new clinical information becomes available. To determine the status of any particular drug on the Plan's formulary, log onto express-scripts.com or contact Express Scripts Member Services. A medication's inclusion on the formulary is no guarantee of effectiveness.

This ESI Benefit Booklet is incorporated by reference into the Bunge Employee Welfare Benefit Plan and the Bunge Retiree Welfare Benefit Plan Prescription Drug Summary Plan Description (SPD). If there is ever a conflict or a difference between what is written in this Benefit Booklet and the SPD with respect to **the specific benefits provided**, the Benefit Booklets shall govern unless otherwise provided by any federal and state law. If there is a conflict between the Benefit Booklet and the SPD with respect to **the legal compliance requirements of ERISA and any other federal law**, the SPD will rule.

Similarly, if a medication is not on the formulary, it does not mean it is not effective, but rather that a clinically equivalent and more cost-effective alternative is available and on the formulary.

How are claims paid?

Generally, members do not need to submit claims under the prescription plan. A member pays the copay, coinsurance or other amount required by the Plan when filling a prescription. However, if a member needs to submit a paper claim for reimbursement for payment of the cost of a covered drug (for example, if the pharmacy's computer system was not working or the card was left at home), the member download a claim form from the website or call Express Scripts Member Services.

When should a retail pharmacy be used?

The retail pharmacy is the most convenient option when a medication is needed immediately, such as an antibiotic for a short-term illness or infection. Members simply present their ID card to the pharmacist, along with the doctor's written prescription if it has not been sent electronically, to receive a 30-day supply of the medicine.

Express Scripts' retail pharmacy network includes more than 70,000 participating pharmacies, including national chains as well as independent retailers.

Some plans may not cover a medication filled at a neighborhood pharmacy because it is not "in network," but the medication will be covered at a large retail pharmacy chain or grocery store if those pharmacies are "in network." To find a participating retail pharmacy, members can visit express-scripts.com and use the Pharmacy Locator to find a list of pharmacies close to where they live or work. Members can also download the Express Scripts mobile app to find a pharmacy when they're on the go. To download the mobile app for free, search for "Express Scripts" in smartphone app stores. If members do not have computer access, they can call Express Scripts Member Services.

Prescriptions filled at a nonparticipating retail pharmacy are not covered under the Plan, which means if members fill prescriptions there, they pay the full retail price (or 100% of the cost) of the drug and the amount paid does not count against the Plan's deductible or out-of-pocket maximums.

When should the home delivery pharmacy be used?

Express Scripts offers home delivery, or a mail pharmacy service, for prescriptions taken on a regular basis for long-term conditions, such as asthma, depression or high blood pressure. With home delivery, members can receive up to a 90-day supply of medicine from the Express Scripts PharmacySM, often for a lower cost than they would pay at a retail pharmacy.

Home delivery advantages

- Fewer refills and fewer trips to the pharmacy
- Free standard shipping costs included as part of the Plan
- Medicine is delivered in tamper-proof, weather- resistant packages
- Drugs that require refrigeration are shipped in cold packs
- Pill bottles have child-resistant safety caps, but easy-open caps may be requested when the order is

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placed

How to get started with home delivery?

Express Scripts offers members a variety of convenient ways to submit new prescription orders.

- **New prescriptions** may be submitted directly from the doctor's office or through the mail.
- **Refills** can be ordered electronically using the Express Scripts mobile app or website, through the mail or by phone.

Visit express-scripts.com to learn more.

Pharmacy Program Descriptions

Drug Quantity Management (DQM) makes sure that members are getting the right amount of medication and that it is prescribed in the most efficient way. For example, the doctor may say, "take two 20mg pills each morning." If that medication is also available in 40mg pills, Express Scripts will contact the doctor about prescribing one 40mg pill a day instead of two 20mg pills. In addition, if the doctor writes the original prescription for 30 pills (a 15-day supply), the new prescription for 30 pills will last a full month — and the members will have just one copayment, not two.

DQM also makes sure that a member's prescriptions do not exceed the amount of medication that the Plan covers. If the prescription is for too large a quantity, the pharmacist can fill the prescription for the amount that the Plan covers or contact the doctor to discuss other options, such as increasing the strength or getting a prior authorization for the quantity originally prescribed.

Formulary Overview: Express Scripts formulary options help decrease prescription drug expenses. To ensure the clinical appropriateness of their formularies, Express Scripts physicians and pharmacists carefully evaluate pharmaceuticals and prepare recommendations for the National Pharmacy & Therapeutics (P&T) Committee, which reviews and approves Express Scripts formularies.

Medical necessity appeals: Express Scripts performs appeal services internally or facilitates the performance of appeal services through a contracted, independent, third-party utilization management company. Appeal cases are handled by reviewing available information as well as clinical guidelines and current clinical literature to determine if drug coverage is permitted under the plan's pharmacy benefit coverage rules. The review considers plan rules based on Food and Drug Administration (FDA)-approved prescribing and safety information, as well as relevant clinical guidelines.

Prior Authorization monitors both cost and safety. If a pharmacist tells a member that a prescription requires prior authorization, Express Scripts will need to communicate with the doctor to be sure that the medicine is right and will verify that the Plan covers the drug. This is similar to when a healthcare plan authorizes a medical procedure in advance.

When a prescription requires prior authorization, the doctor can call Express Scripts or prescribe a different

medicine that is covered by the Plan. Only doctors can give Express Scripts the information needed to determine if the drug may be covered. Express Scripts answers its prior authorization phone lines 24/7, and a determination can be made right away. If the medicine is covered, the member will pay the normal copay. If the medication is not covered but the member wants to take it, the member will pay the full price of the medicine.

Step Therapy is a program for people who take prescription medicine regularly to treat a long-term condition, such as arthritis, asthma or high blood pressure. It lets members get the treatment they need affordably.

- First-line medicines are the first step. First-line medicines are generic and lower-cost brand-name medicines approved by the U.S. Food & Drug Administration (FDA). They are proven to be safe, effective and affordable. Step therapy suggests that a patient try these medicines first because, in most cases, they provide the same health benefit as more expensive drugs, but at a lower cost.

- Second-line drugs are the second and third steps. Second-line drugs typically are brand-name drugs. They are best suited for the few patients who do not respond to first-line medicines. Second-line drugs are the most expensive options.

The first time a member tries to fill a prescription that is not for a first-line medicine, the pharmacist should explain that step therapy asks the member to try a first-line medicine before a second-line drug. Only the doctor can change the current prescription to a first-line medicine covered by the Plan.

To get a first-line medicine that the Plan covers, a member should ask the pharmacist to call the doctor and ask for a new prescription. If it is easier, the member can also call the doctor to ask for a new prescription. Also, the pharmacist should explain to the member that there's an option to choose a second-line alternative to the first-line medicine. However, because the Plan will not cover second-line drugs until after the member and the doctor have considered a first-line medicine to treat the condition, the member will pay full price for that second-line drug.

	Basic HDHP	Core HDHP	Premium PPO	Premium PPO (Decatur, IN)
Copay/Coinsurance	**Retail Pharmacy (up to a 30 day supply)** $10/$20/$30 Preventive Drugs 20% Generics, Preferred, Non Preferred Brands, and Specialty **Home Delivery (up to a 90 day**	**Retail Pharmacy (up to a 30 day supply)** $10/$20/$30 Preventive Drugs 20% Generics, Preferred, Non Preferred Brands, and Specialty **Home Delivery**	**Retail Pharmacy (up to a 30 day supply)** $10 Generics $40 Preferred Brand $60 Non Preferred Brand $100 Specialty	**Retail Pharmacy (up to a 30 day supply)** $10 Generics $40 Preferred Brand $60 Non Preferred Brand

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	supply) 20% Generics, Preferred and Non Preferred Brands	**(up to a 90 day supply)** 20% Generics, Preferred and Non Preferred Brands	**Home Delivery (up to a 90 day supply)** $20 Generics $80 Preferred Brand $120 Non Preferred Brand	$100 Specialty **Home Delivery (up to a 90 day supply)** $20 Generics $80 Preferred Brand $120 Non Preferred Brand
Deductible	**N/A**	**N/A**	**N/A**	**N/A**
Out Of Pocket*	**$6000 Single** **$12000 Full Family**	**$4000 Single** **$7350 Full Family**	**$4400 Single** **$9800 Full Family**	**$2000 Single** **$4000 Family**

* Out-of-pocket limits protect you in case you or a family member has a condition that requires prescriptions that would be very expensive. The limit is the most you would ever pay out of your pocket for prescription drug expenses. Once your payments reach the limit, the plan pays 100% of your prescription drug expenses for the rest of the year.

Generic Drug Rules

If a member requests a brand name drug when a generic drug is available, the plan will only cover the cost of the generic drug. The member will need to pay the difference in cost between the brand and generic drug plus the generic copay. If there is a clinical reason for the member to receive the brand drug, they should contact Member Services to discuss if a clinical exception can be made.

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Additional Program Descriptions

SaveonSP Copay Offset Program

Express Scripts offers the SaveOnSP program in conjunction with a third party vendor. Within the SaveOnSP program, the Affordable Care Act state benchmarks are utilized to classify certain specialty products as non-essential health benefits, removing them from the accumulator. The plan will then implement higher copays on the targeted drugs to fully utilize the copay assistance amount available, resulting in savings for the patient and the plan. After all funds are applied, the patient's final remaining responsibility will be zero.

SaveOnSP targets drugs in more than 20 specialty categories, including:

- Oncology
- Inflammatory conditions
- Multiple sclerosis
- Blood cell deficiency
- Hepatitis C
- Hereditary angioedema
- Pulmonary arterial hypertension
- Cystic Fibrosis
- Hemophilia
- Asthma & Allergy

Bunge is enrolled in the The SaveOnSP that includes an Exclusive Specialty design with no grace fills of standard specialty medications (non-STAT) at retail pharmacies. Non-STAT medications must be filled at Accredo on the first fill to help optimize clinical care and appropriate counseling for patients.

Out-of-Pocket Protection Plan

To help Bunge minimize the impact of copayment assistance on your plan design while ensuring your members have access to the medications they need, Express Scripts offers the Out-of-Pocket Protection Plan. This program adjusts copayment assistance from members' accumulated out-of-pocket maximums to reflect only what members themselves pay. Express Scripts completes these adjustments retroactively on a nightly basis with communications sent monthly to notify impacted members.

Bunge is enrolled in the Out-of-Pocket Protection Plan with an Exclusive Specialty design with no grace fills at retail pharmacies.

Prescription Plan Definitions

Accredo: An Express Scripts specialty pharmacy.

Acute medication: Drugs taken for a limited time to treat temporary medical conditions or illnesses, such as antibiotics for infections.

Appeal: A review of an initial or first-level appeal denial, along with any additional information provided or available, to determine if the member's use of the drug meets the Plan's intent for coverage. Appeals are related to coverage denials; they are not related to procedures addressing member complaints or grievances. Express Scripts completes appeals according to business policies that are aligned with state and federal regulations. For more information, refer to the Reviews and Appeals Process which can be obtained from Express Scripts.

Appeals process: A specific process that a member needs to follow when making an appeal request. Depending on the appeal type, decisions are made by an Express Scripts pharmacist, physician, panel of clinicians, trained prior authorization staff or an independent third-party utilization management company. Members are notified of the decision and of any rights to appeal an adverse benefit decision. For ERISA plans: Under Section 502(a) of ERISA, members have the right to bring a civil action if their final appeal is denied.

Benefit exclusion: Also referred to as "not covered," this includes a drug or drug class that is not included in the member's benefit and means there are no alternatives to try or exceptions to coverage.

Biosimilar: A biopharmaceutical drug designed to have active properties similar to one that has previously been licensed.

Brand: A drug protected by a patent, which prohibits other companies from manufacturing the drug while the patent is in effect, issued to the original innovator or marketer and manufactured by a single source. The name is unique and usually does not describe the chemical makeup (for example, Tylenol®).

Compound: A medicine that is made of two or more ingredients that are weighed, measured, prepared or mixed according to a prescription order.

Copay/coinsurance: The cost of a covered drug paid by the member at the time the prescription is filled and after the deductible is met (if applicable) per individuals or families.

Coverage review: Also known as the initial review or initial determination, this process is followed when a member requests coverage for a drug, or requests coverage for a drug at a higher benefit. It's the first review of drug coverage based on the Plan's conditions of coverage. The initial review decision is based on the information provided by the prescriber (clinical) or the patient (administrative) and the criteria in place. If the initial review is denied, then the patient/representative may appeal the decision.

Excluded: Drugs that are not covered and will not be reimbursed by the Plan's pharmacy benefit.

Exclusive Specialty: After a Specialty medication is filled a certain number of times as defined by the plan at retail, an additional retail copay or coinsurance applies for retail claims. This amount does not accumulate toward the out-of-pocket maximum.

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Formulary: A preferred list of drug products that typically limits the number of drugs available within a therapeutic class for purposes of drug purchasing, dispensing and/or reimbursement. Products are selected on the basis of safety, efficacy and cost.

Formulary exclusions: Certain drugs are excluded from the formulary. Clinically effective alternatives are available for all excluded products.

Formulary exclusion exception review: The prescriber may request an exception to the formulary exclusion. Express Scripts contacts the prescriber for information to determine if the conditions of coverage are met for an exception to the formulary exclusion. If the formulary exception is denied, the patient or their representative may appeal the decision.

Generic: A drug that has the same active ingredients in the same dosage form and strength as its brand- name counterpart. The color and shape may differ between the generic and brand-name drug; however, the active ingredients must be the same for both. The U.S. Food and Drug Administration (FDA) approves both brand-name and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand-name drugs. These requirements assure that generic drugs are as safe and effective as brand-name drugs. Generic drugs often cost less than brand-name drugs. A generic drug can be produced once the manufacturer of the brand-name drug is required to allow other manufacturers to produce the drug.

Home delivery: A distribution channel in which the member receives a prescription drug through the mail from the Express Scripts Pharmacy℠.

Maintenance medication: Drugs taken over an extended period of time for a long-term condition, such as high blood pressure, depression or asthma. These drugs are typically filled through the home delivery pharmacy for a 90 days' supply to provide members with lower costs and more convenience.

Medical Necessity: Medical necessity is a United States legal doctrine, related to activities which may be justified as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care. In contrast, unnecessary health care lacks such justification.

Network pharmacy: A pharmacy (also called a retail network pharmacy) that participates in the Plan's network. In most cases, members need to use a network pharmacy to pay the amounts specified by the Plan.

Non-network pharmacy: A pharmacy not associated with the retail network. Benefits will not be covered at the same rate as a network pharmacy and members will have to pay the full cost of the medication at non-network pharmacies.

Not covered: Also known as "benefit exclusion," this includes a drug or drug class that is not included in the member's benefit, which means there are no alternatives to try or exceptions to coverage.

Over the counter (OTC): A drug that is available without a prescription from a doctor.

Specialist pharmacist: An Express Scripts pharmacist who receives extra training in medicines used to treat specific long-term and complex conditions. These pharmacists use nationally accepted, evidence-based procedures and work with physicians to identify gaps in care across different providers. Specialist pharmacists personally counsel patients to help them understand and follow through on their treatments.

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Specialty drug: A high-cost drug, including infused or injectable medicines, that usually require close monitoring and special storage. Specialty drugs are generally prescribed to people with an ongoing or complex medical condition.

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Express Scripts Reviews and Appeals Overview

Purpose

The purpose of this document is to outline the Express Scripts Reviews and Appeals procedures for Commercial clients.

Coverage review description

A member has the right to request that a medication be covered or be covered at a higher benefit (e.g. lower copay, higher quantity, etc). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests:

Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.

Administrative coverage review request: A request for coverage of a medication that is based on the Plan's benefit design.

How to request an initial coverage review

To request an initial clinical coverage review, also called prior authorization, the prescriber submits the request electronically. Information about electronic options can be found at www.express-scripts.com/PA.

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing. A Benefit Coverage Request Form, used to submit the request, is obtained by calling the Customer Service phone number on the back of your prescription card. Complete the form and mail or fax it to Express Scripts Attn: Benefit Coverage Review Department PO Box 66587 St Louis, MO 63166-6587. Fax 877 328-9660.

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by the provider by phone at 1 800-753-2851.

How a coverage review is processed

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, the member must submit information to Express Scripts to support their request. The initial determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service*	15 days (Retail) 5 days (home delivery)	Patient: automated call (letter if call not successful) Prescriber: Electronic or Fax (letter if fax not successful)	Patient: letter Prescriber: Electronic or Fax (letter if fax not successful)
Standard Post-Service*	30 days		
Urgent	72 hours**	Patient: automated call and letter Prescriber: Electronic or Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Electronic or Fax (letter if fax not successful)

*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.

**Assumes all information necessary is provided. If necessary information is not provided within 24 hours of receipt, a 48 hour extension will be granted.

How to request a level 1 appeal or urgent appeal after an initial coverage review has been denied

When an initial coverage review has been denied (adverse benefit determination), a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests: Express Scripts Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. **Fax** 1 877-852-4070

Administrative appeal requests: Express Scripts Attn: Administrative Appeals Department, PO Box 66587 St Louis, MO 63166-6587. Fax 1 877-328-9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax:

Clinical appeal requests: **phone** 1 800-753-2851 **fax** 1 877-852-4070

Administrative appeal requests: **phone** 1 800-946-3979 **fax** 1 877-328-9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 1 appeal or urgent appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by a Pharmacist, Physician, trained prior authorization staff member, or independent third party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service	15 days	Patient: automated call (letter if call not	Patient: letter

		successful) Prescriber: Electronic or Fax (letter if fax not successful)	 Prescriber: Electronic or Fax (letter if fax not successful)
Standard Post-Service	30 days		
Urgent	72 hours	Patient: automated call and letter Prescriber: Electronic or Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Electronic or Fax (letter if fax not successful)

The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

How to request a level 2 appeal after a level 1 appeal has been denied

When a level 1 appeal has been denied (adverse benefit determination), a request for a level 2 appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests: Express Scripts Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. Fax 1 877-852-4070

Administrative appeal requests: Express Scripts Attn: Administrative Appeals Department, PO Box 66587, St Louis, MO 63166-6587 Fax 1 877-328-9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If

the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax:

Clinical appeal requests: **phone** 1 800-753-2851 **fax** 1 877-852-4070

Administrative appeal requests: **phone** 1 800-946-3979 **fax** 1 877-328-9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 2 appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by a Pharmacist, Physician, or independent third party utilization management company.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service	15 days	Patient: automated call (letter if call not successful) Prescriber: Electronic or Fax (letter if fax not successful)	Patient: letter Prescriber: Electronic or Fax (letter if fax not successful)
Standard Post-Service	30 days		
Urgent	72 hours	Patient: automated call and letter Prescriber: Electronic or Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Electronic or Fax (letter if fax not successful)