

BUNGE
HEALTH CARE REIMBURSEMENT PLAN
SUMMARY PLAN DESCRIPTION

Effective January 1, 2019

Bunge North America, Inc.
Health Care Reimbursement Plan
Table of Contents

	Page
About Your Benefits	1
Eligibility	1
When Coverage Begins.....	1
The Health Care Reimbursement Plan.....	2
Introduction.....	2
How the Plan Works	3
Contributions to Your Health Care Flexible Spending Account	3
Determining the Amount to Contribute to Your Health Care Flexible Spending Account	3
Reimbursement	3
Reimbursable Expenses	3
Forfeiture of Unused Amounts	4
Other Coverage	4
Eligible Expenses.....	4
Ineligible Expenses	5
Claims Filing.....	6
Filing a Reimbursement Claim	6
Appealing a Claim Relating to a Benefit	6
Appealing a Claim Relating to Eligibility, Enrollment or Changes in Enrollment.	7
Other Administrative Information	9
When Coverage Ends.....	9
Administrative Information	9

ABOUT YOUR BENEFITS

Your Bunge Health Care Reimbursement Plan (the “Plan”) is designed to provide you with the opportunity to receive reimbursement on a pre-tax basis for certain medical care expenses that you, your spouse or your eligible dependents incur. You should refer to the Your Benefit Choices Eligibility and Administrative Booklet (“Eligibility Booklet”) for information about who is eligible to participate in this program. This booklet, along with applicable portions of the Eligibility Booklet, serves as the summary plan description (“SPD”) for the Plan. The SPD describes the benefits provided in easy-to-read terms. It cannot cover every detail of the Plan. If there is any conflict between the description in the SPD and any official Plan documents that may govern the Plan now or in the future, the terms of the official Plan documents will be followed.

ELIGIBILITY

Your Eligibility Booklet describes in detail the eligibility requirements for the Plan.

WHEN COVERAGE BEGINS

Refer to your Eligibility Booklet for details on when coverage begins.

THE HEALTH CARE REIMBURSEMENT PLAN

INTRODUCTION

This Plan gives you an opportunity to save on income and employment taxes by paying for eligible medical care expenses with pre-tax dollars. The type of eligible medical care expenses depends on whether you have a General Purpose Option or a Limited Purpose Option. For Plan years beginning in 2019 or after, if you elect the High-Deductible Health Plan, you will be automatically enrolled in the Limited Purpose Option for that Plan year.

Even though other plans may cover the cost of most of your medical care expenses, you may have some out-of-pocket expenses. These expenses could include copayments, deductibles or the cost of medical care not covered by other plans.

This chart highlights some of the main features of the Plan.

PLAN FEATURES	DESCRIPTION
Maximum Annual Contribution	\$2,650.00
Minimum Claim Amount	\$50.00
Last Day to Submit a Claim for Reimbursements	April 30 following the last day of the Grace Period (Grace Period means through March 15 th immediately following the end of a Plan year).
Federal Taxes Applicable to Contributions	None
Federal Taxes Applicable to Reimbursements	None
Period During Which Eligible Medical Care Expense Must be Incurred	During the Plan year and Grace Period following the end of the Plan year.
Whose Eligible Medical Care Expenses may be reimbursed under the Plan?	Eligible medical care expenses incurred by you, your spouse or dependent(s).

HOW THE PLAN WORKS

CONTRIBUTIONS TO YOUR HEALTH CARE FLEXIBLE SPENDING ACCOUNT

The “Enrollment” section in your Eligibility Booklet describes in detail when and how you may elect to participate in the Plan and how you may make enrollment changes.

When you enroll, you elect the annual amount you want to contribute to the Plan. An amount equal to the total amount you elect to contribute divided by the number of your paychecks in a Plan year will be deducted on a pre-tax basis from each of your paychecks throughout the Plan year. The deducted amounts will be credited to your health care flexible spending account.

DETERMINING THE AMOUNT TO CONTRIBUTE TO YOUR HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Identify deductibles, copayments and other eligible medical care expenses not covered by a medical plan that you are likely to incur during an upcoming Plan year to determine the amount you wish to contribute to the Plan. You may refer to the Eligible Expenses section to identify other reimbursable expenses. The maximum amount that you may elect to contribute for a Plan year is \$2,650.00.

REIMBURSEMENT

You may be reimbursed for eligible medical care expenses up to the total amount you elect to contribute to your health care flexible spending account. The full amount you elect to contribute to your health care flexible spending account, minus any previous reimbursements you have received during the Plan year, may be used for reimbursements of eligible medical care expenses at any time during the Plan year and up through the Grace Period. Eligible medical expenses incurred during a Grace Period will be deemed to have been incurred during the earlier Plan year to the extent you have unused amounts from such Plan year. The minimum reimbursement you may request is \$50 unless you are making your final reimbursement request for a Plan year.

REIMBURSABLE EXPENSES

Under the General Purpose Option, an eligible medical care expense is any medical, dental or vision expense of the type that would be deductible on your federal income tax return in excess of the adjusted gross income limitation, other than expenses incurred for health insurance premiums, qualified long-term care services and certain over-the-counter medicine. Eligible medical care expenses incurred by you, your spouse or dependent(s) may be submitted for reimbursement. The expense must be incurred during the Plan year and up through the Grace Period at a time when you or your family member is covered under the Plan. An expense will be considered to be incurred when you or your family member receives the service that causes the expense. Under the Limited Purpose Option, medical care expenses are limited to the above

expenses, but for vision care, dental care, or preventive care only. The table in the following sections lists some common medical care expenses eligible and ineligible for reimbursement.

FORFEITURE OF UNUSED AMOUNTS

Under Internal Revenue Service rules, amounts credited to your health care reimbursement account for a Plan year cannot be used to pay for medical care expenses incurred in the following year. However, you may submit reimbursement claims for expenses incurred during a Plan year and up through the Grace Period, through April 30 of the following Plan year. After April 30, any remaining amounts from the prior year will be forfeited.

OTHER COVERAGE

If you receive reimbursement for a medical care expense through other health plan coverage or otherwise, you may not receive reimbursement for that medical care expense through your health care flexible spending account. In addition, premium payments for plan coverage under any other health plan are not eligible medical care expenses.

ELIGIBLE EXPENSES

Eligible medical care expenses are expenses incurred for medical care. Medical care expenses include amounts paid for the diagnosis, care, mitigation, treatment, or prevention of disease or illness and for treatments affecting any part of function of the body. Expenses incurred for the following services and products are eligible for reimbursement. The Internal Revenue Service publishes an official list of eligible medical care expenses in Publication 502, "Medical and Dental Expenses." You may obtain a copy of the publication at www.irs.gov.

- Acupuncture
- Amount applied to any medical or dental deductible
- Automobile equipment to assist the physically disabled
- Birth control pills
- Certain special schooling for disabled persons
- Child birth preparation classes
- Chiropractic expenses
- Contact lenses and solutions
- Coinsurance
- Cost of guide or guide dogs for persons who are visually or hearing impaired
- Cost for smoking cessation program
- Cost of special diet when medically necessary and only to extent that costs exceed normal diet persons
- Crutches
- Diabetic Supplies
- Elevators (in home) for disabled
- Expenses in excess of medical, dental or vision plan limits
- Expenses for services connected with donating an organ

- Eye exams, eyeglasses and contact lens
- Hearing aids
- Infertility treatment
- Learning Disability tutoring fees
- Medically necessary mattresses and boards
- Orthodontia
- Physical Therapy
- Prescription Drugs
- Psychotherapy
- Radial Keratotomy
- Routine physical exams
- Specialized equipment for disabled
- Special devices, such as tape recorder or typewriter, for persons who are visually impaired
- Speech Therapy
- Sterilization surgery
- Well baby & well child care
- Wheelchairs

INELIGIBLE EXPENSES

- Cosmetic surgery
- Expenses claimed on your income tax return
- Expenses not eligible to be claimed as an income tax deduction
- Expenses reimbursed by other sources, such as insurance companies
- Fees for exercise/athletic/health clubs where there is no specific medical reason for membership
- Hair transplant or electrolysis
- Illegal treatments, operations, or drugs
- Insurance premiums
- Long-term care
- Vitamins
- Weight reduction programs for general well being

CLAIMS FILING

FILING A REIMBURSEMENT CLAIM

You may manage your reimbursements through the PayFlex app or online at www.payflex.com. To receive reimbursement of eligible expenses, you may also submit a claim form to PayFlex through the mail or by fax. The address and number to submit claims this way is available by accessing your PayFlex account online.

PayFlex will issue you a reimbursement as soon as administratively possible after receiving a properly submitted claim with the required information included.

You must attach a statement from an independent third-party stating that the medical care expenses have been incurred and the amount of such expenses, and that the medical expenses have not been reimbursed or are not reimbursable under any insurance or other plan. You will be reimbursed by the Claim Administrator as soon as administratively possible after you submit a properly completed claim form with the required information attached.

You must file all claims for eligible expenses incurred during a Plan year and up through the Grace Period no later than April 30 following the last day of the Grace Period. After April 30, any remaining balance in your account from the prior Plan year will be forfeited.

If you switch to a Limited Purpose Option for a Plan year beginning in 2019 or after, you may continue to submit claims for eligible expenses under the General Purpose Option incurred during the preceding Plan year up through the Grace Period no later than April 30 of the current Plan year, to be reimbursed from your available General Purpose Option amounts for the preceding Plan year.

APPEALING A CLAIM RELATING TO A BENEFIT

PayFlex is the Claim Administrator who will review your health care flexible spending account claims. Upon receipt of a claim for benefits, the Claim Administrator will review the claim and render a decision within 30 days. This period may, for reasonable cause, be extended for up to an additional 15 days, in which case, you will be notified of the extension. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information. If the claim is denied, in whole or in part, you will receive a written decision explaining why it was denied, including reference to the specific provisions of the Plan on which the denial is based, explaining your right to request that the Claim Administrator review the decision, a description of additional information needed and why the information is needed, a description of the Plan's appeal procedures and deadlines, a statement of your right to sue under ERISA Section 502(a) following a denial on appeal and any other information required by law.

If a claim is denied and a review is desired, you must notify the Claim Administrator in writing within 180 days of the receipt of notice of denial. In requesting a review, you may review the Plan or any document relevant to your claim and submit any written issues and comments you deem appropriate. A document is relevant if it was relied on in making the claim decision; was submitted, considered, or generated in making the decision; demonstrates compliance with the Plan's procedural and administrative safeguards or is a policy statement on how the Plan handles treatment claims for your diagnosis. The Claim Administrator shall then review the claim by considering all submitted information without deference to the initial decision. The appeal will be performed by an impartial fiduciary, who may not be the person that made the initial decision or that person's subordinate. The Claim Administrator will provide a written decision within 60 days. The decision, if adverse, will state the specific reason for the decision, include reference to specific provisions of the Plan on which the decision is based, a statement that you may obtain all relevant records for free; a statement of your right to sue under ERISA Section 502(a) and any other information required by law. The decision will also include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency." The Claim Administrator's decision on review is the final decision on your claim.

Effective January 1, 2019, any claim that you may have relating to or arising under the Plan may only be brought in the US District Court for the Eastern District of Missouri. No other court is a proper venue for your claim. The US District Court for the Eastern District of Missouri will have personal jurisdiction over you and any other participant or beneficiary named in the action.

APPEALING A CLAIM RELATING TO ELIGIBILITY, ENROLLMENT OR CHANGES IN ENROLLMENT.

If your claim relates to an eligibility decision (such as the status of a child as a full-time student) or to an enrollment issue (such as your choice of benefit options during open enrollment), you should address your request to the Plan Administrator at:

Vice President of Human Resources
Bunge North America, Inc.
1391 Timberlake Manor Parkway
Chesterfield, MO 63017

You will be notified in writing of the decision on your claim within 15 days of receipt of your claim. This period may be extended one time for up to 15 days, if an extension is necessary due to matters beyond the control of the Plan. If this occurs, you will be notified, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

If the decision is a denial of your claim, the written notice will give specific reasons for the denial and reference the specific plan provisions on which the denial is based. It will also describe any additional material necessary for you to resubmit your claim and explain the Plan's claim review procedures and your right to bring a civil action under law.

Within 180 days after your receipt of the written notice of a claim denial, you or your authorized representative may submit a written request for reconsideration to the address above. Be sure to state why you believe the claim should not have been denied and submit any data, questions or comments you think are appropriate. You may also review any pertinent Plan documents or other documents relevant to your claim. Your claim will be reviewed by a Plan official or committee who is not the individual who made the initial decision or the subordinate of that individual.

A decision on the appeal will be made within 30 days after receipt of your request for review. The decision on review will be in writing and will include the specific reasons for the decision as well as specific references to the appropriate plan provisions on which the decision is based and any other information required by law. This is the final decision on your claim.

OTHER ADMINISTRATIVE INFORMATION

WHEN COVERAGE ENDS

Your Eligibility Booklet describes in detail the dates and circumstances under which your coverage under this Plan will end. Your Eligibility Booklet also describes the special COBRA and other Plan provisions that may permit you to continue coverage. COBRA continuation coverage is available for the Plan only in very limited circumstances. You will be notified if COBRA applies to your health care flexible spending account in the event you experience a qualifying event.

ADMINISTRATIVE INFORMATION

Information about many subjects relating to the administration of this Plan may be found in your Eligibility Booklet. Subjects discussed in that Booklet include the rights of your employer and the Claim Administrator to interpret the Plan; your rights under the federal law known as ERISA, including your right to appeal any claim that has been denied; the employer's right to amend or terminate the Plan; and other important administrative information about the Plan.