

BUNGE
EMPLOYEE WELFARE BENEFIT PLAN
ELIGIBILITY AND ADMINISTRATIVE
BOOKLET

As Amended and Restated effective January 1, 2024

Bunge
Employee Welfare Benefit Plan
Eligibility and Administrative Booklet

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Bunge
Employee Welfare Benefit Plan
Eligibility and Administrative Booklet

INTRODUCTION

This booklet is intended for hourly employees of Bunge employed at the Cairo, Illinois facility who are represented by the collective bargaining unit between Bunge and United Steelworkers, Paper and Forestry, Rubber, Manufacturing, Energy, Allied-Industrial and Service Workers International Union AFL-CIO-CLC, on behalf of Local #7-1538. It provides information about who is eligible to participate in the company's health and welfare benefit program including your medical (including prescription), dental, vision, long-term disability, short-term disability, health care flexible spending account, dependent care flexible spending account, critical illness, hospital stay, accidental injury, employee assistance program, identity protection, legal, life and accidental death and dismemberment (AD&D) insurance. This booklet contains information on when coverage under the individual plans begins, ends and continues, individual plan enrollment procedures, coordination of benefits and administrative procedures that apply to most of the individual plans.

This booklet, along with separate booklets describing various health, life and other programs, serves as a summary plan description (SPD). It serves as one of the official plan documents but is not intended to replace any other official plan documents, such as insurance contracts, which govern in the event of any conflict.

ELIGIBILITY — WHO IS ELIGIBLE TO PARTICIPATE

EMPLOYEE

You are eligible to participate in the health and welfare program if you are classified on your employer's records as a full-time hourly employee represented by the collective bargaining unit between Bunge and United Steelworkers, Paper and Forestry, Rubber, Manufacturing, Energy, Allied-Industrial and Service Workers International Union AFL-CIO-CLC, on behalf of Local #7-1538. To be considered a full-time employee, you must be regularly scheduled to work at least 30 hours per week.

Contingent workers, temporary employees (regardless of length of service with the employer), part-time employees, independent contractors and employees of other organizations, sometimes called leasing companies, are not entitled to benefits described in this booklet. For purposes of the health and welfare program, your classification on your employer's records, not your actual status, determines your eligibility. You must be in the classification described above to be eligible.

An individual who is not eligible for benefits described in this booklet may be eligible for separate programs described in other booklets. If you are not sure which programs apply to you, contact your local human resources representative or the Corporate Benefits Department in St. Louis. For a list of participating employers, see the last page of this booklet.

DEPENDENTS

If you are enrolled in a benefit option under the plan, you may also enroll your eligible dependents in that option, to the extent applicable:

- your lawful spouse (see below)
- your child from birth to age 26 regardless of financial dependency or student or marital status
- your child of any age who is dependent on you for support because of a disability which occurred prior to age 26

An insured benefit offered under the Plan may allow enrollment of a dependent who does not otherwise meet the definition of an eligible dependent under the Plan, including a domestic partner. Please refer to the certificates for the insured benefits for additional information.

Spouse Rules

Common-law spouses (unless your state recognizes common-law marriages), ex-spouses, girlfriends, boyfriends, domestic partners* (of the same or opposite sex) or anyone else to whom you are not currently married cannot be carried as a dependent. Your marriage to an individual of the same or opposite sex must have been registered and solemnized by a person authorized by law to solemnize marriages or otherwise specifically sanctioned under current state law. If you enroll a non-qualifying individual as your spouse, disciplinary action up to and including discharge may be taken by your employer. You may be asked to complete documentation or otherwise satisfactorily demonstrate your marital status.

*A domestic partner is not eligible for any benefits under the Welfare Benefit Plan, except that you may enroll a domestic partner in the Accidental Injury, Critical Illness or Hospital Care Plans. During the dependent audit process, you will be required to provide proof of your domestic partnership.

If Both You and Your Spouse Work for Participating Employers

If you and your spouse work for or are retired from a participating employer and are both eligible for a health care plan, these rules apply:

- each of you may enroll separately; however, an employee may not be covered as both an employee and a dependent.
- one of you may waive coverage while the other selects family coverage.
- Dependent children may only be enrolled by you or your spouse, not both.

Eligible Child

An eligible child is your biological child, your stepchild, your adopted child, a child placed 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. You may request a copy of the Plan's written procedures for medical child support orders from the Corporate Benefits Department in St. Louis. A foster child is not eligible for coverage. Grandchildren cannot be covered unless the grandchild otherwise qualifies under this section. The eligible child does not have to be a student, live with you, be dependent upon you for financial support, or be unmarried. However, the spouse of your child is not eligible to be enrolled in the plan. You may be asked to provide proof of dependency for any child you wish to cover as a dependent.

Disabled Child

When a disabled child reaches age 26, you may apply for continued health benefits. 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. You must submit the proper form, available from your claims administrator, signed by a doctor certifying the child's disability. In addition, the child must be unable to hold a self-sustaining job and be dependent on you for support. To qualify for consideration, this form must be submitted to the Corporate Benefits Department in St. Louis within 31 days of the date of your child's 26th birthday or your first day of eligibility as an employee, whichever is later. If approved, the health coverage continues as long as the disabled child meets these requirements.

Dependent Certification

With respect to each dependent (other than your spouse) whom you enroll in a benefit under the Plan which is a group health plan (medical (and prescription), dental, vision), you must notify the company if you are not eligible to have the value of the dependent's coverage excluded from your income. In general, tax preferred treatment of benefits is available for your dependents who are your "qualifying child" or "qualifying relative," as described in Section 152 of the Internal Revenue Code, or (to the extent not covered under those definitions) your son, daughter, stepson or stepdaughter until they attain age 26, as described in Section 105(b) of the Internal Revenue Code. Please note that these tax definitions apply only for purposes of determining whether the cost of coverage for a dependent is taxable or nontaxable. In order for a dependent to be eligible for coverage under the Plan, he or she must satisfy the applicable definition in the Plan. Please refer to the section of this Booklet entitled, "Eligibility – Who is Eligible to Participate" to determine if a dependent is eligible under the Plan.

ENROLLMENT

When you become eligible for coverage, you will decide which of your dependents will be covered and choose among any plan options available at your location. Enrolled dependents must participate in the same health plan option as you. By using the enrollment system, you authorize any applicable payroll deductions for the coverage you have elected.

You will be required to provide proof of dependent status with a certified birth certificate, certified marriage license, adoption certificate, adoption placement papers, court orders and other required documents to complete the enrollment.

INITIAL ENROLLMENT

To enroll yourself and your eligible dependents, you must use the enrollment procedures described in your enrollment package. Dependents must be enrolled when you enroll or when they first become eligible, whichever is later. If you do not enroll in the medical (and prescription), dental, vision, spending accounts, long-term disability, identity protection, legal, critical illness, accidental injury, or the hospital stay plan within 31 days of your initial enrollment opportunity, you and your dependents will not be covered. For long-term disability coverage, if you do not enroll when you are first eligible and wish to enroll sometime in the future, you will be required to provide Evidence of Insurability to the appropriate Insurance Carrier and will only be enrolled in the plan if they approve your application.

It is not necessary to enroll in the short-term disability, employee assistance, basic life insurance, or basic accidental death and dismemberment or dependent life insurance programs. You will have opportunities to enroll in other programs as shown below. If you have questions, contact the benefits department.

For medical (and prescription), dental, vision, critical illness, accidental injury and the hospital stay plans you have five enrollment choices:

- employee only
- employee plus spouse
- employee plus child or children
- family coverage
- no coverage

For the legal plan, only a family tier is available, and for identity protection, you have the following enrollment choices: employee only or family.

BENEFITS ELECTED OR PROVIDED DURING INITIAL ENROLLMENT – WHEN COVERAGE BEGINS

Benefit	Effective Date for New Employees	Effective Date for Enrolled Dependents
Medical (and Prescription), Dental and Vision	Date of hire	Date your coverage begins or date they legally become your dependents, if later
Basic Life and Accidental Death and Dismemberment Insurance and Dependent Life Insurance	Date of hire	Dependent life insurance is effective the date your coverage begins or the date they legally become your dependents, if later.
Short-Term Disability	60 days after date of hire	N/A
Long-Term Disability	1 st of the month after 90 days	N/A
Dependent Care and Health Care Flexible Spending Accounts	Date of hire	N/A
Identity Protection	Date of hire	Date your coverage begins or date they legally become your dependents, if later
Legal	Date of hire	Date your coverage begins or date they legally become your dependents, if later
Critical Illness, Accidental Injury and Hospital Stay	Date of hire	Date your coverage begins or date they legally become your dependents, if later
Employee Assistance Program	Date of hire	Date your coverage begins or date they legally become your dependents, if later

ANNUAL OPEN ENROLLMENT

In the fall of each year you will have the opportunity to enroll or disenroll yourself and eligible family members for coverage for the following calendar year. At that time, you will also choose among any plan options available at your location. This is referred to as the “open enrollment” period throughout this booklet.

You cannot change your election outside of open enrollment unless you have a change in status or are entitled to a special enrollment opportunity. Changes in status are described in the section entitled “Change in Status.” Special enrollment rights are described in the section entitled “Special Enrollment Rights.”

If you decline enrollment under the medical (and prescription), dental or vision programs for yourself, your spouse or your dependents because of other health insurance coverage, you may in the future be able to enroll yourself, spouse or your dependents in these programs. You must request this special enrollment within 31 days after such other coverage ends.

If you do not enroll during an open enrollment period for the upcoming year, your elections in effect on December 31 for medical (and prescription), dental, vision, long-term disability, identity protection, legal, critical illness, hospital stay and accidental injury coverages will be carried over to the following year with any applicable changes in contribution rates unless the open enrollment communications require re-enrollment (normally required if there is a change in vendors for any of the plans listed above). Dependent Care and/or Health Care Flexible Spending Accounts and the Health Savings Account require re-enrollment every year. If you do not affirmatively enroll in the Dependent Care and/or Health Care Flexible Spending Accounts or the Health Savings Account, you will be treated as having elected not to participate in those options.

BENEFITS ELECTED DURING OPEN ENROLLMENT- WHEN COVERAGE BEGINS

Benefit	Effective Date for Employees	Effective Date for Enrolled Dependents
Medical (and Prescription), Dental and Vision	January 1	January 1
Long-Term Disability	January 1 or after evidence of insurability is approved by the carrier, whichever is later.	January 1 or after evidence of insurability is approved by the carrier, whichever is later.
Dependent Care and Health Care Flexible Spending Accounts	January 1	N/A
Health Savings Account	January 1	N/A
Identity Protection	January 1	January 1
Legal	January 1	January 1
Critical Illness, Accidental Injury and Hospital Stay	January 1	January 1

CHANGE IN STATUS

Enrollment changes during the calendar year may be made if you have a change in status. For most enrollment changes, you have 31 days from the date of the status change. For a birth, adoption, placement for adoption or obtainment of legal guardianship or custody of a child, you are allowed 60 days from the date of the status change. In addition, for the first six status changes listed below, the enrollment change must be consistent with the status change. An enrollment change will only be considered to be consistent with the applicable changes in status if the enrollment change is on account of and corresponds with a change in status that affects eligibility for coverage under this program or another employer plan. An enrollment change will be effective on the date the change in status occurs. Changes in status include:

- marriage, divorce or annulment
- addition of a child through birth, adoption, placement for adoption, legal guardianship or custody
- death of your spouse or dependent
- change in employment status of you, your spouse or your dependent, including termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or a change that affects eligibility under this program or another plan
- any change in your child's eligible dependent status
- a change in the place of residence of you, your spouse or dependent that affects your coverage eligibility
- a qualified medical child support order that requires you to provide medical coverage for a child or that requires your spouse, former spouse or another individual to provide medical coverage for the child if that coverage is actually provided
- you and/or your family member becomes eligible, or loses eligibility, for Medicare or Medicaid
- a significant increase or decrease in your cost for any benefit
- a change in coverage, including a significant curtailment of coverage under this program, the addition or significant improvement of a benefit, a change that corresponds with a permissible change under another employer plan, or the loss of health coverage sponsored by a governmental or educational institution
- a leave of absence or return from leave under the Family and Medical Leave Act

The company may add a dependent child to your coverage and/or change your coverage option, without your consent, if necessary to comply with a qualified medical child support order. If so, you would be responsible for any applicable contribution increase resulting from such an addition or change. The company's procedures governing medical child support orders will be provided to you free of charge at your request from the Corporate Benefits Department in St. Louis.

You will be required to provide proof of dependent status with a certified birth certificate, certified marriage license, adoption certificate, adoption placement papers, court orders and other required documents to complete the enrollment.

You may make a change in your long-term disability insurance enrollment prior to the next open enrollment period if you have a change in status, but the change will be approved only if you comply with the carrier's evidence of insurability requirements.

SPECIAL ENROLLMENT RIGHTS

If you decline enrollment under the medical (and prescription), dental or vision programs for yourself, your spouse, or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself, your spouse, and your eligible dependents in these programs if you or they lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' coverage). You must request this special enrollment within 31 days of the date your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you acquire a new dependent as a result of marriage, you may submit a change of coverage through the Enrollment System within 31 days of the date of the marriage. If you acquire a new dependent as a result of a birth, adoption, placement for adoption or obtainment of legal guardianship or custody of a child you have 60 days to submit the change. As a result of one of these events you may enroll yourself (if not currently enrolled) and your dependents in coverage. A telephone contact will not be sufficient to add a newly eligible dependent.

If you enroll your new dependent within 31 days or 60 days for a birth, adoption, placement for adoption or obtainment of legal guardianship or custody of a child, he or she will begin participating in the medical (and prescription), dental or vision programs on the date of becoming a dependent. If you do not enroll a new dependent in these programs within 31 days or 60 days for a birth or adoption, placement for adoption or obtainment of legal guardianship or custody of a child, you will only be able to enroll the dependent during the next open enrollment period. The effective date of coverage will be the open enrollment effective date.

If you or your dependents who are eligible for coverage under the terms of the Bunge group health plan but are not enrolled in that plan either:

- lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you or your dependents are no longer eligible for that coverage, or
- become eligible for a state's premium assistance program, with respect to coverage under the Bunge group health plan, under Medicaid or CHIP,

You will have 60 days from the date of either the termination of Medicaid/CHIP coverage, or the date of determination of eligibility for premium assistance, to request enrollment in the Bunge group health plan. Note that this 60-day period does not apply to enrollment opportunities other than the Medicaid/CHIP changes described herein.

You will be required to provide proof of dependent status with a certified birth certificate, certified marriage license, adoption certificate, adoption placement papers, court orders and other required documents to complete the enrollment.

MEDICAID

When enrolling an individual as an eligible employee or eligible dependent in a medical plan or in determining or making any payments for benefits under a medical plan, the fact that the individual is eligible for or is provided benefits through Medicaid shall not be taken into account. In addition, payment of benefits will be made in accordance with any assignment of rights made by or on behalf of an eligible Participant or eligible dependent under the medical plan as required by Medicaid.

PLAN OPTIONS UNDER THE HEALTH, DISABILITY AND LIFE PROGRAMS

YOUR HEALTH OPTIONS (MEDICAL (AND PRESCRIPTION), DENTAL AND VISION)

You may have medical (and prescription), dental and vision plan choices. You will choose among the health options available at your location and benefits will be provided according to your selection. The same health plan options will apply to all enrolled family members unless one or more are eligible for Medicare. The company may change your enrollment of dependents and choice of available health plans without your consent if necessary to comply with a qualified medical child support order or as necessary to make the order administratively feasible under our programs.

A general comparison of your health options is available from the Corporate Benefits Department in St. Louis. More detailed descriptions of your plans are available in the summary plan descriptions.

YOUR LIFE, ACCIDENTAL DEATH & DISMEMBERMENT, SHORT-TERM DISABILITY, CRITICAL ILLNESS, ACCIDENTAL INJURY, HOSPITAL STAY, IDENTITY PROTECTION AND LEGAL INSURANCE

You are automatically covered by the basic life, basic accidental death and dismemberment and short-term disability plans. Your spouse and your dependents are automatically covered under the dependent life insurance plan. These plans are provided at no cost to you.

No elections are required from you, however designation of a beneficiary for the life and accidental death and dismemberment coverages is required.

Critical illness, accidental injury, hospital stay, identity protection and legal coverage is available to you and your spouse and dependents. You will pay the entire cost of this coverage on an after-tax basis if elected.

YOUR LONG-TERM DISABILITY OPTION

You may choose to be covered under the long-term disability insurance plan. Required contributions will be deducted from your paycheck on an after-tax or pre-tax basis, as you choose. The implications of contributing each way are described in the enrollment materials for the long-term disability plan. Changes to long-term disability contribution elections can be made outside of open enrollment only if you experience a qualifying change in status and comply with the carrier's evidence of insurability requirements.

YOUR SPENDING ACCOUNT AND SAVING ACCOUNT OPTIONS

You may elect to have a portion of your paycheck credited to a Health Care Flexible Spending Account, a Dependent Care Flexible Spending Account and/or a Health Savings Account. Your designated amounts will be deducted from your paycheck on a pre-tax basis.

SEPARATE BOOKLETS

Each of the programs listed above is fully described in a separate booklet.

PAYING FOR THE PLAN

EMPLOYEE CONTRIBUTIONS FOR MEDICAL (AND PRESCRIPTION) AND DENTAL BENEFITS

Currently the company pays a portion of the cost for medical (and prescription) and dental coverage for you and your dependents. For details of the cost sharing arrangement, please see your Collective Bargaining Agreement.

You and the company will share the cost of coverage under the medical (and prescription) and dental plans. You will pay for coverage with pre-tax dollars as long as permitted by law. These pre-tax contributions are deducted from your paycheck before federal income tax, social security tax, and (in most cases) state or local income taxes. The amount of your contribution may change annually and will depend on the medical and dental plan options you select and which dependents you cover. You will be told the amount of your contribution before you make your enrollment decisions.

The medical plan is self-insured. In other words, benefits are paid with Bunge dollars rather than with an insurance company's funds. The company has arranged for insurance companies, acting as claims administrators, to oversee payment of medical (and prescription) and dental claims. In addition to the claim payments, the company pays an administrative fee to the administrators.

EMPLOYEE CONTRIBUTIONS FOR OTHER BENEFITS

Your employer currently pays the entire cost of your benefits under the basic life insurance, basic accidental death, dependent life insurance, short-term disability and employee assistance programs. If you choose long-term disability coverage, vision, critical illness, accidental injury, hospital stay, identity protection or legal coverage you pay 100% of the cost for this insurance. Contributions for the vision plan are taken on a pre-tax basis. Critical illness, accidental injury, hospital stay, identity protection and legal insurance for you and your dependents is taken on a post-tax basis. Long-term disability deductions can be taken on either a pre-tax or post-tax basis, as you choose. If you choose to participate in the Health Care Flexible Spending Accounts, the Dependent Care Flexible Spending Account and/or the Health Savings Account, the amounts you elect to contribute will be deducted from your paycheck on a pre-tax basis.

CONTRIBUTIONS DURING A LAYOFF OR MEDICAL OR FAMILY CARE LEAVE OF ABSENCE

Contributions are required during a layoff or certain leaves of absence. If you are receiving a paycheck from Bunge while you are on leave, all benefit deductions will be continued unless you otherwise elect to discontinue coverage as permitted by the Plan. If you do not receive a regular paycheck when you are on a layoff or leave of absence, no deductions are taken during the leave. Deductions will be held in arrears up to a maximum of 26 weeks or until your return to work.. If you are eligible to retain benefit coverage during your leave in excess of 26 weeks, you are required to make monthly payments to Bunge for your portion of any benefit premiums on the first of the month for which benefits are continued. E.g. premiums for February insurance, must be paid by February 1. If payment is not made within a maximum of thirty (30) days following the due date, coverage will end as of the last day for which a timely payment was received.

Upon return, your deductions will be doubled each pay period until the arrears balance is paid off. If you do not return to work, you will need make the necessary payment to Bunge.

If contributions are not submitted for any reason on a timely basis as described above, coverage for you and your enrolled dependents will be cancelled as described below.

TIMELY PAYMENT OF CONTRIBUTIONS

If you are an active employee, your deductions held in arrears will begin when you return to active status.

If you are not returning to work, you must make the necessary payment to Bunge within thirty (30) days of your termination. If you are unable to make the necessary payment within the required timeframe, you must contact Bunge prior to the end of the thirty (30) day period to make necessary arrangements. If payment or an arrangement is not made, coverage will end as of the last day for which a timely payment was received.

CLAIMS AND APPEAL PROCEDURES

CLAIMS AND APPEALS

Unique claims and appeals procedures apply to the individual benefit programs described in separate booklets. Please refer to these materials for details about filing a claim for benefits or appealing a denial. Follow the directions on the explanation of benefits or denial of benefits you received from the claims administrator for filing an appeal.

CLAIMS AND APPEALS RELATED TO ELIGIBILITY, ENROLLMENT AND CHANGES IN ENROLLMENT

If your claim relates to an eligibility decision or to an enrollment issue (such as your choice of benefit options during open enrollment), you should address your request to:

Sr. Director of Total Rewards
Bunge North America, Inc.
1391 Timberlake Manor Parkway
Chesterfield, Missouri 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 nor 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.

HEALTH CARE COORDINATION OF BENEFITS

In many families, especially if both husband and wife work, family members may be covered by more than one group health care plan. Each plan pays benefits, but the Plans coordinate their payments so that the total payments are not more than 100% of the allowable expenses. Allowable expenses mean any necessary, reasonable and customary charge for medical (and prescription) or dental care or services covered by either one or both plans. Allowable expenses do not include the difference between the cost of a private hospital room and the cost of a semiprivate hospital room unless the stay in the private room is medically necessary.

Group Health Care Plan

For coordination of coverage, a group health care plan includes:

- group policies or plans, whether insured or self-insured
- government-sponsored programs
- employer-sponsored or association-sponsored plans
- a plan that is arranged through a trust or union
- a prepayment plan such as an HMO
- individual no-fault auto insurance

The Bunge medical plans and most other plans have coordination of benefits (COB) rules which determine the sequence of payments. Under these rules, one plan has primary responsibility and pays first as if the other plan did not exist. The other plan has secondary responsibility and pays benefits for any remaining covered expenses up to that plan's limitations.

If the Plan is secondary, the amount payable by the Plan is calculated without considering the other plan. The benefit payable is then reduced by benefits paid by the primary plan and only the difference is paid. If primary insurance pays more than the Bunge plan would have paid if it were primary, nothing is payable from the Bunge plan.

If none of the following rules can be used to establish the order of benefit payment, the benefit plan that has covered the patient for the longer period is primary. If the other plan has no COB rules, it always pays first.

ORDER OF PAYMENT

The chart shows which plan is designated as primary or secondary under applicable COB rules. These rules apply, for example, when a husband and wife work for different employers and have a child or children covered under both employer plans.

Claimant	Primary Plan	Secondary Plan
Husband	Husband's	Wife's
Wife	Wife's	Husband's
Child	Parent whose birthday is earliest in the year*	Other parent's
* This assumes both plans have adopted this rule. If not, and the other plan has a rule based on the gender of the parent and the Plans therefore do not agree on the rules, then the rule in the other plan will determine the order of benefits.		

If the parents of a covered dependent child are divorced or separated, the Plan of the parent who has responsibility for health care expenses for that child under a court decree is primary. If the decree does not establish responsibility, the Plan of the parent with custody is primary.

If there is no decree specifying responsibility for health care expenses, and the parent with custody remarries, that parent's plan remains primary, the stepparent's plan is secondary, and the non-custodial parent's plan pays third.

If the specific terms of a court decree state that the parents have joint custody, without stating that one parent is responsible for the child's health care expenses, the Plans covering the child follow the ordering rules that apply for a child whose parents are not separated or divorced.

If you are covered by another group health care plan as an active employee and you have coverage under a Bunge plan as a former, retired, inactive or laid-off employee, if applicable, the other plan pays first for health care expenses.

Medical coverage under a Bunge plan will be secondary to coverage under any automobile insurance contract issued under any law requiring coverage regardless of fault. If an employee or covered dependent elects that medical coverage under a no-fault automobile insurance policy be secondary to medical coverage under the Bunge plan, that election will be disregarded in all respects for purposes of determining the benefits payable under the Bunge plan. Proof of auto insurance payment or denial and deductible amount must be submitted along with the actual bills.

Some plans contain unique provisions that state they will never pay benefits first. In this case, the Bunge plan will pay benefits only after the other plan pays all of its benefits.

SUBMITTING CLAIMS FOR COORDINATION OF BENEFITS

If the Bunge plan is secondary for the claim you are filing, submit the claim to the patient's primary plan first. Attach the Explanation of Benefits (EOB) sheet you receive from the primary plan to the claim form you submit for benefits from the Bunge plan along with a copy of the itemized bill.

If the coverage described in this booklet is secondary, and the claim has not been considered by the primary plan, the claim will be denied. Of course, if information about benefit payment or coverage is later supplied, the claim can be reconsidered.

COORDINATION WITH HMOs

Coordination of benefits with HMOs works differently than described earlier in this section due to the prepaid nature of the Plan. Benefits are not usually coordinated for services such as physician office visits, prescription drug co-payments or services paid at 100%.

If the HMO is the secondary carrier and you wish to pursue coordination of benefits, you should follow all HMO rules as if the HMO was primary. For example, you must coordinate your care through your primary care physician, obtain the proper referrals and receive services from the required HMO participating providers. To process a request for payment, you may be required to obtain special billing statements which are not otherwise available. If a charge is associated with this, it is your financial responsibility.

You may want to contact your HMO to determine how to maximize your benefits.

COORDINATION WITH MEDICARE

The Bunge medical plans pay benefits in accordance with the Medicare Secondary Payer requirements of federal law.

Active Employees

If you are covered as an active employee under a Bunge plan and are eligible for Medicare, the Bunge plan will pay benefits first for you and your dependents. You have the right to refuse coverage under the Bunge plan at any time. In that case, Medicare will pay benefits first and all coverage under the Bunge medical plan for you and your dependents will end.

If you are covered by Medicare due to treatment of end-stage renal disease, the Bunge plan automatically pays first for the period of time specified by law, after which Medicare assumes primary responsibility.

Active Employees with Dependents who are Eligible for Medicare

If you are an active employee with a spouse or other dependent eligible for Medicare, benefits for the Medicare-eligible dependent will be coordinated with the Bunge plan responsible as the primary plan.

Your dependents who are eligible for Medicare have the right to refuse coverage under the Bunge plan. In that case, Medicare will pay benefits first and all coverage under your Bunge medical plan will end.

Important – Medicare Enrollment Requirements

When the Bunge medical plan pays benefits first, without regard to Medicare, and the Participant wants Medicare to pay after the Bunge plans, the Participant must enroll for Medicare Parts A and B and Medicare Part D (when available). If the Participant does not enroll for Medicare when he or she is first eligible, the Participant must enroll during the special enrollment period which applies to that person when the person stops being eligible under this Plan.

When Medicare pays benefits first, benefits available under Medicare are deducted from the amounts payable under the Bunge plan, whether or not the person has enrolled for Medicare. If Medicare pays first, the Participant should enroll for both Parts A and B of Medicare and Part D of Medicare (when available) when that Participant is first eligible; otherwise, the expenses may not be covered by the Bunge plan or Medicare.

How the Bunge Plan Pays When Medicare is Primary

If Medicare pays benefits first, the Bunge plan pays benefits as described below. This method of payment only applies to Medicare eligibles. It does not apply to any Participant unless that Participant becomes eligible under Medicare and Medicare is the primary payer.

The amount of charges for covered expenses under the Bunge plan is determined first. However, the amount of covered expenses is based on the amount of charges allowed under Medicare rules instead of the reasonable charges as defined by the Bunge plan. Then the amount payable under Medicare for the same expenses is subtracted from the amount of covered expenses. This Plan pays the difference between the two amounts.

The amount payable under Medicare which is subtracted from the Bunge plan's benefits is determined as the amount that would have been payable under Medicare when Medicare is primary even if:

- The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B and Medicare Part D (when available).
- The person is enrolled in a managed Medicare (Medicare Part C) plan and receives non-covered, out-of-network services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and Medicare Part D (when available).
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if: (i) the services were covered under Medicare Parts A and B and Medicare Part D (when available); and (ii) the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.

- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B and Medicare Part D (when available).

Government Plans (Other Than Medicare and Medicaid)

If the Participant is also covered under a government plan, the Bunge plan does not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to that Participant under the government plan.

This provision does not apply to any government plan which by law requires the Bunge plan to pay primary.

A government plan is any plan, program, or coverage, other than Medicare or Medicaid, which is established under the laws or regulations of any government, or in which any government participates other than as an employer.

WHEN COVERAGE ENDS

This section of your booklet describes when coverage for you or your family members ends. It also provides information about your right under the federal law known as COBRA to continue health care coverage by paying the full cost of coverage. Your right, where available, to convert medical and life insurance coverage to an individual policy is also described in this section.

EMPLOYEES

As a participating employee, your coverage under the Plans referred to in this booklet ends at midnight on the earliest of the following dates:

- the date your employment with a participating employer ends for any reason
- you cease active work unless coverage is continued as described in the section entitled “When Coverage Continues”
- you are no longer eligible for coverage as described in this booklet
- you die
- the date the availability of the specific plan ends for any reason
- the last day of the period for which required contributions were made on a timely basis

DEPENDENTS

Coverage for your dependents ends at midnight on the earliest of the following dates:

- your coverage ends
- you die
- a family member is no longer eligible for coverage as described in this booklet
- the last day of the period for which contributions were made on a timely basis
- the date the availability of the specific plan ends for any reason
- your child who turns 26

WHEN COVERAGE CONTINUES

LEAVES OF ABSENCE AND LAYOFF

Coverage under the Plans referred to in this booklet continues for you and your covered family members during:

- an authorized medical leave of absence due to a non-occupational injury or illness up to a maximum of 26 weeks, or local benefit eligibility period, whichever is greater, following the date the authorized leave related to such injury or illness begins.
- an authorized medical leave of absence due to an occupational injury or illness up to a maximum of 26 weeks, or local benefit eligibility period, whichever is greater, following the date the authorized leave related to such injury or illness begins.
- an authorized Family and Medical leave of absence for up to 12 weeks.
- An authorized leave of absence, not described above, up to a maximum of 26 weeks or local benefit eligibility period, whichever is greater.

For any other type of absence, except for military service as described below, coverage ends on your last day of active work. Continued coverage during a layoff or medical leave of absence will end before the prescribed time period if you die, retire, go to work for another employer, become self-employed or otherwise lose coverage under such leave of absence plan or program. Additional COBRA continuation rights for you and your covered dependents are described later in this booklet.

MILITARY SERVICE

During a qualifying absence for military service up to 31 days, coverage under the Plans referred to in this booklet continues for you and your covered family members as long as any required contributions are made as described earlier in this booklet.

During a qualifying absence for military service exceeding 31 days, you may choose to continue medical coverage for you, your spouse and your covered family members by paying the full cost. Medical coverage may continue for up to 24 months following the date your qualifying absence commences or, if less, until the day after the date on which you fail to apply for or return to active employment with the company. You will also be entitled to coverage under the other plans referred to in this booklet on the same terms and conditions generally provided to eligible employees on a leave of absence.

CONTINUING YOUR HEALTH CARE COVERAGE UNDER COBRA

When coverage ends, you, your spouse and your covered children may be eligible to continue health care coverage by paying the full cost. You may choose to continue medical (and prescription), dental and/or vision coverage under the provisions of COBRA, the Consolidated Omnibus Budget Reconciliation Act of 1985. If you participate in the Health Care Flexible Spending Account Plan (“Health FSA”), and you have received reimbursements during the Plan Year which are less than the amount credited to your account under the plan, you will be able to continue coverage under that plan until the end of the Plan Year. If your reimbursements during the Plan Year exceed the amount credited to your account, COBRA continuation will not be available to you for the Health FSA.

A COBRA enrollment form will be sent directly to the person eligible for this continued coverage. The enrollment form includes information about your rights to continue coverage and the cost of this coverage. To notify the company of your intent to continue coverage, you must return the completed form to the COBRA administrator within 60 days as described in your COBRA notification letter. Then, you have 45 days to pay the initial required premium retroactive to the date coverage was lost. If the initial contribution is not made within the required time frame, you lose your right to continue coverage. Subsequent monthly payments are due on the first of each month and must be postmarked within 30 days after the first day of each month. If you fail to make any monthly payment before the end of the 30-day grace period, you will lose all rights to COBRA continuation coverage.

The following chart describes events that end coverage for you or your family, and how long COBRA coverage can be continued.

If Coverage Ends Because	Coverage Can be Continued from the Date Coverage Ends for*
Your employment ends for any reason (other than gross misconduct) or your hours are reduced so that you are no longer a full-time employee	Up to 18 months for you and/or your covered family members, or up to 36 months from your 65 th birthday for covered family members if you are age 65 or older when coverage ends, whichever is longer
You die	Up to 36 months for your covered family members; a family member must notify the company within 60 days of your death
You divorce	Up to 36 months for your covered family members; you or a covered family member must notify the company within 120 days of the date of your divorce order or decree
You become entitled to Medicare	Up to 36 months for your covered family members; you or a family member must notify the company within 60 days of the date you become entitled to Medicare

If Coverage Ends Because	Coverage Can be Continued from the Date Coverage Ends for*
Your covered child no longer qualifies for coverage	Up to 36 months for the child; you or a family member must notify the company within 60 days of when your child no longer qualifies for coverage
Your employment is terminated or hours reduced, and you or a covered family member qualify for Social Security disability benefits within the first 60 days of COBRA continuation coverage	Up to a total of 29 months for the disabled person and any covered family members; you or a family member must notify the company before the end of the first 18 months and within 60 days of qualifying for Social Security disability coverage

* Continuation coverage under the Health Care Flexible Spending Account Plan, when available, can only be in effect until the end of the current Plan Year.

ADDITIONAL COBRA CONTINUATION RIGHTS

You or a covered family member may elect up to 18 months of continued coverage if your employment ends or your hours are reduced. You or a covered family member may also elect an additional continuation period of up to 18 months, if during the initial continuation period:

- you die
- your child no longer qualifies for coverage
- you become entitled to Medicare
- you divorce

To be eligible for the additional continued coverage, it is your (or a covered family member's) responsibility to notify the company by contacting your local human resources representative or the Corporate Benefits Department in St. Louis within 60 days of the first three events listed above or within 120 days of the date of the divorce order or decree in the case of your divorce.

SPECIAL COBRA CONTINUATION RIGHTS

Special COBRA continuation coverage rights apply to individuals (“TAA Eligible Employees”) who lose health coverage as a result of a termination or reduction of hours and who qualify for a “trade readjustment allowance” or “alternative trade adjustment assistance” under a federal law known as the Trade Act of 1974. If you are a TAA Eligible Employee, you are entitled to a second opportunity to elect COBRA continuation coverage for yourself and certain family members (if COBRA continuation coverage was declined when first offered) during a special second election period. If you are or may be a TAA Eligible Employee, contact the Plan Administrator for additional information. You must contact the Plan Administrator immediately after becoming a TAA Eligible Employee or you will lose your special COBRA continuation coverage rights.

WHEN COBRA CONTINUATION COVERAGE ENDS

Coverage stops before the end of the continuation period if:

- the required premium is not paid on a timely basis
- the company no longer offers health coverage to its employees
- you or a dependent become entitled to Medicare
- you become covered by another group health plan

If you or a dependent continues coverage due to a qualified Social Security disability, coverage ends as soon as one of the above events occurs. Coverage will also end the first day of the month following 30 days after you or your dependent is no longer considered disabled by Social Security.

Continuation coverage may also be terminated for any reason the medical Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

When your maximum COBRA continuation period ends, there are no conversion policies available.

PAYING FOR COBRA CONTINUATION COVERAGE

Generally, you or your covered family members, as qualified beneficiaries, will be required to pay the entire cost of the continuation coverage. The amount you or any other qualified beneficiary may be required to pay may not exceed 102% of the cost to the medical Plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. This percentage is increased to 150% in the case of an extension of COBRA continuation coverage due to a disability.

The Trade Act of 2002 created a new tax credit for certain individuals who become TAA Eligible Employees. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282.

CONVERTING COVERAGE TO AN INDIVIDUAL POLICY

HEALTH COVERAGE AND LONG-TERM DISABILITY COVERAGE

There are no medical (and prescription), dental, vision or long-term disability conversion policies available.

LIFE, ACCIDENTAL DEATH & DISMEMBERMENT, CRITICAL ILLNESS, ACCIDENTAL INJURY, HOSPITAL STAY, IDENTITY PROTECTION AND LEGAL COVERAGE

You can replace your life, accidental death and dismemberment, critical illness, accidental injury, hospital stay, identity protection and legal coverages with individual policies in certain circumstances. See your separate benefit booklets for details.

PRIVACY OF YOUR PERSONAL HEALTH INFORMATION

In addition to this summary plan description booklet and the related booklets describing the medical, dental and other plans, there are also other formal documents that govern the Plan's operation. One of these is the Bunge Employee Welfare Benefit Plan. Among other subjects, one topic covered is how the company, as administrator of the medical plan(s), will use and disclose certain information that may be considered "Protected Health Information" under the federal law known as HIPAA. This law provides comprehensive requirements concerning your protected health information.

These rules are briefly summarized here but are described in further detail in the "Notice of Privacy Practices" you received from the Plan. You may obtain another copy of the Notice by contacting the Corporate Benefits Department in St. Louis. You may also obtain a copy of the Bunge Employee Welfare Benefit Plan in the same manner.

The company is permitted to use and disclose your protected health information without your consent or authorization, as necessary, to carry out its duties in administering the Plan. For example, the company may obtain data on your health claims and provide it to third parties so that bids can be obtained for plan insurance programs. Individuals employed by the company may obtain your health information from you or from others to assist you in obtaining a benefit.

The company and the Plan will comply with a law that requires a disclosure of your health information, such as a court order or subpoena. The company is not permitted, however, to use any protected health information it obtains from the Plan to make any employment-related decision.

Please review the Notice of Privacy Practices for a more complete discussion about how the Plan and the company may use your protected health information and disclose it to third parties.

ADMINISTRATIVE INFORMATION

This section of your booklet contains important administrative information and information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA applies to the benefits referred to in this booklet to the extent described in the separate series of booklets for that particular benefit. This section also describes the legal rights held by these ERISA benefit programs, the insurance companies through which some benefits are underwritten and Bunge North America, Inc.

INTERPRETATION OF THE PLAN

As plan administrator, the company has complete discretion to interpret the Plan provisions and determine who is eligible for coverage under the programs referred to in this booklet. Any ambiguous or incomplete term will be interpreted by the company except where this responsibility has been delegated to a claims administrator.

The claims administrators under each program have complete authority and discretion to determine the proper payment of any claim or to make any related determination under that program. In determining the right of any covered person to a benefit for which the Plan purchases insurance, such as life insurance, the insurance company, rather than the company, will make final benefit determinations.

AMENDMENT OR TERMINATION

Currently, the company pays a portion of the cost for many of the benefits for you and your dependents. The company reserves the right to add to or change the amount of your contributions, premiums, co-payments, deductibles and/or co-insurance at any time.

While the company expects to continue indefinitely the coverages referred to in this booklet, it reserves the right to amend or terminate these coverages at any time, including after your retirement, for any reason. The Vice President, Human Resources, of Bunge North America, Inc. and any other designated individual is authorized to change these plans on behalf of the company. The company also reserves the right to increase, decrease or otherwise change any feature of this Plan at any time. The company reserves these rights subject to any applicable collective bargaining agreement.

ASSIGNMENT OF BENEFITS

Most benefits payable under the separate benefit programs may be assigned to the provider of services or supplies at your option. Payments made in accordance with an assignment are made in good faith and discharge the Plan's obligation to the extent of the payment.

The claims administrator may also honor benefit assignments made prior to your death in relation to the remaining benefits payable by the Plan. Any payment made by the Plan in accordance with this provision will fully release the Plan of its liability to you.

FACILITY OF PAYMENT

In plans that reimburse you for covered expenses, reimbursements are ordinarily payable to you and may only be paid directly to another party upon signed authorization from you. If, in the opinion of the claims administrator operating under the authorization of the Plan, conditions exist under which a valid release or assignment cannot be obtained, payment may be made to any individual or organization that has assumed the care or principal support for you or is otherwise equitably entitled to payment. In addition, payments may be made to any other party as required to comply with applicable law and any court order. Any payment made by the Plan in accordance with this provision will fully release the Plan of its liability to you.

SUBROGATION AND THIRD-PARTY PROVISION

When this provision applies: If you, your covered dependent or anyone who receives benefits under this Plan becomes ill or is injured and is entitled to receive money from any source, including but not limited to any party's liability insurance and uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the Bunge medical plan are secondary, not primary, and will be paid only if the covered person fully cooperates with these terms and conditions.

As a condition of receiving benefits under a Bunge medical plan, the covered person agrees that acceptance of benefits is constructive notice of this provision in its entirety and acknowledges and agrees that the Plan's right of subrogation extends to the full amount of benefits that the Plan has paid or is obligated to pay on your behalf or behalf of your dependent, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, and without regard to whether such recovery has made you and/or your dependent whole for the injuries suffered. The person receiving benefits further acknowledges and agrees that any funds received by:

1. such person
2. his or her attorney; and/or
3. any other person or entity on behalf of, or for the benefit of the covered person or as a result of the illness or injury of you or another covered person;

From any source for any purpose shall be held in constructive trust by such person or entity for the benefit of the Plan until such time as the obligation under this provision is fully satisfied. If the covered person retains an attorney, then the covered person agrees to only retain one who will not assert the common fund or made-whole doctrines.

If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

The covered person agrees to sign any documents requested by the Plan including but not limited to reimbursement and/or subrogation agreements as the Plan or its agent(s) may request. Also, the covered person agrees to furnish any other information as may be requested by the Plan or its agent(s). Failure or refusal to execute such agreements or furnish information shall not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be

utilized or applied to the Plan's subrogation interest. Any excess after full satisfaction of the Plan's subrogation interest may be divided up between the covered person, his or her attorney and/or any other person or entity entitled to such funds. Any accident-related claims made after satisfaction of this obligation shall be paid by the covered person and not the Plan.

The covered person agrees to take no action which in any way prejudices the rights of the Plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against the covered person (and/or any other person who or entity which receives the funds on behalf of, or for the benefit of, the covered person or as a result of the employee's or covered person's illness or injury), then the individual or entity against whom or which the action is initiated by the Plan shall pay the Plan's attorneys' fees and costs associated with the action regardless of the action's outcome. In the event that the covered person, including, without limitation, an attorney representing the covered person, fails to honor the Plan's subrogation interest in full or takes any action to prejudice the Plan's right of subrogation, the Plan may deny payment on future claims to the extent of its subrogation claim.

If the covered person takes no action to recover money from any source, then the covered person agrees to allow the Plan to initiate its own direct action for reimbursement.

CLAIMS OF CREDITORS

To the extent permitted by law, neither the benefits nor payments under the Plan will be subject to the claims of creditors or to any legal process by any creditor of the covered individual or beneficiary. The Plan will comply, however, with the terms of any qualified medical child support order.

RECOVERY OF EXCESS PAYMENTS

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of the benefit plans, the Plans have the right to recover excess payments from any individual, insurance company or other organization to whom excess payments were made. The excess payments must be refunded to the Plans. If the excess payments are due from another individual, insurance company or other organization, the covered person agrees to help the company get the refund when requested. The Plans also have the right to withhold payment of future benefits due under the Plan(s) until the overpayment is recovered. The Plans may have other rights in addition to the right to reduce future benefits.

If benefits are paid under the Plans for expenses incurred on account of a covered person, that covered person or any other individual or organization that was paid must make a refund to the Plans if all or some of the expenses did not legally have to be paid by the covered person.

RECOVERY OF ERRONEOUS PAYMENTS

Whenever it is determined that any payments under a benefit Plan should have been paid by another plan or organization or person, the Plan may recover the amount paid from the other plan or organization or person.

PAYMENT ADJUSTMENTS

When payments should have been made under any of the benefit plans, but were already paid under some other plan, the Plan will have the right to make payment to the other plan.

ERISA RIGHTS

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and 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. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare 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 the 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 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, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN IDENTIFICATION

NAME OF PLAN

The name of the Plan is the Bunge Employee Welfare Benefit Plan.

COST TO EMPLOYEES

Participating employers presently pay most of the cost of the Plan. You will receive written notice of the cost to participate. Participating employers reserve the right to add or change the amount of your contributions or increase, decrease or otherwise change any feature of this Plan at any time subject to any applicable collective bargaining agreement. Changes may also be made after your retirement.

PLAN SPONSOR

Bunge North America, Inc.
1391 Timberlake Manor Parkway
Chesterfield, Missouri 63017
(314) 292-2000

EMPLOYER IDENTIFICATION NUMBER (EIN)

The employer identification number is 13-4977260.

PLAN NUMBER

The Plan number is 501.

TYPE OF PLAN

This is an employee welfare benefit plan that provides medical (and prescription), dental, vision, life, disability, accidental death and dismemberment, critical illness, accidental injury, hospital stay, identity protection, legal, commuter reimbursement, and health care flexible spending, and dependent care flexible spending account coverages. Different employee groups may be eligible for selected programs only.

TYPE OF ADMINISTRATION

The Plan is administered by the company, insurers and third-party plan administrators. Claims are processed by third-party administrators or the applicable insurer.

PLAN ADMINISTRATOR

Bunge North America, Inc.
1391 Timberlake Manor Parkway
Chesterfield, Missouri 63017
(314) 292-2000

CLAIMS ADMINISTRATORS

Claims administrators are identified in the separate benefit booklets.

PLAN ASSETS

The benefits provided under the Plan are paid from general assets of Bunge North America, Inc. Some coverages are secondarily funded through the purchase of insurance contracts or through other group benefit arrangements.

AGENT FOR SERVICE OF LEGAL PROCESS

Bunge North America, Inc.
1391 Timberlake Manor Parkway
Chesterfield, Missouri 63017
Attention: General Counsel
(314) 292-2000

PLAN YEAR

The Plan year is January 1 through December 31.

PARTICIPATING EMPLOYERS

Employees of Bunge North America, Inc. participate in this Plan as well as employees of additional participating employers. For a complete list of participating employers, contact the Plan Administrator in writing. Not all employees of a participating employer are eligible to participate and different groups of employees have different programs available to them. This is intended to be only a general description of the covered groups. Each group may have further requirements for participation, such as classification as a full-time employee. For those employees to whom this eligibility booklet does not apply, the separate eligibility booklet should be consulted for a complete description of covered employee groups and programs offered.