SCHREIBER FOODS INC

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN

SUMMARY PLAN DESCRIPTION

EFFECTIVE January 1, 2026

I. INTRODUCTION

Schreiber Foods Inc ("Schreiber Foods") has established the Schreiber Foods Inc Health Reimbursement Arrangement (HRA) Plan ("Plan"), a group health plan, for the benefit of its eligible employees. This Summary Plan Description ("SPD") briefly describes the basic features of the Plan, the eligibility rules, the expenses that qualify for reimbursement, and other important information concerning the Plan. This is followed by the Claims and Appeals Procedures, a description of your rights under ERISA, a general notice of COBRA Continuation Coverage Rights, and the Plan's Notice of Privacy Practices.

There is also a written Plan document that serves as the formal Plan rules, a copy of which you may obtain upon request. In the event there is a conflict between this SPD and the Plan document, the Plan document will control. You should direct any questions you have to Schreiber Foods.

II. DEFINITIONS

Carrot. Carrot Fertility, Inc., (or its successor) and its affiliates and subsidiaries.

Claims Administrator. The entity designated by the Employer to administer claims. Carrot Fertility, Inc. is the Plan's Claims Administrator.

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985, and Treasury Regulations and guidance issued thereunder, as amended.

Code. The Internal Revenue Code of 1986, as amended, and Treasury Regulations and guidance issued thereunder.

Covered Expense. A medical expense that is incurred by a Participant or Qualified Beneficiary, or their eligible spouse (who must be enrolled in Schreiber Foods Inc's medical plan), for care described in Appendix C to the Plan ("Covered Expenses"). Subject to any exceptions permitted by Carrot policy, prescription pharmacy expenses are not Covered Expenses unless incurred using Carrot Rx Services.

Effective Date. January 1, 2026.

Eligible Employee. An Employee who is enrolled in Schreiber Foods's medical plan.

Employer. Schreiber Foods.

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

Participant. An individual who is an Eligible Employee.

Period of Coverage. January 1, 2026 - December 31, 2026. Any subsequent Period of Coverage is each 12-month period beginning on January 1.

Plan. The Schreiber Foods Inc Health Reimbursement Arrangement (HRA) Plan, and any modification, amendment, extension or renewal thereof.

Plan Administrator. Schreiber Foods, notwithstanding that certain administrative functions for the Plan may be delegated to another entity or individual.

Plan Sponsor. The Employer.

Qualified Beneficiary. A Participant in the Plan, or a Participant's spouse who was covered under the Plan on the day before a qualifying event that provides such individual an opportunity to continue Plan coverage under COBRA, provided such individual (a) elects COBRA coverage under the Plan and timely pays the applicable COBRA premium, and (b) elects COBRA coverage under a group health plan sponsored by the Employer that meets the requirements of Treasury Regulation §54.9815-2711(d)(2)(ii) and timely pays the applicable COBRA premium for such coverage.

III. PLAN INFORMATION

A. Plan Sponsor and Plan Administrator

The Plan is sponsored by Schreiber Foods, which also serves as the Plan Administrator. The Plan Administrator administers the Plan and has full and sole discretionary authority to administer the Plan, to interpret all Plan provisions and to determine all issues arising under the Plan, including issues of eligibility, coverage and benefits. The decision of the Plan Administrator on any construction, interpretation, or administration shall be final, conclusive, and binding on all persons having an interest in or under the Plan.

The Plan Administrator's failure to enforce any provision of the Plan shall not affect its right to later enforce that provision or any other provision of the Plan. The Plan Administrator may delegate some of its administrative duties, and such delegation includes discretionary authority unless that authority is specifically limited in the delegation. The Plan Administrator has delegated to the Claims Administrator responsibility for the adjudication and processing of Participant claims and appeals.

You may contact the Plan Administrator for any further information about the Plan at:

Schreiber Foods Inc
400 N Washington St, Green Bay, Wisconsin 54301, US
Phone: (920) 437-7601
Federal ID: 39-1017450

The Plan Administrator is the Plan's agent for service of legal process.

B. Eligibility and Participation

Only Eligible Employees and Qualified Beneficiaries may participate in the Plan. Any person who does not meet the definition of an Eligible Employee or a Qualified Beneficiary will not be entitled to any benefits under the Plan.

If you are a Participant, you and your spouse must provide the Plan Administrator, or the Claims Administrator, if applicable, with any information reasonably requested for the administration of the Plan. You and your spouse must notify the Plan Administrator if you divorce or terminate your partnership.

C. Cost of Coverage

Except with respect to COBRA, the Plan Sponsor pays the cost of coverage under the Plan. All reasonable expenses incurred in administering the Plan are paid by the Employer.

D. Termination of Participation

Except for continuation coverage as may be provided under COBRA, participation in the Plan terminates upon the earlier of:

a. The effective date of termination of the Plan;
b. The date on which a Participant is no longer an Eligible Employee; or
c. The date on which a Participant has received reimbursements for Covered Expenses for themselves and their eligible spouse that meets the lifetime maximum.

If an Eligible Employee who is an employee of the Employer permanently terminates his or her employment and then is rehired by the Employer and again becomes a Participant in the Plan, the Lifetime Maximum Benefit for such Participant will be reduced by all amounts previously reimbursed under the Plan and any family forming benefits offered by the Employer.

E. Funding

All benefits under the Plan will be paid by Schreiber Foods from its general assets. Participant contributions to the Plan are not permitted, except with respect to COBRA coverage.

F. Plan Benefits

Surest Participants: For each Period of Coverage, a Participant who is not concurrently enrolled in a high-deductible health plan ("HDHP") within the meaning of Code section 223(c)(2) with a health savings account ("HSA") within the meaning of Code section 223(d) is eligible to receive reimbursement of Covered Expenses incurred on and after the Effective Date of the Plan until the Participant's participation in the Plan terminates, after the Participant has satisfied a $1,000 minimum deductible of Covered Expenses, and subject to a maximum lifetime limit of $20,000.

High-Deductible Health Plan Participants: For each Period of Coverage, a Participant who is concurrently enrolled in a HDHP with an HSA is eligible to receive reimbursement of Covered Expenses incurred on and after the date the Participant has incurred medical expenses within the definition of Code section 213(d) in excess of the applicable health plan deductible, subject to a maximum lifetime limit of $20,000.00.

A Qualified Beneficiary is eligible to receive reimbursement of Covered Expenses as provided under COBRA.

NOTE: If you terminate your employment and then are rehired and again become a Participant in the Plan, the lifetime maximum benefit for you will be reduced by all amounts previously reimbursed under the Plan and any other Carrot benefit reimbursements.

The limits on benefits under the Plan may be changed by Schreiber Foods and any changes will be communicated to Eligible Employees.

Duplication of benefits is not permitted for a spouse each employed by the Company.

Additional details about the benefits provided under the Plan are available at get-carrot.com.

G. Circumstances that May Limit, Terminate, or Reduce Benefits

The Claims Administrators and the Plan Administrator have the right to repayment if they overpay a claim for any reason or pay a claim in error and may offset other Plan benefits to recover the overpayment amount as permitted under applicable law. Benefits may be limited, reduced or terminated in the case of an Eligible Employee's fraud or intentional misrepresentation, or as required to comply with legal requirements applicable to the Plan.

H. Corrections

If you are overpaid benefits from the Plan, you are obligated to immediately notify the Plan Administrator of the overpayment and return the overpaid amount to the Plan. The Plan Administrator has the right to increase or decrease any benefits or collect previously paid benefits if, after payment was made, an error in pertinent information or a mistake in payment is discovered. The Plan possesses a lien on any amounts paid but not owed under the terms of the Plan in the amount of the overpayment plus interest, and has the authority to take whatever action is necessary to enforce the Plan's lien on the overpayment.

I. Indemnification

If you receive one or more payments or reimbursements in connection with the Plan that appeared to be, but are not, reimbursable under the Plan, you must indemnify and reimburse the Employer for any liability the Employer incurs for failure to withhold income or Social Security tax from those payments or reimbursements. However, any such indemnification and reimbursement will not be greater than the following: the additional income tax that you would have owed if the payments or reimbursements had been made to you as regular cash compensation, plus your share of any Social Security tax that would have been paid on that compensation, less any such additional income and Social Security tax actually paid by you.

J. Amendment and Termination; Reservation of Rights

Schreiber Foods, in its sole discretion, may amend or terminate all or any part of the Plan. Any Covered Expenses incurred after the effective date of the Plan's termination will not be reimbursed under the Plan.

IV. CLAIMS

A. Claims Processing

The Claims Administrator is the Plan's named fiduciary for claims and appeals. The Claims Administrator has full and sole discretionary authority to determine all claims and appeals and decisions of the Claims Administrator are conclusive and binding. Carrot is the Plan's Claims Administrator and is responsible for the adjudication and processing of Participant reimbursement claims.

Only Covered Expenses will be reimbursed under the Plan. To receive a reimbursement under the Plan for a Covered Expense, you must upload a paid statement or superbill from a qualifying provider approved

by Carrot via the Carrot online platform. Claims must be filed by 90 days following the end of each Period of Coverage to receive reimbursement of eligible Covered Expenses incurred in the previous Period of Coverage, unless the Participant terminates employment prior to the end of a Period of Coverage (and he or she only has until 30 days following their termination date to submit eligible claims for reimbursement). An expense is incurred at the time the care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the service.

No reimbursements will be made for Covered Expenses incurred after participation in the Plan terminates. A Participant may submit a claim for reimbursement of any Covered Expense incurred during the Period of Coverage immediately prior to termination of participation in the Plan, within 30 days after the Participant's termination.

Claims for reimbursement must include:

1. the name of the individual(s) for whom a Covered Expense was incurred;
2. the nature and date of the Covered Expense incurred;
3. the amount of the requested reimbursement; and
4. a statement that such Covered Expense has not otherwise been reimbursed and is not reimbursable through any other source and that you will not request reimbursement from any other source.

You are entitled to notification of the decision on your claim within 30 days after the Claims Administrator's receipt of the claim. This 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Claims Administrator, including in cases where a claim is incomplete. The Claims Administrator will notify you of the need for the extension and the time by which you will receive a determination on your claim. If your claim does not include the required information or does not follow the Plan's procedures for filing claims, the Claims Administrator will notify you within 30 days of the informational or procedural deficiency and how it may be cured. You will be given 45 days after such notice to submit the additional information. If you do not submit the additional information, the Claims Administrator will make the decision based on the information that it has.

If your claim is approved, you will be paid by automated clearing house ("ACH") payment pursuant to the claims processing schedule agreed to by Schreiber Foods and Carrot.

B. Denied Claims

If your claim is denied, the notice that you receive from the Claims Administrator will include the following information:

(a) The specific reason for the denial;
(b) A reference to the specific Plan provision(s) on which the denial is based;
(c) A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
(d) The Plan's appeal procedures and the time limits applicable to such procedures and the Claimant's right to bring a civil action under ERISA if the appeal is denied;
(e) If an internal rule, guideline, protocol, or similar criteria was relied upon in denying the claim, either a copy of the specific rule, guideline, or protocol, or a statement that such a

rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and

(f) If the denial is based on experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your circumstances, or a statement that such explanation will be provided free of charge upon request.

C. Appeal Procedures

You have the right to appeal the Claims Administrator's denial of your claim. Your appeal must be in writing, must be provided to the Claims Administrator, and must include the following information:

(1) Your name and address;
(2) The fact that you are disputing a denial of a claim or the Claims Administrator's act or omission;
(3) The date of the notice that the Claims Administrator informed you of the denied claim; and
(4) The reason(s), in clear and concise terms, for disputing the denial of the claim or the Claims Administrator's act or omission.

You should also include any documentation that you have not already provided to the Claims Administrator. Your appeal must be delivered to the Claims Administrator within 180 days after receiving the denial notice or the Claims Administrator's act or omission. If you do not file your appeal within this 180-day period, you lose your right to appeal.

At any time before the appeal deadline, you may submit copies of all relevant documents, records, written comments, and other information to the Claims Administrator. The Plan is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your appeal, the Claims Administrator will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

The appeal determination will not afford deference to the initial claim denial and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal nor a subordinate of that individual. If deciding an appeal that is based in whole or in part on a medical judgment, the Claims Administrator will consult with an independent health care professional that is qualified in the areas of dispute and was not involved in the initial claim denial. Upon request, the Claims Administrator will provide the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, even if the advice was not relied upon in making the benefit determination.

You will receive notification of the decision on your appeal within 60 days after receipt of your request for review.

If your appeal is denied, the notice that you receive will include the following information:

(1) The specific reason for the denial upon review;
(2) A reference to the specific Plan provision(s) on which the denial is based;
(3) A statement providing that you are required to receive, upon request and free of charge, reasonable access to any document (a) relied on in making the determination, (b) submitted,

considered or generated in the course of making the benefit determination, (c) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied appeal without regard to whether the statement was relied on;

(4) If an internal rule, guideline, protocol, or similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, or protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request;

(5) If the adverse determination is based on experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to your circumstances, or a statement that this will be provided to you free of charge upon request; and

(6) A statement describing your right to bring a civil action under ERISA § 502(a), including notice of the Plan's limitations period for bringing a civil action.

PLEASE NOTE: A civil action related to a claim for benefits may not be filed unless and until you have exhausted the claims and appeal process described above and must be filed within one year from the date on which the Claims Administrator provides notice that your appeal has been denied, regardless of any state or federal statutes establishing provisions relating to limitations of actions. Any claim for benefits that you may have relating to or arising under the Plan may only be brought in the U.S. District Court for the Northern District of California. No other court is a proper venue or forum for your claim. The U.S. District Court for the Northern District of California will have personal jurisdiction over you and any other participant or beneficiary named in the action.

V. YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including copies of the latest updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

Continue health care coverage for yourself or your spouse if there is a loss of coverage under the Plan as a result of a qualifying event. You or your spouse 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.

Prudent Actions by Plan Fiduciaries

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

otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the Plan's claims and appeals procedures.

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.

VI. MISCELLANEOUS

A. Non-Discrimination Requirements

The Plan must comply with applicable non-discrimination requirements under Code section 105(h). If you are deemed to be a "highly compensated employee," reimbursements to you may be limited or treated as taxable compensation by Schreiber Foods so that the Plan as a whole does not unfairly favor those who are highly paid. You will be notified of these limitations if you are affected.

B. Governing Law

The Plan is intended to comply with applicable provisions of the Code and ERISA. This SPD shall be construed and reformed as necessary to meet these laws as applicable. Except as described in this document, no one may rely on any statement or representation that alters, modifies, amends, or is inconsistent with the written terms of the official governing plan document. This is true regardless of whether the statement or representation is oral, written, electronic, or otherwise.

The laws of the State of California shall apply to the Plan unless preempted by federal law.

C. COBRA

An Eligible Employee who participates in the Plan, and any spouse of an Eligible Employee who participates in the Plan, who is a "qualified beneficiary" within the meaning of COBRA, and whose coverage terminates under the Plan because of a "qualifying event" within the meaning of COBRA, will be given the opportunity to continue the Plan coverage that they had on the day before the qualifying event for the periods prescribed by COBRA, if the Qualified Beneficiary (i) elects COBRA coverage under this Plan and under a group health plan sponsored by the Employer, that meets the requirements of Treasury Regulation §54.9815-2711(d)(2)(ii) and (ii) timely pays the applicable COBRA premium for such coverage. The Plan Administrator will determine the COBRA premium each year. See Appendix A for more information about COBRA.

D. No Employment Rights Conferred

Participation in the Plan does not give you the right to employment with Schreiber Foods.

E. No Guarantee of Tax Consequences

Neither Schreiber Foods nor the Claims Administrator make any commitment or guarantee that any amounts paid to or for the benefit of a Participant or Qualified Beneficiary under this Plan will be excludable from their gross income for federal, state, or local income tax purposes. It is the obligation of the Participant or Qualified Beneficiary to determine whether each payment under this Plan is excludable from their gross income for federal, state, and local income tax purposes.

VII. EXECUTION

This Plan has been established by: _____ ,
dated December 7, 2025 .

APPENDIX A – GENERAL NOTICE OF COBRA COVERAGE CONTINUATION RIGHTS THROUGH CARROT

Introduction
You're getting this notice because you recently gained coverage under the Plan. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your partner, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This notice is based on the model COBRA general notice published by the U.S. Department of Labor and includes general information about COBRA for group health plans that typically provide a wider range of benefits than your Carrot group health plan.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and your partner when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You and your partner could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced from your spouse.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

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

For all other qualifying events (divorce of the employee and spouse), you must notify the Plan Administrator within 30 days of the qualifying event occurring. This notice must be done through a Workday life event, and event verification must be provided within the same 30 day period (event date being day 1 of 30).

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouse.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your eligible family members may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Notice of such disability must be provided to the Plan Administrator and must include your full name, the name of the disabled individual, and the date of disability.

Second qualifying event extension of 18-month period of continuation coverage
If your partner experiences another qualifying event during the 18 months of COBRA continuation coverage, your partner can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension

may be available to your partner getting COBRA continuation coverage if you die or become entitled to Medicare benefits (under Part A, Part B, or both); or if you and your partner get divorced or legally separated. This extension is only available if the second qualifying event would have caused your partner to lose coverage under the Plan had the first qualifying event not occurred. Notice of a second qualifying event must be provided to the Plan Administrator and must include your full name, the name of your partner, and the type and date of the second qualifying event.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your partner through the Health Insurance Marketplace, Medicare, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. Other coverage options that may be available through the Health Insurance Marketplace, Medicare, Medicaid, or other group health plan coverage options (such as a spouse's plan) may not provide the same types of benefits as COBRA coverage under Carrot. You can learn more about many of these options at **www.healthcare.gov**.[1]

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes
To protect you and your partner's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
All inquiries regarding this Notice should be sent to the Plan Administrator.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

APPENDIX B – NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.** This notice is effective as of January 1, 2026.

Summary

Your Rights
You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures
We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Plan Contact Information:
For any inquiries related to this Appendix B, please contact legal@get-carrot.com.

Details

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page B-1.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.
- The complaint should generally be filed within 180 days of when the act or omission complained of occurred.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, and on our web site, or we will mail a copy to you.

APPENDIX C. COVERED EXPENSES

COVERED INFERTILITY CARE EXPENSES

Covered Infertility Care Expenses include procedures and services to overcome an inability to have children as indicated by a medical diagnosis of infertility, or to address other medical necessity.

- Covered Infertility Care Expenses must be recommended and supervised by an eligible provider:
    - Reports to Center for Disease Control and Prevention (CDC) and/or Society for Assisted Reproductive Technology (SART);
    - Have a Medical Director, or practicing staff physician, with Subspecialty Board Certification in Reproductive Endocrinology and Infertility by The American Board of Obstetrics and Gynecology (ABOG) or a physician who meets grandfathered REI criteria set by American Society for Reproductive Medicine (ASRM);
    - Laboratory is appropriately accredited through either the College of American Pathologists (CAP) or The Joint Commission (TJC);
    - Laboratory director must be an Embryology Laboratory Director (ELD), or a High-complexity Clinical Laboratory Director (HCLD); for ELDs or HCLD's being credentialed today, both of which require either an MD or a PhD.
- Examples of covered treatments include, but are not limited to:
    - Fertility consultations;
    - Semen analysis;
    - Fertility preservation for males and females;
    - Genetic testing related to fertility (e.g., PGT-A, PGT-M);
    - Intrauterine insemination;
    - In vitro fertilization;
    - Transportation of reproductive material with an approved vendor;
    - Storage costs for eggs, sperm, and/or embryos;
    - Fertility medications; and
    - Acupuncture (when recommended by an eligible provider).
- Examples of treatments not covered include, but are not limited to:
    - Any expense that is not eligible for reimbursement under Code Section 213(d);
    - Treatment by an ineligible provider;
    - Fertility-related treatments under the care of primary care providers;
    - Herbal treatments;
    - Nutrition counseling;
    - General genetic tests;
    - Physical therapy or fitness-related expenses; and
    - Any expense which is not incurred or submitted in accordance with the Plan.

SCHREIBER FOODS INC

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN

EFFECTIVE January 1, 2026

TABLE OF CONTENTS

ARTICLE I ESTABLISHMENT AND PURPOSE OF THE PLAN

I.01 Establishment of Plan.

Effective January 1, 2026, Schreiber Foods Inc hereby establishes this Health Reimbursement Arrangement ("HRA") Plan (hereinafter "Plan") for the purpose of providing certain benefits to Eligible Employees who become Participants in the Plan.

I.02 Purpose.

a. Tax Treatment

This Plan is intended to qualify as an employer-provided medical reimbursement plan under Internal Revenue Code ("Code") Sections 105 and 106 and regulations issued thereunder, and as a "health reimbursement arrangement" or "HRA" as defined under IRS Notice 2002-45. The Plan will be interpreted at all times to accomplish that objective. Amounts reimbursed under the Plan are intended to be eligible for exclusion from Plan participants' gross income under Code Section 105(b).

b. ERISA Group Health Plan

This Plan document is intended to serve as a written instrument for the Plan as required under Employee Retirement Income Security Act of 1974 ("ERISA") Section 402(a)(1). Notwithstanding the foregoing, or any other provision of the Plan, Carrot itself is not subject to ERISA or any regulations promulgated thereunder except as specifically provided for in this Plan.

ARTICLE II DEFINITIONS

When used in this Plan, the following words and phrases shall have the following meanings:

II.01 Carrot.

Carrot Fertility, Inc., (or its successor) and its affiliates and subsidiaries.

II.02 Claims Administrator.

The entity designated by the Employer to administer claims under Section V.03 of this Plan.

II.03 Claimant.

An individual who makes a claim for reimbursement in accordance with Section V.03 of this Plan.

II.04 COBRA.

The Consolidated Omnibus Budget Reconciliation Act of 1985, and Treasury Regulations and guidance issued thereunder, as amended.

II.05 Code.

The Internal Revenue Code of 1986 as amended, and Treasury Regulations and guidance issued thereunder, as amended.

II.06 Covered Expense.

A medical expense that is incurred by a Participant or Qualified Beneficiary, or their eligible spouse (who must be enrolled in Schreiber Foods Inc's medical plan), for care described in Appendix A to the Plan ("Covered Expenses"). Subject to any exceptions permitted by Carrot policy, prescription pharmacy expenses are not Covered Expenses unless incurred using Carrot Rx Services.

II.07 Effective Date.

January 1, 2026.

II.08 Eligible Employee.

An Employee who is enrolled in Schreiber Foods's medical plan.

II.09 Employer.

Schreiber Foods.

II.10 HIPAA.

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

II.11 HRA.

A health reimbursement arrangement as defined in IRS Notice 2002-45, and related IRS guidance.

II.12 Participant.

An Eligible Employee who has met the eligibility requirements under Section III.01 and commenced participation in the Plan under Section III.02. A Qualified Beneficiary shall also be treated as a Participant for purposes of payment of benefits under Article V, but only to the extent required under COBRA.

II.13 Period of Coverage.

January 1, 2026 – December 31, 2026. Any subsequent Period of Coverage is each 12-month period beginning on January 1.

II.14 Plan.

This Schreiber Foods Inc Health Reimbursement Arrangement (HRA) Plan, as set forth herein, and any modification, amendment, extension or renewal thereof.

II.15 Plan Administrator.

Schreiber Foods, notwithstanding that certain administrative functions for the Plan may be delegated to another entity or individual.

II.16 Plan Sponsor.

The Employer.

II.17 Qualified Beneficiary.

Qualified Beneficiary means a Participant in the Plan, or a Participant's spouse who was covered under this Plan on the day before a qualifying event that provides such individual an opportunity to continue Plan coverage under COBRA, provided such individual (a) elects COBRA coverage under the Plan and timely pays the applicable COBRA premium, and (b) elects COBRA coverage under a group health plan sponsored by the Employer that meets the requirements of Treasury Regulation §54.9815-2711(d)(2)(ii) and timely pays the applicable COBRA premium for such coverage.

ARTICLE III ELIGIBILITY AND PARTICIPATION

III.01 Eligibility for Participation.

Only an Eligible Employee or a Qualified Beneficiary, as defined in Article II, may participate in the Plan. Any person who does not meet the definition of an Eligible Employee or a Qualified Beneficiary will not be entitled to any benefits under the Plan.

III.02 Commencement of Participation.

For Periods of Coverage beginning on and after the Effective Date, all Eligible Employees are Participants in the Plan as of the later of the Effective Date or when they meet the eligibility criteria.

III.03 Termination of Participation.

Except for continuation coverage as may be provided under section V.07 of the Plan, coverage under the Plan will terminate upon the earlier of:

a. The effective date of termination of the Plan;

b. The date on which a Participant ceases to be an Eligible Employee; or

c. The date on which a Participant has received reimbursements for Covered Expenses for themselves and their eligible spouse that, together with amounts reimbursed to the Participant meets the lifetime maximum.

III.04 Participation Following Termination of Employment.

If an Eligible Employee who is an employee of the Employer permanently terminates his or her employment and then is rehired by the Employer and again becomes a Participant in the Plan, the Lifetime Maximum Benefit for such Participant will be reduced by all amounts previously reimbursed under the Plan and any family forming benefits offered by the Employer.

ARTICLE IV FUNDING

a. **Participant Contributions.**

Participant contributions to the Plan are not permitted except as provided in section V.07 in relation to COBRA coverage.

IV.01 Employer Funding.

All benefits under the Plan will be paid by Employer.

IV.02 No Funding under Cafeteria Plan.

Under no circumstances will benefits be funded with salary reduction contributions, employer contributions (e.g., flex credits) or otherwise under a cafeteria plan.

IV.03 Funding of the Plan.

All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no requirement for a trust to be established under the Plan.

ARTICLE V BENEFITS

V.01 Benefits Eligibility.

a. Except as provided in Section V.01(b), a Participant shall be eligible to receive reimbursement of Covered Expenses incurred on and after the Effective Date until the Participant's participation in the Plan terminates under Section III.03. An expense is incurred at the time the care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the service.

b. Surest Participants: For each Period of Coverage, a Participant who is not concurrently enrolled in a high-deductible health plan ("HDHP") within the meaning of Code section 223(c)(2) with a health savings account ("HSA") within the meaning of Code section 223(d) is eligible to receive reimbursement of Covered Expenses incurred on and after the Effective Date of the Plan until the Participant's participation in the Plan terminates, after the Participant has satisfied a $1,000 minimum deductible of Covered Expenses, and subject to a maximum lifetime limit of $20,000.

c. High-Deductible Health Plan Participants: For each Period of Coverage, a Participant who is enrolled a high-deductible health plan within the meaning of Code section 223(c)(2) with a health savings account within the meaning of Code section 223(d) shall be eligible to receive reimbursement of Covered Expenses incurred on and after the date the Participant has incurred medical expenses within the definition of Code section 213(d) in excess of their health plan deductible.

d. A Qualified Beneficiary shall be eligible to receive reimbursement of Covered Expenses as provided under COBRA.

V.02 Benefits Limit.

The Plan will reimburse Covered Expenses up to the Maximum Benefit amount, $20,000 lifetime, described below. No other benefit is provided under the Plan.

a. Maximum Benefit.

The maximum benefit payable for Covered Expenses in any Period of Coverage is $20,000 and shall be reduced by the amount reimbursed to the Participant for any other benefits offered by Schreiber Foods through Carrot.

Duplication of benefits is not permitted for a spouse each employed by the Company.

b. Period of Coverage.

Only expenses incurred by a Participant during a Period of Coverage will be eligible for reimbursement.

c. Changes.

The Maximum Benefit for future Periods of Coverage may be changed by the Employer and shall be communicated to employees.

d. Nondiscrimination.

Reimbursements to highly compensated individuals may be limited or treated as taxable compensation by the Employer to comply with Code §105(h).

V.03 Claims for Reimbursement.

As of the Effective Date, the Plan Administrator has designated Carrot as the Claims Administrator and delegated to the Claims Administrator responsibility for the adjudication and processing of Participant reimbursement claims.

a. Eligible Expenses.

To receive a reimbursement under the Plan, a Participant or Qualified Beneficiary or their eligible spouse must incur an expense that qualifies for reimbursement, i.e. a Covered Expense.

b. Manner of Claim.

A claim for reimbursement shall be made by the Participant or Qualified Beneficiary, or his or her authorized representative ("Claimant"), by uploading a paid statement or superbill from a qualifying provider approved by Carrot via the platform established, or by such other method determined, from time to time, by the Claims Administrator.

c. Time Period for Filing Claims.

Participants shall have until 90 days following the end of each Period of Coverage to submit requests for reimbursement of eligible Covered Expenses incurred in the previous Period of Coverage.

d. Claims Substantiation.

In addition to any other requirements, a claim must set forth:

1. the name of the individual(s) for whom a Covered Expense was incurred;

2. the nature and date of the Covered Expense incurred;

3. the amount of the requested reimbursement; and

4. a statement that such Covered Expense has not otherwise been reimbursed and is not reimbursable through any other source and that Claimant (or Claimant's spouse) will not request reimbursement from any other source.

e. Denied Claims.

Sections V.04, V.05 and V.06, below, apply to denied claims.

f. Reimbursements After Termination.

No Covered Expense incurred after participation in the Plan terminates shall be reimbursed. A Participant (or the Participant's estate) may submit a claim for reimbursement of any Covered Expense incurred during the Period of Coverage immediately prior to termination of participation, by 30 days after the Participant's termination.

V.04 Claims Review and Payment of Benefits.

a. Timing of Claims Review.

1. Within thirty (30) days after receipt by the Claims Administrator of a claim for reimbursement of any Covered Expense, the Claims Administrator will notify the Claimant of its determination of the claim. The 30-day time period may be extended for an additional fifteen (15) days for matters beyond the control of the Claims Administrator, including in cases where a claim is incomplete. The Claims Administrator will provide written notice of any extension, including the reasons for the extension.

2. If the claim does not include substantially all of the information required, or otherwise fails to follow the Plan's procedures for filing claims, the Claims Administrator shall notify the Claimant (or the Claimant's authorized representative) within thirty (30) days of the informational or procedural deficiency and how it may be cured. The Claimant shall be given forty-five (45) days to provide the necessary information.

b. Payment of Benefits.

Reimbursement of approved claims will be paid by automated clearing house ("ACH") payment pursuant to the claims processing schedule agreed to by the Employer and the Claims Administrator.

V.05 Notice of Denied Claims.

Any denial of a claim shall be provided in writing and shall include:

a. The specific reason(s) for the denial;

b. References to the Plan provisions on which the denial was based;

c. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

d. The Plan's appeal procedures and the time limits applicable to such procedures and the Claimant's right to bring a civil action under ERISA if the appeal is denied;

e. If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; and

f. If the denial is based on experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's circumstances, or a statement that such explanation will be provided free of charge upon request.

V.06 Appeal Procedures.

a. Named Fiduciary.

Notwithstanding that Carrot is not subject to ERISA except as specifically provided in this Plan, the Claims Administrator is the "appropriate named fiduciary" under Department of Labor Regulation 2560.503-1(h)(1). As the Plan's named fiduciary for claims and appeals, Carrot has discretionary authority to determine all claims and appeals. The Claims Administrator's determinations shall be final and binding on all persons.

b. Timing of Filing an Appeal.

A Claimant whose claim is denied, in whole or in part, must file a written request for review (appeal) with the Claims Administrator within one hundred eighty (180) days after the receipt of written notice of such denial from the Claims Administrator. If a request for review is not made within the above-referenced timeframe, all rights to an appeal and to file suit in court will be permanently forfeited.

c. Review by Claims Administrator.

The following procedures shall apply to the review of the appeal:

1. The Claimant shall have the opportunity to submit written comments, documents, records, and other information relating to the claim;

2. The Claimant shall 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 (other than privileged documents);

3. The review shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such comments, documents, records, and other information were submitted or considered in the initial benefit determination;

4. The review shall not afford deference to the initial claim denial and shall be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual;

5. In deciding an appeal that is based in whole or in part on a medical judgment, the Claims Administrator shall consult with an independent health care professional that is qualified in the areas of dispute and was not involved in the initial claim denial; and

6. The Claims Administrator shall, upon request, provide for the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

d. Timing of Notice of Decision on Appeal.

If a Claimant appeals, the Claims Administrator shall transmit its written decision of the appeal to the Claimant within sixty (60) days of its receipt of the request for review.

e. Notice of Denial of Appeal.

A notice of an adverse determination on review (denied appeal) shall set forth, in a manner calculated to be understood by the Claimant (or the Claimant's authorized representative):

1. The specific reason(s) for the adverse determination;

2. Reference to the Plan provisions on which the adverse determination is based;

3. A statement that the Claimant (or the Claimant's authorized representative) is entitled to receive without charge reasonable access to any document (a) relied on in making the determination, (b) submitted, considered or generated in the course of making the benefit determination, (c) that demonstrates compliance with the administrative processes and safeguards required in making the

determination, or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied appeal without regard to whether the statement was relied on;

4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request;

5. If the adverse determination is based on experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's circumstances, or a statement that this will be provided without charge on request; and

6. A statement describing the Claimant's right to bring a civil action under ERISA §502(a), including notice of the Plan's limitations period for bringing a civil action.

f. Limitations Period.

Notwithstanding any other provision of the Plan, a civil action related to a claim for benefits may not be filed unless and until you have exhausted the claims and appeal process described above and must be filed within one year from the date on which the Claims Administrator provides notice that the Claimant's appeal has been denied, regardless of any state or federal statutes establishing provisions relating to limitations of actions.

V.07 COBRA.

An Eligible Employee who participates in this Plan, and any spouse of an Eligible Employee who participates in this Plan, who is a "qualified beneficiary" within the meaning of COBRA, and whose coverage terminates under the Plan because of a "qualifying event" within the meaning of COBRA, shall be given the opportunity to continue the Plan coverage that he or she had on the day before the qualifying event for the periods prescribed by COBRA, only if the Qualified Beneficiary elects COBRA, subject to all conditions and limitations under COBRA. However, in the event that such coverage is modified for all similarly-situated non-COBRA Participants prior to the date continuation coverage is elected, such a Qualified Beneficiary shall be eligible to continue the same coverage that is provided to similarly-situated non-COBRA Participants. A premium for continuation coverage shall be charged to the Qualified Beneficiary in such amounts and shall be payable at such times as are established by the Plan Administrator and permitted by COBRA. The Plan Administrator shall determine the COBRA premium annually. The twelve-month determination period begins each January 1 (the calendar year).

ARTICLE VI PLAN ADMINISTRATION

VI.01 Plan Administration.

The Employer is the Plan Administrator and may delegate any duty or power to another entity or individual. The Plan shall be administered for the exclusive benefit of persons entitled to participate in the Plan.

VI.02 Duties of Plan Administrator.

Unless delegated to another person or entity, the Plan Administrator has the duty and full power to administer this Plan.

a. General Powers and Duties.

Except as delegated to the Claims Administrator, the Plan Administrator shall have full and sole discretionary authority to determine all questions concerning the administration, interpretation, and application of the Plan, including full and sole discretionary authority to determine eligibility for benefits and to construe the terms of the Plan. Any such determination by the Plan Administrator made in exercise of its discretionary authority shall be conclusive and binding upon all persons. The discretionary power of the Plan Administrator shall be exercised in a non-discriminatory manner with regard to all similarly situated Eligible Employees or Participants. The Plan Administrator shall be deemed to have properly exercised its authority unless it has abused its discretion hereunder by acting arbitrarily or capriciously.

b. Specific Duties.

The powers and duties of the Plan Administrator include, but are not limited to, the following:

1. To adopt such procedures and regulations as are necessary for the proper and efficient administration of the Plan and consistent with the terms and purposes of the Plan;

2. To request and receive from all Eligible Employees such information as the Plan Administrator will from time to time determine to be necessary for the proper administration of the Plan;

3. To maintain all necessary records for the administration of the Plan; and

4. To comply with any applicable statutory or regulatory requirement under local, state or federal law to disclose or report information about the Plan, Participants, Eligible Employees, or the Employer, and to disclose such information subject to any legal enforcement activity or subpoena.

c. Claims Administration.

As of the Effective Date, the Plan Administrator has delegated to the Claims Administrator responsibility for the adjudication and processing of Participant claims and appeals, limited to the power and duty to:

1. Make any determination as to what constitutes a Covered Expense;

2. Authorize the payments of benefits;

3. Prescribe procedures to be followed and the forms to be used to claim reimbursements pursuant to this Plan; and

4. Review claims or claim denials under the Plan.

d. Payment of Expenses of Administering the Plan.

All reasonable expenses incurred in administering the Plan are paid by the Employer.

VI.03 Indemnification.

To the extent permitted by law, the Claims Administrator shall be indemnified by the Employer against any and all liabilities, losses, damages, costs, and expenses (including legal fees, claims, and expenses) which may be imposed on, incurred by, or asserted against the Claims Administrator by reason of the acts or omissions relating to the duties delegated to the Claims Administrator under the Plan.

VI.04 Corrections.

a. General Rule.

Amounts paid in error belong to the Plan. The Plan Administrator may require an increase or decrease in any benefits or may collect previously paid benefits if, after payment has commenced, any error in any pertinent information or any mistake in payment is discovered.

b. Lien.

The Plan possesses a lien on any amounts paid but not owed under the terms of the Plan in the amount of the overpayment plus interest. The lien is enforceable regardless of the reason for the mistake in payment or the fault or knowledge of the person in possession of the mistakenly paid amount. Any person in receipt of an amount paid but not owed under the Plan has an obligation to immediately notify the Plan Administrator of the overpayment and to promptly return the overpaid amount to the Plan. The lien shall remain in effect until the Plan is repaid in full.

c. Corrective Action.

The Plan Administrator may, on behalf of the Plan, take whatever action is necessary to enforce the Plan's lien on any overpayments. The Plan Administrator has sole discretion to choose the methods for enforcing the Plan's lien. These methods include, without limitation, the Plan's recoupment of the overpayment from future benefit payments, payroll deductions, and a court action seeking imposition of a constructive trust and disgorgement of the overpaid amount plus interest, or any other claim under applicable law.

d. Mistake of Fact.

Any mistake of fact or misstatement of fact, other than benefits paid in error, shall be corrected when it becomes known and proper adjustment shall be made. The Employer and Claims Administrator shall not be liable in any manner for any determination of fact made in good faith.

VI.05 Inability to Locate Payee.

If the Plan Administrator is unable to make payment to any person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such person will be forfeited following a reasonable time after the date any such payment first became due.

VI.06 Appointment of Advisors.

The Plan Administrator may engage the service of advisers, professionals and other persons to help it carry out its responsibilities.

VI.07 Allocation of Responsibility.

Except to the extent required by law, no party acting (or declining to act) shall have any liability for a breach of duty of another party with respect to the Plan.

ARTICLE VII PROTECTED HEALTH INFORMATION

VII.01 Definitions.

Whenever used in this Article, the following terms shall have the respective meanings set forth below. All capitalized terms used but not otherwise defined in this Article VII shall have the same meaning as those terms have under HIPAA and the HITECH Act, including the regulations implementing the privacy and security rules of HIPAA and the HITECH Act.

a. "Health Information" means information (whether oral or recorded in any form or medium) that is created or received by a health care provider, health plan (as defined in 45 CFR § 160.103), employer, life insurer, school or university, or health care clearinghouse (as defined in 45 CFR § 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

b. "Protected Health Information" ("PHI") means Health Information, including demographic information, that is (1) transmitted or maintained in any form or medium, (2) collected from an individual and created or received by a health care provider, health plan, employer, or health care clearinghouse, and (3) identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved. PHI includes electronic PHI ("ePHI") described in 45 CFR §160.103.

c. "Summary Health Information" means Health Information that summarizes the claims history, expenses, or types of claims by individuals for whom the Plan provides benefits, and from which the following information has been removed:

    1. names;

2. geographic information more specific than state;

3. all elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);

4. other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;

5. facial photographs or biometric identifiers (e.g., fingerprints); and

6. any information of which the Plan Sponsor has actual knowledge that could be used alone or in combination with other information to identify an individual.

VII.02 Disclosure of Summary Health Information.

Except as prohibited by 45 CFR §164.502(a)(5)(i), the Plan may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

VII.03 Disclosure of Enrollment Information and PHI.

The Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan. The Plan will disclose PHI to the Plan Sponsor only in accordance with 45 CFR § 164.504(f) and the provisions of this Article.

VII.04 Certification.

This Article shall constitute certification by the Plan Sponsor that this Plan includes the provisions required under 45 CFR § 164.504(f).

VII.05 Plan Sponsor Obligations

With respect to PHI, the Plan Sponsor agrees to:

a. Not use or disclose PHI other than as permitted or required by the Plan document or as required by law;

b. Ensure that any agents to whom the Plan Sponsor provides PHI received from the Plan Administrator agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

c. Not to use or disclose PHI for employment-related actions and decisions unless authorized by the Participant;

d. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the Participant;

e. Report to the Plan any PHI use or disclosure of information that is inconsistent with the uses or disclosures in this Article of which it becomes aware;

f. Make PHI available to the Participant in accordance with 45 CFR § 164.524;

g. Make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;

h. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

i. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining the Plan's compliance with 45 CFR Part 164;

j. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible; and

k. Ensure that adequate separation between the Plan and the Plan Sponsor, as required by this Article and by 45 CFR § 164.504(f)(2)(iii), is established and maintained.

VII.06 Plan Sponsor's Access to PHI.

Adequate separation will be maintained between the Plan and the Plan Sponsor. Therefore, in accordance with HIPAA, only the Plan Administrator may be given access to PHI, and such person or entity may use and disclose PHI only for Plan administration functions that the Plan Sponsor performs.

VII.07 Noncompliance.

If the persons described herein or any other employees do not comply with the Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. The Plan Sponsor shall cooperate with the Plan Administrator to correct and mitigate any such noncompliance.

VII.08 Security of Electronic PHI.

The Plan Sponsor will reasonably and appropriately safeguard electronic PHI ("ePHI") created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the Plan. Specifically, the Plan Sponsor will:

a. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

b. Ensure that the adequate separation between the Plan and Plan Sponsor, as required by this Article and by 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

c. Ensure that any agent to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the ePHI; and

d. Report to the Plan any security incident concerning ePHI of which it becomes aware.

ARTICLE VIII AMENDMENT AND TERMINATION

VIII.01 Amendment.

The Employer may amend all or any part of this Plan at any time for any reason.

VIII.02 Termination.

The Employer reserves the right to terminate or partially terminate the Plan, or discontinue Employer contributions to the Plan at any time. Nothing in the Plan is intended to or will be construed to entitle any Eligible Employee or other person to vested or non-terminable benefits.

VIII.03 Effective Date of Amendment or Termination.

Any such amendment, discontinuance or termination will be effective as of the date the Employer determines.

VIII.04 Limitation of Obligations.

The Employer shall provide all benefits accrued by Eligible Employees under the Plan through its termination. No reimbursements shall be made for Covered Expenses incurred after the effective date of the Plan's termination.

ARTICLE IX MISCELLANEOUS

IX.01 Limitation of Rights.

Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits under the Plan, shall be construed as giving to any Participant or other person any legal or equitable right against the Plan Sponsor, the Employer, the Plan Administrator, the Claims Administrator or the Plan, except as specifically provided in the documents setting forth the Plan.

IX.02 Restriction on Alienation.

The interests of persons entitled to benefits under the Plan are not subject to their debts or other obligations and, except as may be required by the tax withholding provisions of the Code or any state's income tax act, may not be voluntarily or involuntarily sold, transferred, alienated, assigned, or encumbered. In no event shall any health care or other provider be a "participant" or "beneficiary" under the Plan and no such provider shall have standing under ERISA or the claims procedures of this Plan except

as an authorized representative within the meaning of Department of Labor Regulation section 2560.503-1(a)(4), as determined by the Plan Administrator.

IX.03 Facility of Payment.

When any person entitled to benefits under the Plan is disabled or is in any way incapacitated so as to be unable to manage his/her affairs, the Plan Administrator may cause such person's benefits to be paid to such person's legal representative for his/her benefit, or to be applied for the benefit of such person in any other manner that the Plan Administrator determines appropriate.

IX.04 Termination of Coverage.

Coverage under the Plan may be terminated due to fraud or an intentional misrepresentation of material fact, or because the Participant knowingly provided the Plan Administrator or Claims Administrator with false information. Upon 30 days written notice, the Employer has the right to terminate coverage in such circumstances and to seek reimbursement of all expenses paid by the Plan.

IX.05 No Employment Contract.

This Plan is not an employment contract. Any employment rights of an Eligible Employee are neither enlarged nor diminished by the establishment of the Plan.

IX.06 Severability.

If any provision of the Plan is declared invalid or unenforceable by a court or agency of competent jurisdiction, such stricken provision shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

IX.07 Plan Provisions Control.

If any term or provision of any summary or description of this Plan is, in any construction, interpreted as being in conflict with a provision of this Plan, as set forth in this document, the provision of this Plan shall control.

IX.08 Notice.

Any notice to be delivered to a Participant or Qualified Beneficiary under this Plan shall be given in writing and delivered, personally or by first-class mail, postage prepaid, addressed to the Participant at his or her last known address. Any communication addressed to such Participant at the last known address shall be binding upon the Participant for all purposes of the Plan. Notwithstanding the foregoing, a Participant may be provided any notice required under this Plan via electronic delivery, to the extent permitted under ERISA.

IX.09 No Guarantee of Tax Consequences.

Neither the Employer nor the Claims Administrator make any commitment or guarantee that any amounts paid to or for the benefit of a Participant or Qualified Beneficiary under this Plan will be excludable from their gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant or Qualified Beneficiary to determine whether each payment under this Plan is excludable

from their gross income for federal, state, and local income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Qualified Beneficiary is includable in their gross income for federal, state or local income tax purposes, then under no circumstances will the recipient have any recourse against the Employer, the Plan Administrator or the Claims Administrator with respect to any increased taxes or other losses or damages suffered by the Participant or Qualified Beneficiary as a result thereof.

IX.10 Gender/Number.

Whenever any words are used in this Plan in the masculine gender, they should be construed as though they were also used in the feminine gender in all situations where they would so apply; wherever any words are used in this Plan in the singular form, they should be construed as though they were also used in the plural form in all situations where they would so apply, and vice versa.

IX.11 Applicable Laws.

Except to the extent superseded by the laws of the United States, this Plan and all rights and duties thereunder shall be governed, construed, and administered in accordance with the laws of the State of California.

IX.12 Forum Selection.

Any court action must be brought in the U.S. District Court of the Northern District of California.

IX.13 Headings.

The headings and subheadings of this Plan have been inserted for convenience of reference only and are to be ignored in any construction of the provisions hereof.

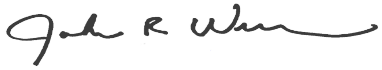
IX.14 No Waiver of Terms.

No term, condition or provision of the Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of the Plan except by written agreement of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

CERTIFICATE OF EXECUTION

To record the establishment of the Plan the Employer's authorized representative hereby executes this document on this date: _____ .

Schreiber Foods Inc

By: 

Title: Executive Vice President & Chief Human Resources and Strategy Officer

Date: December 7, 2025

APPENDIX A. COVERED EXPENSES

COVERED INFERTILITY CARE EXPENSES

Covered Infertility Care Expenses include procedures and services to overcome an inability to have children as indicated by a medical diagnosis of infertility, or to address other medical necessity.

- Covered Infertility Care Expenses must be recommended and supervised by an eligible provider:
    - Reports to Center for Disease Control and Prevention (CDC) and/or Society for Assisted Reproductive Technology (SART);
    - Have a Medical Director, or practicing staff physician, with Subspecialty Board Certification in Reproductive Endocrinology and Infertility by The American Board of Obstetrics and Gynecology (ABOG) or a physician who meets grandfathered REI criteria set by American Society for Reproductive Medicine (ASRM);
    - Laboratory is appropriately accredited through either the College of American Pathologists (CAP) or The Joint Commission (TJC);
    - Laboratory director must be an Embryology Laboratory Director (ELD), or a High-complexity Clinical Laboratory Director (HCLD); for ELDs or HCLD's being credentialed today, both of which require either an MD or a PhD.
- Examples of covered treatments include, but are not limited to:
    - Fertility consultations;
    - Semen analysis;
    - Fertility preservation for males and females;
    - Genetic testing related to fertility (e.g., PGT-A, PGT-M);
    - Intrauterine insemination;
    - In vitro fertilization;
    - Transportation of reproductive material with an approved vendor;
    - Storage costs for eggs, sperm, and/or embryos;
    - Fertility medications; and
    - Acupuncture (when recommended by an eligible provider).
- Examples of treatments not covered include, but are not limited to:
    - Any expense that is not eligible for reimbursement under Code Section 213(d);
    - Treatment by an ineligible provider;
    - Fertility-related treatments under the care of primary care providers;
    - Herbal treatments;
    - Nutrition counseling;
    - General genetic tests;
    - Physical therapy or fitness-related expenses; and
    - Any expense which is not incurred or submitted in accordance with the Plan.