2018 Benefit Plan Summary Information Booklet

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BROWN PACKING CO., INC.

Salaried & Office Hourly Personnel

11/27/2017

November 27, 2017

Brown Packing Co., Inc.
P.O. Box 130
Gaffney, SC 29342-0130

All Employees:

We have included a Summary of Benefits and Coverage of each employee benefit plan in this booklet. The Summary of Benefits and Coverage is an important document that informs participants what each plan provides and requires. It provides information on when an employee can begin to participate in the plans, how service and benefits are calculated, when benefits becomes vested, when and in what form benefits are paid, and how to file a claim for benefits.

We are pleased to announce the offering of an affordable short-term disability policy beginning in January. This short-term disability policy is offered by Standard Insurance Company for a $5.46/week post-tax deduction that will pay $300/week for up to 90 days in the event of a short-term disability claim you experience. The policy is pending good employee participation by the 12/31/2017 open enrollment deadline.

If you are a new or returning employee, we welcome you and are pleased that we can offer these benefits to you this year. Please make sure you reach out to us to enroll in benefits prior to your eligibility date. The information in this booklet is only a summary of our benefit plans. For details relating to your eligibility, benefits, and coverage you should refer to the Plan Documents. Plan Documents are available free on either your Employee Self Service login with Paycom Payroll or by hardcopy in the main office.

Sincerely,

Steven C. Blanton, Jr.
Controller

Health Policy Rates, Effective January 1, 2018

Vendor: ***Planned Administrators, Inc.***

Weekly Pre-Tax Premiums

Employee Only: $24.00 ***(*$ 15.00)***
Employee and Spouse: $74.00 ***(*$ 65.00)***
Employee and Child(ren): $69.00 ***(*$ 60.00)***
Family (Employee, Spouse, and Child(ren)): $77.50 ***(*$ 68.50)***

Deductibles

Employee: $700
Family: $1,400

Discounted premiums for employees who participated in the Brown Packing Wellness Program's Biometric Screening Component January 1 – December 31, 2017. New employees have until the first day of the month following two calendar months of employment to participate.

COBRA Health Monthly Premiums

Employee Only: $527.09
Employee and Spouse: $916.69
Employee and Child(ren): $847.93
Family (Employee, Spouse, and Child(ren)): $1,352.11

In-Network, Out-of-Pocket Limit on Expenses

Employee: $3,000
Family: $6,000

Dental Policy Rates, Effective January 1, 2018

Vendor: ***Standard Insurance Company***

Weekly Pre-Tax Premiums

Employee Only: $3.42
Employee and Spouse: $9.33
Employee and Child(ren): $10.58
Family (Employee, Spouse, and Child(ren)): $15.22

COBRA Dental Monthly Premiums

Employee Only: $15.12
Employee and Spouse: $41.24
Employee and Child(ren): $46.76
Family: $65.27

Vision Policy Rates, Effective January 1, 2018

Vendor: ***Physicians Eyecare Plan***

Weekly Pre-Tax Premiums

Employee Only: $1.75
Employee and Spouse: $3.42
Employee and Child(ren): $3.55
Family (Employee, Spouse, and Child(ren)): $5.45

COBRA Vision Monthly Premium

Employee Only: $7.75
Employee and Spouse: $15.10
Employee and Child(ren): $15.71
Family: $24.07

Short-Term Disability Policy Rates, Effective January 1, 2018*

Vendor: ***Standard Insurance Company***

Weekly After-Tax Premiums	**COBRA Monthly Premium**
Employee Only: $5.46	Ineligible

Benefit: $300/week for 90 days after 7 days of suffering a disability.

***This policy is pending a minimum amount of employee participation in enrollment** by 12/31/17.

Brown Packing Co., Inc. Employee Retirement Investment Plan

If your employee contribution/deferral is …	Brown Packing contributes/matches …
1%	1%
2%	2%
3%	3%
4%	3.5%
5% - 100%	4%

Maximum Employee Deferral in 2018 is $18,500.
Employees at least 50 years old during the year 2018 can defer up to $24,500.

FLEXIBLE BENEFIT PLAN

AMENDED & RESTATED
SUMMARY PLAN DESCRIPTION

ADOPTED BY:
BROWN PACKING CO., INC.

AMENDED AND RESTATED:
JANUARY 1, 2017

SUMMARY PLAN DESCRIPTION

PART 1. GENERAL INFORMATION ABOUT THE PLAN

Your Employer (hereinafter “the Employer") is pleased to sponsor an employee benefit plan known as the Flexible Benefit Plan (“the Plan") for you and all eligible Employees. The Plan allows you to choose from several different benefit programs (referred to as "Benefit Options") according to your individual needs, and allows you to reduce your pay before taxes are deducted (“pre-tax contributions”) to pay for the Benefit Options that you elect. This Plan helps you, because the Benefit Options you elect are non-taxable (i.e., you save Social Security and federal and state income taxes on the amount of your salary reduction).

This Summary Plan Description (“SPD”) describes information relating to the Plan and is intended to give you an overview of the plan and how it works. For example, the Plan Information Summary includes plan details such as eligibility requirements and available Benefit Options. The SPD describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it.

The Plan is also established pursuant to a written Plan Document into which the SPD has been incorporated. If there is a conflict between the Plan Document and the SPD, the SPD will govern. Certain terms in this document are capitalized. Capitalized terms reflect important terms that are specifically defined in this SPD or in the Plan Document into which this SPD is incorporated. You should pay special attention to these terms as they play an important role in defining your rights and responsibilities under the Plan.

Participation in the Plan does not give any Participant the right to be retained in the employ of the Employer or any other right not specified in the Plan. If you have any questions regarding your rights and responsibilities under the Plan, you may also contact the Plan Administrator.

PART 2. FLEXIBLE BENEFIT PLAN SUMMARY

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to allow eligible Employees to pay for certain eligible benefits (“Benefit Options”) with pre-tax contributions, therefore saving valuable tax dollars and increasing take-home income. The tax savings created by the plan are further explained below. The Benefit Options to which you may contribute with pre-tax contributions under the Plan are described in the Plan Information Summary. You will receive information from your Employer during each annual enrollment period explaining the Benefit Options offered for the next Plan Year and eligible for pre-tax coverage. Rules regarding pre-tax contributions are described in more detail in this SPD.

Q-2. Who can participate in the Plan?

Each Employee who satisfies the Plan’s eligibility requirements will be eligible to participate in the Plan. If you meet these requirements, you may become a Participant as of the Plan Entry Date. The Eligibility Requirements and the Plan Entry Date are described in the Plan Information Summary. Those Employees who participate in the Plan and pre-tax for eligible benefits are "Participants.” You may use this Plan to pay for Benefit Options covering only yourself and your tax dependents as defined in Section 152 of the Internal Revenue Code (“Code”) (except as otherwise defined in Code Section 105(b) and expanded, as applicable, by ERISA Section 714). The terms of eligibility of this Plan do not override the terms of eligibility of each of the Benefit Options. In other words, if you are eligible to participate in this Plan, it does not necessarily mean you are eligible to participate in all of the Benefit Options. For details regarding eligibility provisions, benefit amounts, and premium schedules for each of the Benefit Options, please refer to the plan summary for each Benefit Option or contact the Employer.

Q-3. When does my participation in the Plan end?

Your coverage under the Plan ends on the earliest of the following to occur:

(i) The date that you make an election not to participate in accordance with the terms of the Plan;
(ii) The date that you no longer satisfy the eligibility requirements of this Plan or all of the Benefit Options;
(iii) The date that you terminate employment with the Employer; or
(iv) The date that the Plan is either terminated or amended to exclude you or the class of Employees of which you are a member.

If your employment with the Employer is terminated during the Plan Year, or you otherwise cease to be eligible, your participation in the Plan will automatically end, and you will not be able to make any more pre-tax contributions under the Plan, including any Pre-tax Contributions from severance pay except as otherwise provided pursuant to policies and procedures established by the Plan Administrator. If you are re-hired within the same Plan Year and are eligible for the Plan (or you become eligible again), you may make new elections if you are re-hired or become eligible again more than 30 days after your employment terminated or you otherwise lost eligibility (subject to any limitations imposed by the Benefit Option(s)). If you are re-hired or again become eligible again within 30 days of termination, your Plan elections that were in effect when you terminated employment or lost eligibility will be reinstated and remain in effect for the remainder of the Plan Year. This 30-day "step back into" rule is mandated by IRS rules in Code Section 125.

Q-4. How do I become a participant?

If you have satisfied the eligibility requirements, you may become a Participant by automatic enrollment (*see below*) or by signing an individual Salary Reduction Agreement in which you agree to pay your share of the cost of the Benefit Options that you elect with pre-tax contributions. Where applicable, you will be provided a Salary Reduction Agreement on or before your Eligibility Date, and you must complete the form and submit it to the Plan Administrator (per the instructions provided) during one of the election periods described under Q-6(a) or (b) below. You may also enroll during the year if you previously elected not to participate and you experience a qualifying event that allows you to become a participant during the year. If that occurs, you must complete an election change form during the Election Change Period described under Q-8 below.

Automatic Election: In lieu of a Salary Reduction Agreement, this Plan is designed to allow automatic enrollment. With automatic enrollment, if you are participating in any of Benefit Options and you paying for coverage with salary reductions, the Employer will automatically sign you up for the Plan so that you are experiencing pre-tax benefits and tax savings. Automatic enrollment is used for the benefit of Participants. Where automatic enrollment is used, there is nothing that you need to sign to participate – enrollment will be handled by the Employer.
If you wish for any reason to decline participation in the Plan and pay any portion of premiums for Benefit Options with post-tax dollars, you may waive coverage by completing a waiver form available from the Plan Administrator.

In some cases, the Employer may require you to pay your share of the Benefit Option coverage that you elect with pre-tax Contributions. If that is the case, your election to participate in the Benefit Option(s) will constitute an election under this Plan.

Q-5. What are tax advantages and disadvantages of participating in the Plan?

By participating in the Plan, you save federal income tax, FICA (Social Security), and state income taxes (for each state where applicable) on all salary reductions for eligible premiums under the Plan. Consider the following example to illustrate the potential tax savings under the Plan:

Example: You are married and have one child. The Employer pays for 80% of your medical insurance premiums, but only 40% for your family. You pay $2,400 in premiums ($400 for your share of the Employee-only premium, plus $2,000 for family coverage under the Employer's major medical insurance plan). You earn $50,000 and your spouse (a student) earns no income. You file a joint tax return.

	If you participate in the Plan		If you do not participate in the Plan
1. Gross Income	$50,000		$50,000
2. Salary Reductions for Premiums	$2,400 (pre-tax)		$0
3. Adjusted Gross Income	$47,600		$50,000
4. Standard Deduction	($9,700)		($9,700)
5. Exemptions	($9,300)		($9,300)
6. Taxable Income	$28,600		$31,000
7. Federal Income Tax (Line 6 x applicable tax schedule)	($3,590)		($3,950)
8. FICA Tax (7.65% x Line 3 Amount)	($3,641)		($3,825)
9. After Tax Contributions	($0)		($2,400)
10. Pay after taxes and contributions	$40,365		$39,821
11. Take Home Pay Difference	$544		

Plan participation will reduce the amount of your taxable compensation. Under some limited circumstances there could be a decrease in your Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance) that are based on taxable compensation. If you need further assistance with that issue, you may wish to consult an accountant or tax advisor.

Q-6. What are the election periods for entering the Plan?

The Plan has three basic election periods: (i) the Initial Election Period, (ii) the Annual Election Period, and (iii) the Election Change Period, which is the period following the date you have a Change in Status Event (described below). The following is a summary of the Initial Election Period and the Annual Election Period.

6a. What is the Initial Election Period?

If you want to participate in the Plan when you first become eligible, you must enroll during the Initial Election Period described in the enrollment materials you receive. If you make an election during the Initial Election Period, your participation in this Plan will begin on the later of your Eligibility Date or the first pay period coinciding with or next following the date that your election is received. The effective date of coverage under the Benefit Options will be effective on the date established in the governing documents of the Benefit Options.

If you are participating in any of the Benefit Options and you do not make an election during the Initial Election Period to participate in the Plan, you will be automatically enrolled in the Plan during the Initial Election Period unless you affirmatively waive coverage by completing a waiver form, which is available from the Plan Administrator.

For example, if you are a newly eligible employee that elects to participate in any of the Benefit Options and you fail to make an election during the Initial Election Period to participate in the Plan, your failure to make an affirmative election shall constitute (1) an election to participate in the Plan for the remainder of the Plan Year, and (2) an agreement to a reduction in your compensation for the remainder of the Plan Year equal to the cost of such Benefit Options. If you wish for any reason to decline participation in the Plan and pay any portion of premiums for Benefit Options with post-tax dollars, you must waive coverage on or before the due date specified by the Plan Administrator by completing a waiver form available from the Plan Administrator.

In addition, your share of the contributions for Benefit Options will be automatically withdrawn from your pay on a pre-tax basis. The election that you make (or fail to make) during the Initial Election Period is effective for the remainder of the Plan Year and generally cannot be changed during the Plan Year unless you have a Change in Status Event.

6b. What is the Annual Election Period?

The Plan also has an Annual Election Period during which you may enroll (if you did not enroll during the Initial Election Period) or change your elections for the next Plan Year. The Annual Election Period will be identified in the enrollment material distributed to you prior to the Annual Election Period.

Note that if you fail to complete, sign, and file a Salary Reduction Agreement during the Annual Election Period, your failure to make such election shall constitute (1) a re-election of the same coverage or coverages, if any, under the Plan as were in effect just prior to the end of the preceding Plan Year (to the extent such coverage remains available as an Benefit Option under the Plan), and (2) an agreement to a reduction in the Participant's compensation for the subsequent Plan Year equal to the cost of such coverage or coverages (adjusted to reflect any increase/decrease in applicable premium/contributions). This is called an "Evergreen Election."

The election that you make (or fail to make) during the Annual Election Period is effective the first day of the next Plan Year and cannot be changed during the Plan Year unless you have a Change in Status Event.

The Plan Year is generally a 12-month period. The beginning and ending dates of the Plan Year are described in the Plan Information Summary.

Q-7. How is my Benefit Option coverage paid for under this Plan?

This Plan allows you to pay for any Benefit Option coverage that you elect with pre-tax contributions. Alternatively, your Employer allows you to pay your share of the contributions with after-tax contributions if you choose to do so. However, the default setting of the Plan is that all Employee contributions for Benefit Options will be paid with pre-tax payroll deductions.

When you elect to participate in an eligible Benefit Option, an amount equal to your share of the annual cost of those Benefit Options that you choose divided by the applicable number of pay periods you have during that Plan Year is deducted from each paycheck after your election date. If you use pre-tax contributions, the deduction is made before any applicable federal and/or state taxes are withheld.

Your Employer may choose to pay for a portion of the cost of the Benefit Options you elect with Employer Contributions. The amount of Employer Contributions towards the cost of the Benefit Option(s) for each Participant and/or level of coverage is subject to the sole discretion of the Employer and it may be adjusted upward or downward in the Employer's discretion at any time. The Employer Contribution amount will be calculated for each Plan Year in a nondiscriminatory manner and may be based upon your dependent status, commencement or termination date of your employment during the Plan Year, and such other factors that the Employer deems relevant. In no event will any Employer Contribution be disbursed to you in the form of additional, taxable compensation except as otherwise provided in the Plan Information Summary (such as in the case of a cashable Benefit Credit).

The Employer may provide you with Employer Contributions over which you have discretion to allocate the contributions to one or more Benefit Options available under the Plan. These elective employer contributions are called “Flex Credits” or “Benefit Credits.” If any Flex Credits or Benefit Credits are provided by the Employer, they will be described in detail in the Plan Information Summary.

Q-8. Under what circumstances can I change my election during the Plan Year?

Generally, you cannot change your pre-tax elections during the Plan Year. There are certain exceptions. First, your election will automatically terminate if you terminate employment or lose eligibility under this Plan or under all of the Benefit Options that you have chosen. Second, you may change your election during the Plan Year if you satisfy the following conditions (determined by federal law):

(a) You experience a Change in Status Event that affects your eligibility under this Plan and/or a Benefit Option; or
(b) You experience a significant cost or coverage change; and

(c) You complete and submit a written Election Change Form within 30 days of the event.

The following is a summary of the applicable Change in Status Events and cost or coverage changes.

1. **Changes in Status**. If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of, and correspond with, the Change in Status. Those occurrences which qualify as a Change in Status include the events described below, as well as any other events which the Plan Administrator determines are permitted under subsequent IRS regulations:

- Change in your legal marital status (such as marriage, legal separation, annulment, divorce, or death of your Spouse);
- Change in the number of your tax Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
- Any of the following events that change the employment status of you, your Spouse, or your Dependent that affect benefit eligibility under a flexible benefit plan (including this Plan) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid, union to non-union, or part-time to full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit;
- Event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, getting married, or ceasing to be a student);
- Change in your, your Spouse's, or your Dependent's place of residence; or
- Such other events that the Plan Administrator determines (in its sole discretion) will permit the revocation of an election (and, if applicable, the filing of a new election) during a plan year under regulations and rulings of the Internal Revenue Service.

If a Change in Status occurs, you must inform the Plan Administrator and complete a new election for pre-tax contributions within 30 days of the event.

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of, and corresponds with, the Change in Status. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of, and corresponds with, a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status Event if the event affects coverage eligibility. A Change in Status affects coverage eligibility if it results in an increase or decrease in the number of dependents who may benefit under the plan.

In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Dependent Eligibility*. For accident and health benefits (e.g., health, dental and vision coverage, accidental death and dismemberment coverage), a special rule governs which type of election change is consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse; the death of your Spouse or your Dependent; or your Dependent ceasing to satisfy the eligibility requirements for coverage, your election to cancel accident or health benefits for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements, would fail to correspond with that Change in Status. Hence, you may only cancel accident or health coverage for the affected Spouse or Dependent.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year plan that allows employees to elect no health coverage, employee-only coverage, employee + 1 coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year. Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee + 1 coverage would be consistent with this Change in Status.

- You may increase your election to pay for COBRA coverage under the Employer's plan for yourself (if you still have pay) or any other individual who lost coverage but is a still a tax dependent (e.g. a child who lives with you and to whom you provide over half of their support but who has lost eligibility under the Plan).
- *Gain of Coverage Eligibility under Another Employer's Plan*. For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's flexible benefit plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.
- *Group Term Life Insurance, Disability Income, or Dismemberment Benefits.* In the case of group term life insurance or disability income and dismemberment benefits, if you experience any Change in Status, you may elect to either increase or decrease coverage.

Example: Employee Mike is married to Sharon and they have one child. The employer's plan offers a flexible benefit plan which funds group-term life insurance coverage (and other benefits) through salary reduction. Before the plan year Mike elects $10,000 of group-term life insurance. Mike and Sharon subsequently divorce during the plan year. The divorce constitutes a Change in Status. An election by Mike either to increase or to decrease his group-term life insurance coverage would be consistent with this Change in Status.

2. **Special Enrollment Rights**. If you, your Spouse, and/or a Dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible Dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (such as legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage. Furthermore, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. An election change that corresponds with a special enrollment must be prospective, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, which may be retroactive up to 30 days back to the date of the birth, adoption, or placement for adoption.

The Plan is designed to allow all special enrollment rights allowed by HIPAA and other federal regulations, including special enrollment that is provided when you are eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP). If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

If you or your Dependents are already enrolled in Medicaid or CHIP you can contact your state Medicaid or CHIP office to find out if premium assistance is available. If you or your Dependents are <u>not</u> currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find

out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your Dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your Dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Please refer to the group health plan description for an explanation of other special enrollment rights. Contact the Plan Administrator if you believe you may qualify for a special enrollment right based on your situation (or that of your Dependent(s)).

3. **Certain Judgments, Decrees, and Orders**. If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former Spouse) cover the Dependent child, and such coverage is actually provided, you may change your election to revoke coverage for the Dependent child.

4. **Entitlement to Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the Plan, elect to begin or increase that person's accident or health coverage.

5. **Change in Cost**. If the Plan Administrator notifies you that the cost of your coverage under the Plan significantly increases or decreases during the Plan Year, regardless of whether the cost change results from action by you (such as switching from full-time to part-time) or the Employer (such as reducing the amount of Employer contributions for a certain class of Employees), you may make certain election changes. If the cost significantly increases, you may choose either (a) to make an increase in your contributions, (b) revoke your election and receive coverage under another Benefit Option which provides similar coverage, or (c) drop coverage altogether if no similar coverage exists. If the cost significantly decreases, you may revoke your election and elect to receive coverage provided under the option that decreased in cost. For insignificant increases or decreases in the cost of Benefit Options, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost. The Plan Administrator (in its sole discretion) will determine whether the requirements of this Part are met.

Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, the Employee may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

6. **Change in Coverage**. If the Plan Administrator notifies you that your coverage under the Plan is significantly curtailed, you may revoke your election and elect coverage under another Benefit Option which provides similar coverage. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves a benefit option during the Plan Year, you may revoke your election and elect to receive, on a prospective basis, coverage provided by the newly-added or significantly improved option, so long as the newly added or significantly improved option provides similar coverage. Also, you may make an election change that is on account of and corresponds with a change made

under another employer plan (including a plan of the Employer or another employer), so long as: (a) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage which is different from the period of coverage under the other employer plan. Finally, you may change your election to add coverage under this Plan for yourself, your Spouse, or your Dependent if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution. The Plan Administrator (in its sole discretion) will determine whether the requirements of this Part are satisfied.

Other Election Rules: With the exception of special enrollment resulting from birth, placement for adoption or adoption, all election changes are prospectively effective from the date of the election or such later time as determined by the Plan Administrator. Additionally, the Plan's Administrator reserves the right to adjust or modify your pre-tax election(s) during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the IRS Code) and such a mid-year adjustment is necessary to prevent the Plan from failing applicable non-discrimination testing required by IRS law**.**

Also, an election under this Plan may be modified during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the applicable federal income tax law**.**

If coverage under a Benefit Option ends, the corresponding pre-tax contributions for that coverage will automatically end. No election is needed to stop the contributions.

Q-9. What happens to my participation under the Plan if I take a leave of absence?

The following is a general summary of the rules regarding participation in the Plan during a leave of absence. In general, the beginning of a leave of absence constitutes a qualifying even that allows a participant to make certain election changes consistent with the leave. If coverage is to be continued, it must be paid for in accordance with the Plan (see below). The specific election changes that you can make under this Plan upon a leave of absence are described here and in the Benefit Option summaries for each included benefit. If you have any questions about how a particular leave of absence scenario affects your benefits and pre-tax elections, contact the Plan Administrator.

(a) If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 ("FMLA"), the Employer will continue to maintain your Benefit Options that provide health coverage on the same terms and conditions as though you were still active, to the extent required by FMLA (e.g., the Employer will continue to pay its share of the contribution to the extent you opt to continue coverage).

(b) Your Employer may elect to continue all health coverage while you are on paid leave (provided Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during a paid leave (for example, with pre-tax contributions if that is what was used before the FMLA leave).

(c) In the event of unpaid FMLA leave (or paid leave where coverage is not required to be continued), if you opt to continue your group health coverage, you may pay your share of the contribution in one of the following ways:

(i) With after-tax dollars while you are on leave;
(ii) You may pre-pay all or a portion of your share of the contribution for the expected duration of the leave with pre-tax contributions from your pre-leave pay or with post-tax contributions. The only limitation is that pre-payments of pre-tax contributions may not generally be used to fund coverage during the next Plan Year; or
(iii) By other arrangements established by the Plan Administrator.

The payment options provided by the Employer will be established in accordance with Code Section 125, FMLA, and the Employer's policies and procedures regarding leaves of absence and will be applied uniformly to all Participants.

(d) If your coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the Plan and the Benefit Option(s) upon return from such leave on the same basis as you were participating in the plans prior to the leave, or as otherwise required by the FMLA. Your coverage under the Benefit Options providing health coverage may be automatically reinstated provided that coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave.

(e) The Plan Administrator may in its discretion continue your group health coverage for the duration of the leave following your failure to pay the required contribution. Upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and the Employer.

(f) If you are commencing or returning from unpaid FMLA leave, your election under this Plan for Benefit Options providing non-health benefits shall be treated in the same manner that elections for non-health Benefit Options are treated with respect to Participants commencing and returning from unpaid non-FMLA leave.

(g) If you go on an unpaid non-FMLA leave of absence (e.g., personal leave, sick leave, etc.) that does not affect eligibility in this Plan or a Benefit Option offered under this Plan, then you will continue to participate and the contribution due will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If you go on an unpaid leave that affects eligibility under this Plan or a Benefit Option, the election change rules described herein will apply. The Plan Administrator will have discretion to determine whether taking an unpaid non-FMLA leave of absence affects eligibility.

Q-10. How long will the Plan remain in effect?

While the Employer fully expects that this Plan will continue indefinitely, the Plan is subject to the Employer's right to amend or terminate the Plan, as provided below. Nothing in this Plan is intended to be or shall be construed to entitle any Participant, retired or otherwise, to vested or non-terminable benefits.

(a) Employer's Right to Amend. The Employer reserves the right to amend at any time any or all of the provisions of the Plan. All amendments shall be made in writing and shall be approved by the Employer (or an official appointed by the Employer) in accordance with its normal procedures for transacting business. Such amendments may apply retroactively or prospectively as set forth in the amendment. Each Benefit Option shall be amended in accordance with the terms specified therein, or, if no amendment procedure is prescribed, in accordance with this section. Any amendment made by the Employer shall be deemed to be approved and adopted by any Affiliated Employer.

(b) Employer's Right to Terminate. The Employer reserves the right to discontinue or terminate the Plan without prejudice at any time and for any reason without prior notice. Such decision to terminate the Plan shall be made in writing and shall be approved by the Employer (or an official appointed by the Employer) in accordance with its normal procedures for transacting business. Affiliated Employers may withdraw from participation in the Plan, but may not terminate the Plan.

(c) Determination of Effective Date of Amendment or Termination. Any such amendment, discontinuance, or termination shall be effective as of such date as the Employer shall determine.

Q-11. What happens if my request for a benefit under this Plan (e.g., an election change or other issue relevant to pre-tax contributions) is denied?

You will have the right to a full and fair review process. Contact the Plan Administrator for details on how to appeal an adverse determination under the Plan.

PART 3. CASH BENEFITS

During any Plan Year, the maximum salary reduction amount a Participant can elect under this Plan cannot exceed the sum of the cost of the Benefit Options offered under this Plan. Any part of this maximum salary reduction amount that you do not elect will be paid to you as regular, taxable compensation. Where applicable, any Benefit Credits not used towards the cost of Benefit Options made available under the Plan will revert to the Employer and will be forfeited by the Employee.

PART 4. CLAIMS PROCEDURES

Procedures for reviewing claims denied under this Plan are set forth in the Benefit Options' underlying governing documents and are incorporated herein by reference.

PART 5. ADMINISTRATION OF PLAN

(a) Plan Administrator. The administration of the Plan shall be under the supervision of the Plan Administrator. It shall be a principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. The Plan Administrator will have full discretionary power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator's discretionary powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

(i) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;
(ii) To interpret the Plan;
(iii) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;
(iv) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and
(v) To delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such delegation or designation to be in writing.

Any determination by the Plan Administrator, or any authorized delegate, shall be final and conclusive on all persons, in the absence of clear and convincing evidence that the Plan Administrator or delegate acted arbitrarily and capriciously.

(b) Examination of records. The Plan Administrator will make available to each Participant such of its records under the Plan as pertain to the Participant, for examination at reasonable times during normal business hours; provided, however, the Plan Administrator shall have no obligation to disclose any records or information which the Administrator, in its sole discretion, determines to be of a privileged or confidential nature.

(c) Reliance on tables, etc. In administering the Plan, the Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, administrators of the plans, accountants, counsel or other experts employed or engaged by the Plan Administrator.

(d) Nondiscriminatory exercise of authority. Whenever, in the administration of the Plan, any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

PART 6. GENERAL PROVISIONS

(a) **Not an Employment Contract.** Neither this Plan nor any action taken with respect to it shall confer upon any person the right to continue employment with any Employer.

(b) **Applicable Laws.** The provisions of the Plan shall be construed, administered, and enforced according to applicable federal law and the laws of the State of South Carolina to the extent not preempted.

(c) **Requirement for Proper Forms.** All communications in connection with the Plan made by a Participant shall become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Plan Administrator.

(d) **Multiple Functions.** Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

(e) **Tax Effects.** Neither the Employer, nor the Plan Administrator makes any warranty or other representation as to whether any Pre-tax Contributions made to or on behalf of any Participant hereunder will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Beneficiary are includable in an employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof. The Plan is designed and is intended to be operated in accordance with Section 125 of the Code.

(f) **Gender and Number.** Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

(g) **Headings.** The Article and Section headings contained herein are for convenience of reference only, and shall not be construed as defining or limiting the matter contained thereunder.

(h) **Incorporation by Reference.** The actual terms and conditions of the separate component Benefit Options offered under this Plan are contained in separate, written documents governing each respective benefit, and shall govern in the event of a conflict between the individual plan document, and this Plan as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein. In addition, the Employer's enrollment materials contain additional information about the Plan. The Employer's enrollment materials, as amended from time to time, are incorporated herein.

(i) **Severability.** Should a court of competent jurisdiction subsequently invalidate any part of this Plan, the remainder thereof shall be given effect to the maximum extent possible.

(j) **Effect of Mistake.** In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

PART 5. PLAN INFORMATION SUMMARY

Employer Details

Name of Organization:	Brown Packing Co., Inc.
Address of Plan Sponsor:	P.O. Box 130 Gaffney, SC 29342-0130
Entity Type:	S-Corporation
Plan Administrator:	W. Reed Brown
Acceptance of Legal Process:	Brown Packing Co., Inc. 116 Willis Street Gaffney, SC 29341
Federal Employer ID Number:	57-0289483

Plan Details

Plan Name:	Brown Packing Co., Inc. Flexible Benefit Plan
Plan No.:	501
Effective Date of this SPD:	July 1, 2014; Amended and Restated January 1, 2017
Original Effective Date:	January 1, 1994
Plan Year Basis:	1/1 – 12/31 The Plan is designed to operate on a 12-month basis. A short plan year may be used at implementation or when needed to move Plan concurrent with Benefit Options.

Plan Funding

The Plan is self-funded, with no trust arrangement.

Eligibility Requirements

Eligible Employees are those employees employed by the Employer who are active and full-time with a customary weekly employment schedule equal to or greater than 30 hours. Anyone who is covered by a collective bargaining agreement is not eligible, unless the agreement expressly provides for participation in this Plan.

The Eligibility Waiting Period for the Plan is as follows:

New Employees: New employees are eligible to participate on the first day of the month following two (2) calendar months of continuous employment. For example, if a new employee begins working for Employer on February 2 and is employed by Employer for two (2) continuous months (i.e., February 2 to April 2), the new employee will be eligible for coverage on May 1.

Part time or Temporary Employees: Part time or temporary employees are not eligible for coverage under this plan. However, employees moving from a part-time positon to a full-time position are eligible to participate on the first day of the third month following the change in status. For example, if a part-time employee moves from a part-time position to a full-time position on February 2, the part-time employee will be eligible for coverage on May 1.

Further, temporary employees who have been brought in from a temporary staffing agency and are subsequently hired by Employer are eligible to participate on the first day of the month following two (2) calendar months of continuous employment with the Employer. For example, temporary employee was brought in from a temporary staffing agency and was subsequently hired by Brown Packing as a new employee on February 2. If the new employee works for Employer for two (2) continuous months (i.e., February 2 to April 2), the new employee will be eligible for coverage on May 1.

Benefit Options

The following benefits, which are sponsored and maintained by the Employer for the benefit of eligible Employees, are offered under the plan:

Group Health Insurance
Group Dental Insurance
Group Vision Insurance

In the absence of a waiver, any Employee cost for premiums will be automatically deducted on a pre-tax basis.

Benefits Excluded

The following benefits, which are sponsored and maintained by the Employer for the benefit of Eligible Employees, are specifically excluded from pre-tax coverage under this Plan:

Group Life and AD&D Insurance
Group Long-Term Disability Insurance

Authority of Plan Documents

The terms and conditions of the separate Benefit Options offered under this Plan are contained in separate, written documents governing each respective benefit, which will govern in the event of a conflict between the flex plan and a term of a Benefit Option. To that end, each such separate document, as amended or subsequently replaced, is incorporated by reference as if fully recited herein.

Important: This SPD is intended to summarize the benefits under the Plan. Please contact the Plan Administrator if you need further information about any Plan details.

BROWN PACKING CO., INC.
WELLNESS PROGRAM

Effective January 1, 2017
Restated November 27, 2017

INTRODUCTION

As the cost of healthcare continues to rise dramatically each year so does Brown Packing Co., Inc.'s ("Brown Packing") health care costs and employee insurance premiums. In an effort to help control these costs and to promote better health among its employees, Brown Packing hereby establishes the Brown Packing Wellness Program (the "Wellness Program"), effective January 1, 2017.

Under the Wellness Program, participants who (1) complete a biometric screening at the Brown Packing Wellness Clinic, and (2) complete a post-biometric screening follow up to the Wellness Clinic before December 31 of the prior year, will pay less for their health insurance in the following year.

Note: The Wellness Program has specific requirements that must be fulfilled before participants are entitled to receive a benefit. Please review the materials carefully as no exceptions will be made.

HOW THE PROGRAM WORKS

HOW TO PARTICIPATE IN THE BROWN PACKING WELLNESS PROGRAM

ELIGIBILITY, DEADLINES, AND ANNUAL QUALIFICATION

Employees who are enrolled in Brown Packing Medical Group Plan ("Medical Plan") will have an opportunity to participate in the Wellness Program each year during open enrollment.

An eligible employee will become a participant in this Wellness Program on the same day that he or she becomes a participant in the Medical Plan.

BENEFITS OF THE WELLNESS PROGRAM

The Wellness Program is comprised of a biometric screening component.[1] The requirements under the biometric component must be fulfilled before a participant is entitled to receive the component's financial incentive (i.e., premium discount).

Participation in this Wellness Program is completely voluntary. Eligible employees may choose to participate, or not participate, in the Wellness Program. However, eligible employees who choose to participate in the Wellness Program will receive a $9.00 per week discount off the cost of his / her coverage under the Brown Packing Medical Plan.

BIOMETRIC SCREENING COMPONENT

Brown Packing currently provides an onsite Wellness Clinic, which is staffed by licensed Nurse Practitioners and free to all employees.

NEW HIRES & RE-HIRES

New Hires and Re-Hires who (1) complete a biometric screening at the onsite Wellness Clinic, and (2) complete a post-biometric screening follow up to the Wellness Clinic prior to their insurance eligibility

[1] The biometric screening includes measures of height, weight, blood pressure, comprehensive metabolic panel, lipid profile, hemograms, differentials, TSH, and A1C.

date will receive a $9.00 per week discount off the cost of his / her coverage under the Medical Plan once enrolled he / she is enrolled in the Medical Plan. The $9.00 per week discount will remain in effect until the end of the Plan Year.

CONTINUATION OF THE PLAN BEYOND 2017

Effective January 1, 2018, all participants who ANNUALLY (1) complete a biometric screening at the onsite Wellness Clinic, and (2) complete a post-biometric screening follow up to the Wellness Clinic within the 12 months prior to the beginning of the Plan Year will receive a $9.00 per week discount off the cost of his / her coverage under the Medical Plan with the beginning of the next Plan Year. The $9.00 per week discount will remain in effect until the end of the Plan Year.

For example, in order to receive the $9.00 per week discount for the 2018 Plan Year, a participant must have (1) completed a biometric screening at the onsite Wellness Clinic, and (2) completed a post-biometric screening follow up to the Wellness Clinic within the 12 months prior to the beginning of the 2018 Plan Year (i.e., January 1, 2017 to December 31, 2017). Note that the biometric screening and the post-biometric screening follow up completed in 2017 will also count towards the 2018 requirement.

For Plan Years beginning 2019 and beyond, however, a participant must (1) complete a biometric screening at the onsite Wellness Clinic, and (2) complete a post-biometric screening follow up to the Wellness Clinic within the 12 months prior to the beginning of the Plan Year to receive the $9.00 per week discount. For example, in order to receive the $9.00 per week discount for the 2019 Plan Year, a participant must have (1) completed a biometric screening at the onsite Wellness Clinic, and (2) completed a post-biometric screening follow up to the Wellness Clinic within the 12 months prior to the beginning of the 2019 Plan Year (i.e., January 1, 2018 to December 31, 2018).

This provision does not affect the treatment of New Hires or Re-Hires; however, re-hired employees who have previously participated in the Wellness Program within 12 months of their eligibility date will not be required to participant again until the following participation anniversary date of January 1.

REMOTE EMPLOYEES

Eligible employees who perform services for Brown Packing remotely (i.e., employees who work more than 50 miles from Gaffney, SC) ("Remote Employees") may choose to complete the biometric screening and post-biometric screening follow up at a local medical clinic or practitioner's office of his/her choosing. Remote Employees who choose this option must provide proof of completion of the biometric screening and post-biometric screening follow up to the Plan Administrator to be eligible for the discount.

Brown Packing shall reimburse a Remote Employee for reasonable medical costs associated with completing the biometric screening and post-biometric screening follow up (e.g. co-pay, etc.) at a local medical clinic or practitioner's office of his/her choosing. To obtain a reimbursement, Remote Employees must provide receipts to the Plan Administrator.

Eligible employees who are Remote Employees can still use the Wellness Clinic to complete the biometric screening and post-biometric screening follow up free of charge. Eligible employees who are not Remote Employees must use the Wellness Clinic to complete the biometric screening and post-biometric screening follow up.

RENEWAL OF INCENTIVES

Incentives under this Wellness Program do not automatically renew each year. Participants must satisfy the Wellness Program's requirements each year before they are entitled to receive the Wellness Program's incentive.

CLAIMS PROCEDURES

CLAIMS APPEALS PROCEDURE

A participant may file a claim under the Wellness Program by sending it to the attention of the Plan Administrator. However, if a claim has been denied, in whole or in part, notice of the decision shall be furnished to the participant by the Plan Administrator within a reasonable period of time after the receipt of the claim, which notice shall include the following information:

- The specific reason or reasons for the denial;
- Specific reference to the Wellness Program provisions on which the denial is based;
- A description of any additional material or information necessary to complete the claim and an explanation of why this material or information is necessary; and
- An explanation of the steps to be taken if you wish to submit your claim for review.

The notice must be provided within 90 days of the date that the claim is received by the Plan Administrator, unless special circumstances require an extension of the period for processing the claim. If such an extension is required, written notice of the extension shall be provided to the participant prior to the expiration of the 90-day period. The written notice of the extension shall specify the circumstances that require the extension as well as the date upon which a final decision is expected. In no event is the extended period to exceed 90 days from the end of the initial 90-day period.

APPEAL OF DENIED CLAIMS

A participant or the participant's duly authorized representative may appeal a denial of a claim by requesting a review by written application to the Plan Administrator or its designee not later than ninety (90) days after receipt by the participant of written notification of denial of a claim.

The participant or the participant's duly authorized representative:

- May review pertinent documents; and
- May submit issues and comments in writing. Failure to make written request for appeal within the 90 day period after the receipt of the Administrator's notice of denial of the claim shall render the Administrator's decision regarding the claim final, binding, and conclusive on all parties.

A decision on review of a denied claim shall be made by the Plan Administrator not later than sixty (60) days after the Plan Administrator's receipt of a request for review, unless special circumstances require an extension of time for processing, for example, where there exists a need to hold a hearing, in which case a decision shall be rendered within a reasonable period of time, but not later than one hundred twenty (120) days after receipt of a request for review.

The decision on review shall be in writing and shall include the specific reason(s) for the decision and the specific reference(s) to the pertinent Wellness Program provisions on which the decision is based. If an extension of time is required, the participant shall be notified within the sixty-day period that an extension is required. Questions regarding any procedures above may be directed to the Plan Administrator.

PROVISIONS FOR TERMINATION OR CONTINUATION OF COVERAGE

A participant's participation in the Wellness Program terminates (1) when the participant ceases to be a participant of the Medical Plan, or (2) the Wellness Program is terminated by Brown Packing.

If an employee is granted a Military Leave to perform "service in the uniformed services" as defined under the Uniformed Services Employment and Re-employment Rights Act of 1994, coverage is continued subject to the provisions of the Act

ADMINISTRATION

In determining the eligibility of participants for benefits and in construing the Wellness Program's terms, the Plan Administrator has the power to exercise sole discretion in the construction of doubtful, disputed or ambiguous terms or provisions of the Wellness Program, in cases where the Wellness Program instrument is silent, or in the application of terms or provisions to situations not clearly or specifically addressed in the Wellness Program itself.

In situations in which they deem it to be appropriate, the Plan Administrator may evidence (1) the exercise of such discretion, or (2) any other type of decision, directive or determination they may make with respect to the Wellness Program, in the form of written administrative rulings which, until revoked, or until superseded by Wellness Program amendment or by a different administrative ruling, shall thereafter be followed in the administration of the Wellness Program.

All decisions of the Plan Administrator made on all matters within the scope of their authority shall be final and binding upon all persons, including the Company, any trustee, all participants, their heirs and personal representatives, and all labor unions or other similar organizations representing participants. It is

intended that the standard of judicial review to be applied to any determination made by the Plan Administrator shall be the "arbitrary and capricious" standard of review.

Any discretionary acts taken under this Wellness Program by the Plan Administrator or the Company shall be uniform in their nature and shall be applicable to all participants similarly situated, and shall be administered in a nondiscriminatory manner in accordance with the provisions of ERISA and the Code.

The Plan Administrator may employ agents, attorneys, accountants or other persons (who also may be employed by Brown Packing), and allocate or delegate to them such powers, rights and duties as the Plan Administrator may consider necessary or advisable to properly carry out the administration of the Wellness Program.

ADDITIONAL INFORMATION

This Wellness Program is a component of, and is incorporated by reference into, the Medical Plan. This document, along with any other notices, if any, provided by Brown Packing, serve as the Wellness Program plan document and summary plan description ("SPD"). Brown Packing has the right to amend or terminate the Wellness Program, this plan document and SPD and any notices provided by Brown Packing in conjunction with the Wellness Program, or any of the benefits provided under the Wellness Program, at any time, in its sole discretion.

Participation in this Wellness Program is completely voluntary. To qualify for the incentives described above, eligible employees must complete all requirements described in the Section "How the Program Works."

It is intended that this Wellness Program meet all applicable requirements of Health Insurance Portability and Accountability Act ("HIPAA"), the Internal Revenue Code (the "Code"), and the Employee Retirement Income Security Act of 1974, as amended, ("ERISA"), the Affordable Care Act ("ACA"), and of all regulations issued thereunder. This Wellness Program shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Wellness Program and the Code and ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause, or provision of this Wellness Program shall be deemed superseded to the extent of the conflict. Benefits shall be provided in compliance with ERISA, COBRA, HIPAA, ACA, and other group health plan laws to the extent required by such laws.

Please contact Steven Blanton if you have any questions about the Wellness Program requirements or incentives.

Plan Sponsor Information

Plan Name:	Brown Packing Wellness Program
Plan Sponsor:	Brown Packing Co., Inc.
Plan Sponsor's Address:	Brown Packing Co., Inc. Post Office Box 130 Gaffney, SC 29342
Plan Sponsor's Telephone Number:	864-489-5723
Plan Sponsor's EIN:	57-0289483
Effective Date of plan:	January 1, 2017
Plan Year:	January 1 – December 31
Controlling Law:	Except to the extent preempted by federal law, the laws of the State of South Carolina shall apply.
Type of Plan:	Wellness Program.
Funding of Plan:	Incentives under the Plan are paid out of the general assets of Brown Packing.
Plan Administration:	Plan Sponsor administers the Plan with contracts third-party service providers to administer the Plan.
Plan Administrator:	Brown Packing Co., Inc.
Plan Administrator's Address:	Post Office Box 130 Gaffney, SC 29342
Plan Administrator's Phone Number:	864-489-5723
Agent for Service of Legal Process:	Brown Packing Co., Inc.

BROWN PACKING CO., INC.
NOTICE REGARDING
THE BROWN PACKING
WELLNESS PROGRAM

The Brown Packing Wellness Program ("Wellness Program") is a voluntary wellness program available to all employees who participate in the Brown Packing Medical Group Plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the Wellness Program you will be asked to (1) complete a biometric screening at the Brown Packing Wellness Clinic, and (2) complete a post-biometric screening follow up.

You are not required to complete the biometric screening or the post-biometric screening follow up. However, employees who choose to participate in the Wellness Program will receive a $9.00 per week discount off the cost of his / her coverage under the Brown Packing Medical Group Plan.

The information from your biometric screening and post-biometric screening follow up will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the Wellness Program, the Brown Packing Wellness Clinic, and Brown Packing Co., Inc. may use aggregate information it collects to design a program based on identified health risks in the workplace, the Brown Packing Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the Wellness Program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the Wellness Program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Wellness Program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the Wellness Program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the Wellness Program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is the Nurse Practitioner associated with the Brown Packing Wellness Clinic.

In addition, all medical information, if any, obtained through the Wellness Program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the Wellness Program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the Wellness Program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the Wellness Program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Steven Blanton at P.O. Box 130 – Gaffney, SC 29342-0130.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact PAI at 1-800-768-4375 or visit www.paisc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.paisc.com.com or call 1-800-768-4375 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$700 individual / $1,400 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, primary care, prescription drugs and urgent care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $3,000 individual / $6,000 family For out-of-network providers $4,000 individual / $8,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, penalties, balance-billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.paisc.com or call 1-800-768-4375 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit; deductible does not apply	40% coinsurance	Includes primary care visits for mental/behavioral health and substance abuse services. Services rendered at the on-site clinic are covered at no charge to employees only.
	Specialist visit	$15 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/screening/ immunization	No charge deductible does not apply	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Annual physicals, well child care and immunizations are not covered at out-of-network providers. Routine gynecological exams, prostate exams and annual physicals are limited to one per coverage period. Routine mammograms are limited to one mammogram between the ages of 35 and 39 and each year for women 40 and over. Routine colonoscopies are subject to ACA age guidelines.
If you have a test	Diagnostic test (x-ray, blood work)	$15 copay/test when associated with an office visit; deductible does not apply	40% coinsurance	Tests associated with an office visit but billed separately: 20% coinsurance after deductible for network providers and 40% coinsurance after deductible for out-of-network providers.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.paisc.com.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.paisc.com.	Generic drugs	$10 copay/prescription (retail); $30 copay/prescription (mail order); deductible does not apply to prescription drugs	Not Covered	Multiple copays apply when more than one months supply is purchased at one time (i.e., for a 60 day supply, patient would be responsible for 2 copays, for a 90 day supply, patient would be responsible for 3 copays.) If a brand name drug is purchased when a generic drug is available, member is required to pay the difference between the cost of the brand name drug and the generic drug, in addition to the applicable copay and coinsurance equal to 20% of brand cost. Prescription drugs are subject to the following programs: Prior Authorization and Quanity Management.
	Brand drugs (preferred/non-preferred)	$20 copay/prescription (retail); $60 copay/prescription (mail order); deductible does not apply to prescription drugs	Not Covered	
	Specialty drugs	Same as above Brand	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	Accidental Injury: No charge up to $500, then 20% coinsurance	Accidental Injury: No charge up to $500, then 20% coinsurance	Emergency Room Charges for Illness: $50 copay then 20% coinsurance after deductible. Physician Charges for Illness: 20% coinsurance after deductible.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$15 copay/visit; deductible does not apply	40% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.paisc.com.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required. If you do not get preauthorization, room and board charges will be denied.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Preauthorization is required. If you do not get preauthorization, a $200 penalty will apply.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required. If you do not get preauthorization, room and board charges will be denied.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Preauthorization is required. If you do not get preauthorization, room and board charges will be denied.

* For more information about limitations and exceptions, see the plan or policy document at www.paisc.com.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 100 visits per coverage period. Preauthorization is required. If you do not get preauthorization, a $200 penalty will apply.
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization is required. If you do not get preauthorization, room and board charges will be denied.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization is required. If you do not get preauthorization, room and board charges will be denied.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization required if charges are $500 or more.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required. If you do not get preauthorization, a $200 penalty will apply. Bereavement counseling is covered if within 12 months of death.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Vision screening covered for child at no charge under ACA.
	Children's glasses	Not covered	Not covered	Not Applicable
	Children's dental check-up	Not covered	Not covered	Pediatric Oral Exam covered at no charge per ACA guidelines.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Private-duty nursing

* For more information about limitations and exceptions, see the plan or policy document at www.paisc.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform / Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323x61565 or www.cciio.cms.gov / Planned Administrators Inc. at 1-800-768-4375 or visit www.paisc.com. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform/ Planned Administrators Inc. at 1-800-768-4375 or visit www.paisc.com or you can contact your employer's human resources department at 1-864-489-5723.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-768-4375.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-768-4375.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-768-4375.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-768-4375.

————————————————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*————————————————

* For more information about limitations and exceptions, see the plan or policy document at www.paisc.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$700
Specialist copayment	$15
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$700
Copayments	$0
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,060

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$700
Specialist copayment	$15
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$107
Copayments	$1,400
Coinsurance	$27
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,589

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$700
Specialist copayment	$15
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$700
Copayments	$45
Coinsurance	$215
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$960

The plan would be responsible for the other costs of these EXAMPLE covered services.

Brown Packing Co, Inc.
Dental Highlight Sheet

Plan 1: Dental Plan Summary **Effective Date: 1/1/2017**

Plan Benefit	
Type 1	100%
Type 2	80%
Type 3	50%
Deductible	$50/Calendar Year Type 2 & 3
	Waived Type 1
	3 Family Maximum
Maximum *(per person)*	$1,000 per calendar year
Max Keeper	Included
Allowance	90th U&C
Waiting Period	None
Annual Eye Exam	None
LASIK Assist℠	None
Annual Open Enrollment	Included

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

Type 1	Type 2	Type 3
• Routine Exam (1 in 6 months)	• Space Maintainers	• Onlays
• Bitewing X-rays (1 in 12 months)	• Restorative Amalgams	• Crowns (1 in 10 years per tooth)
• Full Mouth/Panoramic X-rays (1 in 5 years)	• Restorative Composites	• Crown Repair
• Periapical X-rays	• Denture Repair	• Endodontics (nonsurgical)
• Cleaning (1 in 6 months)	• Simple Extractions	• Endodontics (surgical)
• Fluoride for Children 13 and under (1 in 12 months)	• Complex Extractions	• Periodontics (nonsurgical)
• Sealants (age 13 and under)	• Anesthesia	• Periodontics (surgical)
• Pre-Diagnostic Test (age 35 and over) (1 in 2 years)		• Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years)

Weekly Rates

Employee Only (EE)	$3.42
EE + Spouse	$9.33
EE + Children	$10.58
EE + Spouse & Children	$15.22

About The Standard

As a leading provider of employee benefits products and services, Standard Insurance Company is dedicated to meeting the unique insurance needs of each customer. More than 27,100 groups trust The Standard for group insurance products and services, and the company covers nearly 7 million employees.

Founded in Portland, Oregon, in 1906, The Standard has built a national reputation for delivering quality insurance products, personalized service and strong financial performance. The Standard wrote its first group insurance policy in 1951, and it remains in force today as a testament to the company's commitment to building successful long-term relationships.

Brown Packing Co, Inc.
Dental Highlight Sheet

Customer Service

Your local Standard Insurance Company Employee Benefits Sales and Service Office will provide most of the ongoing service for your plan and can be reached at 800.633.8575 during normal business hours. We will assign your company a service representative who will provide regular contact and address questions and concerns related to the plan or the services we provide.

We also make it easy for covered employees and dentists to contact us to confirm eligibility or request claims information by calling **1-800-547-9515.** Our customer service representatives are available Monday through Thursday from 5:00 a.m. until 10:00 p.m. Pacific Time and until 4:30 p.m. Pacific Time on Friday. For plan information any time, access our automated voice response system or go online to standard.com.

Max Keeper

With this plan option, benefits for Type 1/Preventive procedures are not deducted from the plan participant's annual maximum benefit. This saves the entire annual maximum for the Type 2/Basic and Type 3/Major procedures that are covered by your plan.

Dental Network Information

Employees and dependents have access to an extensive nationwide network of member dentists. The cost-saving benefits of visiting a network member dentist are automatically available to all employees and dependents who are covered by any of The Standard's dental plans and who live in areas where the nationwide network is available. To find member dentists in your area, visit: **http://www.standard.com/dental** and click on "Find a Dentist." California Residents: When prompted to select your network, choose the network found on your ID Card.

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Open Enrollment

If a member does not elect to participate when initially eligible, the member may elect to participate at the policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Brown Packing Co., Inc.
Vision Plan Description

Physicians Eyecare Plan

SAVE UP TO 70% ON YOUR VISION CARE COSTS

IN NETWORK BENEFITS

- **Comprehensive eye exam every 12 months with a $10 copay.**
- **$150 material allowance every 12 months towards glasses and/or contact lens with a one-time $20 copay.**
- **After your material allowance has been used, receive a 20% discount on glasses and a 15% discount on contact lens at most providers*.**
- **Discounts of 10%-20% on refractive surgery including LASIK at participating providers.**
- **$49 standard contact lens fitting fee or 15% discount off the usual and customary fitting for non-standard contact lens** at most providers*.**
- **No claims or paperwork to file.**

OUT OF NETWORK BENEFITS

- If you choose to use an out-of-network provider, you will be reimbursed the following amounts:
  - Exam including contact lens fitting: $50 less exam copay
  - Materials: 65% of the material allowance that was used, less material copay
- Please submit a claim form (available at www.physicianseyecareplan.com) along with your itemized receipts to: Physicians Eyecare Plan, 48 Courtenay Dr., Charleston, SC 29403

PREMIUMS PER PAY PERIOD (52 PAY PERIODS)

- You will be able to deduct premiums from your paycheck on a pre-tax basis and thereby reduce the amount of taxes withheld from your paycheck.

	Premiums Per Pay Period
Employee	$1.75
Employee + Spouse	$3.42
Employee + Children	$3.55
Employee + Family	$5.45

IMPORTANT INFORMATION

- New members will be mailed a membership card.
- Find an in-network provider by going to www.physicianseyecareplan.com.
- Check your eligibility, print a replacement ID card, download an out-of-network claim form and find answers to frequently asked questions by going to www.physicianseyecareplan.com.
- To make an appointment, call an in-network provider and let them know that you are a PEP member.
- You are responsible for payment to the in-network provider for any amount exceeding the material allowance, any copays and any contact lens fitting fees.
- This is a routine vision program. Medical and surgical treatments of the eyes are not covered benefits.
- Material allowance does not cover non-prescription lenses, non-prescription or cosmetic contact lenses, or non-prescription sunglasses.
- Members will not be able to terminate coverage during their 12 month plan except for a termination resulting from a change in employment or family status.

** Discounts subject to change. Certain providers such as JC Penney Optical, Pearle Vision, Sears Optical, and Target Optical do not offer discounts on disposable contact lens. Participating Walmart Vision Centers do not offer discounts on glasses, contacts, or contact lens fitting fees. Not all Walmart Vision Centers provide eye exam services.*

*** Spherical daily wear, extended wear and disposable contact lens are considered standard contact lens; any other contact lens types are considered non-standard.*

Standard Insurance Company
Brown Packing Co., Inc.
Group Policy #162660
Effective Date January 1, 2017

Group Basic Life and Accidental Death and Dismemberment Insurance

Group Basic Life insurance from Standard Insurance Company helps provide financial protection by promising to pay a benefit in the event of an eligible member's covered death. Basic Accidental Death and Dismemberment (AD&D) insurance may provide an additional amount in the event of a covered death or dismemberment as a result of an accident.

The cost of this insurance is paid by Brown Packing Co., Inc.

Eligibility

Definition of a Member	You are a member if you are an active employee of Brown Packing Co., Inc. and regularly working at least 30 hours each week. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Class Definition	Class 1 - Salaried and Office Personnel Members
Eligibility Waiting Period	You are eligible on the first of the month that follows 2 consecutive months as a member.

Benefits

Basic Life Coverage Amount	Your Basic Life coverage amount is $75,000.
Basic AD&D Coverage Amount	For a covered accidental loss of life, your Basic AD&D coverage amount is equal to your Basic Life coverage amount. For other covered losses, a percentage of this benefit will be payable.
Life Age Reductions	Basic Life and AD&D insurance coverage amount reduces to 50 percent at age 70.

Other Basic Life Features and Services

- Accelerated Benefit
- Life Services Toolkit
- Portability of Insurance Provision
- Repatriation Benefit
- Right to Convert Provision
- Standard Secure Access account payment option
- Travel Assistance
- Waiver of Premium

Other Basic AD&D Features

- Air Bag Benefit
- Family Benefits Package
- Seat Belt Benefit

This information is only a brief description of the group Basic Life/AD&D insurance policy sponsored by Brown Packing Co., Inc. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reductions in benefits, exclusions and when The Standard and Brown Packing Co., Inc. may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 13279-D-SC-162660-C1 (12/17)
5473855-149934

Standard Insurance Company
Brown Packing Co., Inc.
Group Policy #162660

Group Short Term Disability Insurance

Protect your income and those who depend on it.

This coverage replaces a portion of your income when you can't work because of a qualifying disability. Even if you're healthy now, it's important to protect yourself and the people who count on your income. This insurance can help you pay the bills when you're unable to work.

This plan offers:

- Competitive group rates
- The convenience of payroll deduction
- Benefits for a qualifying disability that is not work-related

About This Coverage

See the Important Details section for more information, including requirements, exclusions and definitions.

What Your Benefit Provides This is the benefit you'd receive if you were to suffer a qualifying disability. Eligible earnings are your weekly insured predisability earnings, as defined by the group policy. Your benefit amount will be reduced by deductible income; see the Important Details section for a list of deductible income sources.	**$300** per week.
Benefit Waiting Period If you suffer a qualifying disability, your benefit waiting period is the length of time you must be continuously disabled before you can begin receiving your weekly benefit.	7 days for accidental injury 7 days for physical disease, pregnancy or mental disorder
Extended Benefit Waiting Period This applies if you do not apply for this coverage within 31 days of becoming eligible, were eligible for coverage under a prior plan for more than 31 days but were not insured, or if your insurance ends because you failed to pay your premium and is later reinstated.	60 days for any qualifying disability caused by physical disease, pregnancy or mental disorder occurring during the first 12 months of coverage.
How Long Your Benefits Last This is the maximum length of time you could be eligible to receive a weekly disability benefit.	90 days

Additional Features

Your coverage comes with some added features:

Return to Work Incentive	Your disability benefit will not be reduced by any work earnings you receive until the combined amount of the benefit, earnings and other sources of income exceeds 100 percent of your pre-disability earnings.
Help with Returning to Work	If a worksite modification would enable you to return to work, we can help your employer make approved modifications by covering some or all of the cost.

How Much Your Coverage Costs

Because this insurance is offered through Brown Packing Co., Inc., you'll have access to competitive group rates that may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck.

If you elect this coverage, your weekly premium will be $5.46.

Not being able to work also means not being able to earn a paycheck. As you consider Short Term Disability insurance, think about the expenses you would need to cover if you were to become disabled:

- Mortgage or rent
- Utilities
- Groceries
- Medical bills
- Car insurance
- Childcare costs

To estimate your insurance needs, you'll need to consider your unique circumstances. Use our online calculator at **www.standard.com/disability/needs.**

Important Details

Here's where you'll find the nitty-gritty details about the plan.

Eligibility Requirements

A minimum number of eligible employees must apply and qualify for the proposed plan before the coverage can become effective. If this requirement is not met, this plan will not become effective. To be eligible for coverage, you must be:

- A regular employee of Brown Packing Co., Inc.
- Actively working at least 30 hours per week
- A citizen or resident of the United States or Canada

Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible.

Employee Coverage Effective Date

To become insured, you must:

- Meet the eligibility requirements listed above
- Serve an eligibility waiting period*
- Apply for coverage and agree to pay premiums
- Be actively at work (able to perform all normal duties of your job) on the day before the scheduled effective date of insurance

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Please contact your human resources representative or plan administrator for more information regarding the requirements that must be satisfied for your insurance to become effective.

*Defined as first of the month that follows 2 consecutive months as a member

Definition of Disability

You will be considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder:

- You are unable to perform with reasonable continuity the material duties of your own occupation, and
- You suffer a loss of at least 20 percent in your predisability earnings when working in your own occupation.

You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

Exclusions

Subject to state variations, you are not covered for a disability caused or contributed to by any of the following:

- Your committing or attempting to commit an assault or felony, or your active participation in a violent disorder or riot
- An intentionally self-inflicted injury, while sane or insane
- War or any act of war (declared or undeclared, and any substantial armed conflict between organized forces of a military nature)
- The loss of your professional or occupational license or certification
- An activity arising out of or in the course of any employment for wage or profit

Limitations

Short Term Disability benefits are not payable for any period when you are:

- Not under the ongoing care of a physician in the appropriate specialty, as determined by The Standard
- Not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by The Standard, unless your disability prevents you from participating
- Confined for any reason in a penal or correctional institution
- Able to work and earn at least 20 percent of your predisability earnings in your own occupation but you elect not to
- Receiving sick-leave pay, annual or personal leave pay, severance pay or other salary continuation (including donated amounts) from your employer
- Eligible to receive benefits for your disability under a workers' compensation law or similar law

When Your Benefits End

Your Short Term Disability benefits end automatically on the date any of the following occur:

- You are no longer disabled
- Your maximum benefit period ends
- Long term disability benefits become payable to you under a Long Term Disability plan
- Benefits become payable under any other disability insurance plan under which you become insured through employment during a period of temporary recovery
- You fail to provide proof of continued disability and

entitlement to benefits

- You pass away

Deductible Income

Your benefits will be reduced if you have deductible income, which is income you receive or are eligible to receive while receiving Short Term Disability benefits. Deductible income includes:

- Amounts under unemployment compensation law
- Amounts because of your disability from any other group insurance
- Any retirement or disability benefits received from your employer's retirement plan which are not attributable to your contributions
- Amounts under any state disability income benefit law or similar law
- Earnings from work activity while you are disabled, plus the earnings you could receive if you work as much as your disability allows
- Earnings or compensation included in your predisability earnings which you receive or are eligible to receive while Short Term Disability benefits are payable
- Amounts due from or on behalf of a third party because of your disability, whether by judgment, settlement or other method
- Any amount you receive by compromise, settlement or other method as a result of a claim for any of the above

When Your Insurance Ends

Your insurance ends automatically when any of the following occur:

- The date the last period ends for which a premium was paid
- The date your employment terminates
- The date the group policy (or your employer's coverage under the group policy) terminates
- The date you cease to meet the eligibility requirements (insurance may continue for limited periods under certain circumstances)
- The date Brown Packing Co., Inc. ends participation in the group policy

Group Insurance Certificate

If coverage becomes effective and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage, including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. The information present in this summary does not modify the group policy, certificate or the insurance coverage in any way.

About Standard Insurance Company

For more than 100 years, we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group employee benefits. To learn more about products from The Standard, visit us at **www.standard.com**.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

GP399-STD, GP899-STD, GP309-STD, GP209-STD, GP399/ASSOC, GP399-STD/TRUST

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 12503-D-SC-162660 (12/17)
5466188-146493

Standard Insurance Company
Brown Packing Co., Inc.
Group Policy #162660
Effective Date January 1, 2017

Group Long Term Disability Insurance

Group Long Term Disability insurance from Standard Insurance Company helps provide financial protection for insured members by promising to pay a monthly benefit in the event of a covered disability.

The cost of this insurance is paid by Brown Packing Co., Inc. and may be added to your gross monthly income. If premium payments are made with "after-tax" dollars, benefits are federally tax-free under current federal tax law.

Eligibility

Definition of a Member	You are a member if you are a regular salaried employee and Office Personnel of Brown Packing Co., Inc., actively working at least 30 hours per week, and a citizen or resident of the United States or Canada. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Eligibility Waiting Period	You are eligible on the first of the month that follows 2 consecutive months as a member.

Benefits

Monthly Benefit	60 percent of the first $10,000 of monthly predisability earnings, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, etc.)
Maximum Monthly Benefit	$6,000
Minimum Monthly Benefit	$100
Benefit Waiting Period	90 days

Definition of Disability

For the benefit waiting period and the first 24 months that Long Term Disability benefits are payable, you will be considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder:

- You are unable to perform with reasonable continuity the material duties of your own occupation, and
- You suffer a loss of at least 20 percent of your predisability earnings when working in your own occupation.

You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

After the own occupation period of disability, you will be considered disabled if, as a result of a physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation.

Maximum Benefit Period

If you become disabled before age 62, Long Term Disability benefits may continue during disability until age 65. If you become disabled at age 62 or older, the benefit duration is determined by the age when disability begins:

Age	Maximum Benefit Period
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

Other Features and Services

- 24 hour coverage, including coverage for work-related disabilities
- Employee Assistance Program
- Reasonable Accommodation Expense Benefit
- Rehabilitation Incentive Benefit
- Rehabilitation Plan Provision
- Return to Work Incentive
- Survivors Benefit
- Temporary Recovery Provision
- Waiver of Premium while Long Term Disability benefits are payable

This information is only a brief description of the group Long Term Disability insurance policy sponsored by Brown Packing Co., Inc. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reduction in benefits, exclusions and when The Standard and Brown Packing Co., Inc. may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 13271-D-SC-162660 (12/17)
5444152-143339

BROWN PACKING CO., INC.
EMPLOYEE RETIREMENT INVESTMENT PLAN

SAFE HARBOR NOTIFICATION TO ELIGIBLE EMPLOYEES

This is an annual notice and only applies to the Plan Year beginning on January 1, 2018.

This notice covers the following points:

- How much you can contribute to the Plan;
- What other amounts the Employer will contribute to the Plan for you; and
- When your Plan account will be vested (that is, not lost when you leave your job), and when you can receive a distribution of your Plan account.

You can find out more information about the Plan in the Plan's Summary Plan Description (SPD). You can obtain a copy of the SPD from the Plan Administrator.

I. Employee deferral contributions

You are allowed to defer a portion of your compensation to the Plan. These amounts are referred to as deferrals and are held in an account for your behalf. When you are permitted to take a distribution from the Plan, you will be entitled to all of your deferrals, as adjusted for any gains or losses. The type of compensation that may be deferred under the Plan is explained in the section of the Summary Plan Description entitled "What compensation is used to determine my Plan benefits?" (this is in the Article entitled "COMPENSATION AND ACCOUNT BALANCE").
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Your total deferrals in any taxable year may not exceed $18,500. The dollar limit may increase each year for cost-of-living adjustments. The Administrator will notify you of the maximum percentage you may defer. The amount you elect to defer, and any earnings on that amount, will not be subject to income tax until it is actually distributed to you. However, the amount you defer is counted as compensation for Social Security taxes.

If you are at least age 50 or will attain age 50 during a calendar year, then you may elect to defer an additional $6,000 (called "catch-up contributions") to the Plan. These are additional amounts that you may defer, up to an annual limit imposed by law, regardless of any other limits imposed by the Plan.

II. Employer Safe Harbor Contribution Election

To help you make an informed decision on the level of your own elective deferral contributions, if any, your Employer must inform you about the contributions it will make to the Plan. Your Employer has elected to make the following employer safe harbor contribution:

Safe Harbor Matching Contribution. In order to maintain "safe harbor" status, your Employer will make a safe harbor matching contribution equal to 100% of your elective deferrals that do not exceed 3% of your compensation plus 50% of your elective deferrals between 3% and 5% of your compensation. This safe harbor matching contribution is 100% vested.

For purposes of calculating this safe harbor matching contribution, your compensation and deferrals will be computed for each payroll period.

III. Other Employer Contributions

The Employer may make a Discretionary Additional Matching Contribution. If the Employer makes a Discretionary Additional Matching Contribution, the matching contribution will not apply as to elective deferrals exceeding 6% of your compensation and the total amount of this matching contribution will not exceed 4% of your compensation.

IV. Suspension or reduction of safe harbor matching contribution.

The Employer retains the right to reduce or suspend the safe harbor matching contribution under the Plan. If the Employer chooses to do so, you will receive a supplemental notice explaining the reduction or suspension of the safe harbor matching contribution at least 30 days before the change is effective. The Employer will contribute any safe harbor matching contribution you have earned up to that point. At this time, the Employer has no such intention to suspend or reduce the safe harbor matching contribution.

V. Vesting

The following is a general explanation of the vesting provisions of the Plan. More details can be found in the Article of the SPD entitled "VESTING."

You are always 100% vested in all of your Plan accounts.

VI. Distribution provisions

The Plan and law impose restrictions on when you may receive a distribution from the Plan. Below is general information on when distributions may be made under the Plan. See the SPD for more details, including details on how benefits are paid. Also, at the time you are entitled to receive a distribution, the Plan Administrator will provide you with a notice explaining the rules regarding the taxation of the distribution.

You generally may not withdraw your deferral contributions except when one of the following events occurs: severance from employment with the Employer, death, or attainment of age 59 1/2. You are always 100% vested in your deferral contributions.

If your vested account balance exceeds $5,000, you may elect to have your vested account balance distributed to you as soon as administratively feasible following your termination of employment.

If your vested account balance does not exceed $5,000, a distribution of your vested account balance will be made to you, regardless of whether you consent to receive it, as soon as administratively feasible following your termination of employment regardless of consent.

You may also withdraw money from the Plan from certain accounts if you have reached age 59 1/2. However, there are various rules and requirements that you must meet before any withdrawal is permitted. See the Article in the SPD entitled "DISTRIBUTIONS PRIOR TO TERMINATION OF EMPLOYMENT" for more details.

You may withdraw money from your rollover account at any time. See the Article in the SPD entitled "DISTRIBUTIONS PRIOR TO TERMINATION OF EMPLOYMENT" for more details.

If you: (i) are a reservist or National Guardsman; (ii) were/are called to active duty after September 11, 2001; and (iii) were/are called to duty for at least 180 days or for an indefinite period, you may take a distribution of your elective deferrals under the Plan while you are on active duty, regardless of your age. The 10% premature distribution penalty tax, normally applicable to Plan distributions made before you reach age 59 1/2, will not apply to the distribution. You also may repay the distribution to an IRA, without limiting amounts you otherwise could contribute to the IRA, provided you make the repayment within 2 years following your completion of active duty.

VII. Administrative procedures

The amount you elect to defer will be deducted from your pay in accordance with a procedure established by the Plan Administrator. The procedure will require that you enter into a written salary reduction agreement after you satisfy the Plan's eligibility requirements. Your election will become effective as soon as administratively feasible. Your election will remain in effect until you modify or terminate it.

You may revoke or make modifications to your salary deferral election in accordance with procedures that the Plan Administrator provides.

In addition to any other election periods provided above, you may make or modify a deferral election during the 30-day period immediately preceding the Plan Year for which this notice is being provided. For the Plan Year you become eligible to make deferrals, you may complete a salary deferral agreement during a 30-day period that includes the date you become eligible.

If you decide to start or change your elective deferral, you must complete the salary reduction agreement and return it to the Plan Administrator.

VIII. Investments

Right to direct investment/default investment. You have the right to direct the investment of your Pre-Tax 401(k) deferrals and also other accounts under the Plan (your "directed accounts") in any of the investment choices explained in the investment information materials provided to you.

We encourage you to make an investment election to ensure that amounts in the Plan are invested in accordance with your long-term investment and retirement plans. However, if you do not make an investment election, then the amounts that you could have elected to invest will be invested in a default investment that the Plan officials have selected.

IX. Employer's right to terminate Plan

Pursuant to the terms of the Plan, your Employer has the right, at any time, to terminate the Plan. Termination of the Plan will result in the discontinuance of all contributions to the Plan (including the safe harbor 401(k) contribution) with respect to any compensation you receive after the effective date of the termination. Termination of the Plan will not affect your right to receive any contributions you have accrued as of the effective date of the termination.

X. Additional information

This notice is not a substitute for the Summary Plan Description. The provisions of the Plan are very complex and you should always look at the Summary Plan Description if you have any questions about the Plan. If, after reading the Summary Plan Description, you still have questions, contact the Plan Administrator.

The Plan Administrator is the Employer. You may contact the Employer at:

Contact: Brown Packing Co., Inc.

Address: 116 Willis Street

Gaffney, South Carolina 29341

Telephone: 864-489-5723

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact **Brown Packing Co., Inc.**.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name **Brown Packing Co., Inc.**	4. Employer Identification Number (EIN) **57-0289483**
5. Employer address **P.O. Box 130**	6. Employer phone number **864-489-5723**

7. City **Gaffney**	8. State **SC**	9. ZIP code **29342**

10. Who can we contact about employee health coverage at this job? **Main Office**

11. Phone number (if different from above) **864-489-5723**	12. Email address **info@bropac.com**

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [X] All employees. Eligible employees are:

    Your employer currently offers group health coverage to all employees that meet the following eligibility criteria: Eligible employees are those who are active and full-time with a regular weekly work schedule of 30 or more hours.
  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [X] We do offer coverage. Eligible dependents are:

    Eligible employees are able to enroll themselves and any spouse or dependent(s), as further defined by the Summary Plan Description.
  - [ ] We do not offer coverage.

[X] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid–year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.