SUMMARY PLAN DESCRIPTION

For The

HOG SLAT
WELFARE BENEFITS WRAP PLAN

Effective as of December 1, 2002
Restated effective September 1, 2017

Nota: Una versión en español de este folleto está disponible bajo solicitud a Hog Slat Recursos Humanos

BY MAIL: HOG SLAT HUMAN RESOURCES

PO BOX 300

NEWTON GROVE, NC 28366

BY PHONE: 910-594-0219

HOG SLAT
WELFARE BENEFITS WRAP PLAN
SUMMARY PLAN DESCRIPTION

INTRODUCTION

Hog Slat (the "Company"), has established the Hog Slat Welfare Benefits Wrap Plan (the "Plan") to consolidate in one plan document certain provisions of welfare benefit plans (the "Component Benefit Plans") sponsored by the Company and its affiliated employers, and to provide uniform administration of such welfare benefits. The Component Benefit Plans are listed in Appendix A to this Summary Plan Description. The Plan and Summary Plan Description are effective **December 1, 2002, and restated effective September 1, 2017**.

The insurance contracts, summary plan descriptions, policies and procedures, and any other documents making up the Component Benefit Plans are not affected by the adoption of the Plan and the terms of the Component Benefit Plans will continue to control for purposes of determining your benefits. The terms of the Summary Plan Description for each Component Benefit Plan are incorporated into this Summary Plan Description by reference and will continue to act as the primary source of information for each Component Benefit Plan.

GENERAL INFORMATION PERTAINING TO THE PLAN

Plan Name, Sponsor and Employer Identification Number. The name of the Plan is the **Hog Slat** Welfare Benefits Wrap Plan. The Plan sponsor is **Hog Slat, Inc.**. The Company's address is **17720 Old US Highway 64, Siler City, NC 27344**. The Company's Human Resources telephone number is **(919) 663-3321**. The Company's Federal employer identification number (57-0719254) is **56-0945951**.

Plan Year. The Plan Year is 12-month period beginning on **December 1** and ending on **November 30**.

Plan Number. Each ERISA plan maintained by the Company is issued a Plan Number for reporting purposes. The number of this Plan is **501**.

Type of Welfare Benefits Plan. The Plan provides various welfare benefits under the Component Benefit Plans listed in Appendix A to this Summary Plan Description.

Funding. Benefits under the Plan are funded by one or more of the following methods selected by the Company for a Component Benefit Plan: insured benefits, self-funded benefits (these are benefits funded by general assets of the Company); or a combination of insured benefits and self-funded benefits.

Plan Administration. The Plan Administrator is **Hog Slat**, which, with respect to insured benefits offered through the Plan, shares the responsibility for administering the Component Benefit Plans with the insurance companies providing benefits under the Component Benefit Plans. The insurance companies shown on **Appendix A** to this document are responsible for considering, accepting or denying, and paying claims with respect to the insured benefits. The Plan Administrator is responsible for considering any appeals with respect to the insured benefits

made pursuant to a Component Benefit Plan's claim procedures and, to the extent applicable, the claim procedures set forth in this Plan.

Agent for Service of Legal Process. Hog Slat Employee Benefits Plan, 17720 Old US Highway 64, Siler City, NC 27344

Named Fiduciary. The Plan Administrator is the Named Fiduciary of the Plan and has the exclusive and express discretionary authority to interpret the terms of the Plan and the terms of all the Component Benefit Plans. With respect to the determination of the amount of, and entitlement to insured benefits (when applicable) under any Component Benefit Plan, however, the respective insurance company is also a Named Fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance policy.

Plan Document. The Plan and those documents incorporated by reference constitute a written employee benefit welfare plan as defined by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

ELIGIBILITY AND PARTICIPATION

Eligibility for participation and benefits under the Plan is determined solely under the written terms of each Component Benefit Plan. Please refer to the enrollment materials you received for each Component Benefit Plan for information relating to the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits.

If you have not received enrollment materials for a particular Component Benefit Plan for which you are an eligible participant, contact the Plan Administrator for this Plan or the Component Benefit Plan to obtain a copy.

CONTRIBUTIONS

Both you and the Company contribute to the Plan in the amounts determined for each Component Benefit Plan. You will receive notice of the amount for which you are responsible during the open enrollment period adjusted, if necessary, during the Plan Year. The amount of your employee contributions are indicated on your pay statement. In addition, you may be responsible for co-payments or co-insurance payments for some covered services.

The Plan Administrator shall have the right to recover any payment it made but should not have made or made to an individual or organization not entitled to payment, from the individual or organization or anyone else benefiting from the improper payment.

BENEFIT ELECTIONS

Electing Your Benefits for the Plan Year

Plan Elections are made on a "Plan Year" basis. This Plan operates on a 12-month Plan Year that begins on **December 1** and ends on **November 30**. Please refer to the Summary Plan Description for a Component Benefit Plan to determine the Plan Year for that particular plan.

Once you have made your elections for a Plan Year, they pertain to the entire Plan Year and cannot be changed or cancelled during that time except in certain limited situations, which are described in this Summary Plan Description.

If you first become eligible to participate in the Plan during a Plan Year in progress, your initial elections pertain to the remaining part of that Plan Year. Then, before each new Plan Year begins, you will have an opportunity to change or cancel your elections during the annual election period. The annual election period is described below.

Making Your Elections

In making your elections, you may elect and enroll for some or all of the benefits available under the component plans. You may also elect not to participate in a component plan for which annual elections are then made.

Benefits are elected by completing and submitting an election form before the end of the annual election period. When you make your elections, you also authorize the necessary salary reductions for paying your part of the cost of the benefits you elect.

Once you are a participant in the Plan, if you become eligible for additional benefits during a Plan Year, you will be given an opportunity to elect and enroll for the benefits for which you are newly eligible. Also, if cost of the benefits changes during the Plan Year, the amount of your salary reduction contributions will automatically be adjusted.

Annual Election Period

Before the beginning of each Plan Year, the company will hold an annual election period. The company will notify you when the dates for the annual election period will occur each year. During this time, you may make new elections for the upcoming Plan Year.

Changing Your Elections During a Plan Year

Participants in the Plan generally may not change or revoke your benefits elections during the Plan Year except in accordance with the following rules:

Mid-Year Election Changes Due to HIPAA Special Enrollment Rights. If you become covered, or your spouse or dependent child becomes covered, under our group benefit plan during a "Special Enrollment Period" required by the Health Insurance Portability and Accountability Act ("HIPAA"), you may prospectively make a corresponding change in your Cafeteria Plan election so that you may pay your contributions for the group benefit plans on a pre-tax basis.

Under HIPAA, Special Enrollment Periods are generally allowed due to certain losses of other group health coverage and changes in family status. A Special Enrollment Period is allowed due to a loss of other group health coverage if you:

- declined coverage under our group health plan for yourself or your dependents when you first became eligible for it because you had other group (or "COBRA") coverage;
- lose the other group coverage (or if the employer stops contributing towards your or your dependents' other coverage); and
- request enrollment in our group health plan within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing towards your or your dependents' other coverage).

A Special Enrollment Period is allowed due to a change in family status if you are eligible for coverage under our group health plan and you gain a dependent through marriage, birth, adoption, or placement for adoption.

Mid-Year Election Changes Due to Eligible Status Changes. If you experience an Eligible Status Change, you may prospectively revoke or change your previous benefits elections in a manner that is consistent with the Eligible Status Change. Eligible Status Changes are changes in a person's eligibility status due to at least one of the following events:

- a change in your legal marital status through marriage, the death of your spouse, divorce, legal separation (as determined under state law), or annulment.
- a change in the number of your dependents for federal income tax purposes through birth, adoption, placement for adoption, or the death of a dependent.
- the beginning or termination of your employment or your spouse or dependent's employment.
- a reduction or increase in your working hours, those of your spouse or dependent, including work-hour changes resulting from a switch between part-time and full-time employment, strike, lockout, or the beginning or end of an unpaid leave of absence.
- your dependent satisfying or ceasing to satisfy the requirements for eligibility (for example, by attaining the limiting age or by losing full-time student status).
- a change in your workplace or residence or that of your spouse or dependent.

An election change is "consistent with" an Eligible Status Change only if it is related to and corresponds with the particular Eligible Status Change that has occurred. For example, you may not cancel coverage for your spouse who has become eligible for coverage under another plan due to an Eligible Status Change unless he or she actually becomes covered under the other plan. However, if you are permitted to add coverage under our group health plan for a spouse or dependent child due to an Eligible Status Change, you may also, at the same time, add group health plan benefits for your other eligible family members.

Mid-Year Election Changes Due to Entitlement to COBRA. You may change your election with respect to health benefits if you become, or your spouse or dependent child becomes, entitled to continued coverage under our group health plan under the federal law known as "COBRA" or because of a state-mandated continuation of group health plan coverage.

Mid-Year Election Changes Due to a Qualified Medical Child Support Order. A Qualified Medical Child Support Order (or "QMCSO") is a court judgment, decree, or order (including a court's approval of a domestic relations settlement agreement) that requires health benefit coverage of your child. If you are required to provide health coverage to your child(ren) by a QMCSO issued due to a divorce, legal separation, annulment or change in legal custody, you may change your benefits elections with respect to our group health plan benefits.

Mid-Year Election Changes Due to Changes in Medicare and Medicaid Entitlement. If you become entitled to or cease to be entitled to Medicare or Medicaid, or if your spouse or dependent child does so, you may change your benefits elections with respect to health benefits.

Mid-Year Election Changes Due to Eligible Changes in Coverage under the Plan. If coverage under any benefit provided through the Plan is significantly curtailed or terminated during the Plan Year and you are affected by the change, you may make an election change to elect another option providing similar coverage. Coverage under group health plan benefits is "significantly curtailed" only if there is an overall reduction in coverage that affects all covered participants. If benefits are significantly curtailed and no alternative option is available under the Plan, revocation of the election is permitted.

If benefits are added to or eliminated from the Plan during the Plan Year and you are affected, you may make an election change to elect the new benefits or replace the eliminated benefits with another benefit providing similar coverage, if one is available under the Plan.

Mid-Year Election Changes Due to Eligible Changes in Coverage under a Family Member's Plan. In certain situations, you may make a prospective election change due to and consistent with a change in coverage under a Cafeteria Plan sponsored by the employer of your spouse, former spouse, or dependent. You can do so when the change in coverage results from either: (1) an election change permitted under that plan due to an Eligible Status Change or an eligible change in coverage; or (2) an election change made during that plan's annual election period, if its plan year does not coincide with the Plan Year of our Cafeteria Plan.

Mid-Year Election Changes Due to Changes in Coverage Costs. If the cost that is charged to all participants for a benefit is significantly increased during the Plan Year and you are affected, you may prospectively change your election to elect another benefit option providing similar coverage, if one is available under the Plan. If no such alternative option is available, revocation of the election is permitted.

A mid-year election change due to any of the above events must be made as soon as practicable after the occurrence of the event. It will take effect on the 1st of the month following the date you submit your election change. However, if you are enrolling a dependent child pursuant to the HIPAA Special Enrollment Rights and you notify the company within 30 days of the dependent's birth or adoption, your election change will apply retroactive to the date of birth or adoption.

CLAIMS PROCEDURES

Insured Benefits

Claims for benefits that are insured or administered by a third party administrator should be filed in accordance with the specific procedures contained in the insurance policies or the third party administrative services agreement. The address of the individual insurance company and/or third party administrator that reviews claims made under a Component Benefit Plan is set forth in **Appendix A**. All other general claims or requests should be directed to the Plan Administrator.

General Claims Procedure

The following procedures will be followed for denied claims under a Component Benefit Plan that is not a group health plan or long-term disability plan.

1. If your claim is denied, you or your beneficiary will receive written notification within 90 days after your claim was submitted. The notification will include the reasons for the denial, with reference to the specific provisions of the Component Benefit Plan on which

the denial was based, a description of any additional information needed to process the claim, and an explanation of the claims review procedure. If you do not receive a response within 90 days, your claim is treated as denied.

2. Within 60 days after notification of a claim denial, you may appeal the denial by submitting a written request for reconsideration of the claim to the Plan Administrator. Documents or records in support of your appeal should accompany any such request. The Plan Administrator will review the claim and provide, within 60 days, a written response to the appeal. This 60-day period may be extended an additional 60 days under special circumstances, as determined by the Plan Administrator. The Plan Administrator's response will explain the reason for the decision with specific reference to the provisions of the Plan on which the decision is based. The Plan Administrator has the exclusive and discretionary right to interpret the appropriate plan provisions. Decisions of the Plan Administrator are conclusive and binding.

Special Rules for Group Health Plan Claims

For purposes of ERISA, there are three categories of claims under a Component Benefit Plan that is a group health plan and each one has a specific timetable for approval, payment, request for additional information, or denial of the claim. The three categories of claims are:

1. *Urgent Care Claim* is a claim where failing to make a determination quickly could seriously jeopardize a claimant's life, health, or ability to regain maximum function, or could subject the claimant to severe pain that could not be managed without the requested treatment. A licensed physician with knowledge of the claimant's medical condition may determine if a claim is an Urgent Care claim.

2. *Pre-Service Claim* is a claim for which you are required to get advance approval or pre-certification before obtaining service or treatment for the medical services.

3. *Post-Service Claim* is a request for payment for covered services you have already received.

   (a) Time for Decision on a Claim. The time deadline for making decisions on claims under the Plan depends on the urgency of the claim. You will be notified of any determination on your claim (whether favorable or unfavorable) as soon as possible. If an Urgent Care Claim is denied, you will be notified orally and written notice will be provided to you within three days. The deadlines shown on the chart on page 6 are maximum time limits.

   (b) Notification of Denial. Except for Urgent Care Claims, when notification may be oral followed by written notice within three days, you will receive written notice if your claim is denied. The notice will contain the following information:

      i. The specific reason or reasons for the adverse determination;
      ii. Reference to the specific Plan provisions on which the determination was made;

iii. A description of any additional material or information necessary to perfect your claim and an explanation of why such material or information is necessary;

iv. A description of the Plan's review procedures and the time limits that apply to such procedures, including a statement of your right to bring a civil action under ERISA section 502 if your claim is denied on review;

v. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim;

vi. If an adverse determination is based on an internal rule, guidance, protocol, or other similar criteria, an explanation of those criteria or a statement that the criteria will be provided to you free of charge upon request

vii. If the adverse determination is based on a medical necessity or experimental treatment limit or exclusion, an explanation of the scientific or clinical judgment on which such decision is based, or a statement that such explanation will be provided free of charge upon request.

How to Appeal a Denied Group Health Plan Claim. If your claim is denied, you (or your attorney or other person authorized by you act on your behalf) will have 180 days following the date you receive written notice of the denial in which to appeal you claim. A failure to timely file an appeal request will constitute a waiver of your right to request a review of the denial of your claim. Unless you are appealing the denial of an Urgent Care Claim, your request for review should be made in writing. If you are requesting review of an Urgent Care Claim, you may request review orally or by facsimile. A request for review should contain your name and address, the date you received notice your claim was denied, and your reason(s) for disputing the denial. You may submit written comments, documents, records, and other information relating to your claim. If you request, you will be provided, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to the claim.

The period of time for the Plan to review your appeal request and to notify you of its decision depends on the type of claim as follows:

1. Urgent Care Claim – 72 hours; you will be notified orally and written notice will be provided within three days.
2. Pre-Service Claim – 15 days.
3. Post-Service Claim – 30 days.

The review will take into account all comments, documents, records, and other information you submit relating to your claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will be conducted by a Plan fiduciary other than the person or persons (or subordinate of such person or persons) who conducted the initial claim determination. The Plan fiduciary will provide an independent full and fair review of your claim and shall not give any deference or weight to the initial adverse determination. You will receive a written notice of the decision on review.

Timetable for Group Health Plan Claims

Time Limit	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Make initial claim determination	72 hours	15 days	30 days
Extension (with proper notice and if delay is due to matters beyond Plan's control)	None	15 days	15 days
To request missing information from claimant	24 hours	5 days	30 days
Claimant to provide missing information	48 hours	45 days	45 days
For claimant to request extension of course of treatment	24 hours before expiration of previously approved course of treatment	15 days before expiration of previously approved course of treatment	Not applicable

Special Rule for Disability Claims

A disability claim is a claim that requires the Plan to determine if you are disabled for purposes of eligibility for long-term disability benefits under a Component Benefit Plans. The Plan will notify you of its determination within 45 days after its receipt of your claim. This period can be extended for two additional 30-day periods (up to a total of 105 days) if a decision cannot be made because of circumstances beyond the control of the Plan Administrator. You may appeal the Plan's determination within 180 days following receipt of an adverse determination. The Plan will notify you of its determination on review within 45 days and in accordance with the procedures set forth in Section 4.2(b).

FAMILY MEDICAL LEAVE ACT COVERAGE

A Participant who is on an authorized leave of absence under the Family Medical Leave Act of 1993 (FMLA), may continue participation in the Plan for up to 12 weeks. Such participation will be provided under the terms and conditions of the applicable Component Benefit Plan, including the rate of contributions that would have been applicable if the Participant had continued employment and subject to the terms and conditions of the FMLA policy of the Plan Sponsor.

USERRA COVERAGE

Any Participant covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), shall continue to participate and be eligible to receive benefits under the Plan in accordance with USERRA rules and regulations.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Company's group health and dental plans will provide benefits as required by any qualified medical child support order ("QMCSO") and will provide benefits to dependent children placed with Participants for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of Participants, in accordance with ERISA Section 609(c). The Company has established detailed procedures for determining whether an order qualifies as a QMCSO. Participants' spouses and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

BENEFITS FOR ADOPTED CHILDREN

The Company group health and dental plans will extend benefits to dependent children placed with a Participant for adoption under the same terms and conditions as apply in the case of Dependent children who are natural children of Participants.

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods. In any case, such plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 requires that health plans offering medical and surgical benefits in connection with a mastectomy also provide coverage for (a) reconstruction of the breast on which the mastectomy was performed; (b) surgery and reconstruction of the other breast to provide symmetrical appearance; and (c) prostheses and treatment of physical complications during all stages of the mastectomy, including lymphedema.

COMPANY'S RIGHT TO CHANGE OR END THE PLAN

The Company reserves the right to terminate, suspend, withdraw, amend or modify the Plan, or any Component Benefit Plan, in whole or in part at any time.

COMPANY'S RIGHT TO INTERPRET THE PLAN

The Company has the discretion to interpret the provisions of the Plan and the component benefit Plans. The Company's interpretation is conclusive and binding on all Plan participants.

NO GUARANTEE OF NON-TAXABILITY

The Plan provides benefits intended to be non-taxable; however, the Plan Administrator or any fiduciary or party associated with the Plan shall not be in any way liable for any taxes or any other liability incurred by you or any person claiming through you.

COBRA RIGHTS

Employers who employ twenty or more employees are subject to the group health plan continuation provisions of COBRA. Please refer to the COBRA notice attached to this Summary Plan Description as Appendix B for information about your COBRA rights.

HIPAA PRIVACY RULE

Information you provide for purposes of a health plan sponsored by the company may be "Protected Health Information" under Privacy Standards established under the Health Insurance Portability and Accountability Act, often referred to as HIPAA. Your HIPAA privacy rights are described in a notice set forth in Appendix C attached to this Summary Plan Description.

ERISA RIGHTS

You are entitled to certain rights and protections under ERISA. ERISA provides that Plan participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents. These include insurance contracts, copies of all documents filed by the Plan with the Department of Labor (such as detailed annual reports), and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information by writing to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. Plan fiduciaries have a duty to operate benefit plans prudently and in the interest of plan participants.

- No one may terminate a participant's employment or otherwise discriminate against 'a participant in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA.
- If a participant's claim for a welfare benefit is denied in whole or in part, the participant must receive a written explanation of the reason for the denial.
- The participant has the right to have the Plan Administrator review and reconsider his or her claim.

Under ERISA, there are steps participants can take to enforce the above rights. For instance:

- If a participant requests materials from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the participant up to $110 a day until the materials are received (unless the materials were not sent because of reasons beyond the control of the Administrator).
- If a participant has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a state or federal court.
- If Plan fiduciaries misuse the Plan's money or if a participant is discriminated against for asserting his or her rights, the participant may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay these costs and fees. If the participant loses, the court may order him or her to pay these costs and fees, if, for example, it finds the claim to be frivolous.

If you have any questions about your benefits, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

APPENDIX A

COMPONENT BENEFIT PLAN AND CONTACT INFORMATION FOR FILING CLAIMS FOR BENEFITS UNDER THE HOG SLAT WELFARE BENEFITS WRAP PLAN

Benefit	**Service Provider**	**Where to file a claim?**
Group Health Benefits (including pharmacy benefit)	**Blue Cross and Blue Shield of North Carolina**	P.O. Box 2291 Durham, NC 27702 Phone: 800-291-6315 Website: www.bcbsnc.com
Group Life Group Long-Term Disability	**Guardian Life Insurance Company of America**	7 Hanover Square Customer Service, H-6-D New York, NY 10004 Phone: 888-482-7342
Group Wellness Program	**Internally administered**	n/a
Onsite Medical Clinic (NC Only)	**Internally administered but services provided by external vendor**	n/a

APPENDIX B

General Notice Of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

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

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

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

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: HOG SLAT HUMAN RESOURCES OFFICE. PO BOX 300, NEWTON GROVE NC 28366 OR 919-710-0761

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Hog Slat Health Plan

Hog Slat Human Resources Office

910-594-0219

APPENDIX C

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") applies to Protected Health Information (defined below) associated with Group Health Plans (defined below) provided by HOG SALT, INC to its employees, its employee's dependents and, as applicable, retired employees. This Notice describes how HOG SLAT, INC, collectively we, us, or our may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide individuals covered under our group health plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all policyholders then covered by the Group Health Plan. Copies of our current Notice may be obtained by contacting HOG SLAT INC at the telephone number or address below.

DEFINITIONS

Group Health Plan means, for purposes of this Notice, the following employee benefits that we provide to our employees, employee dependents and, as applicable, retired employees: [Insert the appropriate coverages you provide which might include major medical coverage, dental coverage, vision coverage, long-term care coverage and any other coverages that you provide that meet the definition of a health plan.

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed.

However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining coverage under the group health plan, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Uses and Disclosures for Payment – We may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or a health plan.

Uses and Disclosures for Health Care Operations – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of your Group Health Plan coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Group Health Plan.

Family and Friends Involved in Your Care – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim.

Business Associates – At times we use outside persons or organizations to help us provide you with the benefits of your Group Health Plan. Examples of these outside persons and organizations might include vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations.

Other Products and Services – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing Group Health Plan coverage, and about health-related products and services that may add value to your Group Health Plan.

Other Uses and Disclosures – We may make certain other uses and disclosures of your PHI without your authorization.

- We may use or disclose your PHI for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.

- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaveric organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
- We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as described above, we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard.

RIGHTS THAT YOU HAVE

Access to Your PHI – You have the right of access to copy and/or inspect your PHI that we maintain in designated record sets. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). Access request forms are available from [Insert company name] at the address below. We may charge you a fee for copying and postage.

Amendments to Your PHI – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request. Amendment request forms are available from us at the address below.

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from us at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your PHI – You have the right to request restrictions on certain of our uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. We are not required to agree to your request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the telephone number or address below.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact HOG SLAT, INC's Privacy Office by writing to: HOG SLAT INC, Attn: Denise Holland, PO BOX 300, NEWTON GROVE, NC 28366 or by calling 910-594-0219.

EFFECTIVE DATE

This Notice is effective Dec. 1, 2013.

Hog Slat, Inc. Wellness Plan

Plan Purpose

This voluntary program of formal and informal activities is designed to improve the health and well-being of all employees and reduce or eliminate health issues affecting employee health and work productivity.

Plan Objectives

1. Primary Goal. The Employee Wellness Plan will strive to increase the well-being and productivity of all employees by enhancing all aspects of health. The program seeks to increase awareness of positive health behaviors, to motivate employees to voluntarily adopt healthier behaviors, to reduce incidents of disease and illness and to provide opportunities and a supportive environment to foster positive lifestyle changes.
2. Objectives. The Wellness Plan will focus on the priority objectives of:
    a. Increasing the use of preventive screenings and services
    b. Improving healthy eating among employees
    c. Increasing physical activity among employees
    d. Improving tobacco prevention and cessation policies and benefits
    e. Improving stress management among employees

Eligibility Requirements

All employees and their spouses are eligible for voluntary participation in the wellness activities ("Participants"). Other family members are not eligible to participate in the Wellness Plan.

To be eligible for Wellness Plan Rewards, participants must complete the standards and provide documentation of completion of each element or request an alternate standard.

Program Content/Elements

1. Standards to be met. The Wellness Plan provides participants with health insurance premium reductions for completing the following:
    a. annual wellness biometric screenings and health survey
    b. annual physical
    c. use of tobacco products
    d. key lab values within ranges that are considered healthy.

2. Wellness Plan Rewards. For those Wellness Plan participants who meet the annual plan requirements and/or goals, the following rewards are provided:
    a. Premium discounts for employees insured on the Hog Slat Health Plan
    b. Gift Cards for non Hog Slat insured employees.

3. Alternative Standard. The Wellness Plan shall provide a reasonable alternative for any participant who cannot meet the Plan's standards and makes the request in writing.

4. Other Plan Benefits. The Wellness Plan offers participants the following plan benefits regardless of whether the participant meets the Plan Standards:

    a. partial gym cost reimbursement (which shall be treated as taxable wages);
    b. an onsite gym (certain locations only);
    c. vacation days; and
    d. other rewards for activity and diet based programs offered throughout the year

Effective date: December 1, 2012