Summary Plan Description

for

METROMONT CORPORATION

Health Benefit Plan
(Dental Benefits)

For

Hourly and Salary Employees

Revision and Restatement Date: August 1, 2015

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ADOPTION AGREEMENT

Metromont Corporation (the “Employer”) hereby restates the dental benefits as part of the health care benefits plan (the "Plan") effective as of August 1, 2015. The Employer has duly authorized the adoption of this document (“Summary Plan Description”) which describes the dental benefits and the execution thereof.

The benefits provided under this Plan and the general terms and conditions governing the same are contained in this Summary Plan Description, a copy of which is provided to participants in the Plan, and may also be governed by the provisions of certain insurance contracts purchased on behalf of the Plan. The Summary Plan Description, Plan Document and all such insurance contracts, if any, as the same may be amended from time to time, are hereby incorporated herein by this reference and made a part of this Plan.

This Summary Plan Description contains a summary in English of the Covered Person’s rights and benefits under the Plan. If the Covered Person has difficulty understanding any part of this Summary Plan Description because (s)he requires assistance in understanding English, contact the Plan Administrator at

Metromont Corporation
2802 White Horse Road
P.O. Box 2486
Greenville, SC 29611.

Este folleto contiene un resumen en inglés de los beneficios disponibles en el Corporacion Metromont para los empleados. El resumen de todos los documentos Del plan también está disponible en el Intranet, Internet y puede también obtener una copia impresa en la oficina de Departmento de Recursos Humanos. Si usted tiene dificultad para entender cualquiera de estos documentos del plan, por favor póngase en contacto con el Departmento de Recursos Humanos en:

Metromont Corporation
2802 White Horse Road
P.O. Box 2486
Greenville, SC 29611

By affixing his signature and date to this document, the Plan Sponsor does hereby certify that the Plan Sponsor has reviewed the Summary Plan Description and that it represents the terms and conditions of the Plan adopted by the Plan Sponsor.

_____

Authorized Signature of Health Plan

_____

Date

SCHEDULE OF DENTAL BENEFITS				
Note: The Covered Person is entitled to Dental Benefits only if (s)he has made application for such benefits and been enrolled for Coverage by the Plan Administrator under the Plan.				
	Class 1 Services Preventive Services	**Class 2 Services Basic Restorative Services**	**Class 3 Services Major Restorative Services**	**Class 4 Services Orthodontia Services**
Deductible	Not Applicable	Individual: $50 per Calendar Year		Individual: $50 per lifetime
Coinsurance	100%	80%	50%	50%
Maximum Benefit	Individual: $1,200 per Calendar Year			Individual: $1,000 per lifetime

DENTAL BENEFITS

This section describes the Covered Person's Dental Benefits. All payments will be subject to any applicable Deductible, Coinsurance, Maximum Benefits and other provisions and limitations in this Summary Plan Description and the Schedule of Benefits.

PRE-DETERMINATION OF BENEFITS

If the Covered Person's Dentist plans a course of dental treatment that will cost $200 or more, the Covered Person's Dentist is encouraged to obtain a pre-determination of benefits. This is done by submitting a claim form outlining the treatment plan the Dentist intends to follow in treating the Covered Person. This should be provided to the Plan Administrator, or the Plan's Claims Administrator, prior to the start of the course of treatment. The claim form should include a detailed description of the work to be done and an estimate of the anticipated dental charges.

In addition to the claim form, any existing diagnostic aids and x-rays should be provided. The purpose of a dental pre-determination of benefits is to assist the Dentist and Covered Person in determining what will be covered under the Plan prior to the services being rendered. Coverage must be in effect when the actual dental services are provided in order for the services to be covered under the Plan even if the Covered Person's Dentist has obtained a pre-determination of benefits. It is important to note that pre-determination of benefits is not required and will not result in a loss of Coverage in the event that a pre-determination of benefits is not submitted to the Plan.

MULTIPLE METHODS OF DENTAL TREATMENT

The Plan may feel that there is more than one way to treat the Covered Person's dental condition. When there are two or more methods of treatment for the same condition which meet commonly accepted standards of dental practice, the Plan will pay for the least expensive treatment. This applies even if the Covered Person and the Covered Person's Dentist have chosen a more costly treatment.

In order to determine the benefit amounts for dental covered services, the Plan may ask for x-rays and other diagnostic and evaluative materials. If these materials are not provided, the Plan will determine the benefit amounts on the basis of the information that is available. This may reduce the amount of benefits which otherwise would have been payable.

Coverage will be provided for the Covered Services listed below. They must be billed by or for a Dentist.

DENTAL COVERED SERVICES

Expenses for the following covered services are considered incurred on the date the type of dental service for which the charge is made is completed.

Preventive and Diagnostic Services

1. Routine oral examinations. This includes the cleaning and scaling of teeth. Limited to 2 per Covered Person per Calendar Year;

2. Bitewing x-rays. Limited to one series every 12 months;

3. Full mouth x-rays. Limited to one every 3 years;

4. Fluoride treatment, every 6 months for covered Dependent Children under age 19;

5. Space maintainers used in place of prematurely lost teeth for covered Dependent Children under age 19;

6. Emergency palliative treatment for pain; and

7. Sealants on the occlusal surface of a permanent posterior tooth for Dependent Children under age 19, limited to one treatment per tooth every 2 years.

Basic Restorative Services

1. Dental x-rays not covered under Preventive and Diagnostic Services;

2. Oral surgery. Oral surgery is limited to the removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than ¼ inch;

3. Periodontics:

   - Scaling and root planning – up to 4 quardrants every 2 years;
   - Retreatment of periodontal surgical procedures, once every 2 years;
   - Full mouth debridement, once per lifetime;

4. Endodontics;

5. Extractions. This service includes local anesthesia and routine post-operative care; and

6. Fillings, other than gold.

7. General anesthetics, including IV sedation, upon demonstration of Medical Necessity, for covered oral surgical procedures.

8. Antibiotic drugs.

9. Osseous surgery.

Major Restorative Services

1. Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold;

2. Installation of crowns when teeth are not restorable by other means. Installation of crowns for the purpose of periodontal splinting are not covered;

3. Installation of precision attachments for removable dentures;

4. The installation of partial, full or removable dentures to replace one or more natural teeth. This service also includes all adjustments made during 6 months following the installation;

5. Addition of clasp or rest to existing partial removable dentures;

6. Initial installation of fixed bridgework and removable dentures;

7. Repair of crowns, bridgework and removable dentures;

8. Rebasing or relining of removable dentures;

9. Temporomandibular Joint Disorder (TMJ) treatment, when not covered under the Medical Benefits;

10. Recementing bridges, crowns or inlays;

11. Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or, adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:

    - The existing denture or bridgework was installed at least 5 years prior to its replacement and cannot currently be made serviceable;

    - The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed;

    - If due to loss of natural teeth and the Covered Person has been enrolled in this Plan for at least 2 years.

Orthodontia Services

The Plan will cover orthodontia services for all Covered Persons. Orthodontia services are services for the correction of the position and alignment of the teeth, and include, but are not limited to the following services:

1. Placement of braces on the teeth;

2. Adjustment of braces at regular intervals as determined by the Dentist; and

3. Dental consultations as deemed Medically Necessary for the course of the approved orthodontia treatment program.

DENTAL & GENERAL EXCLUSIONS OR LIMITATIONS

No dental benefits are provided for any of the following:

1. **Anesthesia.** The Plan will not cover expenses in connection with anesthesia, except as specifically set forth herein;

2. **Applicable Section**. The Plan will not cover expenses which are payable under one section of this Plan under any other section of this Plan;

3. **Appliances and Restoration for Vertical Dimension**. The Plan will not cover appliances or restorations to increase the vertical dimension of the mouth or to restore the occlusion. Full mouth equilibration is one example of such a service;

4. **Charges Incurred Due to Non-Payment.** The Plan will not cover charges for sales tax, mailing fees and surcharges incurred due to nonpayment;

5. **Claims Time Frames.** The Plan will not cover charges for claims not received within the Plan's filing limit deadlines as specified under the section entitled Claims Information;

6. **Congenital Malformation**. The Plan will not cover services or supplies for the treatment or correction of a congenital malformation unless Medically Necessary;

7. **Cosmetic Services**. The Plan will not cover services or supplies primarily cosmetic or aesthetic. Examples include capping teeth to cover stains; charges for personalization or characterization of crowns, full or partial dentures or fixed bridgework;

8. **Court Ordered Treatment.** The Plan will not cover charges for court ordered treatment (e.g. substance abuse) unless such treatment would be considered eligible for Coverage under this Plan;

9. **Criminal Act.** The Plan will not cover charges for services and supplies incurred as a result of an Illness or Injury caused by or contributed to by engaging in an illegal act, by committing or attempting to commit a crime or by participating in a riot or public disturbance. However, the Plan may not deny charges for the care or treatment of an Injury which is sustained as the result of an act of domestic violence or a medical condition. As used herein, a medical condition includes a physical or mental condition;

10. **Crowns.** The Plan will not cover crowns for teeth that are restorable by other means or for the purpose of periodontal splinting;

11. **Dental Services for Which Normally There Is No Charge**. The Plan will not cover dental services or supplies for which the Covered Person would not have been charged if the Covered Person had not been covered by this dental insurance. For example: (a) if the Covered Person would have been charged less if (s)he had no insurance, the Plan will base the payment on the lower charge; or (b) if the service would have been provided free by a clinic or health service which is operated by or for the Covered Person's employer, union or similar group, the Plan will not pay any charges;

12. **Dental Visits to Home or in Hospital**. The Plan will not cover charges for dental visits at home or in a Hospital, unless these visits are in connection with dental surgery or emergency care;

13. **Duplicate Devices**. The Plan will not cover duplicate prosthetic devices or appliances;

14. **Excess Charges**. The Plan will not cover charges that are considered excess charges because: (a) the Covered Person transferred from one Dentist to another during a course of treatment; (b) the Covered Person missed an appointment; (c) services were rendered by more than one Dentist; or (d) services were repeated needlessly;

15. **Exclusions.** The Plan will not cover charges for services and supplies which are specifically excluded under this Plan;

16. **Experimental or Investigative.** The Plan will not cover charges for services and supplies which are either experimental or investigational or not Medically Necessary, except as provided herein;

17. **Family Member**. The Plan will not cover expenses or services received from a member of the Covered Person's household or from an Immediate Family Member. For the purposes of this exclusion, Immediate Family Member means the Covered Employee, his or her spouse, brother, sister, parent or the Dependent Child. Immediate Family Member also includes the brother sister, parent or Dependent Child of the employee's spouse;

18. **Implants**. The Plan will not cover implants, including any appliances and/or crowns or the surgical insertion or removal of implants;

19. **Lost or Stolen Supplies**. The Plan will not cover dental services and supplies to replace a lost or stolen crown, bridge or full or partial denture;

20. **Governmental Agency or Program**: The Plan will not cover supplies and services that are furnished or rendered to a Covered Person, or for which the cost is payable, by a governmental agency or governmental program;

21. **Government Owned/Operated Facility**. The Plan will not cover charges for services and supplies in a hospital owned or operated by the United States government or any government outside the United States in which the Covered Person is entitled to receive benefits, except for the reasonable cost of services and supplies which are billed, pursuant to Federal Law, by the Veterans Administration or the Department of Defense of the United States for services and supplies which are eligible herein and which are not incurred during or from service in the Armed Forces of the United States or any other country;

22. **Hazardous Hobby.** The Plan will not cover charges for services and supplies due to an Illness or Injury that results from engaging in a hazardous hobby. A hazardous hobby is an activity that is characterized by a threat of danger or risk of bodily harm. Some examples of hazardous hobbies include, but are not limited to: any kind of organized vehicular speed or endurance contest in the air, on land or water, hang gliding, bungee jumping, stunt driving, ski jumping, snow boarding, jet skiing, scuba diving, snowmobiling without a helmet, motorcycling without a helmet, driving or riding in a motor vehicle without a seat belt, and participating in an aerobatics contest or demonstration. However, the Plan may not deny charges for the care or treatment of an Injury which is sustained as the result of an act of domestic violence or a medical condition. As used herein, a medical condition includes a physical and mental health condition;

23. **Hospital/Facility Employee.** The Plan will not cover charges for services billed by a Provider (Physician or nurse) who is an employee of a hospital or facility and is paid by the hospital or facility for the services rendered;

24. **Illegal Acts**. The Plan will not cover charges for services received as a result of an Injury or Illness occurring directly or indirectly, as a result of a Serious Illegal Act. For purposes of this exclusion, the term Serious Illegal Act shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. However, the Plan may not deny charges for the care or treatment of an Injury which is sustained as the result of an act of domestic violence or a medical condition. As used herein, a medical condition includes a physical or mental condition;

25. **Illegal Drugs, Medications or Alcohol**. The Plan will not charges incurred by a Covered Person for an Injury or Illness which occurred as a result of such person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotics not administered on the advice of a Physician. In addition, the Plan will not cover charges in connection with an Injury or Illness which occurred as a result of the covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for purposes of applying this exclusion. Expenses will be covered for the injured Covered Person other than the person using controlled substances or alcohol and expenses will covered for substance abuse treatment as specified in the Plan. However, the Plan may not deny charges for the care or treatment of an Injury which is sustained as the result of an act of domestic violence or a medical condition. As used herein, a medical condition includes a physical or mental condition;

26. **Legal Obligation.** The Plan will not cover charges for services and supplies for which the Covered Person has no legal obligation to pay or for which no charge has been made;

27. **Maximum Benefit.** The Plan will not cover charges for services and supplies which exceed the Maximum Benefit, as shown in the Schedule of Benefits;

28. **Medical Benefits**. The Plan will not cover dental services or supplies which are covered under any medical benefits or health care coverage;

29. **Medicare.** The Plan will not cover charges for which benefits are payable under Medicare Part A or would have been payable if a Covered Person had applied for Part A; and for which benefits are payable under Medicare Part B or would have been payable if a Covered Person had applied for Part B, except as specified in this Plan Document;

30. **Military Related Disability**. The Plan will not cover charges for services and supplies for any military service-related disability or condition;

31. **No Charge**. The Plan will not cover dental services or supplies which are provided or made available free of charge or are payable by some other agency;

32. **Non-Covered Services.** The Plan will not cover charges in connection with services that are not specifically listed as a Covered Service in this Summary Plan Description;

33. **Non-Dental Charges.** The Plan will not cover charges for: telephone consultations; failure to keep a scheduled visit; completion of a claim form; attending Physician statements; or requests for information omitted from an itemized billing;

34. **Non-Medically Necessary Services.** The Plan will not cover any services that are not deemed to be Medically Necessary except as set forth herein;

35. **Not Under Care of Physician.** The Plan will not cover charges for services and supplies not recommended and approved by a Physician; or services and supplies when the Covered Person is not under the care of a Physician;

36. **Oral Hygiene Instruction or Programs**. The Plan will not cover plaque control programs, oral hygiene or dietary instruction;

37. **Orthognathic Surgery**. The Plan will not cover charges for surgery to correct malpositions in the bones of the jaw;

38. **Porcelain Veneers**. The Plan will not cover porcelain or other veneers of crowns and pontics placed on the molars. If veneers are used, payment will be the same as payment for a full cast gold crown or cast gold pontic;

39. **Professional Medical Standards.** The Plan will not cover charges for services and supplies which are not provided in accordance with generally accepted professional medical standards or for experimental treatment;

40. **Self-Inflicted Injury or Suicide.** The Plan will not cover expenses incurred in connection with a self-inflicted injury, suicide attempt, or suicide, while sane or insane. However, the Plan may not deny charges for the care or treatment of an Injury which is sustained as the result of an act of domestic violence or a medical condition. As used herein, a medical condition includes a physical and mental health condition (e.g. depression);

41. **Splinting**. The Plan will not cover charges for crowns, fillings or appliances that are used to connect (splint) teeth, or charge or alter the way the teeth meet, including altering the vertical dimension, restoring the bite or are cosmetic;

42. **Subrogation Failure**. The Plan will not cover charges for an Illness or Injury suffered by a Covered Person due to the action or inaction of any party if the Covered Person fails to provide information as specified under Subrogation;

43. **Stabilizing Services.** The Plan will not cover services primarily to stabilize the teeth in their supporting structures. Examples include implantology and periodontal splinting;

44. **Travel Expenses.** The Plan will not cover charges for travel, whether or not recommended by a Physician, except as provided herein;

45. **Unnecessary Services or Supplies.** The Plan will not cover expenses for any charge, expense, service or treatment that has been deemed unnecessary or inappropriate by the ADA or is otherwise deemed unnecessary or inappropriate in accordance with accepted dental standards and practice;

46. **War.** The Plan will not cover any charge for services, supplies or treatment related to Illness, Injury, or disability caused by or attributed to an act of war, act of terrorism, riot, civil disobedience, insurrection, nuclear explosion or nuclear accident. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized military forces;

47. **Work-Related Illness or Injury**. The Plan will not cover charges for services and supplies for any condition, disease, defect, ailment, or accidental Injury arising out of and in the course of employment (for wage or profit) whether or not benefits are available under any Workers' Compensation Act or other similar law. This exclusion applies if the Covered Person receives the benefits in whole, part or even if there is no Workers' Compensation coverage in place. This exclusion also applies whether or not the Covered Person claims the benefits or compensation; and

48. **Effective Date and Termination Date Rules**. The Plan will not cover dental services or supplies that are provided before this Dental Coverage goes into effect or after it is terminated. In the case of prosthetic devices and crowns, charges will not be covered if the impressions were taken before Coverage goes into effect, even if the prosthetic device or crown is installed after Coverage goes into effect. If impressions are taken while Coverage is in effect, but the prosthetic device or crown is installed after Coverage terminates, then charges for the prosthetic device or crown will not be covered. In the case of the replacement of missing teeth, the Plan will not cover dental services or supplies for the replacement of a missing tooth or teeth that was missing prior to the effective date of Coverage.

ELIGIBILITY PROVISIONS

ELIGIBLE EMPLOYEES

Employees must meet the following eligibility requirements in order to be considered an Eligible Employee:

1. The Employee must be a full-time hourly or salary Employee regularly working at least 30 hours per week;
2. The Employee cannot be a temporary Employee;
3. The Employee must be Actively Working; and
4. If applicable, the Employee must make the required contribution towards the Coverage.

NOTE ABOUT ACTIVELY AT WORK REQUIREMENT:
The Actively at Work requirement, as it relates to establishing and maintaining eligibility, applies to the extent permitted under applicable HIPAA non-discrimination regulations. In addition, an Employee will retain eligibility for Coverage under the Plan if absent on an approved leave of absence, with the expectation of returning to work following the approved leave of absence as determined by the Employer. The Employer's classification of an individual is conclusive and binding for purposes of determining eligibility under the Plan.

ELIGIBLE DEPENDENTS

Eligible Dependents of an Eligible Employee may only be enrolled for Coverage under the Plan if the Eligible Employee is enrolled for Coverage under the Plan.

The following persons are considered to be Eligible Dependents of a Covered Employee:

1. The Spouse of the Covered Employee;

2. Your child(ren) up to age 26.

    - Children are your natural or lawfully adopted children (including children placed for adoption), stepchildren and persons for whom you are the legal guardian.

NOTE ABOUT CHILDREN:
As used in defining a Dependent Child, the term Child includes the Employee's natural child, step child (provided the child's biological parent remains married to the Employee), legally adopted child or who is under the Employee's legal guardianship pursuant to an interlocutory order of adoption or other court order. For a legally adopted child or one who is in the Employee's legal guardianship pursuant to an interlocutory order of adoption, the child must be under age 18 at time of placement In addition, Coverage for such child shall begin from time of placement in the home for adoption whether or not the adoption proceedings have been completed.

    - A Child who is dependent pursuant to a Qualified Medical Child Support Order ("QMCSO") as set forth under OBRA 1993 will be considered a Dependent Child under this Plan. The QMCSO entitles such child to Coverage even if (i) such child does not reside with the Covered Employee or is not dependent on the Employee for support and (ii) the Employee does not have legal custody of the child and (iii) the Employee is not currently enrolled for Coverage under the Plan. In this instance, both the Employee and the Dependent Child must be enrolled. If the Eligible Employee has not satisfied the applicable Waiting Period, the Plan must cover the

Dependent Child upon the Eligible Employee's completion of such Waiting Period. All other applicable enrollment provisions of the Plan (e.g., Dependent Limiting Age, benefit options, right to continued Coverage, etc.) which are available to Covered Employees or other Covered Dependents shall be made available to the Dependent Child who is eligible pursuant to a Qualified Medical Child Support Order. Contact the Plan Administrator for information concerning the applicable procedures for enrolling a Dependent Child who is eligible in accordance with a QMCSO;

- A Child who: (i) is unmarried; (ii) is eligible for support in accordance with the Internal Revenue Code; (iii) has the same principal place of abode as the Covered Employee for the period of time established by the Internal Revenue Code; (iv) is over the Dependent Limiting Age; (v) is permanently disabled prior to reaching the Dependent Limiting Age; and (vi) is covered under the Plan prior to reaching the Dependent Limiting Age. The Dependent Child must be incapable of self-sustaining employment by reason of mental or physical handicap and primarily dependent upon the Covered Employee for support and maintenance. The Covered Employee must notify the Employer of the child's handicap and continued dependence within 31 days after the Dependent Child reaches the Dependent Limiting Age. Such notification shall include proof satisfactory to the Employer of the Dependent Child's incapacity and dependence upon the Covered Employee.

The Plan Administrator has the right to request information needed to determine the patient's eligibility when a claim is filed. In addition, the Plan Administrator has the right to periodically request that the Covered Employee provide proof of a Dependent Child's eligibility.

APPLYING FOR COVERAGE AND EFFECTIVE DATES

ENROLLMENT PERIOD FOR NEW HIRES

For an Eligible Employees who is newly hired, the Eligible Employee must complete and submit an enrollment application to the Employer within 31 days following the Eligible Employee's date of hire. For an hourly employee who submits an enrollment application to the Employer within this 31-day enrollment period, the Effective Date of Coverage will be the 1st of the month following 60 days. For a salaried employee who submits an enrollment application to the Employer within this 31-day enrollment period, the Effective Date of Coverage will be immediate (i.e. the date of hire).

This same enrollment provision applies to an Eligible Employee who is rehired or has a change of eligibility status which qualifies the employee for Coverage after his or her initial date of hire (e.g. changes from part-time employment status to full-time employment status).

ENROLLMENT PERIOD FOLLOWING LOSS OF OTHER COVERAGE

Eligible Employees who are covered under another dental plan and subsequently lose such coverage are eligible for Coverage following the loss of the other coverage provided they submit a completed application to the Employer within 31 days following termination of the other coverage. If an Employee submits the application within this 31-day enrollment period, Coverage will be effective on the date of the loss of other coverage. The Employee is eligible only if (s)he submitted a written declination of Coverage to the Employer when (s)he was initially eligible to enroll under the Plan.

As used herein, loss of the other coverage must be due to: (a) exhaustion of COBRA benefits; (b) Loss of Eligibility under the prior coverage; or (c) termination of contributions by the employer under the prior plan of coverage. The enrollment opportunity in connection with the loss of other coverage is considered to be a HIPAA Special Enrollment Period.

This HIPAA Special Enrollment Period also applies to Dependents of Eligible Employees who decline enrollment when initially eligible under the Plan due to existing medical benefits under another health plan and state in writing at such time that this is the reason for declining enrollment, provided the application is submitted within the time frame set forth above and loss coverage under the other plan was for one of the reasons set forth above.

ENROLLMENT PERIOD FOLLOWING MARRIAGE

An Eligible Employee may add his or her Spouse during the Employee's initial eligibility period (i.e., when (s)he is initially eligible to enroll for Coverage). However, in the event a Covered Employee marries after his or her Coverage has become effective, the Employee may add his or her spouse to the Coverage by submitting to the Employer a completed application within 31 days of the event. In this event, Coverage will be effective on the date of the marriage. In this instance, the Eligible Employee, the Spouse and any Dependent Children who are newly acquired as the result of the marriage, who did not enroll under the Plan when initially eligible or during a subsequent open enrollment period, if applicable, are permitted to enroll during this special enrollment period.

The enrollment opportunity in connection with the addition of a Spouse following marriage is considered to be a HIPAA Special Enrollment Period.

ENROLLMENT PERIOD FOLLOWING BIRTH OR ADOPTION

An Eligible Employee may add Dependent Coverage to his or her Coverage during the Employee's initial eligibility period (i.e., when (s)he is initially eligible to enroll for Coverage). However, in the event a child is born, adopted or placed for adoption after the Employee's Coverage is in effect, the Employee will be eligible to enroll the child by submitting an application to the Employer within 31 days following the child's birth date, adoption or placement for adoption. In the event the application is submitted within this enrollment period, Coverage shall be made effective on the birth date of the child, or on the date of adoption or the date the child has been placed for adoption. In addition, the Eligible Employee and Spouse, if not already covered, will also be eligible to enroll for Coverage.

The enrollment opportunity in connection with the addition of a Dependent Child following birth, adoption or placement for adoption is considered to be a HIPAA Special Enrollment Period.

ENROLLMENT PERIOD FOR OTHER MID-YEAR ELECTION CHANGES

This provision applies if the Employer offers a Section 125 plan, including but not limited to a Section 125 Premium Only Plan, in which the Employee is participating.

When the Covered Employee experiences an event that would allow him to make a mid-year election change to his current premium payment elections under his Section 125 Plan, the Employee may also be permitted to make a corresponding change under this medical Plan provided such change is permitted by the Employer and is in accordance with the IRS regulations governing Section 125 Plans

The events that would allow such a revocation or change include, but are not limited to the following types of events: change in residence that effects an Employee's or dependent's eligibility; change in family status; increase in the employer's contributions; significant change in employee-cost for a benefit package; significant curtailment of benefits; addition or significant improvement in a benefit option; change in dependent eligibility as the result of a court order or decree; becoming eligible for Medicare or Medicaid; going on FMLA leave of absence; or revocation due to a reduction in hours and revocation due to enrollment in a qualified health plan . Any change or revocation must be consistent with the events permitted as a mid-year change under the Section 125 Plan (as regulated by the IRS) to the extent that it is necessary or appropriate as the result of such change.

Contact the Employer for details concerning this provision.

OPEN ENROLLMENT PERIOD

Open Enrollment Period is the period designated by the Employer during which the Employee may elect Coverage for himself and any eligible Dependents if (s)he is not covered under the Plan. For example, Late Enrollees are only permitted to enroll during the Plan's Open Enrollment Period. During the Open Enrollment Period, an Employee and his Dependents who are not covered under this Plan must complete and submit an application. The Open Enrollment Period under this Plan occurs in the fall months of each calendar year. Coverage for Employees and Dependents who enroll during this Open Enrollment Period will be effective the first day of January.

TERMINATION PROVISIONS

TERMINATION OF EMPLOYEE COVERAGE

Coverage will terminate for the Covered Employee and his/her Covered Dependents on the earliest of the following:

1. The date the Plan terminates;
2. The date the Covered Employee ceases to be an Eligible Employee;
3. The date the Covered Employee dies;
4. The date the Covered Employee reaches the Plan's Lifetime Maximum Benefit;
5. The end of the period for which any required contribution by the Employer or Employee has been made if payment of fees have not been submitted when due;
6. For an Employee who is on a leave of absence as defined under the Family and Medical Leave Act ("FMLA"), at the end of the FMLA leave of absence provided the Employee does not return to work as an Actively Working Employee at the end of such leave of absence (see note below);
7. For an Employee who is on other Employer-approved leave of absence, at the end of the approved leave of absence provided the Employee does not return to work as an Actively Working Employee at the end of the such leave of absence (see note below).

The Employee may be eligible for COBRA Coverage "COBRA Coverage."

SPECIAL NOTE ABOUT LEAVE OF ABSENCE:

The Employer will continue to provide Coverage for an Employee (any Dependents) while an Employee is on a leave of absence for a period not to exceed 12 weeks. The leave of absence may be for a medical leave of absence or it may be a non-medical leave of absence (e.g. temporary layoff). Coverage will be continued during the leave of absence only if there is an anticipation that the Employee will be returning to Actively Working status at the end of the leave of absence. Continued Coverage will be provided only for those Employees and Dependents who were covered on the day preceding the leave of absence and may be contingent on the Employee's payment of any required contribution in connection with such continued Coverage.

The Employer may also require the Employee to use other paid sick leave or other paid leave of absence as may be available under the Plan prior to the FMLA period. In addition, the Employer may require that the Employee substitute accrued paid time under the Employer's sick leave or other paid leave of absence policy for the FMLA period, provided the Employer has notified the Employee in writing that such leave of absence is being counted as FMLA leave of absence.

Contact the Employer for details concerning any applicable company policies concerning time off and FMLA.

TERMINATION OF DEPENDENT COVERAGE

Coverage will terminate for the following Covered Person(s) on the earliest of the following:

1. The date the Plan terminates;
2. The date the Employee's Coverage terminates;
3. The date of the Employee's death;
4. The date a Dependent loses dependency status under the Plan;
5. The date a Dependent reaches the Plan's Lifetime Maximum Benefit; or
6. The end of the period for which any required contribution by the Employer or Employee has been made if payment of fees have not been submitted when due.

The Dependent may be eligible for COBRA Coverage as described in the section entitled "COBRA Coverage."

SPECIAL NOTE ABOUT CANCELLATION OR CESSATION OF COVERAGE IN CONNECTION WITH MID-YEAR CHANGES UNDER SECTION 125 PLAN

There may be additional reasons for cancellation or cessation of coverage for individuals participating in a Section 125 plan. If an employee or dependent is participating in a Section 125 plan offered by the Employer, and the employee/dependent experiences a qualifying event that allows for a mid-year election change resulting in a revocation of a Section 125 election and medical coverage election (e.g. termination of participating under the medical plan), the Employer may allow for a mid-year termination of Coverage on the same date as the revocation of the Section 125 election. This provision only applies if the Employer offers a Section 125 plan and if the Employer's Section 125 plan allows for such revocations in connection with a mid-year election change. The employee/dependent should contact the Employer for details regarding whether (s)he will be permitted to revoke his or her coverage elections under the medical Plan as the result of a Section 125 mid-year election change.

COBRA COVERAGE

A federal law commonly referred to as COBRA requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of benefits ("COBRA Coverage") at group rates in certain instances where Coverage under the Plan would otherwise end. This notice is intended to inform the Covered Person, in a summary fashion, of the rights and obligations under the COBRA Coverage provisions of the law. If the Covered Person does not choose COBRA Coverage, the Coverage under the Plan will end.

COBRA Coverage applies to the medical benefits under the Plan and also applies to any dental and/or vision coverage if covered under the Plan prior to the Qualifying Event. The Covered Person will only be entitled to receive COBRA Coverage for the coverage(s) (s)he elects to continue during the election process as described herein.

Qualified Beneficiaries

As used herein, a Qualified Beneficiary is a Covered Person who loses Coverage under the Plan as the result of a Qualifying Event.

Qualifying Events

Qualifying Events are any one of the following events, which would normally result in termination of Coverage. These events will qualify a Covered Person to continue coverage as a Qualified Beneficiary beyond the termination date described in the Summary Plan Description. The Qualifying Events are listed below.

1. Death of the Covered Employee;

2. The Covered Employee's termination of employment (other than termination for gross misconduct) or reduction in work hours to less than the minimum required for Coverage under the Plan. This includes a Covered Employee whose employment has been adversely affected by international trade and who is eligible for trade adjustment assistance (TAA) or an individual whose employment has terminated following the last day of leave under the Family Medical Leave Act;

3. Divorce or legal separation from the Covered Employee;

4. The Covered Employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan;

5. A Dependent child no longer meets the eligibility requirements of the Plan; and

6. A covered Retiree and their covered Dependents whose benefits were substantially reduced within one year of the Employer filing for Chapter 11 bankruptcy.

Notification Requirements

There are a number of notification requirements under COBRA. First, the Plan Administrator must be alerted to a Qualifying Event in order to offer COBRA Coverage to Qualified Beneficiaries. This notice must be submitted in writing to the Plan Administrator, either by the Employer, or by the Covered Employee or a Dependent. The nature of the Qualifying Event determines which party must notify the Plan Administrator. Second, once the Plan Administrator is notified of a Qualifying Event, the Plan Administrator will provide notices to the COBRA Beneficiary. The notification requirements established under COBRA are described in this COBRA Coverage section.

Notification by Covered Employee or Dependent

The Covered Employee or Dependent must notify the Plan Administrator when eligibility for COBRA Coverage results from divorce or legal separate from the Covered Employee or a Dependent Child loss of eligibility under the Plan.

The Covered Employee or Dependent must provide this notice to the Plan Administrator within 60 days of either the Qualifying Event or date of loss of Coverage, as applicable to the Plan.

For individuals who are requesting an extension of COBRA Coverage due to a disability, the individual person must submit proof of the determination of disability by the Social Security Administration to the Employer within the initial 18 month COBRA Coverage period and no later than 60 days after the Social Security Administration's determination. When the Social Security Administration has determined that a person is no longer disabled, Federal law requires that person to notify the Plan Administrator within 30 days of such change in status.

These notification requirements also apply to an individual who, while receiving COBRA Coverage, has a second or subsequent Qualifying Event. Refer to the section entitled Period of Continued Coverage for additional information.

The Covered Employee or Dependent, or their representative, must deliver this notice **in writing** to the Plan Administrator. The notice must identify the Qualified Beneficiaries, the Plan, the Qualifying Event, the date of the Qualifying Event, and include appropriate legal documentation to confirm the Qualifying Event. The Plan Administrator shall require that any additional information be provided, when necessary to validate the Qualifying Event, before deeming the notice to be properly submitted. If the requested information is not provided within the time limit set forth above, the Plan Administrator reserves the right to reject the deficient notice, which means that the individual has forfeited their rights to COBRA Coverage.

To protect their rights, it is very important that Covered Employees and Dependents keep the Plan Administrator informed of their current mailing address. Any notices will be sent to individuals at their last known address. It is the responsibility of Covered Employees and Dependents to advise the Plan Administrator of any address changes in a timely manner in order to ensure that notices, such as those regarding their rights under COBRA, are deliverable.

Failure to provide notice to the Plan Administrator in accordance with the provisions of this notice requirement will result in the person forfeiting their rights to COBRA Coverage under this provision.

Notification by Employer

The Employer is responsible for notifying the Plan Administrator when eligibility for COBRA Coverage results from any events other than divorce or legal separation, or a Dependent becoming ineligible.

The Employer shall provide this notice to the Plan Administrator within 30 days of either the Qualifying Event or date of loss of coverage, as applicable to the Plan. The Employer must include information that is sufficient to enable the Plan Administrator to determine the Plan, the Covered Employee, the Qualifying Event, and the date of the Qualifying Event.

The Employer must deliver this notice **in writing** to the Plan Administrator. The notice must identify the Qualified Beneficiaries, the Plan, the Qualifying Event, the date of the Qualifying Event, and include appropriate legal documentation to confirm the Qualifying Event. The Plan Administrator shall require that any additional information be provided, when necessary to validate the Qualifying Event, before deeming the notice to be properly submitted.

Notification by Plan Administrator

Election Notice: Once the Plan Administrator receives proper notification that a Qualifying Event has occurred, COBRA Coverage shall be offered to each of the Qualified Beneficiaries by means of a COBRA Election Notice. The time period for providing the COBRA Election Notice shall generally be 14 days following receipt of notice of the Qualifying Event. This time period may be extended to 44 days under certain circumstances where the Employer is also acting as the Plan Administrator.

Notice of Ineligibility: In the event that the Plan Administrator determines that the Covered Employee and/or Dependent(s) are not entitled to COBRA coverage, the Plan Administrator shall notify the Covered Employee and/or Dependent(s). This notice shall include an explanation of why the individual(s) may not elect COBRA Coverage. A notice of ineligibility shall be sent within the same time frame as described for a COBRA Election Notice.

Notice of Early Termination: The Plan Administrator shall provide notice to a Qualified Beneficiary of a termination of COBRA Coverage that takes effect on a date earlier than the end of the maximum period of COBRA Coverage that is applicable to the Qualifying Event. The Plan Administrator shall notify the Qualified Beneficiary as soon as possible after determining that coverage is to be terminated. This notice shall contain the reason coverage is being terminated, the date of termination, and any rights that the individual may have under the Plan, or under applicable law, to elect alternative group or individual coverage.

Election of Coverage

Upon receipt of Election Notice from Plan Administrator, a Qualified Beneficiary has 60 days from the date the notice is sent to decide whether to elect COBRA Coverage. Each person who was covered under the Plan prior to the Qualifying Event has a separate right to elect COBRA Coverage on an individual basis, regardless of family enrollment. For example, the employee's spouse may elect COBRA Coverage even if the employee does not select the coverage. COBRA Coverage may be elected for one, several or all dependent children who are Qualified Beneficiaries and a parent may elect COBRA Coverage on behalf of any dependent child.

In considering whether to elect COBRA Coverage, the Qualified Beneficiary should take into account that a failure to continue coverage may affect future rights under federal law. For example, the Covered Person may lose the right to be provided with a reduction in a pre-existing condition limitation if the gap in coverage is greater than 63 days. The Covered Person also has special enrollment rights under HIPAA that allow him or her to enroll in another group health plan for which (s)he is otherwise eligible when Coverage under this Plan terminates due to a Qualifying Event. The Covered Person also has the same special enrollment rights at the end of the COBRA Coverage if (s)he receives continued coverage for the maximum period available under COBRA.

If the Qualified Beneficiary chooses to have continued coverage, (s)he must advise the Plan Administrator in writing of this choice. This is done by submitting a written COBRA Election Notice to the Plan Administrator. The Plan Administrator must receive this written notice no later than the last day of the 60-day period. If the election is mailed, the election must be postmarked on or before the last day of the 60-day period. This 60-day period begins on the later of the date coverage under the Plan would otherwise end, or the date the notice is sent by the Plan Administrator notifying the person of his or her rights to COBRA Coverage.

Period of Continued Coverage

The law requires that a Qualified Beneficiary who elects COBRA Coverage be afforded the opportunity to maintain COBRA Coverage for 36 months unless (s)he loses Coverage under the Plan because of a termination of employment or reduction in hours. In that case, the required COBRA Coverage period is 18 months.

This 18-month period may be extended if a subsequent or second Qualifying Event (for example, divorce, legal separation, an employee becoming entitled to Medicare or death) occurs during that 18-month period. A second event may be a valid Qualifying Event only if it would have been a valid first Qualifying Event. That is, a second Qualifying Event shall qualify only if it would have caused a Covered Person to lose Coverage under the Plan if the first Qualifying Event had not occurred. A second or subsequent Qualifying Event is therefore limited to the following Qualifying Events:

1. Death of a Covered Employee;

2. Divorce or legal separation between the spouse and the Covered Employee; and

3. Dependent Child's loss of Dependent status under the Plan.

The Covered Employee's Medicare entitlement may also be considered a subsequent or second Qualifying Event for any Dependents who are Qualified Beneficiaries following the first Qualifying Event, but only if the Medicare entitlement would have resulted in loss of Coverage under the Plan had the first Qualifying Event not occurred.

Under no circumstances, however, will Coverage last beyond 36 months from the date of the event that originally made the Covered Person eligible to elect Coverage. Only a person covered prior to the original Qualifying Event or a child born to or Placed for Adoption with a Covered Employee during a period of COBRA Coverage is eligible to continue coverage beyond the original 18-month period as the result of a subsequent Qualifying Event. Any other Dependent acquired during COBRA Coverage is not eligible to continue coverage beyond the original 18-month period as the result of a subsequent Qualifying Event.

Period of Continued Coverage for Disabled Person

A person who is totally disabled may extend COBRA Coverage from 18 months to 29 months. Non-disabled family members may also elect to extend COBRA Coverage even if the disabled individual does not elect to extend his coverage.

The disabled person must be disabled for Social Security purposes at the time of the Qualifying Event or within 60 days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the Employer within the initial 18-month COBRA Coverage period and no later than 60 days after the latest of the following:

1. The date of the Social Security Administration's determination;

2. The date of the Qualifying Event;

3. The date the Qualified Beneficiary would lose Coverage under the plan; or

4. The date the Qualified Beneficiary is informed of the obligation to provide the disability notice, either through this Summary Plan Description or the initial COBRA Notice provided by the Employer.

Refer to the guidelines set forth in the subsection Notification Requirements.

When the Social Security Administration has determined that a person is no longer disabled, Federal law requires that person to notify the Plan Administrator within 30 days of such change in status.

Cost of Coverage and Payments

The Employer requires that Qualified Beneficiaries pay the entire costs of their COBRA Coverage, plus a two percent administrative fee. This must be remitted to the Employer or the Employer's designated representative, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.

The premium for an extended COBRA Coverage period due to a total disability may also be higher than the premium due for the first 18 months. If the disabled person elects to extend coverage the Employer may charge 150% of the contribution during the additional 11 months of COBRA Coverage. If only the non-disabled family members elect to extend coverage the Employer may charge 102% of the contribution.

For purposes of determining monthly costs for continued coverage, a person originally covered as an Employee or as a spouse will pay the rate applicable to a Covered Employee if Coverage is continued for himself alone. Each child continuing Coverage independent of the family unit will pay the rate applicable to a Covered Employee.

Timely payments must be made for the COBRA Coverage. The initial payment must be made within 45 days after the date the person notifies the Employer that he has chosen to continue Coverage. The initial payment must be the amounts needed to provide Coverage from the date continued benefits begin, through the date of election.

Thereafter, payments for COBRA Coverage are to be made monthly. These monthly payments are due on the first day of each month. If the premium is not received by the first day of the month, the Employer will consider that Coverage has been allowed to terminate until the monthly payment has been received.

However, a 30-day grace period is allowed for receipt of this monthly payment before the termination becomes final. Claims will be denied until the monthly premium payment is received. There shall be no grace period for making payments, other than the grace period described in this paragraph.

If the initial payment, or any subsequent monthly payment received, is short by an insignificant amount (the lesser of $50 or 10% of the premium), the Covered Person will be sent a notice at the Covered Person's last known address stating that the remaining amount due must be sent within 30 days to continue Coverage under COBRA if the Plan Administrator requires the payment to be made in full. The Plan Administrator may also choose to accept the payment, which was short by an insignificant amount, as payment in full. Should you have any questions in regards to how payments short by an insignificant amount will be handled under this Plan, please contact the Plan Administrator.

When Continuation Coverage Begins

When COBRA Coverage is elected and the contributions paid within the time period required, coverage is reinstated back to the date of the Qualifying Event or loss of coverage, as applicable to the Plan, so that no break in Coverage occurs. Coverage for Dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

Dependents Acquired During Continuation

A spouse or Dependent child newly acquired during COBRA Coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during COBRA Coverage. A Dependent acquired and enrolled after the original Qualifying Event, other than a child born to or Placed for Adoption with a Covered Employee during a period of COBRA Coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of Coverage.

End of COBRA Coverage

COBRA Coverage will end on the earliest of the following dates:

1. 18 months from the date continuation began because of a reduction of hours or termination of employment of the Covered Employee;

2. 36 months from the date continuation began for Dependents whose coverage ended because of the death of the Covered Employee, divorce or legal separation from the Covered Employee, the child's loss of Dependent status, or Medicare entitlement;

3. The end of the period for which contributions are paid if the Covered Person fails to make a payment on the date specified by the Employer or by the end of the grace period;

4. The date coverage under this Plan ends and the Employer offers no other group health benefit plan;

5. The date the Covered Person first becomes entitled to Medicare after the COBRA election;

6. The date the Covered Person first becomes covered under any other group health plan without regard to a pre-existing condition after the COBRA election. If the replacing group health plan has a pre-existing condition limitation, the Covered Person may remain covered under the Plan until he or she has satisfied the pre-existing condition limitation under the new group health plan, or until he or she is no longer eligible under the COBRA Coverage, as set forth herein;

7. The date the Covered Person is terminated from the Plan for cause, provided an active Covered Employee would be terminated under the Plan for the same cause; or

8. 36 months from the date continuation began for the surviving spouse and Dependent children of a Retiree who dies, when the Retiree's Qualifying Event was the Employer's bankruptcy filing;

The Plan Administrator shall provide notice of any early termination. Refer to subsection Notification Requirements, Plan Administrator.

The COBRA law also requires that an individual who has elected COBRA Coverage be permitted to enroll in any individual conversion health plan that is provided under the Plan. Contact the Plan Administrator about the availability of a conversion policy.

The Plan Administrator and Contact Information

An employee may obtain additional information about his or her COBRA Coverage rights from the Plan Administrator. If the employee has any questions concerning his or her COBRA Coverage rights, or if (s)he wants a copy of the Summary Plan Description, (s)he should contact the Plan Administrator.

Finally, in order to protect the employee's and his or her family's rights, the Covered Person should keep the Plan Administrator informed of any changes to his or her address and the addresses of family members. The employee should also keep a copy, for his or her records, of any notices sent to the Plan Administrator.

The name, address and telephone number of the Plan Administrator is:

Metromont Corporation
2802 White Horse Road
P.O. Box 2486
Greenville, SC 29611

Your Employer may have contracted certain COBRA services to a COBRA administrator. Contact the Employer for details concerning your COBRA rights.

CLAIMS INFORMATION

CLAIM FORMS

When the Covered Person is submitting the claim for benefits on his or her own behalf, (s)he may obtain a claim form from the Employer. If forms are not available, send a written request for claim forms to HealthSCOPE Benefits. Written notice of services rendered may also be submitted to HealthSCOPE Benefits without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

1. Name of patient;
2. Patient's relationship to the Covered Employee;
3. Identification number;
4. Date, type and place of service;
5. Name of Provider; and
6. The Covered Person's signature and the Provider's signature.

TIME FRAME FOR SUBMITTING CLAIM

The claim form must be submitted within 365 days of receiving Covered Services and must have the data needed to determine benefits. An expense is considered incurred on the date the service or supply is given. The claim form should be submitted to the address shown on the Covered Person's identification card.

In the event of termination of the agreement between the Claims Administrator and the Plan Sponsor, all notices of claims for Covered Services received after the termination of such agreement should be provided to the Plan Sponsor.

CLAIM REVIEW PROCEDURE

This section describes the claim review procedures under the Plan. A claim is defined as any request for a benefit made by a Covered Person or by a Provider on behalf of the Covered Person that complies with the Plan's reasonable procedure for making a claim for benefits. The times shown in this section are maximum times only. A period of time begins at the time the claim is filed. The days shown in this section are counted as calendar days.

Under the Plan, the Covered Person can check on the status of a claim at any time by contacting the Customer Service number appearing on the Covered Person's identification card.

The following time frames apply to the review and notification of the benefit determination:

1. **Benefit Determination Period** - The Covered Person will be notified of the benefit determination within 30 days following receipt of notification concerning the claim.

2. **Extension of Benefit Determination Period** - If a benefit determination cannot be made within the standard 30-day benefit determination period due to matters beyond its control, the period may be extended by an additional 15 days, provided the Covered Person is notified of the need to extend the period prior to the end of the initial 30-day benefit determination period. Only one extension is permitted for each claim.

If a benefit determination cannot be made within the standard 30-day benefit determination period due to the Covered Person's failure to provide sufficient information to make the benefit determination, the benefit determination period may be extended, provided the Covered Person is notified of the need to extend the period. The Covered Person must be notified prior to the end of the initial 30-day benefit determination period. The notification must include a detailed explanation of the information needed in order to make the benefit determination. The Covered Person has 45 days following the receipt of the notification to provide the requested information.

CLAIM APPEAL PROCESS

The Plan has a claim appeal process. The claim appeal process and the time limits associated with requesting and responding to a request for claim appeal are described in this section. The Covered Person and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office.

Under the Plan, the Covered Person can check on the status of a claim appeal at any time by contacting the Customer Service number appearing on the reverse side of the Identification Card.

Requesting a Claims Appeal - The Plan has a claim appeals process that allows the Covered Person to submit a request for appeal to the fiduciary that has been named by the Plan Administrator to review a claims appeal ("Named Fiduciary"). Under the Plan, the Plan Administrator will serve as the Named Fiduciary, unless the Plan Administrator has specifically delegated this responsibility to another party. The Named Fiduciary has the sole responsibility for making the decision on an appeal of an adverse benefit determination.

Under the claim appeal process, the Covered Person will be provided with a full and fair review of an adverse benefit determination. This review of an adverse benefit determination must be done by an individual who is neither the individual who made the original adverse benefit determination nor the subordinate of such individual. In addition, if the adverse benefit determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not Medically Necessary, the Named Fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

In the event the Covered Person disagrees with a claim decision concerning the denial of a benefit or scope of benefits, the Covered Person or the Covered Person's authorized representative may submit a request for appeal within 180 days from receipt of the notice of denial or adverse benefit determination.
Under the claims appeal process:

1. The Covered Person is permitted to submit written documents, comments, records and other information relating to the claim;
2. The Covered Person is allowed reasonable access to any copies of documents, records and other information relevant to the claim;
3. The Covered Person is permitted to request the name of the medical provider used in making the initial adverse benefit determination; and
4. All comments, documents, records and other information submitted without regard to whether such information was submitted or considered in the initial determination will be taken into account.

Where to Send the Appeal: The Covered Person's request for an appeal of an adverse benefit determination claims must be submitted in writing and should be submitted to:

Named Fiduciary c/o HealthSCOPE Benefits, Inc.
P.O. Box 2860
Little Rock, Arkansas 72203

If the Covered Person's request for appeal is not submitted to the Named Fiduciary in the manner described in this section, it will not be considered a "claims appeal" under the Plan.

Under this Plan, HealthSCOPE Benefits, Inc. is not the Named Fiduciary for purposes of reviewing claims appeals under the Plan, but is instead acting strictly at the request of the Plan Administrator to coordinate receipt of appeals on behalf of the Plan.

Time Frame for Claims Appeal Review - All claim appeals will be reviewed and written notification of the Named Fiduciary's decision will be prepared and mailed to the Covered Person who submitted the claim appeal within 60 days of receiving the request for appeal of a claim. As used in this section, a claim appeal is an appeal for any adverse claim determination in connection with a claim.

Information Included in an Adverse Appeal Determination - All adverse appeal determinations will include the following information:

1. The reason for the determination;
2. The reference to the specific plan provision(s) on which the benefit determination is based;
3. A statement that the Covered Person is entitled to receive free of charge access to and copies of documents and records pertinent to the claim;
4. A statement of the Covered Person's right to bring a civil action under ERISA section 502(a), which right only applies if the Plan is an ERISA plan;
5. A statement of the Covered Person's right to obtain free of charge, internal rules, guidelines, protocols, or other similar criterion used in making the adverse determination; and
6. Either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan, or a statement that such explanation may be obtained free of charge upon request if the claim was denied on the basis of medical necessity or Experimental or Investigative grounds.

The decision of the Named Fiduciary with regard to an appeal is final.

COORDINATION OF BENEFITS, SUBROGATION AND THIRD PARTY RECOVERY

COORDINATION OF BENEFITS PROVISION

All benefits provided as described in this Summary Plan Description are subject to Coordination of Benefits ("COB"). COB determines when a benefit plan is primary or secondary when a Covered Person is covered by more than one benefit plan.

This COB provision applies when the Covered Person is also covered by this Plan and another benefit plan ("Other Benefit Plan"). When more than one coverage exists, one plan will pay its benefits in full according to the terms of that plan and the other plan(s) will pay a reduced benefit to prevent duplication of benefits. The plan that pays its benefits in full is considered to be the "primary plan." The plan that pays reduced benefits to prevent duplication is considered to be the "secondary plan." A common set of rules is used to determine the order of benefits determination.

When the Plan is primary, the Plan will pay benefits without regard to any Other Benefit Plan. Additionally, when this Plan is secondary, the benefits payable under this Plan will be reduced so that the sum of benefits paid by all Other Benefit Plans and this Plan do not exceed 100% of the total Allowable Expenses. As secondary plan, this Plan would base its payment on the difference between the total amount of the Allowable Expenses and the amount that has been paid by the Other Benefit Plan(s) as the primary plan(s). If the amount paid by the primary plan equals or exceeds the amount that would have been payable by this Plan if were the primary plan, then no further benefit payments will be made by the Plan in connection with that claim. Any applicable Deductible, Copayment or Coinsurance requirement under the Other Benefit Plan and this Plan will not be considered an Allowable Expense. This provision is referred to as "non-duplication of benefits."

Definitions: As used in this section, the following terms are defined as:

"Other Benefit Plan" means any arrangement providing health care benefits or services, including but not limited to: group, blanket, or franchise insurance coverage; group or individual practice or other prepayment coverage; labor management trusteed plans; union welfare plans; employer organization plans, or employee benefit organization plans; or any tax supported or governmental program.

"Allowable Expenses" means any Eligible Expenses incurred while the Covered Person is covered under this Plan, except that any eligible expenses incurred that apply toward the Covered Person's copayment, deductible or coinsurance requirement under this Plan or any Other Benefit Plan will not be included as an Allowable Expense.

Automobile Limitations: When medical payments coverage is available under the vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles or other out-of-pocket requirements under the vehicle plan. This Plan shall always be considered secondary regardless of the Covered Person's election under Personal Injury Protection (PIP) or any no-fault coverage with the automobile carrier.

Motor-Vehicle Related Injury: The Plan will not cover the cost of health care expenses resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent that such services or expenses are payable under any Personal Injury Protection, no-fault, medical payments provision, or any other category (including such benefits mandated by law) of any automobile or vehicle insurance plan.

ORDER OF BENEFITS DETERMINATION (OTHER THAN MEDICARE)

Which plan provides primary or secondary Coverages will be determined by using the first of the following rules that applies:

1. **No COB**. If the Other Benefit Plan contains no COB provision, it will always be primary.

2. **Employee or Member**. The benefit plan covering the Covered Person as an employee, member or subscriber (other than a Dependent) is primary.

3. **Medicare Eligible**. If a Covered Person is eligible for Medicare, benefits will be coordinated with Medicare as set forth in the section entitled "Order of Benefits Determination for Medicare."

4. **Dependent Child of Parents (Not Divorced or Legally Separated)**. When a Dependent is covered by more than one plan of different parents who are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year (excluding year of birth) is primary. If both parents have the same birthday, the plan that covered the parent longer will be primary. If a Dependent is covered by two benefit plans and the Other Benefit Plan does not have coordinate benefits based on the birthday of the parent (e.g., benefits are coordinated based on the gender of the parents), the rule of the Other Benefit Plan will determine the primary and secondary contract.

5. **Dependent Child of Parents Divorced or Legally Separated**. When a Dependent is covered by more than one plan of different parents who are separated or divorced, the following rules apply:

    a. If the parent with custody has not remarried, his or her coverage is primary;

    b. If the parent with custody has remarried, his or her coverage is primary, the stepparent's is secondary and the coverage of the parent without custody pays last; or

    c. If a court decree specifies the parent who is financially responsible for the Child's health care expenses, the coverage of that parent is primary.

6. **Active Employees vs. Laid Off or Retired Employees**. When a plan covers the Covered Person as an active employee or a Dependent of such employee and the Other Benefit Plan covers the Covered Person as a laid-off or retired employee or as a Dependent of such person, the plan that covers the Covered Person as an active employee or Dependent of such employee is primary.

7. **Above Rules Do Not Apply**. When the rules above do not apply, the plan that has covered the Covered Person longer is primary.

8. **Special Note About Continued Coverage**. If the Covered Person is covered under an Other Benefit Plan that is primary but also has continued Coverage under this Plan (e.g., COBRA) due to the Other Benefit Plan's pre-existing condition exclusion, then this Plan will be primary for expenses incurred in connection with such pre-existing condition only.

ORDER OF BENEFITS DETERMINATION FOR MEDICARE

For individuals who are Medicare eligible (e.g. individuals who are Medicare eligible due to age or disability) Medicare will pay primary, secondary or last to the extent dictated by the Medicare Secondary Payer rules and any other applicable federal statutory or regulatory requirements. When Medicare is to be the primary payer, this Plan will base payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

SUBROGATION AND THIRD PARTY RECOVERY

What is Subrogation?

Subrogation applies to situations where the Covered Person is injured and another party is responsible for payment of health care expenses (s)he incurs because of the injury. The other party may be an individual, insurance company or some other public or private entity. Automobile accident injuries or personal injury on another's property are examples of cases frequently subject to subrogation.

The Subrogation provision allows for the right of recovery for certain payments. Any payments made for the Covered Person's injuries under the Plan may be recovered from the other party. Any payments made to the Covered Person for such injury may be recovered from the Covered Person from any judgment or settlement of his or her claims against the other party or parties.

By accepting Coverage under the Plan, the Covered Person automatically assigns to the Plan any rights the Covered Person may have to recover all or part of any payments made by the Plan from any other party, including an insurer or another group health program. Therefore, the Plan Administrator may act as the Covered Person's substitute in the event any payment made by this Plan for health care benefits, including any payment for a Pre-existing Condition, is or becomes the responsibility of another party. Such payments shall be referred to as Reimbursable Payments. This assignment allows the Plan to pursue any claim that the Covered Person may have, whether or not the Covered Person chooses to pursue that claim.

The Covered Person must cooperate fully and provide all information needed under the Plan to recover payments, execute any papers necessary for such recovery, and do whatever else is necessary to secure such rights to the Plan. The other party may be sued in order to recover the payments made for the Covered Person under the Plan.

Right of Reimbursement and Recovery

Specifically, by accepting Coverage under the Plan the Covered Person agrees that if the Covered Person receives any recovery in the form of a judgment, settlement, payment or compensation (regardless of fault, negligence or wrongdoing) from (1) a tortfeasor, (2) a liability insurer for a tortfeasor, or (3) any other source, including but not limited to any form of insured or underinsured motorist coverage, any medical payments, no-fault or school insurance coverages, workers' compensation coverage, premises liability coverage, any medical malpractice recovery, or any other form of insurance coverage ("Recovery"), the Covered Person must repay the Plan in full for any medical, dental, vision, or disability benefits which have been paid or which will in the future be payable under the Plan for expenses already incurred or which are reasonably foreseeable at the time of such Recovery.

Pursuant to *Sereboff v. Mid Atlantic Med. Servs.*, 126 S.Ct. 1869 (2006), the Plan has an equitable lien against the Recovery rights of the Covered Person and has the right to be paid from any such Recovery any and all monies or properties: (1) paid; (2) payable to; or (3) for the benefit of, a Covered Person to the

extent of benefits paid by the Plan ("Subrogated Amount"), whether or not the Covered Person has been "made whole" for the injuries received. This right applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the Covered Person constitute a full or partial recovery, and applies to funds paid for non-health care charges or attorney fees, or other costs and expenses. This right for first priority in contravention of the "make whole" doctrine shall not be affected or limited in any way by the manner in which the Covered Person or any person or entity responsible for paying any Recovery attempts to designate or characterize the Recovery, regardless of whether the recovery itemizes or identifies an amount awarded for Plan benefits or medical expenses, or is specifically linked to certain kinds of damages or payments. Payment of the Subrogated Amount to the Plan shall be without reduction, set-off or abatement for attorney's fees or costs incurred by the Covered Person in the collection of damages. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such monies or properties. At the discretion of the Plan Administrator, the Plan may reduce any future Eligible Expenses otherwise available to the Covered Person under the Plan by an amount up to the total amount of Subrogated Amount that is subject to the equitable lien. All rights of recovery will be limited to the amount of payments made under this Plan.

The equitable lien shall also attach to the first right of Recovery to any money or property that is obtained by anybody, including but not limited to the Covered Person, the Covered Person's attorney, and/or a trust for the direct or indirect benefit of the Insured or for his/her "special needs," as a result of an exercise of the Covered Person's rights of Recovery.

The Plan may, in its sole discretion, require the Covered Person, as a pre-condition to receiving benefit payments, to sign a subrogation agreement and to agree in writing to assist the Plan to secure the Plan's right to payment of the Subrogation Amount from the third party. In the event that the Plan does not receive payment of the Subrogated Amount, the Plan may, in its sole discretion, bring legal action against the Covered Person or reduce or set-off the unpaid Subrogated Amount against any future benefit payments to the Covered Person. If the Plan takes legal action to enforce its subrogation rights, the Plan shall be entitled to recover its attorneys' fees and costs from the Covered Person.

The following provisions apply to the Plan's right of subrogation, reimbursement, and creation of an equitable lien:

1. **"Pursue and Pay."** The Plan Administrator has elected a "pursue and pay" in connection with the subrogation, reimbursement and equitable lien rights. At its sole discretion, the Plan Administrator may elect to "pursue and pay" in connection with the subrogation, reimbursement and equitable lien rights for all claims involving Eligible Expenses of $1,000 or more. Pursuant to the election of "pursue and pay", the Plan Administrator has the right to apply the subrogation, reimbursement and equitable lien rights prior to making any benefit payments under the Plan, and such payment shall be reduced by any amounts that were paid by any other party as described in this section.

2. **Scope of Subrogation, Reimbursement and Equitable Lien Rights.** The subrogation, reimbursement and equitable lien rights apply to any benefits paid by the Plan on behalf of the Covered Person as a result of the Injuries sustained, including, but not limited to:

    a. Any no-fault insurance;
    b. Medical benefits coverage under any automobile liability plan. This includes the Covered Person's Plan or any third party's policy under which the Covered Person is entitled to benefits;
    c. Under-insured and uninsured motorist coverage;
    d. Any automobile medical payments and personal injury protection benefits;
    e. Any third party's liability insurance

f. Any premises/guest medical payments coverage;
g. Any medical malpractice recovery;
h. Workers' compensation benefits. The right of subrogation, reimbursement and equitable lien attach to any right to payment for workers' compensation, whether by judgment or settlement, where the Plan has paid expenses otherwise eligible as Covered Services prior to a determination that the Covered Services arose out of and in the course of employment. Payment by Workers' Compensation insurers or the employer will be deemed to mean that such a determination has been made.
i. Any other governmental agency reimbursement (i.e., state medical malpractice compensation funds).

3. **Excess Payments.** If the Plan erroneously makes total payments that exceed the maximum amount to which the Covered Person is entitled at any time under the Plan, the Plan shall have the right to recover the excess amount from any persons to, or for, or with respect to whom such excess payments were made.

4. **Reduction of Future Benefits.** The Plan provides that recovery of excess amounts may include a reduction of future benefit payments available to the Covered Person under the Plan of any amount up to the aggregate amount of Reimbursable Payments that have not been reimbursed by the Plan.

5. **"Make Whole" and "Common Fund" Rules Do Not Apply.** The provisions of the Plan concerning subrogation, reimbursement, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines and/or state laws commonly referred to as the "make whole" rule and the "common fund" rule.

6. **No Deductions for Costs or Attorneys' Fees.** The reimbursement required under the Plan shall not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation unless separately agreed to, in writing, by the Plan Administrator at the exercise of its sole discretion.

GENERAL PROVISIONS

ALTERATION OF APPLICATION

An enrollment application may not be altered by anyone other than the applicant unless the applicant has given his or her written consent allowing alterations.

AMENDMENT OF THE PLAN

Amendment: The Employer reserves the right to amend this Plan at any time by an instrument duly executed by an authorized officer. Such amendment shall be binding upon the Employer and all Covered Persons. The Employer shall furnish to each Covered Employee a summary, written in a manner calculated to be understood by the average Covered Employee, of any modification to the Plan or change in the information required to be included in the Summary Plan Description.

Retroactive Amendments: An amendment to this Plan may be made retroactively effective so long as it does not adversely affect the rights of Covered Persons to benefits under this Plan for covered health care expenses which are incurred after the effective date of the amendment but before the amendment is adopted.

Material Reduction: Amendments that are a material reduction in Covered Services or benefits must be disclosed not later than 60 days after the date of adoption of the modification or change. A "material reduction in covered services or benefits" means any modification to the plan or change in the information required to be included in the Summary Plan Description that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average Covered Employee to be an important reduction in Covered Services or benefits under the Plan. A "reduction in covered services or benefits" generally would include any Plan modification or change that: eliminates benefits payable under the Plan; reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations; increases premiums, Deductibles, Coinsurance, Copayments, or other amounts to be paid by a Covered Employee.

APPLICABLE LAW

This Plan shall be construed in accordance with the laws of the State of South Carolina and of the United States of America. Any provision of this Plan that is in conflict with applicable law is amended to conform with the minimum requirements of that law.

ASSIGNMENT OF BENEFITS

No assignment of the Plan, or any rights or benefits under the Plan, shall be valid unless permitted under the terms of the Plan or the Plan Sponsor has consented to such assignment in writing.

The Plan will pay benefits under this Plan to the Employee unless payment has been assigned to a Hospital, Physician, or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the Plan unless the Claims Administrator is notified in writing of such assignment prior to payment hereunder.

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible Covered Person is entitled to receive benefits under this Plan. Such right to benefits is not transferable.

BONDING

Every fiduciary and other person who handles funds or other property of this Plan shall be bonded as required by law.

COUNTERPARTS

This Plan may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which together constitute one instrument, which may be sufficiently evidenced by any counterpart.

EFFECTIVE DATE

Except where specifically stated otherwise in this Summary Plan Description, the provisions of this amended and restated Summary Plan Description are effective August 1, 2015 and this Summary Plan Description shall supersede and replace all prior versions of the Summary Plan Description as of that date.

EMPLOYMENT RIGHTS

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between the Covered Employee and the Employer to the effect that (s)he will be employed for any specific period of time or retained in the service of the Employer and does not affect in any way the employee's employment rights.

ERRONEOUS INFORMATION

If any information pertaining to any Covered Person is found to have been reported erroneously to the Plan Sponsor or to HealthSCOPE Benefits, as the claims administrator, and such error affects his or her Coverage, the facts will determine to what extent, if any, the Covered Person was or is covered under the Plan.

EXEMPTION FROM ATTACHMENT

To the full extent permitted by law, all rights and benefits under the Plan are exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any Covered Employee or other Covered Person.

INABILITY TO HANDLE AFFAIRS

If a benefit is owed when the Covered Person is not able to handle his or her affairs, the benefit may be paid to a relative by blood or marriage. This would happen if the Covered Employee had died or become mentally incompetent. The Plan will make payment to a relative whom it judged to be entitled in fairness to the money. Any such payment would discharge any obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the Employer or by the Covered Employee shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense to a claim unless they are contained in writing and signed by the Employer or by the Covered Person, as the case may be. A statement made shall not be used in any legal contest unless such statement is made in writing

and signed by such person and a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

INTERPRETATION OF PLAN PROVISIONS

All provisions of this Plan shall be interpreted and administered in accordance with the provisions of applicable law in a non-discriminatory manner and in a manner that will assure compliance of the Plan's operation therewith. All persons in similar circumstances shall receive uniform, consistent, and non-discriminatory treatment hereunder.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the Plan prior to the expiration of 60 days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the Plan. No such action shall be brought after the expiration of 3 years from the date the expense was incurred.

LIABILITY AND LIMITATION OF ACTION

This Plan will not give the Covered Person any claim, right, action or cause of action against any person or entity other than the Provider rendering Covered Services to the Covered Person for acts or omissions of such Provider.

Contributions being made to and held by the Plan are made to and held by the Plan for the sole purpose of providing benefit payments under the Plan in accordance with its terms. Except with respect to the right of a Covered Person to receive benefits under this Plan, no Covered Person shall have any right or interest in or to the assets of the Plan or in or to any contributions to the Plan.

The Plan Sponsor and HealthSCOPE Benefits do not actually furnish health care services as described in this Summary Plan Description. Rather, Coverage will be provided for the health care services covered under the Plan when rendered by a Provider to the Covered Person.

PLAN RIGHT TO RECOVERY

Whenever payments have been made from the Plan in excess of the maximum amount of payment necessary, according to the terms of the Plan, the Plan will have the right to recover these excess payments. Whenever payments have been made from the Plan that, according to the terms of the Plan, should not have been made, the Plan will have the right to recover these incorrect payments. The Plan has the right to recover any such overpayment or incorrect payment from the person or entity to whom payment was made, or from any other appropriate party, whether or not such payment was made due to the Plan Administrator’s own error.

RIGHTS OF PLAN

To the full extent permitted by law, all rights and benefits under the Plan are exempt from attachment or garnishment or other legal process for the debts or liabilities of any Covered Person.

RIGHT TO ENFORCE PLAN PROVISIONS

Failure by the Plan Sponsor or HealthSCOPE Benefits to enforce any provision of the Plan provision shall not affect the Plan Sponsor's or HealthSCOPE Benefits' right thereafter to enforce such provision or any other provisions of the Plan.

TERMINATION OF THE PLAN

Right to Terminate: It is the intention of the Employer to continue this Plan indefinitely. However, the Plan Sponsor reserves the right to terminate this Plan at any time by an instrument duly executed by it.

Effect of Termination: Unless otherwise provided, upon the effective date of Plan termination, the Coverage of all Covered Persons shall cease and no person shall become entitled to any benefits hereunder for any expenses incurred after the effective date of Plan termination. The Plan shall remain liable to pay benefits for expenses incurred prior to the effective date of Plan termination, but only to the extent of the assets set aside for that purpose.

TITLES ARE FOR REFERENCE ONLY

The titles used in the Plan are for reference only. In the event of a conflict between a title and the content of a Section, the content of the Section shall control.

WORKERS' COMPENSATION COVERAGE

The Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

WORD USAGE

Whenever words are used in this document in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine or neuter form.

WRITTEN DIRECTIONS

Whenever a person must or may act upon the written direction of another, he shall not be required to inquire into the propriety of such direction, and he shall follow the direction unless it is clear on its face that the actions to be taken under that direction are prohibited by law or the terms of this Plan. Moreover, such person shall not be responsible for failure to act without such written direction.

GENERAL PLAN, ERISA AND PLAN ADMINISTRATION INFORMATION

The Plan has been established and operates under the guidelines of ERISA (Employment Retirement Income Security Act of 1974). As an ERISA Plan, there is a requirement that certain disclosures must be made to Plan participants. This page and the following pages provide this information.

1. **GENERAL PLAN INFORMATION**

a. **Name Of The Plan**

Metromont Corporation Health Benefit Plan

b. **Name, Business Address And Telephone Number Of The Plan Sponsor**

Metromont Corporation
2802 White Horse Road
P.O. Box 2486
Greenville, SC 29611

c. **Plan Sponsor Identification Number**

58-2322112

d. **Plan Number**

501

e. **Name, Business Address And Telephone Number Of The Plan Administrator**

Metromont Corporation
2802 White Horse Road
P.O. Box 2486
Greenville, SC 29611

f. **Name And Address Of The Person Designated As Agent For The Service Of Legal Process**

Metromont Corporation
2802 White Horse Road
P.O. Box 2486
Greenville, SC 29611

g. **Plan Year (For Fiscal Record Keeping)**

January 1st to December 31st

h. **Claims Administrator**

HealthSCOPE Benefits, Inc.
27 Corporate Hill Drive
Little Rock, AR 72205
501-225-1551

Send Dental Claims to:
HealthSCOPE Benefits
P.O. Box 99005
Lubbock, TX 79490-9005

i. **Address And Telephone Number Of The Office Of The Department Of Labor**

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Room N-5644
Washington, D.C. 20210
(202) 565-7500

j. **Effective Date Of The Plan**

August 1, 2015

k. **Type of Administration:**

The Plan is self-administered by the Plan Administrator. The Plan Administrator has hired a Claims Administrator to provide claims payment and ministerial administration.

l. **Sources of Contributions and Funding**

Benefits under the Plan will be paid as needed directly from the general assets of the Employer that sponsors the Plan. In addition, if the Employer has purchased insurance contract(s) in connection with the Plan, benefits will also be paid from said insurance contract(s).

Contributions for Plan expenses are obtained from the Employer and from the participating employees. The Employer evaluates the costs of the Plan based on projected Plan expenses and determines the amount to be contributed by the Employer and the amount to be contributed by the participating employees.

Note about COBRA: COBRA premiums will be the Qualified Beneficiaries' full responsibility and are generally 102% of the costs for non-COBRA individuals, except in special circumstances where a greater amount is permitted under COBRA. Refer to the section that addresses COBRA Coverage for additional details.

2. **STATEMENT OF ERISA RIGHTS**

Right to Receive Information About the Plan: As a participant in this Plan, the employee is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to: (a) examine, without charge, at the Plan Sponsor's office and at other specified locations, such as work sites, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions; (b) obtain copies of all Plan documents and other Plan information upon written request of the Plan Sponsor. The administrator may make a reasonable charge for the copies; and (c) receive a summary of the Plan's annual financial report. The Plan Sponsor is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Coverage: The participant may be eligible to continue group health Coverage for himself and his Dependents if there is a loss of Coverage due to a COBRA qualifying event. In this event, Coverage will continue for the period(s) of time set forth in this Summary Plan Description and subject to the conditions and limitations set forth herein. The participant's COBRA rights are explained in this Summary Plan Description.

Actions by the Fiduciary: In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the employee and other Plan participants and beneficiaries. No one, including the Employer, or any other person, may fire the employee or otherwise discriminate against the employee in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA.

Enforcement of Participant Rights: If the participant's claim for a welfare benefit is denied in whole or in part, the employee must receive a written explanation of the reason for denial. The participant has the right to have the Plan review and reconsider his or her claim.

Under ERISA, there are steps the participant can take to enforce the above rights. For instance, if the participant requests materials from the Plan and does not receive them within 30 days, the participant may file suit in a federal court. The Plan's claim procedures must be exhausted by the claimant before the claimant files a benefits suit. Refer to the section entitled "Claims Information" for additional details regarding claim procedures. In such a case, the court may require the Plan Sponsor to provide the materials and pay the employee up to $110 a day until (s)he receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If the participant has a claim for benefits that is denied or ignored, in whole or in part, and if s(he) has exhausted the claims procedures available under the Plan, (s)he may file suit in a state or federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if the participant is discriminated against for asserting his or her rights, (s)he may seek assistance from the U.S. Department of Labor, or (s)he may file suit in federal court. The court will decide who should pay the court costs and legal fees. If the participant is successful, the court may order the person (s)he has sued to pay these costs and fees. If the participant loses, the court may order the participant to pay these costs and fees (e.g. if the court finds the participant's claim is frivolous).

Additionally, if a Plan participant disagrees with the Plan's decision or lack thereof concerning the status of a Qualified Medical Child Support Order (QMCSO), the participant may file suit in a Federal court.

Questions: If the participant has any questions about the Plan, (s)he should contact the Plan Sponsor. If the participant has any questions about this statement or about his or her rights under ERISA, the participant should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor. Participants may also request certain publications about their rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration, U.S. Department of Labor.

3. OPERATION AND ADMINISTRATION OF THE PLAN

Plan Sponsor and Plan Administrator: The Plan is administered through Metromont Corporation which has been established and shall be maintained for the exclusive benefit of the employees. Metromont Corporation is the Employer and Plan Sponsor and also functions as the Plan Administrator, unless another individual or entity is appointed by the Employer. The Plan Administrator shall have full charge of the operation and management of the Plan.

Plan Fiduciary: Metromont Corporation shall also function as the Plan Fiduciary under ERISA unless the Employer appoints another individual or entity to act in this capacity. The Plan Fiduciary shall have maximum legal discretionary authority to construe and interpret the terms and conditions of the Plan, to review all denied claims for benefits under the Plan with respect to which it has been designated named fiduciary, including, but not limited to, the denial of certification of the Medical Necessity of Hospital or medical services, supplies and treatment, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Fiduciary will be final and binding on all interested parties. Every fiduciary and other person who handles funds or other property of this Plan shall be bonded as required by law.

Claims Administrator: Under the Plan, HealthSCOPE Benefits, Inc. ("HealthSCOPE Benefits") has agreed to provide certain administrative services on behalf of the Plan Sponsor according to the terms and limitations of the Plan. The responsibilities of HealthSCOPE Benefits are spelled out in an agreement between the Plan Sponsor and HealthSCOPE Benefits and include but are not limited to the administration of claims on behalf of the Plan Sponsor. Claims for benefits under the Plan shall be filed, processed, reviewed, and, if denied, appealed in accordance with the procedures set forth in this Summary Plan Description.

Except as otherwise provided by law, the appeal procedures set forth in this Summary Plan Description shall be the sole and exclusive remedy.

HealthSCOPE Benefits does not furnish health care services and is not liable for the quality of health care services received by a Covered Person. HealthSCOPE Benefits does not provide insurance coverage or benefits nor does HealthSCOPE Benefits underwrite the liability of this Plan. HealthSCOPE Benefits will not act nor assume the responsibility to act as the Plan Administrator, Plan Fiduciary or Named Fiduciary in connection with this Plan. HealthSCOPE Benefits is merely providing assistance with the administration of this Plan by adjudicating claims in accordance with the terms of the Plan.

Administrative Committee: The Employer, at its option, shall appoint a committee to oversee the administration of the Plan on behalf of the Employer. The members of the Administrative Committee shall serve at the pleasure of the Employer that appointed them.

Delegation of Responsibilities: The Employer may delegate its responsibilities hereunder to other persons or entities. Such delegation shall be effective only if the proposed delegate executes an instrument acknowledging acceptance of the delegated responsibilities.

Administrative Duties: The following responsibilities shall be performed in the administration of the Plan. These duties may be performed by the Employer or by a committee of individuals appointed by the Employer to assist in the administration of the Plan:

a. Maintaining all Plan records;

b. Filing tax returns and reports required under federal and state law and complying with all other governmental reporting and disclosure requirements;

c. Authorizing payments and resolving questions concerning the Plan and interpreting, in its discretion, the Plan's provisions related to benefits and eligibility;

d. Hiring outside professionals to assist with Plan Administration and render advice concerning the responsibility they have under the Plan, including but not limited to hiring a claims administrator, actuaries, attorneys, accountants, brokers, consultants and other specialists to render advice concerning any responsibility they have under the Plan;

e. Establishing policies, interpretations, practices and procedures of the Plan;

f. Receiving all disclosures required of fiduciaries and other service providers under any federal or state law;

g. Acting as the Plan's agent for service of legal process;

h. Administering the Plan, including but not limited to the Plan's claims procedures as set forth in the Summary Plan Description;

i. Paying benefits under the Plan, by drawing checks, or instructing others to draw checks, against the Plan established for this purpose. With respect to claims that are administered by the claims administrator, this responsibility includes instructing the claims administrator to withdraw monies from the funding account for the purpose of administering claims incurred under the Plan; and

j. Performing all other responsibilities allocated to the Plan Administrator.

DEFINITIONS

Actively Working/Actively At Work - Means the employee is performing his or her regular duties on behalf of, and in the regular business of the Plan Sponsor for the hours as set forth in this Summary Plan Description and is reasonably being compensated by the Plan Sponsor on a regular basis for such duties. An employee will retain eligibility for Coverage under the Plan if absent on an approved leave of absence, with the expectation of returning to work following the approved leave of absence as determined by the Employer. The Employer's classification of an individual is conclusive and binding for purposes of determining eligibility under the Plan.

Benefit Period – Means the period beginning on January 1st and ending on December 31st of each year.

Coinsurance - Means a percentage of the Customary and Reasonable Charge that a Covered Person pays for Covered Services.

Coverage - Means the payment for Covered Services as specified and limited by this Summary Plan Description.

Covered Dependent Child(ren) – Means the Dependent Child(ren) who is (are) covered under this Plan.

Covered Employee - Means the employee of the Employer (also referred to as the participant) who has satisfied the eligibility requirements under the Plan and has enrolled for Coverage under the Plan.

Covered Person - Means the Covered Employee, the Covered Spouse and/or Covered Dependent Child(ren).

Covered Services - Means services or supplies that are considered eligible for payment under this Plan.

Covered Spouse – Means the Spouse who is covered under this Plan.

Customary and Reasonable Charge – Means the maximum amount of charges for Covered Services Dentist. The Customary and Reasonable Charge that applies to a given service, treatment or supply which shall not exceed the general level of charges assessed by Dentists rendering the same type of service, treatment or supplies. The Customary and Reasonable Charge is established using historical data collected for charges by Dentists within specific geographic areas for the same or similar services, treatment or supplies. The data may be supplemented with information provided by independent research firms who specialize in the collection of Dentist charge data. Unusual circumstances that reasonably require additional time, skill or experience for a Provider's service, are taken into consideration by the Plan and may result in reimbursement of an amount above the Customary and Reasonable maximum but not exceeding the actual charge.

Deductible - Means the amount a Covered Person must pay for Eligible Expenses incurred in a Benefit Period before benefits begin to be paid for that person under the Plan.

Dental Benefits - Means the Covered Services for non-medical dental related treatment and the payment made by the Plan for such services as set forth in this Summary Plan Description. The Dental Benefits are described in the section entitled "Dental Benefits".

Dental Hygienist - Means a person licensed to practice dental hygiene and who is working under the supervision and direction of a Dentist.

Dentist - Means a person licensed to practice dentistry as defined by the state in which the Covered Service is rendered**.**

Dependent - Means the Spouse and/or the Dependent Child(ren).

Dependent Child - Means a dependent child who satisfies the eligibility criteria set forth in the Summary Plan Description. Refer to the section entitled "Eligibility Provisions."

Dependent Limiting Age - Means the date on which the Dependent Child attains the age of 26.

Effective Date - Means the date on which Coverage begins.

Eligible Employee - Means an employee of the Employer who satisfies the eligibility criteria set forth in this Summary Plan Description. Refer to the section entitled "Eligibility Provisions."

Eligible Expenses - Means expenses for Covered Services that are incurred by a Covered Person. Eligible Expenses do not include expenses in excess of the Customary and Reasonable Charge.

Experimental or Investigative - Means the use of any procedure, treatment, facility, equipment, drug, device or supply which is not approved or accepted as standard medical treatment of the condition being treated or any such item requiring American Medical Association, U.S. Surgeon General, U.S. Department of Public Health, U.S. Food and Drug Administration, National Institute of Health, American Dental Association or American Osteopathic Association or other government approval, if it is not granted at the time services are rendered. In determining whether any treatment, procedure, facility, equipment, drug, device or supply is Experimental or Investigative, the Plan Administrator may consider the views of the state or national medical communities and the views and practices of Medicare, Medicaid and other government financed programs. Although a Physician may have prescribed treatment, such treatment may still be considered Experimental or Investigative within this definition.

Family or Medical Leave of Absence - Means an unpaid leave of absence to care for a newborn, newly adopted Dependent Child, a sick Dependent Child, spouse or parent, or an unpaid leave of absence due to a serious health condition pursuant to the Family and Medical Leave Act.

Maximum Benefit – Means the maximum amount the Plan will pay for a given benefit. The Maximum Benefit can be stated as a dollar amount or the maximum number of days or visits for a specific benefit.

Medically Necessary (or Medical Necessity) - Means the criteria used to determine the Medical Necessity of Covered Services under this Summary Plan Description.

To be Medically Necessary, Covered Services must:

1. Be consistent with the diagnosis and treatment of the Covered Person's dental condition;
2. Be in accordance with the standards of good dental practice;
3. Not be considered Experimental or Investigative; and
4. Not be for the Covered Person's convenience or the convenience of the Covered Person's Dentist.

In order for Covered Services to be paid, the services must be Medically Necessary. Any service failing to meet the Medical Necessity criteria may be the Covered Employee's liability.

Medicare - Means the program of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Other Benefit Plan - Refers to COB and means any arrangement providing health care benefits or services, including but not limited to: group, blanket, or franchise insurance coverage; group or individual practice or other prepayment coverage; labor management trusteed plans; union welfare plans; employer organization plans, or employee benefit organization plans; or any tax supported or governmental program.

Plan Document - Means the governing document for the Health Plan, as required under ERISA, that has been adopted and sponsored by the Plan Sponsor.

Protected Health Information - Means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Personal health information includes information of persons living or deceased. The following components of a member's information also are considered personal health information: a) names; b) street address, city, county, precinct, zip code; c) dates directly related to a member, including birth date, health facility admission and discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code. Protected Health Information includes Electronic Protected Health Information as defined at 45 C.F.R. §160.103 that is received from, or created or received on behalf of the Plan.

Qualified Medical Dependent Child Support Order (QMCSO) – Means a medical child support order which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan. An Eligible Employee may obtain a copy of such procedures from the Plan Sponsor.

Schedule of Benefits - Means a separate schedule showing vital information with respect to the Coverage under this Plan.

Special Enrollment Period – Means a period following the Eligible Employee's initial eligibility under the Plan during which the employee and Eligible Dependents may enroll for Coverage following the loss of other coverage, marriage, birth or adoption of a child as set forth herein.

Spouse – Means an individual of the opposite or same sex who is legally married to the Eligible Employee in accordance with the laws of the state in which the marriage was performed. For purposes of this Plan, "married" shall not include common law marriage.

Summary Health Information - Means information, that may be individually identifiable health information, and a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and b)

from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.

Summary Plan Description – Means the document that is provided by the Plan Administrator and that describes, in understandable terms, the Covered Person's rights, benefits and responsibilities under the Health Plan. This document serves as the Summary Plan Description for the Health Plan administered by the Plan Administer and sponsored by the Plan Sponsor.

HIPAA PRIVACY STATEMENT

1. **Permitted and Required Uses and Disclosure of Protected Health Information**. Subject to obtaining written certification pursuant to paragraph 3 (below) of the Plan, the Plan or a health insurance issuer or HMO with respect to the Plan, may disclose Protected Health Information to the Plan Sponsor, provided the Plan Sponsor does not use or disclose such Protected Health Information except for the following purposes:

   a. To perform Plan administrative functions which the Plan Sponsor performs for the Plan;

   b. Obtaining premium bids from insurance companies, HMOs or other health plans for providing health insurance coverage under the group health plan; or

   c. Modifying, amending, or terminating the group health plan.

   Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose Protected Health Information in a manner that is inconsistent with 45 CFR §164.504(f).

2. **Conditions of Disclosure**. The Plan or a health insurance issuer or HMO with respect to the Plan, shall not disclose Protected Health Information to the Plan Sponsor unless the Plan Sponsor agrees to:

   a. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law.

   b. Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to Protected Health Information, including implementing reasonable and appropriate security measures to protect Electronic Protected Health Information.

   c. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

   d. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

   e. Make available to a Plan participant who requests access the Plan participant's Protected Health Information in accordance with 45 CFR §164.524.

   f. Make available to a Plan participant who requests an amendment the participant's Protected Health Information and incorporate any amendments to the participant's Protected Health Information in accordance with 45 CFR §164.526.

   g. Make available to a Plan participant who request an accounting of disclosures of the participant's Protected Health Information the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.

h. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with 45 CFR §164.504(f).

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

j. Ensure that the adequate separation between Plan and Plan Sponsor required in 45 CFR §164.504(f)(2)(iii) is satisfied, including ensuring reasonable and appropriate security measures.

k. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan.

l. Report to the Plan any security incident relating to Electronic Protected Health Information of which it becomes aware. A security incident is defined at 45 C.F.R. § 164.304 as "the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system."

3. **Certification of Plan Sponsor**. The Plan shall disclose Protected Health Information to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 2 of this section as contained in the Covered Person's Summary Plan Description.

4. **Permitted Uses and Disclosure of Summary Health Information**. The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose Summary Health Information to the Plan Sponsor, provided such Summary Health Information is only used by the Plan Sponsor for the purpose of:

   a. Obtaining premium bids from health plan providers for providing health insurance coverage under the Plan; or

   b. Modifying, amending, or terminating the Plan.

5. **Permitted Uses and Disclosure of Enrollment and Disenrollment Information**. The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information and information on whether individuals are participating in the Plan to the Plan Sponsor, provided such enrollment and disenrollment information is only used by the Plan Sponsor for the purpose of performing administrative functions that the Plan Sponsor performs for the Plan.

6. **Adequate Separation Between Plan and Plan Sponsor**. The Plan Sponsor shall only allow certain employees, or classes of employees, access to the Protected Health Information. Such employees shall only have access to and use such Protected Health Information to the extent necessary to perform the administration functions that the Plan Sponsor performs for the Plan. In the event that any such employees do not comply with the provisions of this Section, the employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

The employees or classes of employees that will be permitted access to Protected Health Information as set forth in this paragraph are: Jason Woodard, Jason Corley, Amy Rowan, and Jill Wolfe.

✦ **Note:** Metromont Corporation will provide the employee with a separate Notice of Privacy Practices outside of this Summary Plan Description.