

**FLEXIBLE BENEFITS PLAN
FOR EMPLOYEES OF
THE STATE OF SOUTH CAROLINA
AND LOCAL SUBDIVISIONS**

Flexible Benefits Plan

Effective July 1, 1987, as amended and
restated, effective January 1, 2016

ARTICLE I.

Foreword and Purpose

The Flexible Benefits Plan for Employees of the State of South Carolina and Local Subdivisions is a program that permits Eligible Employees to elect, among benefit package options, nontaxable benefits for themselves and their eligible Dependents under the group medical, accident, dental, medical reimbursement, optional life insurance and the dependent care assistance plans sponsored by the South Carolina Public Employee Benefit Authority. In addition, Eligible Employees may be able to make pre-tax contributions to Health Savings Accounts (HSAs).

The Plan has been established by the State of South Carolina pursuant to S.C. Code Ann. § 9-1-60, as amended. It is intended that this Plan shall qualify as a “cafeteria plan” under Section 125 of the Internal Revenue Code of 1986, as amended, and shall be construed in a manner consistent with that section of the Code.

ARTICLE II.

Definitions and Construction

2.1. **Definitions:** Where the following words and phrases appear in this Plan, they shall have the meaning set forth below, unless a different meaning is plainly required by the context:

(a) **Code:** The Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.

(b) **Compensation:** The total compensation actually paid to a Participant by the Employer during the Plan Year as wages, salary, overtime pay, bonuses, and commissions,

but excluding expense allowances and all other benefits provided under any benefit plan of the Employer.

(c) Component Plan: Any one of the separate plans offered as a benefit under this Plan that also qualifies as a Statutory Nontaxable Benefit.

(d) Coverage Expenses: The insurance premiums or other costs, including required administrative charges, for the benefit coverage a Participant elects pursuant to Section 3.3, and which is provided under one of the following Component Plans, which are incorporated herein by reference.

(1) The State of South Carolina Health Benefit Plan, which includes all medical coverages sponsored by the Public Employee Benefit Authority, whether self-insured or offered by insurance companies.

(2) The State of South Carolina Dental Benefit Plan, which includes all dental coverages sponsored by the Public Employee Benefit Authority, whether self-insured or offered by insurance companies.

(3) The State of South Carolina Optional Life Insurance Plan.

(4) The State of South Carolina State Vision Plan.

(5) The State of South Carolina Health Savings Account.

For each Plan Year, the State of South Carolina or its electing Local Subdivisions shall specify the costs for benefit coverages that are applicable to each Component Plan and the costs so specified shall be incorporated by reference into this Plan.

(e) Dependent: Any individual who is a tax dependent of the Participant as defined generally in Code Section 152(a), except as otherwise defined for purposes of an

excludable benefit under a Component Plan (e.g., as set forth in Code Section 105(b), or Section 21).

(f) Dependent Care Assistance Plan: The State of South Carolina Dependent Care Assistance Plan, initially established effective January 1, 1989, and as amended from time to time, for the purpose of allowing Participants to elect to receive reimbursement of their Qualified Dependent Care Expenses.

(g) Effective Date: This Plan is a continuation of the flexible benefits plan initially established July 1, 1987, and this Plan document became effective January 1, 2016.

(h) Eligible Employee: An Employee of an Employer who: (i) for purposes of making an election for a Component Plan, is eligible under such Component Plan; and (ii) for purposes of the Dependent Care Assistance Plan and the Medical Reimbursement Plan, an Employee who meets the eligibility requirements for the South Carolina State Health Plan. The term "Eligible Employee" shall not include: (1) temporary or seasonal Employees; (2) any leased employees as defined under Code Section 414(n) or contract employees; (3) any person employed pursuant to a written agreement that provides that such person shall not be eligible for participation under the Plan; (4) any person designated in good faith by an Employer as an independent contractor, regardless of whether such person is later determined to be a common law employee for tax purposes; or (5) for purposes of Group Health/Dental/Vision/Optional Life Insurance Premium Conversion, an Employee covering his or her ex-Spouse following a divorced are not Eligible Employees.

(i) Employee: Any person who receives compensation from a department, agency, board, commission or institution of the State, including clerical and administrative employees of the General Assembly, and judges in the state courts. For purposes of this Plan,

the term shall include other Employees that the General Assembly has made eligible for coverage by statute, including Employees of a school district, county, municipality, or other Employer that has qualified for, and is participating in, coverage under this Plan. The members of the South Carolina General Assembly and elected members of the councils of participating counties or municipalities, whose council members participate in the South Carolina Retirement Systems, and Part-time Teachers are also Employees for purposes of the Plan.

(j) Employer: The State and any local subdivision thereof, which pursuant to a written instrument adopts this Plan.

(k) Employer Contribution: The Employer Contribution for each Plan Year shall be the sum of (1) and (2) below.

(1) Non-elective Contributions: The amount the Employer makes available for the benefit of each of its Eligible Employees who are Participants for the Plan Year pursuant to Section 4.1.

(2) Elective Contributions: The amounts of Flexible Pay applied to a Participant's cost of benefits under each Plan chosen. It is intended hereunder that such amounts shall not be taxable to the Participant but shall constitute an Employer Contribution for purposes of Code Section 125.

(l) ERISA: The Employee Retirement Income Security Act of 1974.

(m) Fiduciaries: The Named Fiduciaries who shall be the Planholder and the Plan Administrator, and other parties designated as fiduciaries by such Named Fiduciaries in accordance with the powers herein provided, but only with respect to the specific responsibilities of each in connection with the Plan.

(n) Flexible Pay: The amount of an Eligible Employee's Compensation which is to be received in cash as taxable income or to be applied (subject to Plan maximums) to purchase available nontaxable benefits.

(o) Health Savings Account: An account as defined in Code Section 223.

(p) High Deductible Health Plan (HDHP): A health benefits plan as defined in Code Section 223.

(q) Highly Compensated Participant: Any Participant who is a highly compensated employee as defined in Code Section 125 and the Regulations thereunder.

(r) Local Subdivision: A public entity in South Carolina that falls within one of the categories established by Section 1-11-720 of the 1976 S.C. Code of Laws, as amended.

(s) Medical Reimbursement Plan: The State of South Carolina Medical Reimbursement Plan, initially established effective January 1, 1989, and as amended from time to time, for the purpose of allowing Participants to elect to receive payments or reimbursements of Qualifying Medical Expenses.

(t) Participant: Any Eligible Employee who has qualified under the terms of the Plan for participation herein, who remains so qualified, and who is participating in the Plan in accordance with the provisions of Article III of each part of the Plan.

(u) PEBA: The South Carolina Public Employee Benefit Authority

(v) Plan: The Flexible Benefits Plan for Employees of the State of South Carolina and Local Subdivisions, the Plan set forth herein, as amended from time to time, also known as MoneyPlus.

(w) Plan Administrator: The South Carolina Public Employee Benefit Authority.

(x) Planholder: The State of South Carolina, by and through the South Carolina Public Employee Benefit Authority or its successor governing authority.

(y) Plan Year: The 12-month period commencing on each January 1 and ending on the following December 31.

(z) Relative: The Participant's son, daughter, grandson, granddaughter, stepson, stepdaughter, brother, sister, stepbrother, stepsister, father, mother, grandfather, grandmother, stepfather, stepmother, nephew, niece, uncle, aunt, and in-laws.

(aa) Section 125 Plan: The Flexible Benefits Plan for Employees of the State of South Carolina and Local Subdivisions, effective July 1, 1987, as amended from time to time.

(bb) Spouse: Unless specifically stated otherwise in the Plan, the spouse of an Eligible Employee in a marriage of two individuals if such marriage would be recognized by any state, possession, or territory of the United States. The term Spouse shall not apply to an individual who has entered into a registered domestic partnership, civil union, or other similar formal relationship with an Eligible Employee that is not denominated as a marriage if the individual is not otherwise married to the Eligible Employee as described in the preceding sentence. For purposes of the Dependent Care Assistance Plan, an individual will not be considered to be the Spouse of an Eligible Employee if: (i) the Eligible Employee and his or her Spouse are divorced; (ii) the Eligible Employee and his or her Spouse are legally separated under a decree of divorce or separate maintenance; or (iii) the Eligible Employee and his or her Spouse file separate returns, the Eligible Employee maintains a household which is the principal place of abode for a Child (with respect to which the Eligible Employee is entitled to a deduction) for more than one-half of the calendar year, the Eligible Employee furnishes more than one-half of the cost of maintaining that household, and the Eligible

Employee's Spouse was not a member of that household during the last six months of the year.

(cc) State: The State of South Carolina, including its state agencies, public school districts, and higher education institutions.

(dd) Statutory Nontaxable Benefit: Shall have the same meaning as "qualified benefit" in Code Section 125(f) and which is offered as a benefit under this Plan.

(ee) Construction: As used in this Plan, the masculine gender includes the feminine, and the singular includes the plural, unless the context clearly indicates to the contrary. The words hereof, hereunder and other similar compounds of the word here mean and refer to the entire Plan, not to any particular provision or section. The Plan shall be construed to be in compliance with Code Section 125 and other applicable provisions of law so that the intended tax consequences of the Plan are achieved. The Medical Reimbursement Plan shall be interpreted to be in compliance with the requirements of Code Sections 105, 106, and 4980B. The Dependent Care Assistance Plan shall be interpreted to be in compliance with the requirements of Code Section 129.

ARTICLE III.

Eligibility, Participation and Enrollment

3.1. Eligibility: Generally, any person who is classified as an Eligible Employee, as defined in Section 2.1., shall be eligible to participate in the Plan. An Employee is considered eligible to enroll in a Health Savings Account if he meets the following criteria: 1) he is covered under a high-deductible health plan (HDHP); 2) he is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing certain limited types of coverage);

3) he is not entitled to benefits under Medicare; and 4) he cannot be claimed as a dependent on another person's tax return.

3.2. Participation:

(a) Commencement of Participation: An Eligible Employee, as defined in Section 2.1., shall commence (or recommence) participation in this Plan on the latest of the following dates:

(1) The Effective Date of the Plan; or
(2) the Employee's first day of employment (or reemployment) as an Eligible Employee; unless the Employee specifically elects in writing not to participate.

(b) Termination of Participation: A Participant shall continue to participate in this Plan until the earlier of the following dates:

(1) The date the Participant terminates employment with an Employer by death, disability, retirement or other separation from service; or
(2) The date the Participant ceases to work for an Employer as an Eligible Employee; or
(3) The date on which the Plan terminates; or
(4) The date the Participant ceases to make required contributions to the Plan.

Notwithstanding the foregoing, a Participant who ceases to be a Participant in the Plan pursuant to this Section may nonetheless be entitled to continue coverage under certain Component Plans under continuation or conversion coverage as provided in the plans or policies which govern such coverages.

(c) Reinstatement of Participation by Former Participants: A former Participant who terminates employment with an Employer and then returns to employment with an

Employer as a Participant within 30 days following his or her termination of employment shall be reinstated in his or her elections under the Plan prior to termination. If such former Participant returns to employment with an Employer as a Participant within thirty (30) days following his or her termination and such Participant's absence spans two calendar years, the Participant must make a new election under the Plan for the remainder of the Plan Year. If such former Participant returns to employment more than 30 days after such termination of employment, such individual must again satisfy the requirements under this Article III and make a new election under the Plan for the remainder of the Plan Year.

3.3. Enrollment: An Eligible Employee may enroll (or reenroll) in the Plan by submitting to the Plan Administrator, or its duly appointed delegate (which may include, but is not limited to, any school board, school district, agency or other payroll center) during an enrollment period described in subsection (a) below, an Election Form, in paper or electronic form, which specifies his elections for the Plan Year as to Dependent status and benefit coverage under the Component Plans for which he is eligible and which meets such other standards for completeness and accuracy as the Plan Administrator may establish. The required contribution for this benefit will be paid by an Elective Contribution through this Plan unless the Employee specifically elects not to participate. Any Election Form submitted by a Participant in accordance with this Section shall remain in effect until the earlier of the following dates: the end of the Plan Year (except as provided under subsection (a)(1) below), the date the Participant terminates participation in the Plan, or the effective date (as determined by the Plan Administrator) of a subsequently filed Election Form submitted pursuant to Section 3.6 below.

(a) Enrollment Periods:

(1) Regular Enrollment Period: Each Eligible Employee who is actively employed prior to October 1 of any Plan Year, shall have a Regular Enrollment Period during which to make elections for the ensuing Plan Year. The Regular Enrollment Period for the immediately ensuing Plan Year shall commence on October 1 prior to such Plan Year and shall terminate 30 days thereafter (October 31). Each Eligible Employee who is not actively employed prior to October 1 of any Plan Year shall also have a Regular Enrollment Period during which to make elections for the ensuing Plan Year. The Regular Enrollment Period for the immediately ensuing Plan Year shall commence on the first day of his employment as an Eligible Employee and shall terminate 31 days thereafter. A Participant's failure to file a completed Election Form within the time period designated by the Plan Administrator shall constitute (i) an election to continue the same Component Plan coverage in effect for the prior Plan Year, if any, and (ii) an election not to have his or her Compensation reduced to credit amounts under the Medical Reimbursement Plan or Dependent Care Assistance Plan, regardless of any election in effect for the prior Plan Year.

(2) Mid-Year Enrollment Period: A Participant who incurs a change in status or other applicable event pursuant to Section 3.6 below shall have a Mid-Year Enrollment Period, which shall commence on the date of the event and shall terminate 31 days thereafter (60 days thereafter in the event of a status change described in Section 3.6(e)(2) below).

(b) Enrolling Dependents: An Eligible Employee may enroll in the Plan any or all of his Dependents that are eligible under a Component Plan during his or her Regular Enrollment Period. An Eligible Employee shall enroll his Dependents by specifying, on such form as the Plan Administrator may require, the Dependents' name and birth dates, and by electing the category of dependent coverage that corresponds to the number of Dependents

the Eligible Employee wishes to enroll. A Participant who incurs a change in status or other applicable event pursuant to Section 3.6 below may enroll any new Dependents during the Mid-Year Enrollment Period commencing on the date such individuals become Dependents of the Participant.

(c) Limitation on Enrollment Elections: A Participant's right to elect certain benefit coverages shall be limited hereunder to the extent such rights are limited in a Component Plan or in rules adopted by the Plan Administrator. Furthermore, a Participant shall not be entitled to revoke, cancel or change an Enrollment Election after the enrollment period has ended or to make a new Enrollment Election unless both the revocation and the new election are on account of and consistent with a change in status or other applicable event described in Section 3.6 below.

3.4. Benefit Options: An eligible Participant may choose any one or more of the following options under this Plan with his share of the cost, including applicable administrative fees, paid by way of Elective Contributions through the Plan by his Employer:

- (a) Group Health/Dental/Vision/Optional Life Insurance Premium Conversion;
- (b) Benefits under the Dependent Care Assistance Plan;
- (c) Benefits under the Medical Reimbursement Plan; and/or
- (d) Benefits under the Health Savings Account.

3.5. Conditions for Receipt of Benefits: As a condition of receiving benefits under the Plan, a Participant must: (i) furnish all applications; enrollment forms, and other documents reasonably required by the Administrator; and (ii) observe all Plan rules and regulations.

3.6. Mid-Year Election Changes:

(a) Significant Change in Cost or Coverage (*Applies to Elections of Component Plans and Elections with Respect to the Dependent Care Assistance Plan*).

(1) If a Participant elects to reduce his or her Compensation with respect to coverage under a Component Plan or the Dependent Care Assistance Plan and the Participant's cost for such coverage then significantly increases or decreases during the Plan Year, and regardless of whether such increases or decreases result from actions taken by the Employer or the Participant, all affected Participants may either: (i) make a corresponding prospective increase or decrease in premium payments; or (ii) in the event of a significant decrease in cost, (A) commence participation in the Plan and elect the coverage that is significantly decreased in cost or (B) in the event of a significant increase in cost, revoke existing elections for such coverage and elect to receive coverage, on a prospective basis, under another benefit package option providing similar coverage, or, if no such coverage is available, drop coverage entirely. Such changes shall be allowed under the Dependent Care Assistance Plan only if the cost change is imposed by a dependent care provider who is not a Relative of the Participant.

(2) If a Participant elects to reduce his or her Compensation with respect to coverage under a Component Plan or the Dependent Care Assistance Plan and the Participant's cost for such coverage then increases or decreases during the Plan Year, regardless of whether such increases or decreases result from actions taken by the Employer or the Participant, and Participants are required to make a corresponding change in their premium payments, the Plan may make a prospective increase or decrease, as appropriate, in such premium payments. Such changes shall be allowed under the Dependent Care

Assistance Plan only if the cost change is imposed by a dependent care provider who is not a Relative of the Participant.

(3) If a Participant elects to reduce his or her Compensation with respect to coverage under a Component Plan or the Dependent Care Assistance Plan and the Participant's (or the Participant's Dependent's) coverage under the Plan is then significantly curtailed such that it results in a "loss of coverage," the affected Participant may revoke his or her existing elections for such coverage and elect to receive coverage, on a prospective basis, under another benefit package option providing similar coverage, or drop such coverage if no other benefit package option providing similar coverage is available under the Plan. For purposes of this subsection, a "loss of coverage" means a complete loss of coverage under the benefit package option or other coverage option (including the elimination of the benefit package option, an HMO ceasing to be available in the area where the individual resides, or the individual losing all coverage under the option by reason of a lifetime or annual coverage limitation, or any other fundamental loss of coverage as determined by the Plan Administrator, in its sole discretion, in a manner consistent with the provisions of Code Section 125).

(4) If a Participant elects to reduce his or her Compensation with respect to coverage under a Component Plan or the Dependent Care Assistance Plan and the Participant's (or the Participant's dependent's) coverage under the Plan is then significantly curtailed (e.g., a significant increase in the deductible, co-pay, or out-of-pocket cost sharing limit under a group health plan coverage option) such that it does not result in a "loss of coverage" within the meaning of Section 3.6(a)(3), the affected Participant may revoke his or her election for such coverage and elect to receive coverage, on a prospective basis, under

another coverage option providing similar coverage. For purposes of this subsection, coverage under the Plan is "significantly curtailed" only if there is an overall reduction in coverage provided under the Plan so as to constitute reduced coverage generally.

(b) Addition or Significant Improvement of Benefit Plan Option Providing Similar Coverage (*Applies to Elections of Component Plans and Elections with Respect to the Dependent Care Assistance Plan*). If during the Plan Year an Employer adds a new benefit plan option or other coverage option (or significantly improves an existing benefit package option or other coverage option), affected Participants may revoke their existing benefit package option and elect the newly-added or significantly improved benefit option providing similar coverage on a prospective basis.

(c) Change in or Loss of Coverage Under Other Employer's Plan or Other Group Health Plan (*Applies to Elections of Component Plans and Elections with Respect to the Dependent Care Assistance Plan*). An affected Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of the Participant's Spouse, former spouse, or dependent's employer if: (i) such other plan permits Participants to make an election change that would be permitted under this Section; or (ii) the Plan permits Participants to make an election for a period of coverage that is different from the period of coverage under such other plan. In addition, an affected Participant may make a prospective election change to add coverage of Component Plans for the Participant or his or her dependents if such persons lose coverage under any group health plan sponsored by a governmental or educational institution within the meaning of Code Section 125 and the regulations thereunder.

(d) New Election or Revocation of Election Due to Change in Status (*Applies to Elections of Component Plans and Elections with Respect to the Dependent Care Assistance Plan and the Medical Reimbursement Plan*). A Participant may change and make a new election or revoke an election to participate in the Plan during the Plan Year, and authorize or revoke Compensation reductions for the remainder of the Plan Year, as applicable, if the Participant has a "change in status" that results in the Participant, Spouse, or dependent gaining or losing eligibility under the Plan or under the Spouse's/dependent's employer plan. Such change or revocation must be both on account of the change in status and necessary or appropriate as a result of the status change as defined in Internal Revenue Service regulations; provided that such change is consistent with the terms and conditions of any Component Plan. For purposes of the Plan, a "change in status" includes the following:

(1) a change in legal marital status, including death of Spouse, divorce, marriage, legal separation, or annulment of marriage of the Participant;

(2) a change in the number of the Participant's dependents, including the death of a Spouse or dependent or the birth or adoption (or placement for adoption) of a child;

(3) a change in the employment status of the Participant or the Participant's Spouse or dependent, including the termination of employment or the commencement of employment, a commencement of or return from an unpaid leave of absence, or a change in worksite;

(4) a dependent satisfying or ceasing to satisfy the definition of dependent under the applicable Component Plan, or meeting the definition of a Qualifying Individual, including attainment of certain age or student status;

(5) a change in the place of residence of the Participant or the Participant's Spouse or dependent; or

(6) the commencement or termination of an adoption proceeding.

(e) New Election Due to Special Enrollment under HIPAA (*Applies to Elections of Component Plans and Elections with Respect to the Medical Reimbursement Plan*).

(1) If a Participant or his or her Spouse or dependent is entitled to special enrollment under HIPAA, due to the addition of a new dependent by adoption, placement for adoption, birth or marriage, or upon the loss of other coverage, the Participant may elect to make a mid-year change in his or her election consistent with his or her change in enrollment.

(2) Eligible individuals may also be enrolled in the Plan during special enrollment periods if (i) the eligible individual is covered under a Medicaid plan under Title XIX of the Social Security Act or a state children's health plan under Title XXI of the Social Security Act, and (ii) coverage under such plans is lost due to a loss of eligibility for such coverage. In addition, an eligible individual may be enrolled under the Plan if the eligible individual becomes eligible for premium assistance under such Medicaid plan or a state children's health plan (including any waiver or demonstration project conducted under or in relation to such plan), to the extent required under HIPAA.

(f) New Election Due to Medicare or Medicaid (*Applies to Elections of Component Plans and Elections with Respect to the Medical Reimbursement Plan*). If the Participant, Spouse, or dependent becomes entitled to Medicare or Medicaid benefits (other than coverage solely under the program for distribution of pediatric vaccines), the Participant may change his or her then current election of applicable Component Plans to cancel or reduce coverage under the Plan for the affected person. If the Participant, Spouse or

dependent loses coverage under Medicare or Medicaid, the Participant may make an election to begin or increase coverage of Component Plans for the affected person.

(g) New Election Due to Court Order (*Applies to Elections of Component Plans and Elections with Respect to the Medical Reimbursement Plan*). If a Participant is subject to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order), the Participant may make a consistent change in his or her election to either (i) cover the child or (ii) cancel coverage of the child; provided, however, that such cancellation should only be effective if the order requires the Spouse, former spouse or other individual to provide coverage for the child and such coverage is, in fact, provided.

(h) Reduction in Hours of Service (*Applies only to Elections for Medical Coverage Under a Component Plan*). A Participant may make an election to revoke medical coverage under a Component Plan for the Participant or the Participant's Spouse or dependent, on a prospective basis, that relates to the Participant's reduction in hours of service. The following criteria must be met:

(1) the Participant's employment status with an Employer was reasonably expected to average at least 30 hours of service per week, and there has been a change in the Participant's employment status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, although the Participant continues to be eligible for medical coverage under a Component Plan; and

(2) the Participant has enrolled, or intends to enroll, himself (and his Spouse and dependents, if applicable) in another plan that provides "minimum essential coverage" (as

defined in Code Section 5000A(f)(1)) that is effective no later than the first day of the second full month following the month that medical coverage is revoked.

The Plan Administrator may require the Participant to certify that he has enrolled, or intends to enroll, himself, and his Spouse and dependents, if applicable, in other minimum essential coverage.

(i) Enrollment in a Qualified Health Plan (*Applies only to Elections for Medical Coverage Under a Component Plan*). A Participant may make an election to revoke medical coverage under a Component Plan for the Participant or the Participant's Spouse or dependent, on a prospective basis, that relates to the Participant's (or his Spouse's or dependent's) enrollment in a "Qualified Health Plan" through a health insurance marketplace (a "Marketplace"). The following criteria must be met:

(1) the Participant is eligible to enroll in a Qualified Health Plan through a Marketplace during either a special enrollment period for such coverage or during the Marketplace's annual open enrollment period; and

(2) the Participant has enrolled, or intends to enroll, himself (and his Spouse and dependents, if applicable) in a Qualified Health Plan through a Marketplace for new coverage that is effective no later than the day immediately following the last day that medical coverage is revoked.

A "Qualified Health Plan" means a fully-insured health plan that has been certified by the applicable authorities to meet the criteria for certification in a Marketplace and is offered by a health insurance issuer that is appropriately licensed to offer such coverage and meets certain other requirements under federal law.

The Plan Administrator may require the Participant to certify that he has enrolled, or intends

to enroll, himself, and his Spouse and dependents, if applicable, in the Qualified Health Plan.

3.7. Authority of Plan Administration to Cancel or Revise Certain Elections:

Notwithstanding any other provisions of the Plan, to the extent required by Code Section 125, the following nondiscrimination rules shall apply: (i) the Plan shall not discriminate in favor of highly compensated employees (as defined by Code Section 125(e)) as to eligibility to participate or as to contributions or benefits; and (ii) the benefits provided to key employees (as defined by Code Section 416(i)(1)) shall not exceed 25% of the aggregate benefits provided to all Participants. If the Plan Administrator determines, before or during any Plan Year, that the Plan (or any part thereof) may fail to satisfy any applicable nondiscrimination requirement imposed by the Code (including, but not limited to, Code Sections 79, 105, 125, and 129), the Plan Administrator shall cancel or revise the elections of key employees and/or highly compensated employees to receive benefits under the Plan to the extent that the Plan Administrator determines that such cancellation or revision is necessary to satisfy the Code's nondiscrimination requirements.

3.8. Adjustments to Prevent Discrimination: The Dependent Care Assistance Plan shall be administered to be in compliance with all applicable nondiscrimination requirements of the Code. Notwithstanding any other provision of the Dependent Care Assistance Plan, the Plan Administrator may limit the amounts paid or reimbursed with respect to any Participant who is a highly compensated employee within the meaning of Code Section 414(q) to the extent the Plan Administrator deems the limitation appropriate to assure compliance with respect to any applicable nondiscrimination requirement.

ARTICLE IV.

Contributions

4.1. Non-elective Contributions: For each Plan Year, each Employer shall make, on behalf of each of its Eligible Employees who is a Participant, a Non-elective Contribution to provide benefits for such Participant and his or her Dependents, if applicable, under the Plan. The amount of a Non-elective Contribution shall be calculated for each Plan Year in a uniform and nondiscriminatory manner based on the Participant's Dependent status category (as determined under Section 3.3), the commencement or termination date of the Participant's employment during the Plan Year, and such other factors as the Plan Administrator and/or Employer shall prescribe. If the amount of the Non-elective Contribution exceeds the cost of the benefit coverage selected by the Participant, no such excess amounts will be paid to the Participant.

4.2. Elective Contributions:

(a) The Participant's Elective Contribution shall equal the difference between the cost of all benefits elected, as determined by the Administrator, and the Employer Non-elective Contribution described in Section 4.1.

(b) Each Participant shall authorize the Employer to withhold from his or her Flexible Pay for the Plan Year an amount equal to his Coverage Expenses in excess of his Non-elective Contribution for such year plus the amounts elected, if any, to be contributed to the Dependent Care Assistance and Medical Reimbursement Plans. Any amounts that are withheld from a Participant's Flexible Pay pursuant to this Section shall be withheld in approximately equal installments from the amounts payable to the Participant for each pay period during the Plan Year (or such portion of the year as the Employer may designate). For Eligible Employees whose salary during the year is paid to them over a period of time less

than a year, Flexible Pay amounts will be withheld by the Employer in installments as determined by the Employer. If an Eligible Employee becomes a Participant after the beginning of the first pay period of the Plan Year, the amount withheld from his Flexible Pay during such year shall be a pro rata share of the amount that would have been withheld had he been a Participant in the Plan as of the beginning of the Plan Year. A Plan Participant, who is eligible to enroll in a Health Savings Account, may change his contribution amount once per month. Maximum annual contributions for Health Savings Accounts are established by the federal government and are subject to change.

(c) An election under subsection (b) to authorize withholding of Flexible Pay shall be made in accordance with Section 3.3. An election to have withheld an amount of Flexible Pay, which in the determination of the Plan Administrator exceeds the limitation on Flexible Pay set forth in subsection (a), may in the discretion of the Plan Administrator be treated either as void or as an election to have withheld the maximum amount permissible under such limitation.

(d) Benefits under the Plan shall cease to be provided to a Participant if such Participant fails to make required contributions with respect to such benefits (other than for the reason of an unpaid leave), and such individual may not make a new benefit election for the remaining portion of that Plan Year. Such individual may again become a Participant in the Plan in the following Plan Year, as provided pursuant to Section 3.3, provided such individual is an Eligible Employee.

4.3. Effect of Change in Status or Other Applicable Event: If a Participant's elections change during the Plan Year because of an election made pursuant to Section 3.3(a)(2) and Section 3.6, then in accordance with rules adopted by the Plan Administrator, appropriate adjustments shall

be made in the amount withheld from or added to the Participant's pay for the balance of the year to reflect any changes in the Participant's Elective Contributions and benefit elections. In the case of any Participant who terminates employment with an Employer, where, as a result of such termination, any coverage under a Component Plan ceases, and where an unearned insurance premium or other benefit cost remains which was paid by an Employer out of the Participant's Flexible Pay, such amount shall be refunded to the Employee and shall be treated as additional wages from the Employer, in accordance with procedures established by the Plan Administrator.

4.4. Post-mortem Payments: Any benefit payable after the death of a Participant under the Medical Reimbursement Plan or the Dependent Care Reimbursement Plan shall be paid to the surviving spouse, or otherwise to the estate.

ARTICLE V.

Administration

5.1. Allocation of Responsibility among Fiduciaries for Plan Administration: The Fiduciaries shall have only those powers, duties, responsibilities, and obligations as are specifically given or delegated to them under this Plan.

(a) The Employers shall have the sole responsibility for making the Employer Contributions under the Plan as specified in Article IV.

(b) The Planholder shall have the sole authority to appoint and remove the Plan Administrator, and terminate this Plan in whole or in part.

(c) The Plan Administrator shall have the authority to amend the Plan, and the sole responsibility for the administration of the Plan, which responsibility is specifically described herein.

(d) Each Fiduciary warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. Furthermore, each Fiduciary may rely upon any direction, information or action of another Fiduciary as being proper under the Plan, and is not required under the Plan to inquire into the propriety of any direction, information or action.

It is intended under this Plan that each Fiduciary shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under the Plan and shall not be responsible for any act or failure to act of another fiduciary.

5.2. Administration: The Plan shall be administered by the Plan Administrator, which may appoint or employ persons to assist in the administration of the Plan and may appoint or employ any other agents it deems advisable, including legal counsel, actuaries, auditors, bookkeepers, and record keepers to serve at the Plan Administrator's direction.

5.3. Appeals Procedure: The Plan Administrator, or a party designated by the Plan Administrator, shall make all determinations as to the right of any person to an Employer Contribution under the Plan. If an assertion of any such right by a Participant or Dependent is wholly or partially denied, the Plan Administrator, or the designated party, will provide such appellant a written notice within 90 days after receipt of the appeal, unless circumstances warrant an extension of time not to exceed an additional 90 days, setting forth:

- (a) The specific reason or reasons for such denial;
- (b) Specific reference to pertinent Plan provisions on which the denial is based;

(c) A description of any additional material or information necessary for the appellant to submit to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's appeal review procedure. The review procedure is available upon written request by the claimant to the Plan Administrator, or the designated party, within 90 days after receipt by the claimant of written notice of the denial, and includes the right to examine pertinent documents and submit issues and comments in writing to the Plan Administrator, or the designated party.

The decision on review shall be made within 90 days after receipt of the request for review, unless circumstances warrant an extension of time not to exceed an additional 90 days. The decision shall be in writing and drafted in a manner calculated to be understood by the appellant, and shall include specific reasons for the decision with references to the specific plan provisions on which the decision is based.

5.4. Other Administrative Powers and Duties: The Plan Administrator shall have full discretionary authority and power as may be necessary to discharge its functions hereunder, including the power:

(a) to construe and interpret the Plan, decide all questions of eligibility and determine the amount, manner and time of payment of any reimbursements hereunder;

(b) to prescribe procedures to be followed by Participants electing benefit coverages or filing applications for reimbursements;

(c) to prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, information explaining the Plan;

(d) to receive from Employees, agents and Participants such information as shall be necessary for the proper administration of the Plan;

(e) to receive, review and keep on file (as it deems convenient or proper) reports of the receipts and disbursements of the Plan;

(f) to appoint or employ individuals or other parties to assist in the administration of the Plan and any other agents it deems advisable, including accountants, legal counsel, bookkeepers and record keepers; and

(g) to designate or employ persons to carry out any of the Plan Administrator's fiduciary duties or responsibilities under the Plan.

All of the Plan Administrator's determinations and interpretations shall be final, conclusive, and binding on all persons affected thereby. The Plan Administrator or its designee shall have full, discretionary authority to correct any defect, supply any omission or reconcile any inconsistency and resolve ambiguities in the Plan in such manner and to such extent as it may deem expedient, and the Plan Administrator or its designee shall be the sole and final judge of such expediency. The Plan Administrator is authorized to accept service of legal process for the Plan and shall be named fiduciary of the Plan. Benefits under the Plan shall be paid only if the Plan Administrator and/or its designee decides in its discretion that a Participant is entitled to such benefits.

5.5. Rules and Decisions: The Plan Administrator may adopt such rules and procedures, as it deems necessary, desirable, or appropriate for the administration of this Plan. All rules, procedures and decisions of the Plan Administrator shall be uniformly and consistently applied to all Participants in similar circumstances pursuant to the guidelines of IRS Code Section 125. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant, an Employer, a Dependent, the duly authorized

representative of an Employer, Participant, or Dependent, or the legal counsel of the Plan Administrator.

5.6. Forms and Requests for Information: The Plan Administrator may require a Participant to complete and file such forms as are provided for herein and all other forms prescribed by the Plan Administrator, and to furnish all pertinent information requested by the Plan Administrator. The Plan Administrator may rely upon all such information, including the Participant's current mailing address.

ARTICLE VI.

Amendment of the Plan

The Plan Administrator shall have the right at any time by instrument in writing, duly executed and acknowledged, to modify, alter or amend this Plan in whole or in part, provided, however, that no such amendment shall diminish or eliminate any claim for any benefit to which a Participant shall have become entitled prior to such amendment. Notwithstanding the foregoing, the Plan Administrator shall have the right to amend the Plan at any time, retroactively or otherwise, in such respects and to such extent as may be necessary to fully qualify it as a cafeteria plan under existing and applicable laws and regulations, including Section 125 of the Code, and if and to the extent necessary to accomplish such purpose, may by such amendment decrease or otherwise affect benefits to which Participants may have already become entitled.

ARTICLE VII.

Termination of the Plan

The Plan herein provided for has been established by the State with the bona fide intention that it shall be continued in operation indefinitely. However, the Planholder reserves the right at any time to terminate or partially terminate the Plan, pursuant to Section 9-1-60 of the 1976 South

Carolina Code of Laws, as amended.

Should the Planholder decide to terminate or partially terminate the Plan, the Plan Administrator shall be notified of such termination in writing and shall proceed at the direction of the Planholder to take such steps as are necessary to discontinue the operation of the Plan in an appropriate and timely manner.

ARTICLE VIII.

Miscellaneous

8.1. Employment Rights: The language used in this document does not create an employment contract between the Employee and the Employer. This document does not create any contractual rights or entitlements. The Plan Administrator reserves the right to revise the content of this document, in whole or in part. No promises or assurances, whether written or oral, which are contrary to, or inconsistent with, the terms of this paragraph, create any contract of employment. Under no circumstances shall the terms of employment of any Participant be modified or in any way affected hereby.

8.2. Spendthrift Clause: To the extent permitted by law, Participants are prohibited from anticipating, encumbering, alienating or assigning any of their rights, claims or interest in this Plan, and no undertaking or attempt to do so shall in any way bind the Plan Administrator or be of any force or effect whatsoever. Furthermore, to the extent permitted by law, no such rights, claims or interest of a Participant in this Plan shall in any way be subject to such Participant's debts, contracts or engagements, or to attachment, garnishment, levy or other legal or equitable process. Provided, however, anything to the contrary herein notwithstanding, to the extent permissible under applicable law, a Participant's interest hereunder is subject to all bona fide and existing debts owed to the Plan by such Participant.

8.3. No Guarantee of Non-Taxability: The Plan is designed and is intended to be operated as a cafeteria plan under Section 125 of the Code. Nonetheless, neither the State, nor any Employer, nor any Plan Fiduciary shall in any way be liable for any taxes or other liability incurred by a Participant or anyone claiming through him by virtue of participation in this Plan. The Plan does not prohibit, and indeed contemplates, the payment of taxable benefits under certain of the Component Plans.

8.4. Nondiscrimination: The Plan is intended not to discriminate in favor of Highly Compensated Participants as to eligibility to participate or as to contributions and benefits as provided in Section 125 and the Sections of the Code applicable to the Component Plans.

8.5. Delegation of Authority by the State: Whenever the State under the terms of this Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by any officer or individual thereunto duly authorized by the State.

8.6. Governing Law: This Plan shall be construed according to the laws of the State of South Carolina, and all provisions hereof shall be administered according to, and its validity and enforceability shall be determined under, the laws of such State, except where preempted by the Code. ERISA, as it currently exists, does not apply to this Plan because of an exception for governmental plans pursuant to Act Section 4(b)(1). Should ERISA hereafter be amended to apply to such plans, then notwithstanding the foregoing, State law shall apply only to the extent that is not preempted by ERISA.

8.7. Headings: The headings of sections and subsections are for ease of reference only and shall not be construed to limit or modify the detailed provisions hereof.

8.8. Separate Cafeteria Plans: Nothing in this Plan prevents a local subdivision, as defined in Section 1-11-720 of the 1976 South Carolina Code of Laws, as amended, from developing or implementing a separate cafeteria plan for the local subdivision's employees for the purpose of offering additional insurance plans that are not offered by the State Plan of Benefits. A local subdivision is prohibited from offering to its employees an insurance plan that is available through the State Plan of Benefits, including, but not limited to, a group health, dental, life, accidental death and dismemberment, or disability insurance plan.

8.9. Entire Plan Stated: This document sets forth the entire Plan. No other employee benefit or employee benefit plan that is or may hereafter be maintained by the State or any Employer on a non-elective basis shall constitute a part of this Plan.

8.10. Severability: If any term or provision of the Plan shall be found to be illegal or unenforceable, then, notwithstanding any such illegality or unenforceability, the remainder of the Plan shall remain in full force and effect and such term or provision shall be deemed to be deleted and severable therefrom.

8.11. Indemnification of Employer by Participants: If a Participant receives one or more reimbursements under his or her Dependent Care Assistance Account that are not for Qualified Dependent Care Expenses or under his or her Medical Reimbursement Account that are not for Qualifying Medical Expenses, the Participant shall indemnify and reimburse the Plan Administrator for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from the reimbursements; provided, however, the Participant's indemnification and reimbursement shall not exceed the amount of additional federal, state, or local income tax that the Participant would have owed if the reimbursements had been made to the Participant as regular cash

compensation, plus the Participant's share of any Social Security tax that would have been paid on that compensation, less any such additional income and Social Security tax actually paid by the Participant.

8.12. Notice: Any notice given under the Plan shall be sufficient if given to the Administrator, when addressed to its office; or if given to a Participant, when addressed to the Participant at his or her address as it appears in the records of the Administrator.

8.13. Disclaimer of Liability: Nothing contained herein shall confer upon a Participant any claim, right, or cause of action, either at law or at equity, against the Plan, Administrator, or any Employer, for the acts or omissions of any provider of services or supplies for any benefits provided under the Plan.

8.14. Right of Recovery: If any Employer or the Administrator or its designee makes any payment that according to the terms of the Plan should not have been made, it may recover that incorrect payment, whether or not it was made due to the Employer's or the Administrator's or its designee's own error, from the person to whom it was made or from any other appropriate party. If any such incorrect payment is made directly to a Participant, the Employer or the Administrator or its designee may deduct it when making future payments directly to that Participant.

8.15. Evidence of Action: All orders, requests, and instructions to the Administrator or its designee by an Employer or by any duly authorized representative, shall be in writing and the Administrator or its designee shall act and shall be fully protected in acting in accordance with such orders, requests, and instructions.

8.16. Protective Clause: Neither any Employer nor the Administrator shall be responsible for the validity of any contract of insurance or other benefit contract or policy by any benefit provider

or for the failure on the part of any insurance company or other benefit provider to make payments thereunder.

8.17. Receipt and Release: Any payments to any Participant shall, to the extent thereof, be in full satisfaction of the claim of such Participant being paid thereby and the Administrator may condition payment thereof on the delivery by the Participant of the duly executed receipt and release in such form as may be determined by the Administrator.

8.18. Benefits Solely from General Assets: Except as may otherwise be required by law:

(a) the benefits provided hereunder shall be paid solely from the general assets of the Employer or the Plan Administrator;

(b) nothing herein shall be construed to require any Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant; and

(c) no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of any Employer from which any payment under the Plan may be made.

8.19. Reliance: The Administrator shall not incur any liability in acting upon any notice, request, signed letter, telegram, or other paper or document believed by the Administrator to be genuine or to be executed or sent by an authorized person.

8.20. Participant Incapacitation: When any Participant is under legal disability or, in the Administrator's opinion, is in any way incapacitated so as to be unable to manage his or her affairs, the Administrator may cause the Participant's benefits to be paid to his legal representative for his or

her benefit. The payment of benefits pursuant to this Section shall completely discharge the liability of any Employer, the Administrator, and the Plan for the benefits.

Schedule A

Contributions Effective for Plan Year 2016

Non-elective contributions (Employer Contributions)

Health Insurance Plan

Dental Insurance Plan

Subscriber	\$344.58
Subscriber/spouse	\$682.54
Subscriber/children	\$528.88
Family	\$854.58

Elective Contributions (monthly contributions)

Plan	Sub Only	Sub/Spouse	Sub/Children	Full Family
Savings	\$9.70	77.40	20.48	113.00
Standard	\$97.68	253.36	143.86	306.56
Tobacco-user Surcharge	\$40.00	60.00	60.00	60.00
Dental	\$0.00	7.64	13.72	21.34
Dental Plus	\$24.58	49.66	57.26	74.22
State Vision Plan	\$7.00	14.00	14.98	21.98

Dependent Care Assistance Plan
Effective January 1, 1989, as amended
and restated, effective January 1, 2016

ARTICLE I.

Introduction

This plan is intended to qualify as a dependent care assistance program under Section 129 of the Internal Revenue Code of 1986, as amended, and is to be interpreted in a manner consistent with the requirements of Section 129. The purpose of the Dependent Care Assistance Plan is to enable Participants to elect to receive payments or reimbursement of their Qualified Dependent Care Expenses that are excludable from the Participants' gross income under Section 129 of the Code.

ARTICLE II.

Definitions

2.1. Unless specifically defined in Section 2.2, words or phrases used in the Dependent Care Assistance Plan shall have the same meaning as provided in the Section 125 Plan.

2.2. **Definitions:** Where the following words and phrases appear in the Dependent Care Assistance Plan, they shall have the meaning set forth below, unless a different meaning is plainly required by the context:

(a) **Dependent:** A qualifying individual as set forth in Sections 21(b)(1) and 129 of the Code. In general, a Dependent is a dependent of the Participant who is under age 13 and with respect to whom the Participant may claim a personal exemption deduction for federal income tax purposes ("Type A Qualifying Individual"), or a dependent or Spouse of the Participant who is physically or mentally unable to care for himself ("Type B Qualifying Individual"). A child of a Participant who is under age 13 or is physically or mentally incapable of caring for himself shall be deemed to be a Type A Qualifying Individual despite

the fact that the former Spouse, and not the Participant, may be entitled to claim a personal exemption deduction with respect to the child.

(b) Dependent Care Assistance Account: The account described in Article V hereof, also referred to as a Dependent Care Spending Account.

(c) Dependent Care Service Provider: A person who provides care or other services described in Section 2.2(f) below, but shall not include (a) a dependent care center (as defined in Section 21(b)(2)(D) of the Code), unless the requirements of Code Section 21(b)(2)(C) are satisfied; or (b) a related individual described in Section 129(c) of the Code.

(d) Earned Income: Earned income as defined in Section 32(c)(2), but excluding any amounts paid or Incurred by an Employer for Dependent Care Reimbursement to a Participant. If the Spouse of the Participant is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, the Spouse shall be deemed to have Earned Income of not less than \$200 per month if the Participant has one dependent, and \$400 per month if the Participant has two or more dependents.

(e) Effective Date: This plan is a continuation of the plan initially established January 1, 1989, and this plan document became effective January 1, 2016.

(f) Highly Compensated Participant: A highly compensated employee within the meaning of Code Section 414(q).

(g) Plan: The State of South Carolina Dependent Care Assistance Plan as set forth herein, together with any and all amendments and supplements hereto.

(h) Qualified Dependent Care Expenses: Expenses incurred by a Participant which (a) are incurred for the care of a Dependent of the Participant or for related household service, (b) are paid or payable to a Dependent Care Service Provider, and (c) are incurred to

enable the Participant and the Participant's Spouse, if applicable, to be gainfully employed or a full-time student for any period for which there are one or more Dependents with respect to the Participant. Qualified Dependent Care Expenses shall not include: (a) expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent regularly spends at least eight hours each day in the Participant's household; (b) an expense paid or payable to certain persons related to the Participant (within the meaning of Code Section 129(c)); nor (c) an expense paid or payable to a dependent care center, unless the center complies with all applicable laws and governmental regulations. Qualified Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

(i) Run-out Period: The 90 days following the close of the preceding Plan Year, whereby Participants may submit for reimbursement those expenses incurred during the Plan Year.

ARTICLE III.

Participation

3.1. Date of Participation: Each active Eligible Employee who has completed the requirements to participate in the Section 125 Plan will be eligible to participate in the Dependent Care Assistance Plan. Such an individual will become a Participant upon the effective date of an election under the Section 125 Plan to receive dependent care assistance under this Plan.

3.2. Cessation of Participation: A Participant will cease to be a Participant as of the earliest of (a) the date on which the Dependent Care Assistance Plan terminates; (b) the date on which his election to receive dependent care assistance expires or is terminated under the Section 125 Plan; or (c) any termination date set forth in the Section 125 Plan.

3.3. Reinstatement of Former Participant. If a former Participant who is eligible under Section 3.1 elects again, in a subsequent year, under the Section 125 Plan to receive dependent care assistance under this Plan, he will again become a Participant in this Plan on the effective date of such election.

ARTICLE IV.

Election to Receive Dependent Care Assistance

4.1. Election Procedure: A Participant may elect to receive dependent care assistance under this Plan by filing a compensation reduction agreement in accordance with the procedures established under the Section 125 Plan. An election to receive dependent care assistance shall be irrevocable during the Plan Year, subject to a change in status or other applicable event, as provided in the Section 125 Plan.

4.2. Maximum Dependent Care Assistance: The maximum amount, which the Participant may receive in any Plan Year in the form of dependent care assistance under this Plan, shall be limited to the credit balance in the Dependent Care Flexible Spending Account of the Participant; provided, however, in no event shall the total amount of claims reimbursed to a Participant from his Dependent Care FSA for any of the Participant's taxable year exceed the lesser of. (i) the Participant's Earned Income for the Participant's taxable year; (ii) if the Participant is married, the actual or deemed Earned Income of the Participant's spouse for the Participant's spouse for the Participant's taxable year; (iii) \$5,000 (of, if the Participant does not certify to the Plan Administrator's satisfaction that he is either unmarried or will file a joint federal income tax returns for the year, \$2,500); or (iv) \$1,500 if the Participant is a Highly Compensated Participant. In the case of two Participants who are married to each other who file joint income tax returns for the Participant's taxable year, the \$5,000 limitation for each of the Participants shall be reduced by the

amount received for the year under the Dependent Care Flexible Spending Account by the Participant's spouse.

ARTICLE V.

Dependent Care Assistance Accounts

5.1. **Establishment of Accounts:** The Plan Administrator will establish a Dependent Care Assistance Account for each Plan Year with respect to each Participant who has elected to receive dependent care assistance for the Plan Year. No interest or other earnings shall be credited to any Participant's Dependent Care Flexible Spending Account.

5.2. **Crediting of Accounts:** A Participant's Dependent Care Assistance Account shall be credited, as of each date that payroll deductions are made, a reduction equal to the pro-rata amount of the annualized election shall be made in the Participant's Compensation in accordance with the Participant's compensation reduction agreement under the Section 125 Plan. All amounts credited to each such Dependent Care Assistance Account shall be the property of the Plan Administrator until paid out pursuant to Article VI.

5.3. **Debiting of Accounts:** A Participant's Dependent Care Assistance Account shall be debited from time to time in the amount of any payment under Article VI to or for the benefit of the Participant for Qualified Dependent Care Expenses incurred during such Plan Year. Amounts debited to each such Dependent Care Assistance Account shall be treated as payments of the earliest amounts credited to the Account and not yet treated as paid under this section, under a first-in/first-out approach.

5.4. **Forfeiture of Accounts:** The amount credited to a Participant's Dependent Care Assistance Account for any Plan Year shall be used only to reimburse the Participant for Qualified Dependent Care Expenses incurred during such Plan Year, and only if the Participant applies for

reimbursement on or before the 90th day following the close of the Plan Year. If any balance remains in the Participant's Dependent Care Assistance Account for any Plan Year after all reimbursements hereunder, such balance shall not be carried over to reimburse the Participant for Qualified Dependent Care Expenses incurred during a subsequent Plan Year, and shall not be available to the Participant in any other form or manner, but shall remain the property of the Plan Administrator, and the Participant shall forfeit all rights with respect to such balance.

ARTICLE VI.

Payment of Dependent Care Assistance

6.1. **Claims for Reimbursement:** A Participant who has elected to receive dependent care assistance for a Plan Year may apply to the Plan Administrator for reimbursement of Qualified Dependent Care Expenses incurred by the Participant during the Plan Year by submitting an application in writing to the Plan Administrator, in such form as the Plan Administrator may prescribe, setting forth:

- (a) the amount, date and nature of the expense with respect to which a benefit is requested;
- (b) the name and address of the person, organization or entity to which the expense was or is to be paid;
- (c) the name of the person for whom the Qualified Dependent Care Expense was incurred and the relationship of the person to the Participant;
- (d) a written statement from an independent third party stating that a Qualified Dependent Care Expense has been incurred and the amount of the Qualified Dependent Care Expense;

(e) a written statement that the Qualified Dependent Care Expense has not been reimbursed or is not reimbursable under another plan (or, if the Qualified Dependent Care Expense has been partially reimbursed or is partially reimbursable, the amount of the reimbursement);

(f) a written statement that the Participant is legally obligated to pay such Qualified Dependent Care Expense; and

(g) such other information as the Plan Administrator may require from time to time.

6.2. Reimbursement or Payment of Expenses: The Plan Administrator shall reimburse the Participant from the Participant's Dependent Care Assistance Account for Qualified Dependent Care Expenses incurred during the Plan Year for which the Participant submits documentation in accordance with Section 6.1.

6.3. Report to Participants on or Before January 31 of Each Year: On or before January 31 of each year, the Plan Administrator shall furnish to each Participant who has received dependent care assistance during the prior calendar year a written statement showing the amount of such assistance paid during such year with respect to the Participant.

ARTICLE VII.

Termination of Participation

In the event that a Participant ceases to be a Participant for any reason, the Participant's election to receive reimbursement of Qualified Dependent Care Expenses and any related compensation reduction agreement made under the Section 125 Plan shall terminate. The Participant (or his estate) or retiree shall be entitled to reimbursement only for Qualified Dependent Care Expenses incurred through the date of termination/retirement, and only if the Participant (or

his estate) or retiree applies for such reimbursement in accordance with Section on or before the 90th day following the date of termination or retirement. No such reimbursement shall exceed the remaining balance, if any, credited to the Participant's Dependent Care Assistance Account for the Plan Year in which the expenses were incurred.

ARTICLE VIII.

Administration

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

- (a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;
- (b) To interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;
- (c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;
- (d) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and

(e) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be by written instrument and in accordance with applicable requirements of law.

8.2. Examination of Records: The Plan Administrator will make available to each Participant such of its records under the Plan as pertain to him, for examination at reasonable times during normal business hours.

8.3. Reliance on Tables: In administering the Plan, the Plan Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by accountants, counsel or other experts employed or engaged by the Plan Administrator.

8.4. Changes by Plan Administrator: If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to Highly Compensated Employees, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by Highly Compensated Employees, with or without the consent of such Employees.

ARTICLE IX.

Amendment or Termination of Plan

9.1. Amendment of Plan: The Planholder reserves the power at any time or times to amend the provisions of the Plan to any extent and in any manner that it may deem advisable, by a written instrument signed by an authorized representative of the Planholder.

9.2. Termination of Plan: The Planholder has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the Planholder will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan at any time without liability. Upon termination or discontinuance of the Plan, all elections and reductions in compensation relating to the Plan shall terminate, and reimbursements shall be made only in accordance with Article VII.

ARTICLE X.

Miscellaneous

10.1. Communication to Employees: Promptly after the Plan is adopted, the Employer will notify all Employees of the availability and terms of the Plan.

10.2. Limitation of Rights: Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against the Planholder, Plan Administrator or the Employer, except as expressly provided herein, and in no event will the terms of employment or service of any Participant be modified or in any way be affected hereby.

10.3. Benefits Solely from General Assets. The benefits provided hereunder will be paid solely from the general assets of the Plan Administrator. Nothing herein will be construed to require the Planholder, Plan Administrator or Employer to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer or the Plan Administrator from which any payment under the Plan may be made.

10.4. Non-assignability of Rights: The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other

method, and will not be subject to be taken by his creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

10.5. No Guarantee of Tax Consequences: Neither the Planholder, Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under Article VI will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under Article VI is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

10.6. Indemnification of Employer by Participants: If any Participant receives one or more payments or reimbursements under Article VI that are not for Qualified Dependent Care Expenses, such Participant shall indemnify and reimburse the Plan Administrator and the Employer for any liability they may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

10.7. Governing Law: The Plan will be construed, administered and enforced according to the laws of the State of South Carolina.

10.8. Severability: If any term or provision of the Plan shall be found to be illegal or unenforceable, then, notwithstanding any such illegality or unenforceability, the remainder of the Plan shall remain in full force and effect and such term or provision shall be deemed to be deleted and severable therefrom.

Medical Reimbursement Plan Effective
January 1, 1989, as amended and
restated, January 1, 2016

ARTICLE I.

Introduction

This plan is intended to qualify as a self-insured medical reimbursement plan under Section 105(b) of the Internal Revenue Code of 1986, as amended, and is to be interpreted in a manner consistent with the requirements of Section 105(b). The purpose of the Medical Reimbursement Plan is to enable Participants to elect to receive payments or reimbursements of Qualifying Medical Expenses that are excludable from the Participants' gross income under Section 105(b) of the Code.

ARTICLE II.

Definitions

2.1. Unless specifically defined in Section 2.2, words or phrases used in the Medical Reimbursement Plan shall have the same meaning as provided in the Flexible Benefits Plan.

2.2. Definitions:

(a) **Dependent:** Any person who falls within the definition of dependent provided in Section 105(b) of the Code.

(b) **Effective Date:** This plan is a continuation of the plan initially established January 1, 1989, and this plan document became effective January 1, 2016.

(c) **Grace Period:** A period during which an individual, who incurs expenses for a qualified benefit during such period, may be paid or reimbursed for those expenses from the unused benefits or contributions relating to that benefit, with such Grace Period not to extend beyond the fifteenth day of the third calendar month after the end of the immediately preceding Plan Year to which it relates.

(d) Medical Reimbursement Account: The account described in Article V hereof, also known as the Medical Spending Account, which consists of two options: the General-Purpose Medical Reimbursement Account and the Limited-Use Medical Reimbursement Account (for Participants in the Health Savings Account).

(e) Medical Spending Account: The account described in Article V hereof, also known as the Medical Reimbursement Account, which consists of two options: the General-Purpose Medical Reimbursement Account and the Limited-Use Medical Reimbursement Account (for Participants in the Health Savings Account).

(f) Plan: The State of South Carolina Medical Reimbursement Plan as set forth herein, together with any and all amendments and supplements hereto.

(g) Qualifying Medical Expense: An expense as described below, but only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense through insurance or otherwise (other than the Plan) and only to the extent that the Participant or his or her Dependents are legally obligated to pay for the expense. “Qualifying Medical Expenses” will vary depending on which Medical Reimbursement Account the Participant has elected:

(1) General-Purpose Medical Reimbursement Account. For the purposes of this Account, Qualifying Medical Expenses means any medical expense incurred by a Participant or his or her Spouse or other Dependent for medical care (as defined in Section 213(d) of the Code, but excluding qualified long-term care services as defined in Section 7702B(c) of the Code or coverage for any product which is advertised, marketed, or offered as long-term care insurance). The term includes insulin (regardless of whether it is dispensed through a prescription), but excludes any other medicine or drug that is not

prescribed (within the meaning of Section 213(b) of the Code). It also does not include any premium paid for any type of insurance coverage.

(2) **Limited-Use Medical Reimbursement Account.** For purposes of this Account, Qualifying Medical Expenses means expenses incurred by a Participant or his Spouse or Dependents for medical care, as defined in Section 213(d) of the Code – provided, however, that such expenses are for vision care and dental care only. The term excludes any medicine or drug that is not prescribed (within the meaning of Section 213(b) of the Code). It also does not include any premium paid for any type of insurance coverage.

(h) **Run-out Period:** The 90 days following the close of the preceding Plan Year, whereby Participants may submit for reimbursement those expenses incurred during the Plan Year and/or Grace Period.

ARTICLE III.

Eligibility and Participation

3.1. **Eligibility and Date of Participation:** Each Eligible Employee who has completed the requirements to participate in the Section 125 Plan will be eligible to participate in the Medical Reimbursement Plan. Such an individual will become a Participant upon the effective date of an election under the Section 125 Plan to receive medical expense reimbursements under this Plan.

3.2. **Cessation of Participation:** A Participant will cease to be a Participant as of the earliest of (a) the date on which the Medical Reimbursement Plan terminates; (b) the date on which his election to receive medical expense reimbursements expires or is terminated under the Section 125 Plan; or (c) any termination date set forth in the Section 125 Plan.

3.3. Reinstatement of former Participant. If a former Participant who is eligible under Section 3.1 elects again, in a subsequent year, under the Section 125 Plan to receive medical expense reimbursements under this Plan, he will again become a Participant in this Plan on the effective date of such election.

3.4. Qualifying Leave under Family and Medical Leave Act: Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (the "FMLA"), then to the extent required by the FMLA, the Participant will be entitled to continue the Participant's coverage under this Medical Reimbursement Plan on the same terms and conditions as if the Participant were still an active Employee. The requirements for continuing coverage, procedures for FMLA leave and payment option(s) provided by the Employer (as described above) will be administered in accordance with the regulations issued under Code Section 125 and in accordance with the FMLA.

3.5. Non-FMLA Leave: If a Participant goes on an unpaid leave of absence that does not affect eligibility under this Medical Reimbursement Plan, then the Participant will continue to participate and the contributions due for the Participant will be paid by one or more of the payment options implemented by the Employer on a uniform and consistent basis in accordance with the Employer's internal policy and procedure. If a Participant goes on an unpaid leave that affects eligibility under this Medical Reimbursement Plan, the election change rules in Section 4.1 of this Medical Reimbursement Plan will apply. If such policy requires coverage to continue during the leave but permits a Participant to discontinue contributions while on leave, the Participant will, upon returning from leave, be required to repay the contributions not paid by the Participant during the leave.

ARTICLE IV.

Election to Receive Medical Expense Reimbursements

EXPENSE REIMBURSEMENTS

4.1. **Election Procedure:** A Participant may elect to receive payments or reimbursements of his Qualifying Medical Expenses under this Plan by filing a compensation reduction agreement in accordance with the procedures established under the Section 125 Plan. An election to receive payments or reimbursements of Qualifying Medical Expenses shall be irrevocable during the Plan Year, subject to a change in status or other applicable event, as provided in the Section 125 Plan.

4.2. **Maximum Reimbursements:** The maximum amount that the Participant may have credited to his or her Medical Reimbursement Account and receive under this Plan, in the form of payments or reimbursements for Qualifying Medical Expenses incurred in any Plan Year, is \$2,550; provided, however, in the case of two Participants who are married to each other, each Participant may elect to have to have the foregoing amount credited to his or her Medical Reimbursement Account.

ARTICLE V.

Medical Reimbursement Accounts

5.1. **Establishment of Medical Reimbursement Account:** The Plan Administrator will establish a Medical Reimbursement Account for each Plan Year with respect to each Participant who has elected to receive reimbursement of Qualifying Medical Expenses incurred during the Plan Year. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under this Article V.

5.2. Crediting of Accounts: There shall be credited to a Participant's Medical Reimbursement Account, as of the beginning of the Plan Year (or as of the later effective date of a Participant's election), the annualized amount which the Participant has elected to have his or her Compensation reduced pursuant to Section 4.1 for the Plan Year for the reimbursement of Qualifying Medical Expenses (subject to the limits in Section 4.2). As of each date that payroll deductions are made, a reduction equal to the pro-rata amount of the annualized election shall be made, in such Compensation in accordance with the Participant's compensation reduction agreement under the Section 125 Plan. All amounts credited to each such Medical Reimbursement Account shall be the property of the Plan Administrator as the required payment of the benefit level elected.

5.3. Forfeiture of Accounts: The Participant's Medical Reimbursement Account for any Plan Year shall be used only to reimburse the Participant for Qualifying Medical Expenses incurred during such Plan Year and/or the Grace Period. The Plan Administrator has established a Grace Period following the end of the Plan Year during which amounts unused as of the end of the Plan Year may be used to reimburse Qualifying Medical Expenses incurred during the Grace Period. In no event can the Grace Period exceed two (2) months and fifteen (15) days following the end of the Plan Year. If any balance remains, at the end of the Grace Period, in the Participant's Medical Reimbursement Account for a Plan Year, and the Participant has not applied for reimbursement on or before the 90th day following the close of the Plan Year, the balance shall not be available to the Participant in any other form or manner, but shall remain the property of the Plan Administrator, and the Participant shall forfeit all rights with respect to such balance. Amounts so forfeited shall be used in a manner that is permitted within the applicable Internal Revenue Service regulations.

ARTICLE VI.

Reimbursement of Qualifying Medical Expenses

6.1. Reimbursement Procedures: A Participant who has elected to receive medical expense reimbursements for a Plan Year may apply to the Administrator for reimbursement of Qualifying Medical Expenses incurred by the Participant during the Plan Year and/or Grace Period by submitting an application in writing to the Administrator, in such form as the Plan Administrator may prescribe, setting forth:

- (a) the amount, date and nature of the expense to which a benefit is requested;
- (b) the name of the person, organization or entity to which the expense was or is to be paid;
- (c) the name of the person for whom the expense was incurred and, if such person is not the Participant requesting the benefit, the relationship of such person to the Participant;
- (d) the amount recovered or expected to be recovered, under any insurance arrangement or other plan, with respect to the expense;
- (e) a written statement from an independent third party stating that the Qualifying Medical has been incurred and the amount of the Qualifying Medical Expense;
- (f) a written statement that the Qualifying Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage (or, if the Qualifying Medical Expense has been partially reimbursed or is partially reimbursable, the amount of the reimbursement);
- (g) a written statement that the Participant is legally obligated to pay such Qualifying Medical Expense; and
- (h) any other information reasonably requested by the Administrator.

Each Participant's Medical Reimbursement Account will be credited for medical reimbursement with amounts withheld from the Participant's Compensation and any Non-elective Contributions allocated thereto by the Employer or where applicable, the Participant. The Account will be debited for medical reimbursements disbursed to the Participant in accordance with this Article. The entire amount elected by the Participant as an annual amount for the Plan Year for medical reimbursement, less any medical reimbursements already disbursed to the Participant for Qualifying Medical Expenses incurred during the Plan Year, shall be available to the Participant at any time during the Plan Year without regard to the balance in the Medical Reimbursement Account (provided that the periodic contributions have been made). Thus, the maximum amount of medical reimbursement at any particular time during the Plan Year will not relate to the amount that a Participant has had credited to his Medical Reimbursement Account. In no event will the amount of reimbursements for Qualifying Medical Expenses in any Plan Year exceed the annual amount specified for the Plan Year in the compensation reduction agreement for reimbursement of Qualifying Medical Expenses.

6.2. Disbursing Medical Expense Reimbursement: Payment shall be made to the Participant in cash as reimbursement for Qualifying Medical Expenses incurred by the Participant or his Dependents while he is a Participant during the Plan Year for which the Participant's election is effective, provided that the substantiation requirements of Section 6.3 herein are satisfied. However, if the Plan Administrator so chooses, the Participant may choose to make payment for Qualifying Medical Expenses with an electronic payment card arrangement. Documentation must be submitted to the Plan Administrator (or its designee) for certain transactions. If a Participant fails to submit documentation to verify certain electronic payment card transactions, the Participant will be subject to punitive measures, as delineated in Section 6.3.

6.3. Repayment of Excess Reimbursements: If, as of the end of any Plan Year, it is determined that a Participant has received payments under this Medical Reimbursement Account that exceed the amount of Qualifying Medical Expenses that have been substantiated by such Participant during the Plan Year as required by Section 6.3 herein, or reimbursements have been made in error (e.g., reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the Plan Administrator (or its designee) shall recoup the excess reimbursements in one or more of the following ways: (i) the Plan Administrator (or its designee) shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the Plan Administrator within sixty (60) days of receipt of such notification; (ii) the Plan Administrator (or its designee) may offset the excess reimbursement against any other Qualifying Medical Expenses submitted for reimbursement (regardless of the Plan Year in which submitted); or (iii) the Plan Administrator may withhold such amounts from the Participant's pay, to the extent permitted under applicable law. If the Plan Administrator (or its designee) is unable to recoup the excess reimbursement through the means set forth in (i) – (iii), the Plan Administrator (or its designee) will notify the Employer that the funds could not be recouped and the Employer will treat the excess reimbursement as it would any other bad business debt.

ARTICLE VII.

Termination of Participation

In the event that a Participant ceases to be a Participant for any reason, the Participant's election to receive reimbursements for Qualifying Medical Expenses and any related compensation reduction agreement made under the Section 125 Plan shall terminate. The Participant (or his estate) or retiree shall be entitled to reimbursement only for Qualifying

Medical Expenses incurred through the date of termination/retirement and only if the Participant (or his estate) or retiree applies for such reimbursement in accordance with Section 6.1 on or before the 90th day following the date of termination or retirement, unless: 1) he is continuing participation on an after-tax basis, if eligible, through COBRA as described in Article XI; or 2) he elects, at the time of enrollment, to accelerate his pretax deductions, and indicates on his enrollment form, up to the full, annual amount, and all such pretax deductions are taken prior to his date of termination or retirement. Following termination, a Participant can only participate for the remainder of the Plan Year in which his qualifying event occurs, if he has not already received, as reimbursement, the maximum benefit available under the Participant's Medical Reimbursement Account for the year. If there is doubt as to the right of any beneficiary of a deceased Participant to receive reimbursement, the Plan Administrator (or its designee) may retain such amount until the rights thereto are determined, without liability for any interest thereon.

ARTICLE VIII.

Administration

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

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

(d) To compute the amount of benefits that will be payable to any Participant or other person in accordance with the provisions of the Plan, and to determine the person or persons to whom such benefits will be paid;

(e) To authorize the payment of benefits;

(f) To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan; and

(g) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation, or designation to be by written instrument.

8.2. Examination of Records: The administrator will make available to each Participant such of his records as pertain to him, for examination at reasonable times during normal business hours.

8.3. Reliance on Tables: In administering the Plan, the Plan Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by any accountant, counsel or other expert who is employed or engaged by the Plan Administrator.

8.4. Named Fiduciary: ERISA does not apply to this Plan. However, in the event that the present exemption for governmental plans is withdrawn, the Plan Administrator shall be the named fiduciary for the purposes of ERISA, with authority to control and manage the operation and administration of the Plan.

8.5. Claims and Review Procedures.

(a) Claims Procedure: If any person believes he is being denied any rights or benefits under the Plan, such person may file a claim in writing with the Plan Administrator. If any such claim is wholly or partially denied, the Plan Administrator will notify such person of its decision in writing. Such notification will be written in a manner calculated to be understood by such person and will contain (i) specific reasons for the denial, (ii) specific reference to pertinent Plan provisions, (iii) a description of any additional material or information necessary for such person to perfect such claim and an explanation of why such material or information is necessary, and (iv) information as to the steps to be taken if the person wishes to submit a request for review. Such notification will be given within 90 days after the claim is received by the Plan Administrator (or within 180 days, if special circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given to such person within the initial 90 day period). If such notification is not given within such period, the claim will be considered denied as of the last day of such period, and such person may request a review of his claim.

(b) Review Procedure: Within 90 days after the date on which a person receives a written notice of a denied claim (or, if applicable, within 90 days after the date on which such denial is considered to have occurred), such person (or his duly authorized

representative) may (i) file a written request with the Plan Administrator for a review of his denied claim and of pertinent documents, and (ii) submit written issues and comments to the Plan Administrator. The Plan Administrator will notify such person of its decision in writing. Such notification will be written in a manner calculated to be understood by such person and will contain specific reasons for the decision as well as specific references to pertinent Plan provisions. The decision on review will be made within 90 days after the request for review is received by the Plan Administrator (or within 120 days, if special circumstances require an extension of time for processing the request, such as an election by the Plan Administrator to hold a hearing, and if written notice of such extension and circumstances is given to such person within the initial 90 day period). If the decision on review is not made within such period, the claim will be considered denied.

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

ARTICLE IX.

Amendment or Termination of Plan

9.1. Amendment of Plan: The Plan Administrator reserves the power at any time or times to amend the provisions of the Plan to any extent and in any manner that it may deem advisable, by a written instrument signed by an authorized representative of the Plan Administrator.

9.2. Termination of Plan: The Planholder has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the Planholder will have no

obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan at any time without liability. Upon termination or discontinuance of the Plan, all elections and reductions in compensation relating to the Plan shall terminate, and reimbursements shall be made only in accordance with Article VII.

ARTICLE X.

Miscellaneous

10.1. Communication to Employees: Promptly after the Plan is adopted, the Employer will notify all Employees of the availability and terms of the Plan.

10.2. Limitation of Rights: Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against the Planholder, Plan Administrator or the Employer, except as expressly provided herein, and in no event will the terms of employment or service of any Participant be modified or in any way be affected hereby.

10.3. Benefits Solely from General Assets. The benefits provided hereunder will be paid solely from the general assets of the Plan Administrator. Nothing herein will be construed to require the Planholder, Employer or Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer or the Plan Administrator from which any payment under the Plan may be made.

10.4. Non-assignability of Rights: The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and will not be subject to be taken by his creditors by any process whatsoever, and any

attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

10.5. No Guarantee of Tax Consequences: Neither the Planholder, Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under Article VI will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under Article VI is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

10.6. Indemnification of Employer by Participants: If any Participant receives one or more payments or reimbursements under Article VI that are not for Qualifying Medical Expenses, such Participant shall indemnify and reimburse the Plan Administrator and the Employer for any liability they may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax that the Participant would have owed if the payments of reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

10.7. Governing Law: The Plan will be construed, administered and enforced according to the laws of the State of South Carolina.

10.8. Severability: If any term or provision of the Plan shall be found to be illegal or unenforceable, then, notwithstanding any such illegality or unenforceability, the remainder of the Plan shall remain in full force and effect and such term or provision shall be deemed to be deleted and severable therefrom.

ARTICLE XI.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The following COBRA continuation provisions, in accordance with Article VII, apply with respect to the Participant's Medical Reimbursement Account, but only if the maximum amount that the Medical Reimbursement Account can require the Participant to pay for the remainder of the Plan Year in which a Qualifying Event occurs is less than the maximum benefit still available for such Plan Year. Otherwise, COBRA continuation coverage shall not be available for the Medical Reimbursement Account.

11.1. Qualified Beneficiary: Only Qualified Beneficiaries may elect continuation coverage under the Plan after a Qualifying Event. For purposes of this Article, a "Qualified Beneficiary" is a person who is covered under the Plan on the day before a Qualifying Event who is:

- (a) an Eligible Employee who is covered under the Plan (hereinafter referred to as "Covered Employee");
- (b) a Spouse of a Covered Employee; or
- (c) a dependent child of a Covered Employee (including a child born to or placed for adoption with the Covered Employee while the Covered Employee is covered under continuation coverage).

11.2. Qualifying Events: The right to continued coverage is triggered by any of five Qualifying Events, which, but for the continued coverage, would result in a loss of coverage under the Plan. For purposes of this Article, a “Qualifying Event” occurs upon:

- (a) the death of a Covered Employee;
- (b) the termination (other than by reason of gross misconduct) of the Covered Employee's employment, or reduction of hours of a Covered Employee that would result in a termination of coverage under the Plan;
- (c) the divorce or legal separation of the Covered Employee from the Covered Employee's Spouse;
- (d) the Covered Employee becoming entitled to Medicare benefits; or
- (e) a child of the Covered Employee ceasing to be a dependent child under the eligibility requirements of the applicable benefit plan.

If any of the above-mentioned Qualifying Events occur to a Qualified Beneficiary, then that Qualified Beneficiary may elect to continue coverage under the Plan.

11.3. Election of Continuation Coverage. Continuation coverage does not begin unless it is elected by a Qualified Beneficiary. The election period shall begin on or before the date that the Qualified Beneficiary would lose coverage under the Plan due to the Qualifying Event, and shall not end before the date that is 60 days after the later of: (i) the date the Qualified Beneficiary would lose coverage due to the Qualifying Event; or (ii) the date on which notice of the right to continued coverage is sent by the Plan Administrator or its designee. The election of continuation coverage must be made on a form provided by the Plan Administrator or its designee and payment for coverage, as described in the notice, must be made when due. An election is considered to be made on the date it is sent to the Plan Administrator or its designee.

11.4. Period of Continuation Coverage. COBRA coverage in the Medical Reimbursement Account shall extend only until the end of the Plan Year in which the Qualified Beneficiary's Qualifying Event occurs, except as set forth in Section 11.5.

11.5. End of Continuation Coverage: Notwithstanding Section 11.4, continuation coverage shall end earlier than the period elected if:

- (a) timely payment of premiums for the continuation coverage is not made;
- (b) the Qualified Beneficiary first becomes covered under any other group health plan, after the COBRA election, as an employee or otherwise, unless such other plan contains a limitation (other than a limitation which does not apply by virtue of HIPAA) with respect to any pre-existing condition of the Qualified Beneficiary;
- (c) the Qualified Beneficiary first becomes entitled to benefits under Medicare, after the COBRA election; or
- (d) the Employer ceases to provide any group health plan to any Employee.

11.6. Cost of Continuation Coverage: The Qualified Beneficiary is responsible for paying the cost of continuation coverage, hereinafter referred to as "premium." The premiums are payable on a monthly basis. After a Qualifying Event, a notice shall be provided which shall specify the amount of the premium, to whom the premium is to be paid, and the date of each month payment is due. Failure to pay premiums on a timely basis shall result in termination of coverage as of the date the premium is due. Payment of any premium, other than that referred to below, shall only be considered to be timely if made within 30 days after the date due. A premium must be paid for the cost of continuation coverage for the time period between the date of the event which triggered continuation coverage and the date continued coverage is elected. This payment must be made within 45 days after the date of election. Notice shall be given which shall specify

the amount of the premium, to whom the premium is to be paid, and the date payment is due. Failure to pay this premium on the date due shall result in cancellation of coverage back to the initial date coverage would have been terminated.

11.7. Notification Requirements: The Plan shall provide, at the time of commencement of coverage under the Plan, written notice to each Covered Employee and to the Spouse of the Covered Employee (if any) of their rights to continuation coverage. The Employer shall notify the Plan Administrator or its designee in the event of a Covered Employee's death, termination of employment, reduction in hours, or entitlement to Medicare benefits within 30 days after the later of: (i) the date of the Qualifying Event; or (ii) the date that the Qualified Beneficiary would lose coverage due to the Qualifying Event. In the case of a divorce or legal separation of the Covered Employee from the Covered Employee's Spouse, or a child ceasing to be a dependent child under the eligibility requirements of the applicable benefit plan, the Covered Employee or Qualified Beneficiary must notify the Plan Administrator or its designee as soon as possible but not later than 60 days after the later of: (i) the date of such Qualifying Event; or (ii) the date that the Qualified Beneficiary would lose coverage due to such Qualifying Event. Failure to provide such timely notice shall result in the loss of any right to elect continuation coverage.

The Covered Employee and the Covered Employee's dependents shall be notified by the Plan Administrator or its designee of their right to elect continuation coverage: (i) in the event of the Covered Employee's death, termination, reduction in hours, or entitlement to Medicare benefits; and (ii) if the Covered Employee is notified by the Plan Administrator or its designee initially, in the event of divorce or legal separation of the Covered Employee from the Covered Employee's Spouse, or in the event of a child ceasing to be a dependent child under the requirements of the applicable benefit plan, within 14 days of the date on which the Plan Administrator or its designee

was notified of these Qualifying Events. Any notification to a Qualified Beneficiary who is the Spouse of the Covered Employee shall be treated as a notification to all other Qualified Beneficiaries residing with such Spouse at the time such notification is made.

11.8. Continuation Health Benefits Provided: The continuation coverage provided to a Qualified Beneficiary who elects continued coverage shall be identical to the coverage provided under the Plan to similarly situated persons covered by the Plan with respect to whom a Qualifying Event has not occurred. If coverage is modified under the Plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all Individuals who are Qualified Beneficiaries under the Plan. Continuation coverage may not be conditioned on evidence of good health.

11.9. Bankruptcy Proceedings: Notwithstanding any of the preceding provisions, in the event of a bankruptcy proceeding under Title XI of the United States Code, where a loss of coverage occurs with respect to a Qualified Beneficiary within one year before or after the date of the commencement of the bankruptcy proceeding, continuation coverage shall be provided under the Plan to the extent required under Section 4980B of the Code.

ARTICLE XII.

HIPAA Privacy and Security

The Plan Administrator and any business associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) and its implementing regulations, as described in this Article. Plan Sponsor shall mean, for the sole purpose of compliance with the mandates of HIPAA, the Public Employee Benefit Authority 67

its successor governing authority, which established, and maintains, the Group Health Benefits Plan of the Employees of the State of South Carolina, the Public School Districts, and Participating Entities as well as the Group Dental Insurance Benefit Plan for South Carolina Public Employees, Active and Retired. Capitalized terms in this Article that are not otherwise defined shall have the same meaning as those terms in 45 CFR Parts 160, 162, and 164. Any reference to a regulation or section in the Code of Federal Regulations ("CFR") shall include any corresponding regulation subsequently issued regardless of the date of issue.

12.1. Adoption: This Article is adopted to reflect certain provisions of HIPAA. It is intended as good faith compliance with the requirements of HIPAA and is to be construed in accordance with HIPAA and guidance issued thereunder. The Plan shall comply with all requirements under this Article to the extent applicable, as described below.

12.2. Supersession of Inconsistent Provisions: This Article shall supersede the provisions of the Plan to the extent those provisions are inconsistent with the provisions of this Article.

12.3. Use and Disclosure of Protected Health Information: The Plan shall use and disclose Protected Health Information to the extent of and in accordance with the uses and disclosures permitted by HIPAA, as set forth in the Privacy Regulations. Specifically, the Plan shall use and disclose Protected Health Information for purposes related to health care treatment, Payment for health care, and Health Care Operations.

12.4. Plan Documents: In order for the Plan to disclose Protected Health Information to the Plan Sponsor or to provide for or permit the disclosure of Protected Health Information to the Plan Sponsor by a health insurance issuer or HMO with respect to the Plan, the Plan must ensure

that the Plan documents restrict uses and disclosures of such information by the Plan Sponsor consistent with the requirements of HIPAA.

12.5. Disclosures by Plan to the Plan Sponsor: The Plan may:

(a) Disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of:

(1) Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

(2) Modifying, amending, or terminating the Plan.

(b) Disclose to the Plan Sponsor information on whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer offered by the Plan.

(c) Disclose Protected Health Information to the Plan Sponsor to carry out Plan administration functions that the Plan Sponsor performs, consistent with the provisions of Sections 12.6 to 12.8 of this Article.

(d) With an authorization from the Eligible Employee, disclose Protected Health Information to the Plan Sponsor for purposes related to the administration of other employee benefit plans and fringe benefits sponsored by the Plan Sponsor.

(e) Not permit a health insurance issuer with respect to the Plan to disclose Protected Health Information to the Plan Sponsor except as permitted by this Section.

(f) Not disclose (and may not permit a health insurance issuer to disclose) Protected Health Information to the Plan Sponsor as otherwise permitted by this Section unless a statement is included in the Plan's notice of privacy practices that the Plan (or a

health insurance issuer with respect to the Plan) may disclose Protected Health Information to the Plan Sponsor.

(g) Not disclose Protected Health Information to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

12.6. Uses and Disclosures by Plan Sponsor: The Plan Sponsor may only use and disclose Protected Health Information as permitted and required by the Plan, as set forth within this Article. Such permitted and required uses and disclosures may not be inconsistent with the provisions of HIPAA. The Plan Sponsor may use and disclose Protected Health Information without an authorization from an Eligible Employee for Plan administrative functions including Payment activities and Health Care Operations. In addition, the Plan Sponsor may also use and disclose Protected Health Information to accomplish the purpose for which any disclosure is properly made pursuant to Section 12.5.

12.7. Certification: The Plan may disclose Protected Health Information to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions provided for in this Section and that the Plan Sponsor so agrees to the provisions set forth therein.

12.8. Conditions Agreed to by the Plan Sponsor: The Plan Sponsor agrees to:

(a) Not use or further disclose Protected Health Information other than as permitted or required by the Plan document or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected

Health Information, and that any such agents or subcontractors agree to implement reasonable and appropriate security measures to protect any Electronic Protected Information belonging to the Plan that is provided by the Plan Sponsor;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions unless authorized by an Individual;

(d) Not use or disclose Protected Health Information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an Individual;

(e) Report to the Plan any Protected Health Information use or disclosure that is inconsistent with the uses or disclosures provided for by this Article, or any Security Incident of which it becomes aware;

(f) Make Protected Health Information available to an Individual in accordance with HIPAA's access requirements pursuant to 45 CFR § 164.524;

(g) Make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR § 164.526;

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

(i) Make internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA;

(j) 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 Protected Health Information when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible);

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

(l) Ensure that the separation and requirements of Sections 12.9, 12.10, and 12.11 of the Plan are supported by reasonable and appropriate security measures.

12.9. Adequate Separation Between the Plan and the Plan Sponsor: In accordance with HIPAA, only the designated Privacy Officer and those individuals identified in the HIPAA Policies and Procedures who have a need for Protected Health Information to help administer the Plan may be given access to Protected Health Information.

12.10. Limitations of Access and Disclosure: The persons referenced in Section 12.9 of this Article may only have access to and use and disclose Protected Health Information for Plan administration functions that the Plan Sponsor performs for the Plan.

12.11. Noncompliance: If the persons or classes of persons referenced in Section 12.9 of this Article do not comply with this Plan document, the Plan and the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.