

**FLEXIBLE BENEFITS PLAN
FOR EMPLOYEES OF
THE STATE OF SOUTH CAROLINA
AND OPTIONAL EMPLOYERS**

ADOPTED BY
THE SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY
Effective January 1, 2025

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ARTICLE 1

PURPOSE

1.01 Preliminary Information

This Flexible Benefits Plan for the Employees of the State of South Carolina and Local Subdivisions (“Plan”) is a complete amendment and restatement of the Plan, effective as of January 1, 2025, except as otherwise provided. The purpose of the Plan is to provide eligible employees of the State of South Carolina and participating local subdivisions the ability to design a package of benefits that fits their individual needs on a favorable tax basis. This Plan is a governmental plan, as defined in 29 U.S.C. § 1002(32) of the Employee Retirement Income Security Act of 1974 (“ERISA”), that is exempt from the requirements of ERISA and certain other federal health insurance law requirements that are applicable to private health insurance plans, including certain provisions of the Public Health Service Act. Any reference to a period of time in “days” means calendar days unless otherwise specified.

1.02 Purpose of Plan

The Plan has been established pursuant to Section 9-1-60 of the South Carolina Code of Laws. The Plan is intended to qualify as a “cafeteria plan” within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended (“Code”). To the extent permitted under the Code and any applicable state tax law, benefits elected by Participants in lieu of cash under the Plan are excluded from their taxable income.

ARTICLE 2

DEFINITIONS AND RULES OF INTERPRETATION

2.01 Definitions

Whenever used herein, the following terms shall have the following meanings when the first letter of the term is capitalized:

- A. “Accounts” means the separate flexible spending accounts maintained by or under the direction of the Plan Administrator for each electing Participant described as follows:
 - 1. “Dependent Care Spending Account” means the accounting record maintained under the Plan for each electing Participant directing amounts to such an account for reimbursement of Dependent Care Expenses.
 - 2. “Medical Spending Account” means the accounting record maintained under the Plan for each electing Participant directing amounts to such an account for reimbursement of Qualifying Medical Care Expenses.
 - a. “General Purpose Medical Spending Account” means the Medical Spending Account available to all Participants who do not contribute to, and whose spouse does not contribute to, a Health Savings Account.

b. "Limited-use Medical Spending Account" means the Medical Spending Account available to Participants who contribute to, or whose spouse contributes to, a Health Savings Account.

B. "Active Employment" means the Employee is actively at work on a full-time basis, performing all the regular duties of their occupation at an established business location of the Employer or another location to which they may be required to travel to perform the duties of their employment. An Employee shall be deemed to be engaged in Active Employment while on jury duty or on any regular nonworking day including holidays or vacation days established and published by the Employer if the Employee was engaged in Active Employment on the last preceding regular working day.

The Employee's participation in the Plan will not be prevented or delayed if (i) the Employee's absence from work is due to any health-related reason, including a medical condition, hospital confinement, or a disability; or (ii) the Employee is on leave under the Family and Medical Leave Act on the Effective Date of this Plan. In no event, however, will an Employee be considered to be in Active Employment if they have not reported for work or if they or their Employer has terminated their employment.

C. "Carryover Amount" means 20% of the indexed maximum salary contribution limit under Code Section 125(i), as amended, beginning with unused amounts from the 2024 Plan Year.

D. "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

E. "Code" means the Internal Revenue Code of 1986, as amended from time to time.

F. "Compensation" means, with respect to a Participant, the cash remuneration received by the Participant from an Employer that is reportable by the Employer as wages for federal income tax purposes, plus any elective deferrals or any other amounts excludable from taxable income because of an election under Code Section 125 or 403(b). Compensation shall not include cash remuneration received before the Participant began participation in the Plan.

G. "Debit Card" means the card available for point of service direct debiting of the Participant's qualifying expenses from the Medical Spending Account.

H. "Dependent" means any individual who is a tax dependent of the Participant as defined 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).

I. "Denial" means any of the following: a denial, reduction, termination, or failure to provide or make payment (in whole or in part) for a benefit, including determinations based on eligibility.

J. "Dependent Care Expenses" means expenses Incurred to enable the Participant and the Participant's spouse, if applicable, to be gainfully employed for any period during which there are one (1) or more Qualifying Individuals with respect to the Participant, including expenses for household services and expenses for the care of a Qualifying Individual, determined pursuant to Code Section 129 and the regulations thereunder. The term Dependent Care Expenses shall not include:

1. An expense Incurred for services outside of the household of the Participant, unless the services were Incurred for a Type A Qualifying Individual or a Type B Qualifying Individual who spends at least eight hours each day in the Participant's household;
 2. An expense paid or payable to certain persons related to the Participant (within the meaning of Code Section 129(c)); nor
 3. An expense paid or payable to a dependent care center, unless the center complies with all applicable laws and governmental regulations.
- K.** "Dependent Care Reimbursement" means reimbursement for services that, if paid for by the Participant, would be considered employment-related expenses under Code Section 21(b)(2).
- L.** "Earned Income" means earned income as defined in Code Section 32(c)(2), but excluding any amounts paid or Incurred by the Third Party Administrator 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, 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.
- M.** "Electronic Protected Health Information" or "EPHI" means "electronic protected health information" as defined at 45 CFR § 160.103.
- N.** "Eligible Employee" for purposes of making an election under Paragraph 4.01(a) means an Employee of an Employer who is eligible under the applicable underlying benefit plan or policy providing the Qualifying Benefit. For purposes of making an election under Paragraph 4.01(b) and for receiving benefits under Articles VI and VII, an "Eligible Employee" means an Employee of an Employer who meets the eligibility requirements for the State Health Plan. The term "Eligible Employee" shall not include 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 by any federal, state, or local governmental entity or instrumentality. Furthermore, the term "Eligible Employee" shall not include any Employee who is employed under a written contract with an Employer if such written contract excludes such Employee from participation in the Plan. An "Eligible Employee" shall include a Special Participant as provided under the Paragraph entitled "COBRA Medical Premiums."
- O.** "Employee" means any Employee of an Employer, except an individual who is a nonresident alien and who receives no earned income (within the meaning of Code Section 911(d)(2)) from an Employer that constitutes income from sources within the United States within the meaning of Code Section 861(a)(3).
- P.** "Employer" means the State of South Carolina and any local subdivision thereof that adopts this Plan pursuant to a written instrument.
- Q.** "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.
- R.** "Fiduciaries" means 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.

- S.** “FMLA” means the Family and Medical Leave Act of 1993.
- T.** “Grace Period” means the period of January 1 through March 15 following the end of a prior Plan Year.
- U.** “Health Care Operations” means “health care operations” as defined by 45 CFR § 164.501, as amended.
- V.** "Health Savings Account" or "HSA" means a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary that meets the requirements of Code Section 223(d) and that is recognized by the Plan Administrator, in its sole discretion, as eligible to receive salary reduction contributions.
- W.** "High Deductible Health Plan" or "HDHP" means an option under the State Health Plan, or under any other health plan, that meets the requirements of Code Section 223.
- X.** “HIPAA” means the Health Insurance Portability and Accountability Act of 1996.
- Y.** "HSA Eligible Employee" means an Eligible Employee who meets all of the following criteria:
 - 1.** He or she is a participant in an HDHP option under the State Health Plan;
 - 2.** He or she is not, while covered under an HDHP, covered under any other health plan that is not an HDHP and that provides coverage for any benefit that is covered under the HDHP (except as provided in Code Section 223(c)(1)(B));
 - 3.** He or she is not enrolled in Medicare benefits;
 - 4.** If he or she has a Medical Spending Account under this Plan, such Account is a Limited-use Medical Spending Account only and not a General Purpose Medical Spending Account;
 - 5.** He or she is not claimed as a dependent on another individual's tax return; and
 - 6.** He or she is not covered by a government or military health care plan (e.g., TRICARE).
- Z.** “Incurs” or “Incurred” refers to the date on which the care or services that give rise to a covered expense are provided, not the date on which the Participant is formally billed or pays for such care or services. Expenses are not treated as Incurred unless the care or services giving rise to the expenses are provided after the individual becomes a Participant or dependent, as applicable.
- AA.** “Participant” means an Eligible Employee who has commenced participation in accordance with Paragraph 3.01 and has not subsequently become ineligible to participate under Paragraph 3.02.

- BB.** “Payment” means “payment” as defined by 45 CFR § 164.501, as amended.
- CC.** “Plan Administrator” means the South Carolina Public Employee Benefit Authority.
- DD.** “Planholder” means the State of South Carolina, by and through the South Carolina Public Employee Benefit Authority or its successor governing authority.
- EE.** “Plan” or “Flexible Benefits Plan” means the Flexible Benefits Plan for the Employees of the State of South Carolina and Local Subdivisions, as set forth in this document, as amended from time to time.
- FF.** “Plan Year” means the 12-consecutive month period beginning on January 1 and ending on December 31 of each year.
- GG.** “Post-Service Claim” means any claim relating to medical benefits that have already been received.
- HH.** “Privacy Regulations” mean the regulations under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164, as amended).
- II.** “Protected Health Information” means “protected health information” as defined at 45 CFR § 164.501, as amended.
- JJ.** “Qualified Benefits” means the benefits identified in Appendix A that are available to Eligible Employees and for which an Eligible Employee may pay for his or her share of their cost through the Flexible Benefits Plan hereunder.
- KK.** “Qualifying Individual” means 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 and who shares the Participant’s principal place of abode (which shall not be in violation of local law) for more than one-half of the year (“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.
- LL.** “Qualifying Medical Care Expense” means:
- 1.** For a General Purpose Medical Spending Account, any medical, dental, or vision expense (as defined in Code Section 213(d), and as allowed under Code Section 105 and Code Section 106(f), and the rulings and Treasury regulations thereunder) Incurred by a Participant or his or her spouse and dependents. The Participant or his or her dependents must not otherwise be entitled to reimbursement for the expense through insurance or otherwise, and reimbursement may occur only to the extent that the Participant or his or her dependents are legally obligated to pay for the expense.
 - 2.** For a Limited-use Medical Spending Account, any dental or vision expense (as defined in Code Section 213(d), and as allowed under Code Section 105 and Code Section 106(f), and the rulings and Treasury regulations thereunder) Incurred by a Participant or his or her

spouse and dependents. The Participant or his or her dependents must not otherwise be entitled to reimbursement for the expense through insurance or otherwise, and reimbursement may occur only to the extent that the Participant or his or her dependents are legally obligated to pay for the expense.

3. In any event, Qualifying Medical Expenses shall not include:
 - a. Any premiums paid for health, dental, or vision coverage;
 - b. Qualified long-term care services as defined in Code Section 7702B(c); or
 - c. Coverage for any product which is advertised, marketed, or offered as long-term care insurance.
4. For purposes of this definition, the term “dependent” shall have the same meaning as the term “Dependent” in the State Health Plan; provided, however, that it shall include children who are covered under a “Qualified Medical Child Support Order” as defined by ERISA or any applicable state law.

MM. “Relative” means 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.

NN. “Run-Out Period” means the period that ends ninety (90) days following the end of the Plan Year for claims Incurred during either:

1. The previous Plan Year; or
2. With respect to the Dependent Care Spending Account, the seventy-five (75) day Grace Period immediately following the end of the Plan Year.

Claims Incurred during the Plan Year that immediately precedes the Grace Period and claims incurred during the Grace Period may be submitted up to ninety (90) days immediately following the preceding Plan Year.

OO. “Security Incident” means “security incident” as defined at 45 CFR § 164.304, as amended.

PP. “Security Regulations” mean the regulations under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Parts 160 and 164, as amended).

QQ. “Special Participant” means an individual who is deemed to have elected coverage pursuant to Paragraph 13.37.

RR. “Spouse” means 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:

1. The Eligible Employee and their Spouse are divorced;
 2. The Eligible Employee and their Spouses are legally separated under a decree of divorce or separate maintenance; or
 3. The Eligible Employee and their 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.
- SS.** "State Health Plan" means the Group Health Benefits Plan of the Employees of the State of South Carolina, the Public School Districts, and Participating Entities.
- TT.** "Summary Health Information" means "summary health information" as defined at 45 CFR § 164.504(a), as amended.
- UU.** "Third Party Administrator" means the entity retained by the Plan to receive, process, and pay claims and reimbursements for the Participant's Accounts.
- VV.** "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994.

2.02 Rules of Interpretation

In interpreting the Plan, the following rules of interpretation shall apply:

- A.** 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.
- B.** The Medical Spending Account shall be interpreted to be in compliance with the requirements of Code Sections 105, 106, and 4980B.
- C.** The Dependent Care Spending Account shall be interpreted to be in compliance with the requirements of Code Section 129.
- D.** The Plan shall be construed, enforced, and administered and the validity thereof determined in accordance with applicable provisions of the Code and, to the extent not inconsistent with the Code, in accordance with the laws of the State of South Carolina.
- E.** Words used herein in the masculine gender shall be construed to include the feminine gender, and words used in the singular or plural shall be construed as being in the plural or singular, where appropriate.
- F.** Headings and subheadings are inserted for convenience and are not to be considered in the

construction of any provision of the Plan.

- G.** If a provision of the Plan is held illegal or invalid for any reason, that provision shall be deemed null and void, but the invalidation of that provision shall not otherwise impair or affect the Plan.
- H.** Any reference to a Section of the Code or ERISA shall be deemed a reference to any comparable or succeeding provision of any legislation that amends, supplements, or replaces such Section.

ARTICLE 3

PARTICIPATION AND TERMINATION

3.01 Commencement of Participation

- A.** An Eligible Employee shall become a Participant under the Plan as to Qualified Benefits under Paragraph 4.01(a) effective as of the first payroll following the date the individual becomes an Eligible Employee and completes a benefit election and salary reduction agreement.
- B.** An Eligible Employee may become a Participant under the Plan with respect to the Medical Spending Account and/or the Dependent Care Spending Account as of the first day of the month following the Eligible Employee's date of employment with the Employer if the Eligible Employee elects to reduce his or her compensation pursuant to Paragraph 4.01(b).

3.02 Cessation of Participation

Except as provided under Article 10, a Participant shall cease to be a Participant as of the earliest of:

- A.** The date on which the Plan terminates;
- B.** The first day of the month after the day the Participant terminates his employment with the Employer or retires;
- C.** The first day of the month after the day the Participant ceases to work as an Eligible Employee for an Employer (except as otherwise required by USERRA or the FMLA);
- D.** With respect to Qualified Benefits, the date on which the Participant's coverage for such Qualified Benefits ends; or
- E.** The date a Participant ceases to make required contributions to the Plan.

Notwithstanding the provisions contained in this Paragraph, a Participant who ceases to be a Participant in the Plan pursuant to this Paragraph may nonetheless be entitled to continue certain Qualified Benefits, as provided in the plans which govern such coverage, and may be eligible to continue participation in the Medical Spending Account if the Participant is eligible for continuation coverage pursuant to Article 10.

3.03 Reinstatement of Participation by Former Participants

A former Participant who terminates employment with an Employer and then returns to employment with an Employer within the same Plan Year and within thirty (30) days following termination, shall be reinstated to the Participant's election under the Plan prior to the termination. If such former Participant returns to employment within the same Plan Year as the Participant's termination of employment and more than thirty (30) days after termination of employment, such individual must satisfy the requirements under Paragraph 3.01 and make a new election under the Plan for the remainder of any applicable Plan Year; provided, however, that such individual may not elect to participate in the Medical Spending Account or Dependent Care Spending Account for the remainder of the Plan Year. A former Participant who terminates employment with an Employer in one Plan Year and returns to employment in the following Plan Year must satisfy the requirements under Paragraph 3.01 and make a new election under the Plan for the Plan Year in which the individual returns to employment.

3.04 Unpaid FMLA Leaves of Absence

A Participant taking an unpaid leave of absence which qualifies as an FMLA leave of absence may cease all or a portion of required contributions consistent with the requirements of the FMLA; provided, however, such person shall be able to elect coverage for Qualified Benefits, as well as coverage under a Medical Spending Account (subject to Paragraph 6.08(b)) upon reinstatement of participation during the same Plan Year. If the Participant elects to continue coverage while the Participant is on an unpaid FMLA leave of absence, payments shall be made in accordance with the Employer's existing rules for payment by Employees on an unpaid leave. The right to cease contributions under this Paragraph shall be in addition to a Participant's right to cease contributions under Paragraph 4.03. No other new elections may be made under the Plan upon return from such leave unless otherwise consistent with the provisions of Paragraphs 4.04 through 4.12 or the FMLA.

3.05 Non-FMLA Leave

If a Participant goes on an unpaid leave of absence that does not affect eligibility under this 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 Plan, the election change rules in Article IV of this Plan will apply. If such policy requires coverages 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.

3.06. Conditions for Receipt of Benefits

As a condition of receiving benefits under the Plan, a Participant must (i) furnish all applications, election forms, and other documents reasonably required by the Plan Administrator, and (ii) observe all Plan rules and regulations.

ARTICLE 4

CONTRIBUTIONS AND BENEFIT ELECTIONS

4.01. Compensation Reduction Elections

- A.** A Participant may elect to receive his full Compensation in cash, or he may elect to reduce his cash Compensation, per payroll period for a Plan Year, by a specified amount and direct the Employer to use the reduction amount to pay the Employee cost of one or more Qualified Benefits. The reduction shall be on a pretax basis as set forth under Article V, unless the Participant chooses to have their compensation reduced on a post-tax basis, which election shall remain in place unless revoked. The Employee cost for Qualified Benefits shall be established by the Plan Administrator from time to time. If a Participant makes an election with respect to a Plan Year, the elected reduction amount shall be used to reduce his cash Compensation by substantially equal amounts for each pay period occurring during the Plan Year. The amount of the Participant's reduction for a Plan Year shall not exceed the lesser of:
1. The Participant's Compensation; or
 2. The total maximum contribution for the elected Qualified Benefits for the Plan Year.

Such election must be filed within the applicable election period specified in Paragraph 4.02.

- B.** Regardless of a Participant's election under Paragraph 4.01(a), a Participant may elect to receive his full Compensation in cash during a Plan Year, or he may elect to reduce his cash Compensation by a specified amount and direct the Employer to credit the reduction amount to his General Purpose Medical Spending Account, Limited-use Medical Spending Account, and/or Dependent Care Spending Account for a Plan Year. The reduction amount shall be applied pursuant to and shall be subject to the limitations specified in Articles VI and VII, as applicable. A Participant who desires for the Employer to use part of his cash Compensation to purchase Qualifying Medical Care Expense coverage and/or Dependent Care Expense coverage, as applicable, must file an election within the applicable election period specified in Paragraph 4.02.
- C.** A Participant who is an HSA Eligible Employee may elect to reduce his or her cash compensation, on a pretax basis per pay period, to pay for contributions to a Health Savings Account, subject to the limitation set forth in this Paragraph. The HSA Eligible Employee is responsible for verifying his or her eligibility to establish and contribute to a Health Savings Account. Notwithstanding the limitation on Employee contributions described in this Paragraph, the HSA Eligible Employee, and not the Plan Administrator or Employer, is solely responsible for complying with any applicable contribution limits in effect under the law with respect to the Health Savings Account. The Plan Administrator may require such documentation that it deems necessary to confirm that an individual is an HSA Eligible Employee prior to making a contribution to such individual's Health Savings Account.

4.02. Elections and Election Period

- A. The Plan Administrator shall provide written materials regarding the Plan (which shall include a salary reduction agreement and election form) to each new Eligible Employee as soon as practicable after he becomes an Eligible Employee. In addition, within a reasonable period before the beginning of each Plan Year, the Plan Administrator shall provide a written election form to all Eligible Employees so that they may make elections during the Open Enrollment Period. Open Enrollment occurs every year in the month of October. During Open Enrollment, Eligible Employees may enroll in, make changes to, or disenroll from their account(s).
- B. To make an election to reduce his or her compensation to pay for the Employee cost of Qualified Benefits under Paragraph 4.01(a) and 4.01(b) for the Plan Year in which an individual becomes an Eligible Employee, the Eligible Employee must submit a completed election form to the Plan Administrator within thirty-one (31) days after the date he becomes eligible to participate in the Plan. An election shall be effective (i) on the first day of the month that the Eligible Employee commences Active Employment, provided that the Eligible Employee commences Active Employment on the first calendar day of that month; or (ii) on the first day of the following month provided that the Eligible Employee commences Active Employment on any day other than the first calendar day and the first working day of the month.
- C. To make an election under Paragraphs 4.01(a) and 4.01(b) for any Plan Year after an individual becomes an Eligible Employee, an Eligible Employee must submit a completed election form to the Plan Administrator during the Open Enrollment Period. An election pursuant to this Subparagraph shall be effective on the first day of such following Plan Year. A Participant's failure to return a completed election form under this Paragraph 4.02(c) to the Plan Administrator within the time period designated by the Plan Administrator shall constitute:
 - 1. A re-election of the same coverage of Qualified Benefits that is in effect for the then current Plan Year, if any, and, if an election for such coverage had been made, an agreement to reduce the Participant's Compensation equal to the premium cost applicable to such Qualified Benefits as it may exist for the upcoming Plan Year, and
 - 2. An election not to have his Compensation reduced to credit amounts under the General Purpose Medical Spending Account, Limited-use Medical Spending Account, and/or the Dependent Care Spending Account, regardless of any election in effect for the then current Plan Year.
- D. To make a new election within a Plan Year as a result of a change in status or applicable event pursuant to Paragraphs 4.04 through 4.12 below, a Participant must submit a completed election form to the Plan Administrator within thirty-one (31) days of the change in status or applicable event (sixty (60) days in the event of a status change under Paragraph 4.08(b)). An election pursuant to this Subparagraph shall be effective no later than the first day following the later of:
 - 1. The filing of the new election form with the Plan Administrator; or
 - 2. The change in status or applicable event.

4.03. Cessation of Required Contributions

Subject to Paragraphs 3.03 and 3.04, benefits shall cease to be provided to a Participant if such Participant fails to make required premium payments 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 Paragraph 4.02(c), provided such individual is an Eligible Employee.

4.04 Significant Change in Cost or Coverage

(Applies to Elections of Qualified Benefits and Elections with Respect to the Dependent Care Spending Account)

- A.** If a Participant elects to reduce his Compensation with respect to coverage under Article V or Article VII of the Plan and the Participant's cost for such coverage then significantly increases or decreases during the Plan Year, 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, commence participation in the Plan and elect the coverage that significantly decreased in cost or, 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 Spending Account only if the cost change is imposed by a dependent care provider who is not a Relative of the Participant.
- B.** If a Participant elects to reduce his Compensation with respect to coverage under Article V or Article VII of the Plan and the Participant's cost for such coverage then increases or decreases during the Plan Year, the Participant shall make a corresponding change in his premium payments and the Plan shall make a prospective increase or decrease, as appropriate, in such premium payments. Such changes shall be allowed under the Dependent Care Spending Account only if the cost change is imposed by a dependent care provider who is not a Relative of the Participant.
- C.** If a Participant elects to reduce his Compensation with respect to coverage under Article V or Article VII of the Plan and the Participant's (or the Participant's dependent's) coverage under the Plan is then significantly curtailed with or without a loss of coverage, the affected Participant may revoke existing elections for such coverage and elect to receive coverage, on a prospective basis, under another benefit package option providing similar coverage. In the event of a significant curtailment that results in a loss of coverage, a Participant may also choose to drop coverage if no similar coverage option is available.

4.05 Addition (or Elimination) of Benefit Plan Providing Similar Coverage

(Applies to Elections of Qualified Benefits and Elections with Respect to the Dependent Care Spending Account). If during the Plan Year the Plan Administrator adds a new benefit plan option or other coverage option (or eliminates an existing benefit package option or other coverage option), affected Eligible Employees may elect the newly-added option (or elect another option if an option has been eliminated) on a prospective basis and make corresponding election changes with respect to other benefit package options providing similar coverage.

4.06 Change in Coverage of the Spouse or Dependent under Other Employer's Plan

(Applies to Elections of Qualified Benefits and Elections with Respect to the Dependent Care Spending Account). An affected Eligible Employee may make a prospective election change that is on account of and corresponds with a change made under the plan of the Eligible Employee'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 Article; or (ii) the plan permits participants to make an election for a Plan Year that is different from the plan year under such other plan.

4.07. New Election or Revocation of Election Because of a Change in Status

(Applies to all Benefits under Paragraph 4.01). An Eligible Employee 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 Eligible Employee has a "change in status" that results in the Eligible Employee, 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 plan providing Qualified Benefits. For purposes of the Plan, a "change in status" includes the following:

- A.** A change in legal marital status, including death of spouse, divorce, marriage, legal separation, or annulment of marriage of the Eligible Employee;
- B.** A change in the number of the Eligible Employee's dependents, including the death of a spouse or dependent or the birth or adoption (or placement for adoption) of a child;
- C.** A change in the employment status of the Eligible Employee or the Eligible Employee's spouse or dependent, including the termination of employment or the commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, or a change in worksite;
- D.** A dependent satisfying or ceasing to satisfy the definition of dependent under a Qualified Benefit, or meeting the definition of a Qualifying Individual, including attainment of certain age or student status; or
- E.** A change in the place of residence of the Eligible Employee or the Eligible Employee's spouse or dependent.

4.08. New Election Due to Special Enrollment under HIPAA

(Applies to Elections of Qualified Benefits).

- A.** If an Eligible Employee or his 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 Eligible Employee may elect to make a mid-Plan Year change in his election consistent with his change in enrollment if such election is made within thirty-one (31) days of the event.

- B. The special enrollment period for a Eligible Employee is extended to sixty (60) days if (i) the Eligible Employee or his spouse or dependent 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, a Eligible Employee or his spouse or dependent may be enrolled under the Plan if the 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.

4.09. New Election Due to Medicare or Medicaid

(Applies to Elections of Qualified Benefits). If the Eligible Employee, spouse, or dependent become entitled to Medicare or Medicaid benefits (other than coverage solely under the program for distribution of pediatric vaccines), the Eligible Employee may change his election to cancel or reduce coverage under the Plan for the affected person. If the Eligible Employee, spouse or dependent loses coverage under Medicare or Medicaid, the Eligible Employee may make an election to begin or increase coverage under the Plan for the affected person.

4.10. New Election Due to Court Order

(Applies to Elections of Qualified Benefits). If a Participant is subject to a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody, the Participant may make a consistent change in his election under the Plan to either: (1) cover the child; or (2) cancel coverage of the child.

4.11. New Election Due to Reduction in Hours of Service

(Applies Only to Elections of Medical Plan Coverage). A Participant may make an election to revoke medical plan coverage 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:

- A. The Participant’s employment status with the Employer was reasonably expected to average at least thirty (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 thirty (30) hours of service per week after the change, although the Participant continues to be eligible for Medical Plan coverage; and
- B. 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.

4.12. New Election Due to Enrollment in a Qualified Health Plan

(Applies Only to Elections of Medical Plan Coverage). A Participant may make an election to revoke medical plan coverage 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:

- A. 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
- B. 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.

4.13. Health Savings Accounts

Participants who are HSA Eligible Employees enrolled in the PEBA-sponsored high-deductible health plan may also enroll in the PEBA-sponsored Health Savings Account. Participants in this Health Savings Account who elect to reduce their Compensation under Paragraph 4.01(c) may increase, decrease, or cease their contributions as they see fit, up to the annual contribution maximum established by the IRS, but no more frequently than once per month. Such HSA Eligible Employee's election will be effective upon receipt of a completed election form to the Plan Administrator with reasonable processing time.

4.14. Irrevocability of Elections

An election, once made, shall remain in effect until the earliest of: (i) the date on which the Eligible Employee ceases to be a Participant; (ii) the effective date of a new election; or (iii) the end of the Plan Year. Except as provided in Paragraphs 4.04 through 4.13, an election may be changed only as of the beginning of the Plan Year after the election is made.

4.15. Completion of Annual Election Form

All Eligible Employees enrolling in a Flexible Spending Account who meet the requirements under Paragraph 3.01 shall be required to complete and return an election form to the Plan Administrator during the Open Enrollment Period of each Plan Year.

4.16. Authority of Plan Administrator 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, 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.

4.17. Adjustments to Prevent Discrimination

The Dependent Care Spending Account shall be administered to be in compliance with all applicable nondiscrimination requirements of the Code. Notwithstanding any other provision of the Dependent Care Spending Account, 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 5

QUALIFIED BENEFITS

The benefits, participation requirements, and other terms and conditions for Qualified Benefits are provided subject to the terms and conditions of the plan or policy governing each Qualified Benefit. Qualified Benefits shall be offered under the Plan on a pretax basis pursuant to Article IV of the Plan.

ARTICLE 6

MEDICAL SPENDING ACCOUNT

6.01 Establishment of Medical Spending Account

The Third Party Administrator shall establish a separate Medical Spending Account for each Plan Year with respect to each Participant who has elected benefits pursuant to Paragraph 4.01(b). Medical Spending Accounts shall be maintained for bookkeeping purposes only, and except as otherwise required by law, amounts credited to a Participant's Medical Spending Account shall remain part of the assets of the Plan Administrator until paid pursuant to this Article. No interest or other earnings shall be credited to any Participant's Medical Spending Account.

6.02. Crediting of Medical Spending Account

There shall be credited to a Participant's Medical Spending Account, as of the beginning of the Plan Year, the annualized amount which the Participant has elected to have his Compensation reduced pursuant to Paragraph 4.01(b) for the Plan Year for the reimbursement of Qualifying Medical Care Expenses. Notwithstanding the preceding sentence, the maximum amount that may be credited to a Participant's Medical Spending Account for a Plan Year shall be limited to the maximum amount set by the Internal Revenue Service for that Plan Year. In the case of two Participants who are married to each other, each Participant may elect to have such maximum amount credited to their Medical Spending Account.

6.03. Debiting of Medical Spending Account

As of the date of any payment under this Article to or for the Participant's benefit for Qualifying Medical Care Expenses Incurred during a Plan Year, the Participant's Medical Spending Account shall be debited by the amount of the payment, subject to the annualized amount credited to the Medical Spending Account for the Plan Year.

6.04. Forfeiture of Medical Spending Account

Except as provided in Paragraph 6.08, the amount credited to a Participant's Medical Spending Account shall be used only to reimburse the Participant for Qualifying Medical Care Expenses Incurred during the Plan Year while a Participant, and only if the Participant applies for reimbursement by the end of the Run-Out Period. Any balance credited to a Participant's Medical Spending Account after all reimbursements for the Plan Year have been made hereunder, in excess of the Carryover Amount, shall be forfeited as of the last day of the Plan Year. Such forfeited amounts shall be used to pay expenses and fees of the Plan, or be retained by the Plan Administrator.

6.05. Carryover of Funds

Funds up to the Carryover Amount remaining in a Medical Spending Account, after all claims for Qualified Medical Care Expenses for the prior Plan Year have been reimbursed through the Run-Out Period, shall be carried forward into the subsequent Plan Year. If a Participant is eligible for and elects during Open Enrollment to contribute to a Health Savings Account in the new Plan Year, and has any funds in a General Purpose Medical Spending Account that will carryover into the new Plan Year, the Third Party Administrator will convert the General Purpose Medical Spending Account into a Limited-use Medical Spending Account at the beginning of the new Plan Year. The carryover funds will then be credited to the Limited-use Medical Spending Account.

6.06. Claims for Qualifying Medical Care Expenses Reimbursement

- A.** A Participant who has elected benefits under the Medical Flexible Spending Account for a Plan Year may apply to the Third Party Administrator for reimbursement of Qualifying Medical Care Expenses Incurred during the Plan Year while a Participant by either:
- 1.** Submitting a claim form to the Third Party Administrator, or
 - 2.** Using a Debit Card, not later than the end of the Run-Out Period following the end of the Plan Year in which the Qualifying Medical Care Expense was Incurred.

No reimbursement shall be due under the Plan for any claim filed after such time. Qualifying Medical Care Expenses Incurred shall not be reimbursable under this Plan unless the Participant (or the estate of a deceased Participant) applies for reimbursement and any reimbursement of a claim other than a Debit Card claim shall be paid solely to the Participant (or such estate). Debit Card claim reimbursements shall be made to the provider of the Qualifying Medical Care Expense. The claim for reimbursement may be made before or after the Participant has paid the Qualifying Medical Care Expense, but not before the Participant has Incurred the Qualifying Medical Care Expense.

- B.** The Participant's written claim shall include:
- 1.** The amount, date, and nature of the Qualifying Medical Care Expense;
 - 2.** The name of the person, organization, or entity to which the Qualifying Medical Care Expense was or is to be paid;
 - 3.** The name of the person for whom the Qualifying Medical Care Expense was Incurred and, if the person requesting the benefits is not the Participant, the relationship of the person

to the Participant;

4. A written statement from an independent third party stating that the Qualifying Medical Care Expense has been Incurred and the amount of the Qualifying Medical Care Expense;
5. A written statement that the Qualifying Medical Care Expense has not been reimbursed or is not reimbursable under any other health plan coverage (or, if the Qualifying Medical Care Expense has been partially reimbursed or is partially reimbursable, the amount of the reimbursement);
6. A written statement that the Participant is legally obligated to pay such Qualifying Medical Care Expense; and
7. Any other information reasonably requested by the Third Party Administrator.

The Participant shall submit relevant bills, receipts, or other statements with respect to the Qualifying Medical Care Expense, together with any additional documentation that the Third Party Administrator may request. Any dispute regarding a claim for reimbursement of Qualifying Medical Care Expenses shall be governed by Article IX.

- C. Upon request by the Third Party Administrator, any Debit Card claim must be submitted for review and substantiation on a form supplied by the Third Party Administrator unless the charge is for a copayment, a recurring expense, or the charge is substantiated at the point of sale by the provider. All reimbursements requiring substantiation are considered conditional until substantiated. In the event a conditional Debit Card claim is not substantiated or the Plan otherwise becomes aware of an improper payment using the Debit Card, the Plan Administrator and Third Party Administrator reserve the right to take some or all of the following steps to recover the improper payment:
1. Until the amount of the improper payment is recovered, the Participant's Debit Card may be de-activated, and the Participant must request payments or reimbursements of Qualifying Medical Expenses by submitting a written claim form to the Third Party Administrator.
 2. The Third Party Administrator will notify the Participant of the improper payment and request repayment in an amount equal to the improper payment.
 3. If, after the demand for repayment, the Participant fails to repay the amount of the improper charge, the Third Party Administrator may withhold the amount of the improper charge from the Participant's pay or other compensation, to the full extent permitted under applicable law.
 4. If any portion of the improper payment remains outstanding after attempts to recover the amount as described above, the Third Party Administrator will offset future reimbursements due under the Participant's Medical Spending Account to resolve the improper payment.
 5. If the above procedures do not result in full repayment of the improper charge, the Third Party Administrator will refer the claim to the Plan Administrator for handling as any other

business debt, which may include taxation of the improper payment or other legal action.

Substantiation of a conditional claim includes submission of the information described in Paragraph (b) of this Paragraph.

6.07. Reimbursement of Qualifying Medical Care Expenses

- A.** If a Participant submits a written claim and documentation as required by Paragraph 6.06, and the Third Party Administrator approves the claim, the Third Party Administrator shall reimburse the Participant from the Participant's Medical Spending Account for Qualifying Medical Care Expenses Incurred during the Plan Year at such times as the Third Party Administrator shall prescribe, but no less frequently than monthly. The amount of any reimbursement hereunder shall not exceed the amount credited to the Participant's Medical Spending Account at the time of the reimbursement.
- B.** If a Participant uses his or her Debit Card pursuant to Paragraph 6.06 and the transaction is approved, the Third Party Administrator shall automatically debit the Medical Spending Account of the Participant for Qualifying Medical Care Expenses Incurred. The amount debited hereunder shall not exceed the amount credited to the Medical Spending Account at the time of the transaction.

6.08. Cessation of Participant and/or Dependent Status

Subject to Paragraph 6.09, a Participant who ceases to be a Participant, as provided in Paragraph 3.02, during a Plan Year shall be entitled to reimbursement of Qualifying Medical Care Expenses from his Medical Spending Account only to the extent provided in this Paragraph.

- A.** A Participant who ceases to be a Participant, as provided in Paragraph 3.02, during a Plan Year shall be entitled to reimbursement of Qualifying Medical Care Expenses Incurred before he ceased to be a Participant, to the same extent as if he were still a Participant; provided, however, that such a Participant must apply to the Third Party Administrator for reimbursement of Qualifying Medical Care Expenses that are Incurred prior to the end of the Run-Out Period.
- B.** If a Participant on an unpaid FMLA leave elects pursuant to Paragraph 3.04 to continue coverage under the Medical Spending Account during such leave, the Participant shall be entitled to reimbursement of Qualifying Medical Care Expenses Incurred during that Plan Year while on such unpaid FMLA leave. To the extent a Participant ceases making contributions to the Medical Spending Account while on unpaid FMLA leave pursuant to the provisions contained in Paragraph 3.04, such person shall not be entitled to reimbursement of Qualifying Medical Care Expenses Incurred during the period while such person ceased making contributions to the Medical Spending Account during such unpaid FMLA leave. Upon return from such leave during the same Plan Year, such Participant may either:
 - 1.** Resume coverage at the level in effect before the FMLA leave, and make up any unpaid premium payments; or
 - 2.** Resume coverage at a level that is reduced on a pro rata basis for the period during which required contributions were not made, and resume premium payments at the level in effect prior to the FMLA leave.

Regardless of whether the Participant resumes participation under (i) or (ii) above, the Participant's coverage level shall be reduced by any prior reimbursements during the Plan Year (whether made before or after the FMLA leave).

- C. A Participant shall not be entitled to reimbursement for Qualifying Medical Care Expenses Incurred by a Participant's dependent after the person ceases to be a dependent as defined in the definition of Qualifying Medical Care Expenses.
- D. Immediately upon termination of eligibility to participate in the Plan, a Participant's Debit Card shall be canceled.

6.09. Continuation of Coverage

To the extent required by Code Section 4980B, if a person ceases to be a Participant and agrees to pay the premium for COBRA continuation coverage, the person shall be treated as a Participant to the extent required by law, and coverage under the Medical Spending Account shall continue as long as such premiums are paid, if applicable, but not beyond the end of the Plan Year in which the COBRA qualifying event occurs, subject to Article X and the terms and conditions of the Plan.

ARTICLE 7

DEPENDENT CARE SPENDING ACCOUNT

7.01. Establishment of Dependent Care Spending Account

The Third Party Administrator shall establish a separate Dependent Care Spending Account for each Plan Year with respect to each Participant who has elected benefits pursuant to Article IV. Dependent Care Spending Accounts shall be maintained for bookkeeping purposes only, and except as otherwise required by law, amounts credited to a Participant's Dependent Care Spending Account shall remain part of the assets of the Plan Administrator until paid pursuant to this Article. No interest or other earnings shall be credited to any Participant's Dependent Care Spending Account.

7.02. Crediting of Dependent Care Spending Account

- A. There shall be credited to a Participant's Dependent Care Spending Account, as of each payroll date, the amount the Participant has elected to have his Compensation reduced pursuant to Paragraph 4.01(b) for the reimbursement of Dependent Care Expenses.
- B. Notwithstanding the preceding sentence, the maximum amount of reimbursement for Dependent Care Expenses for each Participant shall be limited to the credit balance in the Dependent Care Spending Account of the Participant; provided, however, in no event shall the total amount of claims reimbursed to a Participant from his Dependent Care Spending Account for the Participant's taxable year exceed the lesser of:
 - 1. The Participant's Earned Income for the Participant's taxable year;
 - 2. If the Participant is married, the actual or deemed Earned Income of the Participant's spouse for the Participant's taxable year; or

3. \$5,000 (or, 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 return for the year, \$2,500).
- C. 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 Spending Account by the Participant's spouse.

7.03. Debiting of Dependent Care Spending Account

As of the date of any payment under this Article to or for a Participant's benefit for Dependent Care Expenses Incurred during a Plan Year or within the Grace Period, the Participant's Dependent Care Spending Account shall be debited by the amount of the payment. If the Dependent Care Expense exceeds the credit balance in the Dependent Care Spending Account of a Participant, the amount to be paid to the Participant shall equal such credit balance and such Dependent Care Spending Account shall be reduced to zero; provided, however, if the Participant had an election for Compensation reduction in effect at the time the expense which generated the approved claim was paid, a record of any such unpaid Dependent Care Expense shall be maintained, and thereafter, if there is a credit balance in the Dependent Care Spending Account of the Participant during the Plan Year, the Participant shall be paid an amount equal to the lesser of (i) any such unpaid Dependent Care Expense, or (ii) such credit balance in the Dependent Care Spending Account of the Participant, and the Dependent Care Spending Account shall be debited by the amount of such payment.

7.04. Forfeiture of Dependent Care Spending Account

Except as provided under Paragraph 7.07, the amount credited to a Participant's Dependent Care Spending Account shall only be used to reimburse the Participant for Dependent Care Expenses Incurred during the Plan Year or within the Grace Period while a Participant, and only if the Participant applies for reimbursement by the end of the Run-Out Period. Any balance credited to a Participant's Dependent Care Spending Account after all reimbursements for the Plan Year and the Grace Period have been made hereunder shall be forfeited as of the last day of the Plan Year. Such forfeited amounts shall be used to pay expenses and fees of the Plan, or be retained by the Plan Administrator.

7.05. Claims for Dependent Care Expenses Reimbursement

- A. A Participant who has elected benefits under the Dependent Care Spending Account for a Plan Year may apply to the Third Party Administrator for reimbursement of Dependent Care Expenses Incurred during the Plan Year or Grace Period while a Participant by submitting a claim form to the Third Party Administrator not later than the end of the Run-Out Period following the end of the Plan Year or Grace Period in which the Dependent Care Expense was Incurred. No reimbursement shall be due under the Plan for any claim filed after such time. Covered Dependent Care Expenses Incurred shall not be reimbursable under this Plan unless the Participant (or the estate of a deceased Participant) applies for reimbursement and any reimbursement of a claim shall be paid solely to the Participant (or such estate). The claim for reimbursement may be made before or after the Participant has paid the Dependent Care Expenses, but not before the Participant has Incurred the Dependent Care Expense.
- B. The Participant's written claim shall include (i) the amount, date, and nature of the Dependent Care Expense; (ii) the name, address, and taxpayer identification number of the person, entity, or

organization performing the services subject to reimbursement; (iii) the name of the person for whom the Dependent Care Expense was Incurred and the relationship of the person to the Participant; (iv) a written statement from an independent third party stating that a Dependent Care Expense has been Incurred and the amount of the Dependent Care Expense; (v) a written statement that the Dependent Care Expense has not been reimbursed or is not reimbursable under another plan (or, if the Dependent Care Expense has been partially reimbursed or is partially reimbursable, the amount of the reimbursement); (vi) a written statement that the Participant is legally obligated to pay such Dependent Care Expense; and (vii) any other information reasonably requested by the Third Party Administrator. The Participant shall submit relevant bills, receipts, or other statements with respect to the Dependent Care Reimbursement, together with any additional documentation that the Third Party Administrator may request. Any dispute regarding a claim for reimbursement of Dependent Care Expenses shall be governed by Article IX.

7.06. Reimbursement of Dependent Care Expenses

If a Participant submits the written claim and documentation as required by Paragraph 7.05, and the Third Party Administrator approves the claim, the Third Party Administrator shall reimburse the Participant from the Participant's Dependent Care Spending Account for Dependent Care Expenses Incurred during the Plan Year or Grace Period at such times as the Plan Administrator shall prescribe, but no less frequently than monthly. The amount of any reimbursement hereunder shall not exceed the amount credited to the Participant's Dependent Care Spending Account at the time of the reimbursement.

7.07. Cessation of Participation

A Participant who ceases to be a Participant, as provided in Paragraph 3.02, during a Plan Year or a Grace Period shall be entitled to reimbursement of Dependent Care Expenses Incurred not later than the end of the Plan Year or Grace Period in which such person ceases participation, but not to exceed the credit balance in the Dependent Care Spending Account of such former Participant at the time he ceases to be a Participant; provided, however, that a Participant who ceases to be a Participant must apply to the Third Party Administrator for reimbursement of Dependent Care Expenses that are Incurred prior to the end of the Grace Period and before the end of the Run-Out Period.

ARTICLE 8

ADMINISTRATION OF THE PLAN

8.01. 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 for Qualified Benefits under the Plan as specified in Article IV.
- B.** 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.
- C.** 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.

8.02. Plan Administrator

PEBA shall be the Plan Administrator of the Plan; provided, however, PEBA may from time to time designate a person, committee, or organization to perform certain administrative functions. Any such individual, committee, or organization shall hold office until removed by the Plan Administrator, which removal may be without cause and without advance notice. The Plan Administrator shall have full, discretionary authority to control and manage the operation and administration of the Plan and shall be the named fiduciary of the Plan. The Plan Administrator is also authorized to accept service of legal process for the Plan. The Plan Administrator shall have all power necessary or convenient to enable it to exercise such authority including the power to:

- A.** To construe and interpret the Plan, decide all questions of eligibility and determine the amount, manner, and time of payment of any reimbursements payable under the Plan;
- B.** To prescribe procedures to be followed by Participants electing benefit coverages or filing applications for reimbursements;
- C.** To prepare and distribute, in such a manner as the Plan Administrator determines to be appropriate, information explaining the Plan;
- D.** To receive from Employees, Employers, 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; and
- F.** 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, subject to review pursuant to Paragraphs 9.01 and 9.02. 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. Benefits under the Plan shall be paid only if the Plan Administrator or its designee decides in its discretion that a Participant is entitled to such benefits. The Plan Administrator or its designee may provide rules and regulations, not inconsistent with the provisions hereof, for the operation and management of the Plan and may from time to time amend or rescind such rules or regulations. The Plan Administrator shall have full discretion, power, and duty to take all action necessary or proper to carry out its duties required by law. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon the accuracy of information furnished by Third Party Administrator, a Participant, a Dependent, the duly authorized

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

8.03. Information to be Furnished to Plan Administrator

Employer shall furnish the Plan Administrator such information as may be required by the Plan Administrator. The records of the Employer as to an Employee's or Participant's period of employment, termination of employment, and compensation will be conclusive on all persons unless determined by the Plan Administrator to be incorrect. Participants and other persons entitled to benefits under the Plan shall furnish to the Plan Administrator such evidence or information as requested.

8.04. Questions of Interpretation

The Plan Administrator or its designee shall have full, discretionary authority to enable it to carry out its duties under the Plan, including but not limited to, the authority to determine eligibility under the Plan, to construe the terms of the Plan, and to determine all questions of fact or law arising hereunder. All such determinations and interpretations shall be final, conclusive, and binding on all persons affected thereby, subject to judicial review as provided in Subparagraphs 9.01(i) and 9.02(e). The Plan Administrator and/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. Benefits under the Plan will be paid only if the Plan Administrator and/or its designee decides in its discretion that a Participant is entitled to them, subject to the appeals procedure in Paragraphs 9.01 and 9.02.

8.05. Forms and Requests for Information

The Plan Administrator may require a Participant to complete and timely file such forms as are prescribed by the Plan Administrator and/or its designee, and to furnish all pertinent information requested by the Plan Administrator and/or its designee. The Plan Administrator and/or its designee may rely upon all such information, including the Participant's current mailing address.

ARTICLE 9

CLAIMS PROCEDURE

The claims and appeal procedures set forth below shall apply with respect to claims under the Medical Spending Account and the Dependent Care Spending Account. All notifications by the Third Party Administrator and/or Plan Administrator to a claimant for claim review, denial, approval, and appeal (see Paragraphs 9.01 and 9.02) may be done in writing or electronically, unless otherwise indicated.

9.01. Claims for Reimbursement

- A. Initial Claim.** Any claim to receive reimbursement of Qualifying Medical Care Expenses and/or Dependent Care Expenses must be filed with the Third Party Administrator within the time period set forth on the designated form, and shall be deemed filed upon receipt. A Participant must submit with the claim relevant information as required under Paragraph 6.05.
- B. Initial Review.** When a claim for reimbursement of Qualifying Medical Care Expenses and/or Dependent Care Expenses has been filed, the claimant shall be notified of the approval or denial no

later than thirty (30) days after the Third Party Administrator receives the properly filed claim, as required under Paragraph 6.05 or 7.05, as applicable.

If the claim is based, in whole or in part, on a medical judgment, the Third Party Administrator shall consult with an appropriate health care professional. The Third Party Administrator shall identify any medical experts whose advice was obtained.

If the Third Party Administrator determines that any person who has submitted a claim for the payment or reimbursement of benefits under this Plan is not entitled to receive all or part of the benefits sought, the Third Party Administrator shall inform the claimant of that determination and the reasons for the denial. The exclusive remedy for the denial of benefits shall be as provided by statute, this Plan, and by the procedures of the Plan Administrator.

- C. Initial Denial.** If any claim for reimbursement is partially or wholly denied, the claimant shall be given notice which shall contain:
1. The reasons for the denial;
 2. References to Plan provisions upon which the denial is based;
 3. The specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the denial;
 4. A description of any additional material or information needed and why such material or information is necessary;
 5. A description of the review procedures and time limits; and
 6. A description of the appeal rights to the Plan Administrator.
- D. Appeal of Claim Denial to Plan Administrator.** A claimant may appeal a claim denial under Paragraph 9.01(c) by filing a written appeal with the Plan Administrator within ninety (90) days after receipt of a denial from the Third Party Administrator. The written appeal must contain the reasons why the claimant believes the claim ought to be approved. The appeal shall be deemed filed upon receipt by the Plan Administrator. If the request is not timely, the decision of the Third Party Administrator shall be the final decision of the Plan.
- E. Appeals Process.** Appeals under this Paragraph may be brought only by the Participant at issue, their authorized representative (who cannot be a Provider, a Provider's Representative, Employer, or agent of the Employer), or a licensed attorney admitted to practice in South Carolina. The filing of this appeal shall be deemed to be consent for the Plan Administrator or its designee to review all medical records necessary for a determination of the appeal.
- F. Information to be Considered.** The Participant may submit additional information for review within 30 days of filing their appeal. The Plan Administrator or its designee may request from the Third Party Administrator the information it reviewed, including the pertinent medical records, and may request any additional information from the Third Party Administrator, the claimant, independent medical personnel, or other sources as in its judgment may be required to make a determination.

The Plan Administrator or its designee shall consider all information submitted, along with the terms and conditions of the Plan, and shall issue a written decision within 180 days of all material provided by the Participant and/or requested by the Plan Administrator or its designee. In the event the Participant does not respond to a request for information within 60 days, the appeal will be deemed to be waived and will be dismissed.

- G. Decision of the Plan Administrator.** The Plan Administrator or its designee shall provide specific reasons for the decision, including citation to the pertinent Plan provisions, and may deny the claim of the Participant. The Plan Administrator or its designee may approve the claim or such portion as is appropriate. The decision of the Plan Administrator or its designee on these matters is binding and conclusive, subject to review pursuant to Paragraph 9.03(e).
- H. Authority.** The discretionary authority provided to the Plan Administrator or its designee under this provision is not in lieu of, or in derogation of, and does not alter, affect, or reduce the authority or power of the director to administer this Plan.
- I. Judicial Review.** The exclusive remedy for the denial of benefits shall be as provided in Paragraph 9.01 and by judicial review of that decision under S.C. Code Ann § 1-23-380, as amended, as provided by statute. No request for judicial review may be brought until a Participant has exhausted the review procedure set forth in Paragraph 9.01(a) through (c), nor will such action be brought after the expiration of the applicable period for commencing such actions. Any construction or interpretation of the Plan; determination of eligibility; any decision arising under the Plan; or any exercise of judgment or discretion given to the Plan Administrator by the Plan or Planholder shall be binding and conclusive so long as the decisions of the Plan Administrator or its duly authorized agent are not arbitrary, capricious, or in violation of applicable statutes.

9.02. Review of Administrative Claims by the Plan Administrator

An “administrative claim” is an administrative decision by the Plan Administrator that does not involve the filing of a claim for benefits under this Plan, including, but not limited to, decisions concerning: an individual’s eligibility to participate in the Plan; a subscriber’s COBRA eligibility; enrollment matters; and dependent documentation. An individual may request review of the Plan Administrator’s determination concerning administrative claims in accordance with the procedures set forth in this Paragraph.

- A. Informal Denial.** If an individual or their Employer or Employer’s agent makes an informal oral or written request regarding an administrative claim that is denied by the Plan Administrator, the individual or their Employer or Employer’s agent may seek review of this informal denial by filing a written request for Departmental Review in accordance with Paragraph 9.02(b).
- B. Departmental Review.** An individual or their Employer or Employer’s agent may submit a written request to the Plan Administrator for Departmental Review of an administrative claim.
 - 1.** The individual or Employer or Employer’s agent may submit the written request for Departmental Review: (i) of a previous informal denial of the administrative claim under Paragraph 9.02(a); or (ii) as an initial request to the Plan Administrator regarding an administrative claim.
 - 2.** The relevant department of the Plan Administrator shall review the written request and

make a written determination regarding the administrative claim. If the written request is denied, a written determination will be provided to the individual. The written determination will contain an appeals notice informing the individual that the Departmental Review denial may be appealed to the Plan Administrator or its designee within 90 days of the date of the Departmental Review denial.

- C. Administrative Appeals to Plan Administrator.** An individual (the “appellant”) whose administrative claim was denied in whole or in part pursuant to Departmental Review may appeal the denial to the Plan Administrator or its designee within 90 days of the date of the Departmental Review denial. Appeals may be brought only by the appellant at issue, their authorized representative (who cannot be a Provider, a Provider’s Representative, Employer, or agent of the Employer), or a licensed attorney admitted to practice in South Carolina. The appellant may submit additional information for review within 30 days of filing their appeal.
1. The Plan Administrator or its designee shall consider all written information submitted, the applicable terms and conditions of the Plan, all information received in response to requests for information, and other sources as in its judgment may be required to make a determination. The Plan Administrator or its designee shall issue a written decision within 180 days after the receipt of all material provided by the appellant and/or requested by the Plan Administrator or its designee. In the event the appellant does not respond to a request for information within 60 days, the appeal will be deemed to be waived and will be dismissed.
 2. The Plan Administrator or its designee shall provide specific reasons for the decision, including citation to the pertinent Plan provisions, and may deny the request of the appellant. The Plan Administrator or its designee may approve the request or such portion as is appropriate. The Plan Administrator or its designee must state in writing the provisions of the Plan justifying the result. The decision of the Plan Administrator or its designee on these matters is binding and conclusive, subject to review pursuant to Paragraph 9.02(e).
- D. Authority.** The discretionary authority provided to the Plan Administrator or its designee under this provision is not in lieu of, or in derogation of, and does not alter, affect, or reduce the authority or power of the director to administer this Plan.
- E. Judicial Review.** The exclusive remedy for the denial of an administrative claim shall be as provided in Paragraph 9.02, and by judicial review of that decision under S.C. Code Ann. Section 1-23-380, as amended, as provided by statute. No appeal may be brought until an appellant exhausts the review procedure set forth in Paragraphs 9.02(a) through (c), nor will such action be brought after the expiration of the applicable period for commencing such actions, following the occurrence giving rise to the action. Any construction or interpretation of the Plan, determination of eligibility or any other decision arising under the Plan, or exercise of judgment or discretion given to the Plan Administrator by the Plan or Planholder, shall be binding and conclusive so long as the decisions of the Plan Administrator or its duly authorized agent are not arbitrary, capricious, or in violation of applicable statutes.

9.03. For All Claims

- A. Authorized Representative.** The Plan shall not prevent an authorized representative of a claimant from acting on behalf of the claimant in pursuing a benefit claim or appeal, pursuant to reasonable procedures.
- B. Full and Fair Review.** Upon request and free of charge, the claimant or his authorized representative shall be given reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim, or may submit to the appropriate person or entity written comments, documents, records, and other information relating to the claim. If timely requested, review of a denied claim shall take into account all comments, documents, records, and other information submitted by the claimant or his duly authorized representative relating to his claim without regard to whether such information was submitted or considered in the initial benefit determination.
- C. Exhaustion of Remedies.** If a claimant fails to file a request for review of a denial, in whole or in part, of benefits in accordance with the procedures herein outlined, such claimant shall have no right to review and shall have no right to bring action, at law or in equity, in any court and the denial of the claim shall become final and binding on all persons for all purposes.

ARTICLE 10

CONTINUATION OF COVERAGE

The following COBRA continuation provisions, along with Paragraph 6.08, shall apply with respect to the Participant's Medical Spending Account.

10.01 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).

10.02 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.

10.03 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 sixty (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.

10.04 Period of Continuation Coverage

COBRA coverage under the Medical Spending Account shall extend only until the end of the Plan Year in which the Qualified Beneficiary's Qualifying Event occurs. Qualified Beneficiaries who have a carryover balance under Paragraph 6.05 at the end of the Plan Year may extend their COBRA coverage through the remainder of the 18, 29, or 36 month COBRA period to which they are entitled under law.

10.05 End of Continuation Coverage

Continuation coverage shall end earlier than the period set forth in Paragraph 10.04 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 Plan Administrator ceases to provide Medical Spending Accounts to any Employee.

10.06 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 thirty (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 forty-five (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.

10.07 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. Employers 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 thirty (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 sixty (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 fourteen (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.

10.08 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.

10.09 Prefunding Alternative

Prior to termination of employment, a Medical Spending Account Participant may waive his COBRA rights under this Article and instead elect to prefund his remaining annual election. The Participant's monthly account fee will be deducted from his Medical Spending Account balance. The Participant may incur expenses through the end of the Plan Year and submit requests for reimbursement through the Run-Out Period. Participants who elect this Alternative will not be eligible to carryover funds into the subsequent Plan Year. Any funds remaining after the last day of the Plan Year will be forfeited.

ARTICLE 11

AMENDMENT AND TERMINATION

The Plan Administrator shall have the right, in its sole discretion, to amend the Plan at any time and from time to time and to any extent it may deem advisable. The amendment of the Plan shall be effective upon the date of approval or such later date as the Plan Administrator may determine in connection therewith. To the extent allowed by the Code, any such modification or amendment may be effective retroactively. The Planholder shall have the right to terminate the Plan at any time.

ARTICLE 12

WITHDRAWAL OF PARTICIPATING OPTIONAL EMPLOYERS

12.01 Withdrawal from the Plan

- A.** Any Employer entitled to participate in this Plan under S.C. Code Ann. § 1-11-720 is an "Optional Employer." Optional Employers may elect to withdraw from the Plan as provided within the Optional Employer's contract with the Plan Administrator to participate in the group insurance benefits offered by the Plan Administrator.
- B.** The entry or withdrawal of an Optional Employer shall not affect the Medical Spending Account and Dependent Care Spending Account or the participation of other Employers hereunder. If the withdrawal is a part of the complete termination and dissolution of said Optional Employer's business or the complete discontinuance of the Plan, without termination of its business, each Eligible Employee of the withdrawing Optional Employer shall continue to be eligible to submit claims incurred prior to the Optional Employer's withdrawal under any Account for the remainder of the Plan Year, to the extent there is any amount remaining in the Medical Spending Accounts and Dependent Care Spending Accounts. In such case, no additional contributions or Compensation reductions shall be made or credited to the Medical Spending Accounts or Dependent Care Spending Accounts.
- C.** If the withdrawal of any Optional Employer hereunder is the result of the establishment of a new and different flexible benefits plan for its Eligible Employees, which shall immediately upon withdrawal of said Optional Employer from the Plan cover Eligible Employees of such Optional Employer who are Participants under the Plan, the Optional Employer, upon receiving evidence of the terms of such new plan shall establish said Optional Employer's Eligible Employees' interest in

the value of the Medical Spending Accounts and Dependent Care Reimbursement Accounts. The value of said Eligible Employees' interest in the Medical Spending Accounts and Dependent Care Reimbursement Accounts shall be determined and, after reduction for charges and expenses incurred to process withdrawal of the Optional Employer, shall be transferred to the new plan, in cash. The application of the withdrawing of the Optional Employer's Employees' interest in the Medical Spending Accounts and Dependent Care Spending Accounts pursuant to the terms of this Article shall constitute a complete discharge of the Planholder and the Plan Administrator.

ARTICLE 13

MISCELLANEOUS

13.01 Report to Participants on or before January 31 of Each Year

On or before January 31 of each year, the Third Party Administrator shall furnish to each Participant who has received Dependent Care Reimbursement during the prior calendar year a written statement showing the amount of all Dependent Care Reimbursement paid to or on behalf of the Participant during the prior calendar year and any balance remaining.

13.02 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.

13.03.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.

13.04.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.

13.05.Governing Law

This Plan shall be construed according to the laws of the State of South Carolina, and all provisions of this Plan 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.

13.06.Headings

The headings of Paragraphs and Subparagraphs are for ease of reference only and shall not be construed to limit or modify the detailed provisions of this Plan.

13.07.Separate Cafeteria Plans

Nothing in this Plan prevents an Optional Employer, 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 Optional Employer's employees for the purpose of offering additional insurance plans that are not offered by or competing with those offered by the Plan Administrator. A local subdivision is prohibited from offering to its employees an insurance plan that is available through the Plan Administrator, including, but not limited to, a group health, dental, vision, term life, accidental death and dismemberment, or disability insurance plan.

13.08.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.

13.09.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 Plan 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 Plan Administrator.

13.10.Additional Taxes or Penalties

If there are any taxes or penalties payable by the Plan Administrator on behalf of any Participant, such taxes or penalties shall be payable by the Participant to the Plan Administrator to the extent such taxes would have been originally payable by the Participant had this Plan not been in existence.

13.11.Right of Recovery

If the Third Party Administrator, the Plan Administrator, or a designee of the foregoing 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 Third Party Administrator's or the Plan Administrator'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 Third Party Administrator, the Plan Administrator, or their designee, may deduct it when making future payments directly to that Participant.

13.12.Indemnification of Plan Administrator by Participants

If a Participant receives one (1) or more reimbursements under his Dependent Care Flexible Spending Account that are not for Dependent Care Expenses or under his Medical Spending Account that are not for Qualifying Medical Care Expenses, the Participant shall indemnify and reimburse the Plan Administrator and/or the Employer for any liability either 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.

13.13.No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Third Party Administrator makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan shall be excludable from the Participant's gross income for federal, state, or local income tax purposes or for Social Security tax purposes, or that any other federal or state tax treatment shall apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether payment under the Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes, and Social Security tax purposes, and to notify the Plan Administrator if the Participant has reason to believe that any such payment is not excludable.

13.14.Newborns' and Mothers' Health Protection Act of 1996

The Plan shall comply with the requirements under the Newborns' and Mothers' Health Protection Act of 1996.

13.15.Women's Health and Cancer Rights Act of 1998

The Plan shall comply with the requirements under the Women's Health and Cancer Rights Act of 1998.

13.16.Mental Health Parity Act of 1996

The Plan shall comply with the requirements under the Mental Health Parity Act of 1996. Effective July 1, 2010, the Plan shall further comply with the requirements under the Mental Health Parity and Addiction Equity Act of 2008, which amends the Mental Health Parity Act, and any regulations issued thereunder.

13.17.Family and Medical Leave

The Plan shall comply with the requirements under the FMLA.

13.18.Uniformed Services Employment and Reemployment Rights Act

The Plan shall comply with the requirements under USERRA.

13.19.HIPAA Compliance

To the extent required under HIPAA and consistent with Paragraph 4.08, the Plan shall comply with HIPAA and any regulations issued thereunder, to the extent required thereunder, and to the extent not otherwise inconsistent with the requirements under Code Section 125 and any regulations issued thereunder.

13.20.Limitation of Rights and Obligations

Neither the establishment nor maintenance of the Plan nor any amendment thereof, nor any act or omission under the Plan or resulting from the operation of the Plan shall be construed:

- A. As conferring upon any Participant, beneficiary, or any other person a right or claim against the Third Party Administrator or the Plan Administrator, except to the extent that such right or claim shall be specifically expressed or provided in the Plan;
- B. As creating any responsibility or liability of the Third Party Administrator or the Plan Administrator for the validity or effect of the Plan;

- C. As a contract or agreement between the Third Party Administrator or the Plan Administrator and any Participant or other person;
- D. As being consideration for, or an inducement or condition of, employment of any Participant or other person, or as affecting or restricting in any manner or to any extent whatsoever the rights or obligations of the Employer or any Participant or other person to continue or terminate the employment relationship at any time; or
- E. As to give any Participant or other person, the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or other person at any time.

13.21. Nonalienation

Except as provided pursuant to a Qualified Medical Child Support Order under ERISA Section 609, no benefit under the Plan prior to actual receipt thereof by a Participant or beneficiary, shall be subject to any debt, liability, contract, engagement, or tort of any Participant or his beneficiary, nor subject to anticipation, sale, assignment (except in the case of medical benefits), transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation, or any other voluntary or involuntary alienation or other legal or equitable process.

13.22. 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. To the extent permissible under applicable law, a Participant's interest under the Plan is subject to all bona fide and existing debts owed to the Plan by such Participant.

13.23. Misrepresentation

Any material misrepresentation on the part of the Participant making application for coverage or receipt of benefits shall render the coverage null and void.

13.24. Designation of Responsibilities

The Plan Administrator may designate another person or persons to carry out any responsibilities of the Plan Administrator under the Plan. The Plan Administrator shall not be liable for any act or omission of such person in carrying out such responsibility.

13.25. Responsibilities

To the extent permitted under law, no agent of the Plan shall be liable for any act or omission in carrying out the agent's responsibilities under the Plan.

13.26. Allocation of Responsibilities

To the extent permitted under law, each agent under the Plan shall be responsible only for the specific duties assigned under the Plan and shall not be directly or indirectly responsible for the duties assigned to another agent.

13.27. Notice

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

13.28. 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, Plan Administrator, or the Third Party Administrator for the acts or omissions of any provider of services or supplies for any benefits provided under the Plan.

13.29. Legal Counsel

The Plan Administrator and/or its designee, may from time to time consult with counsel, who may be counsel for the Plan Administrator and shall be fully protected in acting upon the advice of such counsel.

13.30. Benefits Solely from Plan Administrator Assets

Except as may otherwise be required by law:

- A. The benefits provided hereunder shall be paid solely from the assets of the Plan Administrator,
- B. Nothing herein shall be construed to require the Third Party Administrator or the Plan 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 the Plan Administrator from which any payment under the Plan may be made.

13.31. Reliance

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

13.32. Qualified Medical Child Support Orders

The Plan shall provide benefits in accordance with the applicable requirements of a Qualified Medical Child Support Order, as required by ERISA Section 609, received by the Plan.

13.33. Participant Incapacitation

When any Participant is under legal disability or, in the Plan Administrator's opinion, is in any way incapacitated so as to be unable to manage his affairs, the Plan Administrator may cause the Participant's benefits to be paid to his legal representative for his benefit. The payment of benefits pursuant to this Paragraph shall completely discharge the liability of the Plan Administrator, Plan, or any Employer for the benefits.

13.34. Participant Death

In the event of a Participant's death, the Participant's spouse (or, if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursement of Qualifying Medical Care Expenses or Dependent Care Expenses, as applicable. The payment of benefits pursuant to this Paragraph shall completely discharge the liability of the Plan Administrator, Plan, or any Employer for the benefits.

13.35. Entire Plan

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.

13.36. Special Participation in the Plan for Former Employees

- A.** Notwithstanding any provision contained in this Plan to the contrary, any contributions received by the Plan Administrator for a former employee's coverage for any Qualified Benefit or Account—whether due to retirement or COBRA eligibility—shall be deemed to be made pursuant to an election for such coverage on an after-tax basis under this Plan. An individual described in the preceding sentence shall be considered to be a “Special Participant” for purposes of this Paragraph.

- B.** Elections of coverage under this Paragraph shall continue in place until the first to occur of the following: (i) the date on which the Plan terminates, (ii) the date on which such underlying coverage terminates or is exhausted with respect to such Special Participant pursuant to the terms and conditions thereof, or (iii) the date on which such Special Participant revokes or ceases such coverage or fails to make timely contributions for such coverage (as determined under the terms of the applicable plan providing such coverage). During the period that a Special Participant's election for coverage under this Paragraph remains in force, the Special Participant may make changes in such coverage only to the extent permitted under the underlying coverage and only to the extent (i) such change is on account of a change in status (within the meaning of Paragraph 4.05) and (ii) such change is necessary or appropriate as a result of such change in status (within the meaning of Paragraph 4.05) pursuant to the continuation of coverage requirements of COBRA or a qualified medical child support order. Any such changes in coverage must be requested by the Special Participant within thirty-one (31) days following the change in status and shall be effective the first of the month after the later of the date on which such coverage is requested, provided the Special Participant makes any required contributions resulting from such change in a timely manner. Except as otherwise specifically provided herein, a Special Participant within the meaning of this Paragraph shall not be considered a Participant for any other purpose or provision under this Plan.

ARTICLE 14

PROTECTED HEALTH INFORMATION

14.01. 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.

14.02. Disclosures by Plan

The Plan may:

- A.** Disclose Summary Health Information to the Plan Administrator and Plan Sponsor, if the Plan Administrator or 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 Administrator and Plan Sponsor information on whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance benefit offered by the Plan.
 - C. Disclose Protected Health Information to the Plan Administrator to carry out Plan administration functions that the Plan Administrator performs.
 - D. With an authorization from the Eligible Employee, disclose Protected Health Information to the Plan Administrator for purposes related to the administration of other employee benefit plans and fringe benefits offered by the Plan Administrator.
 - E. Not permit a health insurance issuer with respect to the Plan to disclose Protected Health Information to the Plan Sponsor or Plan Administrator except as permitted by this Paragraph.
 - F. Not disclose (and may not permit a health insurance issuer to disclose) Protected Health Information to the Plan Sponsor or Plan Administrator as otherwise permitted by this Paragraph 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 or Plan Administrator.
 - G. Not disclose Protected Health Information to the Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

14.03. Uses and Disclosures by Plan Administrator

The Plan Administrator 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 Administrator 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 Administrator may also use and disclose Protected Health Information to accomplish the purpose for which any disclosure is properly made pursuant to Paragraph 14.02.

14.04. Certification

The Plan may disclose Protected Health Information to the Plan Administrator only upon receipt of a certification from the Plan Administrator that the Plan documents have been amended to incorporate the provisions provided for in this Paragraph and that the Plan Administrator so 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 Administrator provides Protected Health Information received from the Plan agree to the same restrictions and conditions

that apply to the Plan Administrator 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 Health Information belonging to the Plan that is provided by the Plan Administrator;

- 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 Employer 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 Administrator 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 Paragraphs 14.05 – 14.07 of the Plan are supported by reasonable and appropriate security measures.

14.05. Adequate Separation Between the Plan and the Plan Administrator

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.

14.06. Limitations of Access and Disclosure

The persons described in Paragraph 14.05 of this Article may only have access to and use and disclose

Protected Health Information for Plan administration functions that the Plan Administrator performs for the Plan.

14.07. Noncompliance

If the persons or classes of persons described in Paragraph 14.05 of this Article do not comply with this Plan document, the Plan Administrator shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

End of Plan

APPENDIX A

QUALIFIED BENEFITS

- Group Health Benefits Plan of the Employees of the State of South Carolina, the Public School Districts, and Participating Entities
- MUSC Group Health Benefits Plan for Employees of the Medical University of South Carolina, the Medical University Hospital Authority, and Participating Entities
- Group Dental Insurance Benefit Plan for South Carolina Public Employees, Active and Retired
- State Vision Plan
- State Group Optional Life Insurance
- TRICARE Supplement Plan
- Health Savings Account