AGENDA
OCONEE COUNTY COUNCIL

SPECIAL MEETING / PUBLIC HEARINGS
FY 2017-2018 BUDGET ORDINANCES

Tuesday, June 13, 2017
6:00 p.m.
Council Chambers
Oconee County Administrative Offices
415 South Pine Street, Walhalla, South Carolina 29691

Call to Order

Public Hearings for the Following Ordinances

Ordinance 2016-01 "AN ORDINANCE TO ESTABLISH THE BUDGET FOR **OCONEE COUNTY** AND TO PROVIDE FOR THE LEVY OF TAXES FOR ORDINARY COUNTY PURPOSES; FOR THE TRI-COUNTY TECHNICAL COLLEGE SPECIAL REVENUE FUND, FOR THE ROAD MAINTENANCE SPECIAL REVENUE FUND, FOR THE VICTIM SERVICES SPECIAL REVENUE FUND, FOR THE BRIDGE AND CULVERT CAPITAL PROJECT FUND, AND FOR THE ECONOMIC DEVELOPMENT CAPITAL PROJECT FUND, ALL IN OCONEE COUNTY FOR THE FISCAL YEAR BEGINNING JULY 1, 2017 AND ENDING JUNE 30, 2018."

Ordinance 2016-02 "AN ORDINANCE TO ESTABLISH THE BUDGET FOR **THE SCHOOL DISTRICT OF OCONEE COUNTY** (the "School District") AND TO PROVIDE FOR THE LEVY OF TAXES FOR THE OPERATIONS OF THE SCHOOL DISTRICT OF OCONEE COUNTY FOR THE FISCAL YEAR BEGINNING JULY 1, 2017 AND ENDING JUNE 30, 2018."

Ordinance 2016-03 "AN ORDINANCE TO PROVIDE FOR THE LEVY OF TAXES FOR THE **KEOWEE FIRE SPECIAL TAX DISTRICT** AND TO ESTABLISH THE BUDGET FOR THE KEOWEE FIRE SPECIAL TAX DISTRICT FOR THE FISCAL YEAR BEGINNING JULY 1, 2017 AND ENDING JUNE 30, 2018."

Other Business *[to include First and/or Action on matters brought up for discussion, if required]*

Adjourn

[This agenda is not inclusive of all issues which Council may bring up for discussion at this meeting.]

Oconee County Council & Committee meeting schedules and agendas are posted in the Oconee County Administration Building and are available on the County Council Website www.oconeesc.com/council.html
[All upcoming meetings will be held in Council Chambers unless otherwise noted]

Council meetings shall be conducted pursuant to South Carolina Freedom of Information Act, Council's Rules and the Model Rules of Parliamentary Procedure for South Carolina Counties, latest edition. The agenda may not be inclusive of all issues which Council may bring up for discussion at the meeting. Items on Council's agenda to give public notice of the anticipated issues to be discussed, acted upon, received as information and/or deferred at during the meeting. Items listed on Council's agenda may be taken up, acted, postponed, reconsidered, removed or otherwise changed or as provided for under Council's Rules and Model Rules of Parliamentary Procedure for South Carolina Counties, as modified under Council's rules.

STATE OF SOUTH CAROLINA
COUNTY OF OCONEE
ORDINANCE 2017-01

AN ORDINANCE TO ESTABLISH THE BUDGET FOR OCONEE COUNTY AND TO PROVIDE FOR THE LEVY OF TAXES FOR ORDINARY COUNTY PURPOSES, FOR THE TRI-COUNTY TECHNICAL COLLEGE SPECIAL REVENUE FUND, FOR THE ROAD MAINTENANCE SPECIAL REVENUE FUND, FOR THE VICTIM SERVICES SPECIAL REVENUE FUND, FOR THE BRIDGE AND CULVERT CAPITAL PROJECT FUND, AND FOR THE ECONOMIC DEVELOPMENT CAPITAL PROJECT FUND, ALL IN OCONEE COUNTY FOR THE FISCAL YEAR BEGINNING JULY 1, 2017 AND ENDING JUNE 30, 2018.

BE IT ORDAINED by the County Council for Oconee County, South Carolina, (the "County Council"), in accordance with the general law of the State of South Carolina and the Acts and Joint Resolutions of the South Carolina General Assembly, as follows:

SECTION 1
Pursuant to Section 4-9-140 of the South Carolina Code of Laws, 1976, as amended, the following amounts are hereby appropriated for the 2017-2018 fiscal year for Oconee County (the "County") for ordinary county purposes:

General Fund	$ 44,397,501
Special Revenue Funds:	
Emergency Services Protection	$ 1,460,000
Victim Services - Sheriff's Office	$ 152,000
Victim Services - Solicitor's Office	$ 58,000
911 Fund	$ 1,034,000
Tri-County Tech Operations	$ 1,670,000
Road Maintenance Fund	$ 1,470,000
Capital Project Funds:	
Economic Development	$ 615,000
Bridge & Culvert	$ 525,000
Enterprise Fund:	
Rock Quarry	$ 4,988,500
Debt Service Fund	$ 1,958,544
TOTAL	$ 58,328,545

SECTION 2

A tax of sufficient millage to fund the aforestated appropriations for the Oconee County Budget for the fiscal year beginning July 1, 2017 and ending June 30, 2018, after crediting against such appropriations all other unrestricted revenue anticipated to accrue to Oconee County and any fund balance budgeted to be used during said fiscal year, is hereby directed to be levied upon all taxable property, eligible to be lawfully taxed for such purposes, in Oconee County. The Auditor of Oconee County is hereby requested to recommend to the Oconee County Council, for approval by Oconee County Council, a sufficient millage levy and the Treasurer of Oconee County is herein directed to collect sufficient millage on taxable property in Oconee County to provide for the aforestated operations appropriations and direct expenditures of Oconee County for the fiscal year beginning July 1, 2017 and ending June 30, 2018. The Auditor and Treasurer of Oconee County are hereby directed to fund such bond repayment sinking fund(s) as are necessary to provide for an orderly and timely payment of the debt service of Oconee County and to satisfy any debt covenants.

SECTION 3

A tax of 3.0 mills to provide funding for the Tri-County Technical College Special Revenue Fund is hereby levied on all taxable property, eligible to be lawfully taxed for such purposes, in Oconee County. The revenue from this levy is hereby appropriated, for expenditures in an amount not to exceed $1,670,000, for support of Tri-County Technical College. The Auditor of Oconee County is hereby requested to levy and the Treasurer of Oconee County is herein directed to collect the millage on taxable property in Oconee County to provide for the aforestated appropriations of the Tri-County Technical College Special Revenue fund for the fiscal year beginning July 1, 2017 and ending June 30, 2018. To the extent such levy results in revenues in excess of the amount appropriated above, all such revenues shall be retained and accounted for in the Tri-County Technical College Special Revenue Fund and shall be carried forward from year to year as fund balance in this fund to be appropriated by Oconee County Council through future budget adoption or budget amendments.

SECTION 4

A tax of 2.9 mills to provide funding for the Emergency Services Protection Special Revenue Fund is hereby levied on all taxable property within the special tax district, eligible to be lawfully taxed for such purposes, in Oconee County. The combined revenue from this levy and a portion of fund balance as authorized by County Council is hereby appropriated, for expenditures in an amount not to exceed $1,460,000, for the Emergency Services Protection Special Revenue Fund. The Auditor of Oconee County is hereby requested to levy and the Treasurer of Oconee County is herein directed to collect the millage on taxable property within the special tax district in Oconee County to provide for the aforestated operations appropriations and direct expenditures of the Emergency Services Protection Special Revenue Fund for the fiscal year beginning July 1, 2017 and ending June 30, 2018. To the extent such levy results in revenues in excess of the amount appropriated above, all such revenues shall be retained and accounted for in the Emergency Services Protection Special Revenue Fund and shall be carried forward from year to year as fund balance in this fund to be appropriated by Oconee County Council through future budget adoption or budget amendments.

SECTION 5

A tax of 2.1 mills to provide funding for the Road Maintenance Special Revenue Fund is hereby levied on all taxable property within the special tax district, eligible to be lawfully taxed for such purposes, in Oconee County. The combined revenue from this levy and a portion of fund balance as authorized by County Council is hereby appropriated, for expenditures in an amount not to exceed $1,470,000, for the Road Maintenance Special Revenue Fund. The Auditor of Oconee County is hereby requested to levy and the Treasurer of Oconee County is herein directed to collect the millage on taxable property within the special tax district in Oconee County to provide for the aforestated operations appropriations and direct expenditures of the Road Maintenance Special Revenue Fund

for the fiscal year beginning July 1, 2017 and ending June 30, 2018. To the extent such levy results in revenues in excess of the amount appropriated above, all such revenues shall be retained and accounted for in the Road Maintenance Special Revenue Fund and shall be carried forward from year to year as fund balance in this fund to be appropriated by Oconee County Council through future budget adoption or budget amendments.

SECTION 6

A tax of 1 mill to provide funding for the Bridge and Culvert Capital Project Fund is hereby levied on all taxable property, eligible to be lawfully taxed for such purposes, in Oconee County. The combined revenue from this levy and a portion of fund balance as authorized by County Council is hereby appropriated, for expenditures in an amount not exceed $525,000, for the Bridge and Culvert Capital Project Fund. The Auditor of Oconee County is hereby requested to levy and the Treasurer of Oconee County is herein directed to collect the millage on taxable property in Oconee County to provide for the aforestated operations appropriations and direct expenditures of the Bridge and Culvert Capital Project Fund for the fiscal year beginning July 1, 2017 and ending June 30, 2018 To the extent such levy results in revenues in excess of the amount appropriated above, all such revenues shall be retained and accounted for in the Bridge and Culvert Capital Project Fund and shall be carried forward from year to year as fund balance in this fund to be appropriated by Oconee County Council through future budget adoption or budget amendments.

SECTION 7

A tax of 1.1 mills to provide funding for the Economic Development Capital Project Fund is hereby levied on all taxable property, eligible to be lawfully taxed for such purposes, in Oconee County. The combined revenue from this levy, other anticipated restricted revenues, transfers, and a portion of fund balance as authorized by County Council is hereby appropriated not to exceed $615,000, for the Economic Development Capital Projects Fund for projects approved by County Council. The Auditor of Oconee County is hereby requested to levy and the Treasurer of Oconee County is herein directed to collect the millage on taxable property in Oconee County to provide for the aforestated operations appropriations and direct expenditures of the Economic Development Capital Project Fund for the fiscal year beginning July 1, 2017 and ending June 30, 2018. To the extent such levy results in revenues in excess of the amount appropriated above, all such revenues shall be retained and accounted for in the Economic Development Capital Project Fund and shall be carried forward from year to year as fund balance in this fund to be appropriated by Oconee County Council through future budget adoption or budget amendments.

SECTION 8

Oconee County receives certain recurring revenues that are restricted for certain purposes. These revenues are accounted for in various special revenue funds including the Victim Services-Sheriff's Office Fund, Victim Services-Solicitor's Office Fund, and 911 Fund, special revenue funds. Any surplus in these funds of the County or any moneys accruing therefrom shall be retained and accounted for in these funds and shall be carried forward from year to year as fund balances in such funds.

SECTION 9

All capital projects and multi-year grant appropriations made by prior year budget ordinances for which the respective monies have been obligated or encumbered are hereby carried forward and reappropriated, as of July 1, 2017, as a part of the budget authorized by this Ordinance.

SECTION 10

Capital projects are budgeted on a project basis instead of an annual basis and as such, unexpended appropriations for uncompleted capital projects are carried forward as a part of the budget authorized by this ordinance.

SECTION 11
All unexpended appropriations as of June 30, 2017, except for those specifically carried forward by this ordinance shall lapse and expire and the monies involved shall revert to the fund balance of the fund from which the appropriation originated.

SECTION 12
The County Administrator, as required by state law, shall oversee and supervise the day-to-day implementation of this budget ordinance, including the execution and delivery, on behalf of the County, of all contractual documents necessary or required for the expenditure of funds authorized by this budget ordinance, for the purposes for which such funds are so authorized. Subject to the procurement policies of the County, the County Administrator is hereby authorized to contract and enter into contracts on behalf of the County for purposes, activities and matters budgeted for herein.

SECTION 13
The fees authorized for all county departments to charge for services of the county and to use for operations of the county are as set forth in a schedule of fees. This schedule of fees attached hereto, as **ATTACHMENT A**, is incorporated herein, by reference, as fully as if set forth verbatim herein, and adopted as part of this Ordinance and the fees are hereby approved to be charged by the appropriate county departments.

SECTION 14
The County began contributing to retiree health benefits (the "Retiree Health Benefit Plan" or "Plan") on behalf of employees and county retirees on January 1, 1985. Several amendments to the County's Plan guidelines have occurred since that time; however nothing in these Plan amendments permits or affords grandfathering eligibility for any individual other than those outlined explicitly in the guidelines, which are hereby incorporated herein by reference, as fully as if set forth verbatim herein, and adopted as part of this Ordinance and the rates are hereby approved to be charged and administered according to the Retiree Health Plan Guidelines. The county administrator is authorized to administer this plan in accordance with these guidelines and to establish health reimbursement accounts for eligible retirees for contributory purposes for the Fiscal year beginning on July 1, 2017 and ending on June 30, 2018. **DUE TO THE RISK OF UNKNOWN CIRCUMSTANCES, THIS PLAN MAY BE DEEMED NON-SUSTAINABLE AT SOME FUTURE TIME. THE RETIREE HEALTH BENEFIT GUIDELINES ARE DISCRETIONARY ON THE PART OF THE COUNTY AND THE EMPLOYEE AND DO NOT CREATE ANY EXPRESS OR IMPLIED CONTRACT OF THIS BENEFIT BEING PROVIDED IN THE FUTURE OR IN ANY PARTICULAR AMOUNT AT ANY TIME. NO PAST PRACTICES OR PROCEDURES, PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, FORM ANY EXPRESS OR IMPLIED AGREEMENT TO CONTINUE SUCH PRACTICES OR PROCEDURES. IT IS EXPLICITLY STATED AND RECOGNIZED BY THE COUNTY AND EVERY EMPLOYEE ACCEPTING BENEFITS UNDER THE PLAN THAT ALL EMPLOYMENT IN OCONEE COUNTY (EXCEPT FOR THE OCONEE COUNTY ADMINISTRATOR) IS "AT WILL" AND THAT NO OCONEE COUNTY EMPLOYEE (EXCEPT FOR THE COUNTY ADMINISTRATOR) HAS AN EMPLOYMENT AGREEMENT OR CONTRACT, AND THAT ALL PROVISIONS OF ANY AND ALL EMPLOYMENT BENEFITS, INCLUDING WITHOUT LIMITATION, THOSE DESCRIBED IN THE PLAN IS ALWAYS SUBJECT TO ANNUAL APPROPRIATION BY OCONEE COUNTY COUNCIL, WHICH IS NEVER GUARANTEED AND NEVER WILL BE GUARANTEED.**

SECTION 15
If any clause, phrase, sentence, paragraph, appropriation, or section of this Ordinance shall be held invalid for any reason, it shall not affect the validity of this Ordinance as a whole or the remaining clauses, phrases, sentences, paragraphs, appropriations, or sections hereof, which are hereby declared separable.

SECTION 16
All other orders, resolutions, and ordinances of Oconee County, inconsistent herewith, are, to the extent of such inconsistency only, hereby revoked, rescinded and repealed.

SECTION 17
This Ordinance shall become effective upon approval on third reading and enforced from and after July 1, 2017.

SECTION 18
The budget provisos attached hereto are hereby incorporated herein, by reference, as fully as if set forth verbatim herein, and adopted as part of this Ordinance.

Adopted in meeting duly assembled this ___ day of June, 2017.

OCONEE COUNTY, SOUTH CAROLINA

_____
Edda Cammick
Chairwoman, Oconee County Council

ATTEST

_____
Katie Smith
Clerk to County Council

First Reading (Title Only): May 16, 2017
Second Reading: June 6, 2017
Public Hearing:
Third Reading:

STATE OF SOUTH CAROLINA
COUNTY OF OCONEE
BUDGET PROVISOS FOR FISCAL YEAR 2017-2018
ORDINANCE 2017-01

Section 1

The appropriations made herein shall not be exceeded without proper authority or amendment by Oconee County Council. Any officer incurring indebtedness on the part of the County in excess of the appropriations herein made shall be liable upon his official bond.

Section 2

The Finance Director and Treasurer of Oconee County shall prepare such separate records and books of account as may be required by the United States Government or any of its agencies or by the State of South Carolina or any of its agencies, reflecting the receipt and disposition of all funds.

Section 3

All purchasing and contracting for the acquisition of goods and services for County purposes shall be in accordance with procedures outlined in the County Procurement Ordinance, as codified. Subject to the provisions of Oconee County policies, whenever possible and practical, goods and services shall be purchased from firms and individuals located in Oconee County whenever goods and services of equal quality and specifications are available from local suppliers at prices less than or equal to prices submitted by nonresident suppliers.

Section 4

No bills or claims against Oconee County shall be approved for payment and no check will be issued for same unless such bills or claims are properly itemized showing the goods purchased or services rendered, dated as of the date of delivery of said goods and/or services and signed by the person receiving said goods or services.

Section 5

No officer, elected official or employee of Oconee County shall furnish any services or sell any materials or supplies to the County for pay, except upon open quote or bid in accordance with the County Procurement Ordinance, as codified.

Section 6

The County Council may transfer funds from any fund, department, activity or purpose to another by normal Council action, subject to all other applicable legal requirements. The County Administrator shall be authorized to transfer appropriations between departments within a fund. All transfers authorized by this section are subject to the overall appropriation limits of this Ordinance.

Section 7

For any equipment, vehicle or any other item that is approved in the budget as a replacement for existing items, the item being replaced will be relinquished to the Procurement Director for disposal or reassignment.

Section 8

The standard mileage rate reimbursed to County employees for use of their personal vehicles will be equal to the amount set, as the authorized rate, by the Internal Revenue Service, at any given time.

Section 9

Oconee County will pay County employees a per diem for meals while traveling on County business, including travel related to training. No per diem will be paid for meals that are included in registration fees. The rates will be $8 for breakfast, $12 for lunch and $15 for dinner. Per Diem for breakfast will be reimbursed if the employee is required to leave home before 7:30 a.m. Per Diem for dinner will be reimbursed if the employee returns home after 6 p.m. For non-overnight travel reimbursement for meals will be based on actual expenditures for meals, limited to the per diem amounts above. Receipts for meals will be required for reimbursements.

Section 10

The First Fifteen Hundred Dollars ($1500) of Oconee County building permit fees (under Community Development on the attached, and incorporated Oconee County Departmental Fees Schedule for this budget year) and related and associated Building Code fees are, to the extent permitted by law, hereby waived and set at $0 for any Oconee County non-profit or eleemosynary entity duly recognized as such by the State of South Carolina and granted tax exempt status by the Internal Revenue Service of the United States ("IRS"), only for so long as such entity maintains such non-profit or eleemosynary status and tax exempt recognition by the IRS. All building permit fees and building code fees in excess of $1500, per applying non-profit, eleemosynary entity per application, will be applied and collected as usual, per this budget, this proviso, and the attached, incorporated Oconee County Departmental Fees Schedule. Oconee County Council hereby determines and finds that this reduction in fees is appropriate and justified by the provision of public services which these non-profit, eleemosynary entities provide to Oconee County and the public of Oconee County – services of public use and public benefit which would otherwise have to be provided by some unit of local government.

Section 11

For all economic development projects in a joint county industrial or business park ("MCIP") in the unincorporated portion of the County, for which revenue is first received on or after July 1, 2017, and subject to any superior agreements allocating portions of such revenue, all revenue or remaining revenue, as the case may be, received from such MCIP which is/was attributable to the levy of all general fund millages shall be divided and distributed in the following percentages, in order to offset the costs of economic development which made the project(s) possible: (1) Oconee County general fund – 33%; Oconee County Economic Development Capital Projects Fund – 34%; School District of Oconee County - 33%; (2) all other taxing entities levying millage at the site in question - 1% each;[1] (3) all other taxing entities in Oconee the County - 0%. Revenue attributable to the levy of debt service millage or other non-general fund millage shall be distributed to the taxing entity levying such millage. For joint county industrial or business parks located within municipal limits, the intergovernmental agreement governing the creation of such MCIP shall govern distribution of revenues. Any unused revenues in such fund at the end of any fiscal year shall be carried over to the succeeding fiscal year.

Section 12

Pursuant to authority given to governing bodies of South Carolina counties by the South Carolina General Assembly in Section 12-43-360 of the South Carolina Code of Laws, 1976, as amended, the Oconee County Council hereby reduces the assessment ratio otherwise applicable in determining the assessed value of general aviation aircraft subject to property tax in Oconee County to a ratio of four percent (4%) of the fair market value of such general aviation aircraft. Such assessment ratio shall apply uniformly to all general aviation aircraft subject to *ad valorem* property taxation in Oconee

[1] If there are other taxing entities levying millage at the site in question, then the County and the SDOC percentages shall apply to the remainder

County. This proviso first became effective in the 2011-2012 budget ordinance and is a part of the budget ordinance beginning July 1, 2017 and ending June 30, 2018.

Section 13

The Oconee County fund balance policy, as stated and established in Oconee County Resolution R2011-09, is hereby implemented as a part of this budget. Oconee County Council hereby sets the following amounts of fund balance for the respectively stated purposes:

Assigned funds for the Solid Waste Reserve General Fund balance:	$1,997,700
Assigned funds for the Healthcare Reserve General Fund balance:	$2,592,895
Assigned funds for the OPEB Reserve General Fund Balance:	$1,207,715
Assigned funds for Old Courthouse Fund Balance:	$ 500,000
Assigned funds for Transportation Fund Balance:	$ 300,000

Section 14

County Council adopts the employee benefit plan and ratifies the designation of the County Administrator to act as the Plan Administrator and affirms all plan amendments prior to the date hereof, attached hereto as **ATTACHMENT B.**

Section 15

County Council adopts the retiree health benefit plan as modified and ratifies the designation of the County Administrator to act as the Plan Administrator and affirms all plan amendments prior to the date hereof, attached hereto as **ATTACHMENT C.**

Section 16

Oconee County receives federal, state and local grants for specified purposes. Oconee County is hereby authorized, absent any other factor, to apply for, receive, and expend all such grants for which no local match is required or for which such funds are budgeted herein, in addition to all other authority elsewhere given, and in accordance with all other policies and directives of Oconee County. These grants, including any local match, are deemed budgeted for the specified purposes upon acceptance of such grants. These grants are budgeted for on a project basis in accordance with the grantors' terms and conditions instead of an annual basis and as such, unexpended appropriations for uncompleted grant projects are carried forward as a part of the budget authorized by this ordinance. The Oconee County Administrator, or his duly authorized representative, is hereby authorized to apply for all federal and state grants for which no County matching funds are required, if all necessary operating funds for the County facility, institution, or programs in question have been made available by County Council through the County's operating and capital budgets or are available in applicable County enterprise fund balances, or for those grants for which County matching funds are required when all necessary County matching funds have been made available by County Council through the annual County operating and capital budgets or are available in applicable County enterprise fund balances, for County Council authorized programs, institutions, and facilities of the County, and to receive and expend such federal and state grant funds, for the purposes authorized in the respective grant applications.

STATE OF SOUTH CAROLINA
COUNTY OF OCONEE
ORDINANCE 2017-02

AN ORDINANCE TO ESTABLISH THE BUDGET FOR THE SCHOOL DISTRICT OF OCONEE COUNTY (the "School District") AND TO PROVIDE FOR THE LEVY OF TAXES FOR THE OPERATIONS OF THE SCHOOL DISTRICT OF OCONEE COUNTY FOR THE FISCAL YEAR BEGINNING JULY 1, 2017 AND ENDING JUNE 30, 2018.

BE IT ORDAINED by the County Council for Oconee County, South Carolina, (the "County Council"), in accordance with the general law of the State of South Carolina and the Acts and Joint Resolutions of the South Carolina General Assembly, as follows:

SECTION 1
The following amounts are hereby approved for budget purposes and appropriated for the 2017-2018 fiscal year for the School District of Oconee County:

School Operations	$	66,463,508
School Debt	$	17,098,280
Total School District	$	83,561,788

SECTION 2
A tax of sufficient millage to fund the aforestated appropriations for the School District of Oconee County Budget for the fiscal year beginning July 1, 2017 and ending June 30, 2018 is hereby directed to be levied upon all taxable property in Oconee County and duly collected.

SECTION 3
The Auditor of Oconee County is hereby requested to recommend to the Oconee County Council, for approval by Oconee County Council, a sufficient millage levy and the Treasurer of Oconee County is herein directed to collect sufficient millage on all taxable property in Oconee County on which school taxes may be levied to provide for the aforestated operations appropriations and direct expenditures of the School District of Oconee County for the fiscal year beginning July 1, 2017 and ending June 30, 2018.

SECTION 4
In accordance with the Constitution and general law of the State of South Carolina, and the Acts and Joint Resolutions of the South Carolina General Assembly, the Auditor of Oconee County shall set the millage levy for the debt service requirements of the School District and the Treasurer of Oconee County shall collect sufficient millage on all taxable property in Oconee County on which school taxes may be levied to provide for the debt service requirements of the School District of Oconee County for the fiscal year beginning July 1, 2017 and ending June 30, 2018.

SECTION 5
If any clause, phrase, sentence, paragraph, appropriation, or section of this Ordinance shall be held invalid for any reason, it shall not affect the validity of this Ordinance as a whole or the remaining clauses, phrases, sentences, paragraphs, appropriations, or sections hereof, which are hereby declared separable.

SECTION 6
All other orders, resolutions, and ordinances of Oconee County, inconsistent herewith, are, to the extent of such inconsistency only, hereby revoked, rescinded and repealed.

SECTION 7
This Ordinance shall become effective upon approval on third reading and enforced from and after July 1, 2017.

Adopted in meeting duly assembled this ___ day of June, 2017.

OCONEE COUNTY, SOUTH CAROLINA

_____
Edda Cammick
Chairwoman, Oconee County Council

ATTEST

_____
Katie Smith
Clerk to County Council

First Reading (Title Only): May 16, 2017
Second Reading: June 6, 2017
Public Hearing:
Third Reading:

STATE OF SOUTH CAROLINA
COUNTY OF OCONEE
ORDINANCE 2017-03

AN ORDINANCE TO PROVIDE FOR THE LEVY OF TAXES FOR THE KEOWEE FIRE SPECIAL TAX DISTRICT AND TO ESTABLISH THE BUDGET FOR THE KEOWEE FIRE SPECIAL TAX DISTRICT FOR THE FISCAL YEAR BEGINNING JULY 1, 2017 AND ENDING JUNE 30, 2018.

BE IT ORDAINED by the County Council for Oconee County, South Carolina, (the "County Council"), in accordance with the general law of the State of South Carolina, including, without limitation, Section 4-9-30, South Carolina Code, 1976, as amended and the Acts and Joint Resolutions of the South Carolina General Assembly, as follows:

SECTION 1
For the fiscal year beginning July 1, 2017 and ending June 30, 2018, $698,200 is hereby appropriated for fire protection services in the Keowee Fire Special Tax District.

SECTION 2
A tax of sufficient millage, not to exceed 14.5 mills, to fund the aforestated appropriations for the Keowee Fire Special Tax District for the fiscal year beginning July 1, 2017 and ending June 30, 2018, after crediting against such appropriations all other unrestricted revenue anticipated to accrue to Keowee Fire Special Tax District and any fund balance budgeted to be used during said fiscal year, is hereby directed to be levied on all taxable property, eligible to be lawfully taxed for such purposes, in the Keowee Fire Special Tax District.

SECTION 3
The Auditor of Oconee County is hereby requested to recommend to the Oconee County Council, for approval by Oconee County Council, a sufficient millage levy and the Treasurer of Oconee County is herein directed to collect sufficient millage on taxable property in the Keowee Fire Special Tax District to provide for the aforestated appropriations and direct expenditures of that Special Tax District for the fiscal year beginning July 1, 2017 and ending June 30, 2018.

SECTION 4
If any clause, phrase, sentence, paragraph, appropriation, or section of this Ordinance shall be held invalid for any reason, it shall not affect the validity of this Ordinance as a whole or the remaining clauses, phrases, sentences, paragraphs, appropriations, or sections hereof, which are hereby declared separable.

SECTION 5
All other orders, resolutions, and ordinances of Oconee County, inconsistent herewith, are, to the extent of such inconsistency only, hereby revoked, rescinded and repealed.

SECTION 6
This Ordinance shall become effective upon approval on third reading and enforced from and after July 1, 2017.

Adopted in meeting duly assembled this ___ day of June, 2017.

OCONEE COUNTY, SOUTH CAROLINA

_____
Edda Cammick,
Chairwoman, Oconee County Council

ATTEST

_____
Katie Smith
Clerk to County Council

First Reading (Title Only): May 16, 2017
Second Reading: June 6, 2017
Public Hearing:
Third Reading:

Katie Smith

From:	Katie Smith
Sent:	Wednesday, May 31, 2017 12:31 PM
To:	classadmgr@upstatetoday.com; Steven Bradley (sbradley@upstatetoday.com); Dick Mangrum (dickmangrum@wgog.com)
Cc:	Katie Smith
Subject:	Legal Ad Request

.....LEGAL AD.....

PLEASE ADVERTISE IN THE NEXT ISSUE OF YOUR NEWSPAPER

"The Oconee County Council will hold a Special Meeting at 6p.m., Tuesday, June 13, 2017 in the Oconee County Council Chambers located at 415 South Pine Street, Walhalla, SC 29691, for public hearings on the following Ordinances:

Ordinance 2017-01 AN ORDINANCE TO ESTABLISH THE BUDGET FOR OCONEE COUNTY AND TO PROVIDE FOR THE LEVY OF TAXES FOR ORDINARY COUNTY PURPOSES, FOR THE TRI-COUNTY TECHNICAL COLLEGE SPECIAL REVENUE FUND, FOR THE ROAD MAINTENANCE SPECIAL REVENUE FUND, FOR THE VICTIM SERVICES SPECIAL REVENUE FUND, FOR THE BRIDGE AND CULVERT CAPITAL PROJECT FUND, AND FOR THE ECONOMIC DEVELOPMENT CAPITAL PROJECT FUND, ALL IN OCONEE COUNTY FOR THE FISCAL YEAR BEGINNING JULY 1, 2017 AND ENDING JUNE 30, 2018;

Ordinance 2017-02 AN ORDINANCE TO ESTABLISH THE BUDGET FOR THE SCHOOL DISTRICT

OF OCONEE COUNTY (the "School District") AND TO PROVIDE FOR THE LEVY OF TAXES FOR THE OPERATIONS OF THE SCHOOL DISTRICT OF OCONEE COUNTY FOR THE FISCAL YEAR BEGINNING JULY 1, 2017 AND ENDING JUNE 30, 2018;

Ordinance 2017-03 AN ORDINANCE TO PROVIDE FOR THE LEVY OF TAXES FOR THE KEOWEE FIRE SPECIAL TAX DISTRICT AND TO ESTABLISH THE BUDGET FOR THE KEOWEE FIRE SPECIAL TAX DISTRICT FOR THE FISCAL YEAR BEGINNING JULY 1, 2017 AND ENDING JUNE 30, 2018."

Please respond to this email to confirm receipt. Thank you!

Katie D. Smith
Clerk to Council
Oconee County
415 S. Pine St. Walhalla
864.718.1023
Fx: 864.718.1024
ksmith@oconeesc.com

Oconee County, South Carolina
Fees Schedule
2017-2018

Description	Rate	FY 2017 Fees	FY 2018 Fees
General County Fees (Applicable to all departments, unless otherwise noted within the Departmental Fees below.)			
Copies			
8.5 X 11	Per Page	$0.25	$0.25
8.5 X 14	Per Page	$0.50	$0.50
11 X 17	Per Page	$0.50	$0.50
County Road Maps			
County Road Map (Less Than 50)	Per Map	$2.00	$2.00
County Road Map Bulk (50 or More)	Per Map	$1.50	$1.50
Noise Ordinance Application Fee **(New)**	$50.00	$0.00	**$50.00**
Departmental Fees			
Animal Control			
Dog Adoption Fee	Per Dog	$75.00	$75.00
Cat Adoption Fee	Per Cat	$65.00	$65.00
Horse Adoption Fee	Per Horse	$100 - $200	$100-$200
Quarantine Fee		$60.00	$60.00
Owner Pick-Up Fee - Cat or Dog		$10.00	$10.00
Boarding Fee - Cat or Dog	Per Day	$10.00	$10.00
Owner Pick-Up Fee - Large Animal		$20.00	$20.00
Boarding Fee - Large Animal	Per Day	$15.00	$15.00
Airport			
T-Hanger Rental Rates - A - 14 Units	Per Month	$235.00	$235.00
T-Hanger Rental Rates - B - 5 Units	Per Month	$235.00	$235.00
T- Hangar Rental Rates- B - 6 Units	Per Month	$160.00	$160.00
T-Hanger Rental Rates - C - 6 Units	Per Month	$160.00	$160.00
T-Hangar Rental Rates - C - 4 Units	Per Month	$235.00	$235.00
T-Hanger Rental Rates - D - 5 Units	Per Month	$235.00	$235.00
T-Hanger Rental Rates - E - 8 Units	Per Month	$270.00	$270.00
Aircraft Tie-Down Rate	Per Month	$30.00	$30.00
Long-Term Parking Fee	Per Month, Per Vehicle	$10.00	$10.00
After Hour Callout Fee		$120.00	$120.00
Event Fee		$25.00 Single Engine $50.00 Multi Engine $100.00 Jet Aircraft	$25.00 Single Engine $50.00 Multi Engine $100.00 Jet Aircraft
Ramp Fee - Transient Business Planes Over 15,000 Pounds		$50.00	$50.00
Airport customers with an Oconee Airport based corporate aircraft who purchase 150 or more gallons of Jet A fuel at one time will receive a $0.10 per gallon discount off the County Airport's normal retail price for the Jet A Fuel.		N/A	N/A
Airport customers who purchase 200 gallons or more of Jet A Fuel at one time will receive a $0.10 per gallon discount off the County Airport's normal retail price for the Jet A Fuel.		$0.10 reduction for 200 gallons or more	$0.10 reduction for 200 gallons or more
Auditor			
Temporary Tags		$5.00	$5.00

Oconee County, South Carolina
Fees Schedule
2017-2018

Description	Rate	FY 2017 Fees	FY 2018 Fees
Community Development			
(See Section 13 of Ordinance to the Oconee County Budget for this year)			
All Buildings, Demolition, and Mechanical Trades $10,000 or Less		$50.00	$50.00
All Buildings, Demolition, and Mechanical Trades $10,000 and Up		$50.00 + $4.00 for each additional $1,000 or fraction thereof	$50.00 + $4.00 for each additional $1,000 or fraction thereof
Farm Exempt Structures		$50.00	$50.00
Manufactured Homes			
Set-Up Permit (Includes County Decal)		$100.00	$100.00
Decal Only		$20.00	$20.00
Manufactured Home De-Title Fee		$40.00	$40.00
Manufactured Home Moving Permit		$20.00	$20.00
Other Permits			
Moving Permits (Structures Other Than Manufactured Homes)		$50.00	$50.00
Sign Fees			
Less Than 50 Square Feet		no fee	no fee
51 Square Feet to 200 Square Feet		$100.00	$100.00
Greater Than 200 Square Feet		$300.00	$300.00
Penalties *(Where work for which a permit is required by this Ordinance is started prior to obtaining said permit, the applicable fee shall be doubled.)*			
Re-Inspection Fee - Shall be charged if an inspection is scheduled and the work is not ready when the inspector arrives.		$50.00	$50.00
Stop Work Order Fee - Shall be charged if the inspector issues a stop work order.		$50.00	$50.00
Commercial Plan Review Fee		1/2 of building permit fee	1/2 of building permit fee
Basic Plat Review - **New for FY 2015**		$25.00	$25.00
Subdivision Review - Minor Subdivision, Less Than 4 Units		$50.00	$50.00
Subdivision Review - Minor Subdivision 4 to 10 Units		$100.00	$100.00
Subdivision Review - Major Subdivision		$100.00	$100.00
Communication Towers - New Build		$6,000.00	$6,000.00
Communication Towers - Collocate		$3,000.00	$3,000.00
Communication Tower Maint Fee - **New for FY 2015**	Annual Fee	$1,000.00	$1,000.00
WiFi Tower - **New for FY 2015**		$250.00	$250.00
Group Homes		$50.00	$50.00
Sexually Oriented Business	Annual Fee	$1,000.00	$1,000.00
Sexually Oriented Business Employee	Per Employee	$25.00	$25.00
Sign Permit - Billboard		$100.00	$100.00
Tattoo Facilities		$1,000.00	$1,000.00
Pre-Bound Document - Less Than 50 Pages		$5.00	$5.00
Pre-Bound Document - Greater Than 50 Pages	Per Page	$5.00 + $0.10 per page	$5.00 + $0.10 per page
Documents on CD		$1.00	$1.00
Maps - 8.5 X 11	Each	$3.00	$3.00
Maps - 18 X 24	Each	$5.00	$5.00
Maps - 24 X 36	Each	$7.00	$7.00
Maps - 36 X 48	Each	$8.00	$8.00
Custom Mapping - Planning and Zoning Projects Only	Per Hour	$30.00	$30.00
Non-CFD Rezoning Application Fee	Per Parcel	$25.00	$25.00
Appeals, Variances, and Special Exception Application Fee		$100.00	$100.00
Zoning Permit Fee - **New for FY 2015**		$25.00	$25.00

Oconee County, South Carolina
Fees Schedule
2017-2018

Description	Rate	FY 2017 Fees	FY 2018 Fees
County Council			
Audio CD	Per Event	$5.00	$5.00
Delinquent Tax Collector			
Administrative Fee		$10.00	$10.00
GIS			
Custom Production - Billed in 1/2 Hour Increments	Per Hour	$35.00	*$35.00*
Roads Directory - Microsoft Access Database CD	Per CD	$20.00	$20.00
Custom Scan and Prints	Per Hour	$35.00	$35.00
GIS A - 8.5 X 11		$3.00	$3.00
GIS B - 11 X 17		$5.00	$5.00
GIS C - 18 X 24		$6.00	$6.00
GIS D - 24 X 36		$8.00	$8.00
GIS E - 36 X 48		$10.00	$10.00
GIS A - 8.5 X 11 (aerial Imagery) New for 2016		$6.00	$6.00
GIS B - 11 X 14 (aerial Imagery) New for 2016		$10.00	$10.00
GIS B - 11 X 17 (aerial Imagery) New for 2016		$10.00	$10.00
GIS C - 18 X 24 (aerial Imagery) New for 2016		$12.00	$12.00
GIS D - 24 X 36 (aerial Imagery) New for 2016		$14.00	$14.00
GIS E - 36 X 48 (aerial Imagery) New for 2016		$16.00	$16.00
Tax Map Grid with Roads		$3.00	$3.00
Voting Precincts and Council Districts		$3.00	$3.00
Library			
Overdue Fines			
Books, Magazines, or Music CD's - Up to a Maximum of $2.00 Per Book, Magazine, or Music CD	Per Day	$0.10	$0.10
Videos and DVD's - Up to a Maximum of $6.00 Per Item	Per Day	$1.00	$1.00
Items Borrowed Through Inter-Library Loan	Per Day, Per Item	$0.50	$0.50
Miscellaneous			
Lost Materials - Books, CD's, Videos, etc.		original price of item	original price of item
South Carolina Room Research (By Mail or E-Mail)		$5.00 + price of photocopies	$5.00 + price of photocopies
Lost Library Cards		$2.00	$2.00
Black and White Prints		$0.15	$0.15
Color Prints		$0.50	$0.50
Out of County Card	Annually *	$50.00	$50.00
** Not charged to patrons from Anderson and Pickens Counties who are in good standing*			
Assessor			
Custom Production - Billed in 1/2 Hour Increments	Per Hour	$35.00	$35.00
Roads Directory - Microsoft Access Database CD	Per CD	$20.00	$20.00
Custom Scan and Prints	Per Hour	$35.00	$35.00
GIS A - 8.5 X 11		$3.00	$3.00
GIS B - 11 X 17		$5.00	$5.00
GIS C - 18 X 24		$6.00	$6.00
GIS D - 24 X 36		$8.00	$8.00
GIS E - 36 X 48		$10.00	$10.00
GIS A - 8.5 X 11 (aerial Imagery) New for 2016		$6.00	$6.00
GIS B - 11 X 14 (aerial Imagery) New for 2016		$10.00	$10.00
GIS B - 11 X 17 (aerial Imagery) New for 2016		$10.00	$10.00
GIS C - 18 X 24 (aerial Imagery) New for 2016		$12.00	$12.00
GIS D - 24 X 36 (aerial Imagery) New for 2016		$14.00	$14.00
GIS E - 36 X 48 (aerial Imagery) New for 2016		$16.00	$16.00
Tax Map Grid with Roads		$3.00	$3.00
Voting Precincts and Council Districts		$3.00	$3.00

Oconee County, South Carolina
Fees Schedule
2017-2018

Description	Rate	FY 2017 Fees	FY 2018 Fees
Parks, Recreation and Tourism			
Admission Fees (All Parks)			
Daily Parking	Per Vehicle	$2.00	$2.00
Daily Parking	Per Boat and Trailer	$5.00	$5.00
Annual Pass - Calendar Year (Oconee County Residents)		$25.00	$25.00
Annual Pass - Calendar Year - Discounted for Senior Citizen (62+ Years Old), Legally Disabled, and Veterans		$15.00	$15.00
Annual Pass - Calendar Year - Out of County, South Carolina Residents		$50.00	$50.00
Annual Pass - Calendar Year - Discounted for Senior Citizen (62+ Years Old), Legally Disabled, and Veterans		$40.00	$40.00
Camping (All Parks)			
Oconee County Resident	Per Night	$20.00	$20.00
Non-Resident	Per Night	$25.00	$25.00
Waterfront Site - Oconee County Resident	Per Night	$25.00	$25.00
Waterfront Site - Non-Resident	Per Night	$30.00	$30.00
Winter Camping Rate (November 1 - February 28)	Per Night	$15.00	$15.00
All campers must have current license plates.			
No site may be occupied for more than thirty (30) days.			
Building Reservations (All Parks)			
A security deposit is required, but refundable if facility and area left clean.			
Recreation Building - 1 to 50 People	1/2 Day	$50.00	$50.00
Recreation Building - 51 to 100 People	1/2 Day	$100.00	$100.00
Recreation Building - 101 to 150 People	1/2 Day	$150.00	$150.00
Recreation Building - 151 to 200 People	1/2 Day	$175.00	$175.00
Recreation Building - 201 to 300 People	1/2 Day	$275.00	$275.00
Recreation Building - 301 or More People	Full Day Only	$450.00	$450.00
Picnic Shelters			
Chau Ram Park			
PiShelter #1 - Maximum Number of 36 People	1/2 Day	$30.00	$30.00
Shelter #2 - Maximum Number of 36 People	1/2 Day	$30.00	$30.00
Shelter #3 - Maximum Number of 12 People	1/2 Day	$20.00	$20.00
Gazebo #1 - Maximum Number of 12 People	1/2 Day	$20.00	$20.00
Gazebo #2 - Maximum Number of 12 People	1/2 Day	$20.00	$20.00
South Cove Park			
Pavilion	1/2 Day	$50.00	$50.00
High Falls Park			
Shelters - 1 to 50 People	1/2 Day	$30.00	$30.00
Shelters - 51 to 75 People	1/2 Day	$40.00	$40.00
Shelters - 76 to 100 People	1/2 Day	$60.00	$60.00
Shelters - 101 to 150 People	1/2 Day	$80.00	$80.00
Weddings and Rehearsals			
Weddings	1/2 Day	$250.00	$250.00
Weddings	Full Day	$500.00	$500.00
Rehearsal Dinners and Receptions (For Off-Site Weddings)			
Less Than 100 People	1/2 Day	$100.00	$100.00
Less Than 100 People	Full Day	$200.00	$200.00
101 or More People		see recreation building rates	
Miscellaneous			
Tennis	Per Hour to Reserve	$5.00	$5.00
Miniature Golf	Per Game	$3.00	$3.00
Softball Field	Per Hour to Reserve	$5.00	$5.00
Volleyball	Per Hour to Reserve	$5.00	$5.00

Oconee County, South Carolina
Fees Schedule
2017-2018

Description	Rate	FY 2017 Fees	FY 2018 Fees
Probate			
Estate and Conservatorship Fees *In estate and conservatorship proceedings, the fee shall be based upon the gross value of*			
(1) Property Valuation Less Than $5,000		$25.00	$25.00
(2) Property Valuation of $5,000.00 But Less Than $20,000		$45.00	$45.00
(3) Property Valuation of $20,000.00 But Less Than $60,000		$67.50	$67.50
(4) Property Valuation of $60,000.00 But Less Than $100,000		$95.00	$95.00
(5) Property Valuation of $100,000.00 But Less Than $600,000		$95.00 + 0.15 of one percent of the property valuation between $100,000 and $600,000	$95.00 + 0.15 of one percent of the property valuation between $100,000 and $600,000
(6) Property Valuation of $600,000.00 or Higher Amount		Set forth in item (5) above + 0.25 of one percent of the property valuation above $600,000	Set forth in item (5) above + 0.25 of one percent of the property valuation above $600,000
Filing Affidavit for Collection of Personal Property Under Section 62-3-1201, the Fee Pursuant to Items (1) Through (6) Above Based Upon Property Valuation Shown		See items (1) through (6) above	See items (1) through (6) above
Filing Affidavit for Collection of Personal Property Where the Property Valuation Is Less Than $100.00		$12.50	$12.50
Filing Initial Petition In Any Action or Proceeding Other Than Items (1) Through (6) Above, Same Fee as Charged for Filing Civil Actions In Circuit Court		$150.00	$150.00
Issuing Certified Copy		$5.00 + $0.25 per page copy fee	$5.00 + $0.25 per page copy fee
Issuing Exemplified/Authenticated Copy		$20.00	$20.00
Filing Demands for Notice		$5.00	$5.00
Filing Conservatorship Accountings		$10.00	$10.00
Filing Conservatorship Orders		$5.00	$5.00
Recording Authenticated or Certified Record		$20.00	$20.00
Reopening Closed Estates		$22.50	$22.50
Appointment of Special, Temporary or Successor Personal Representative		$22.50	$22.50
Filing and Indexing Will Under Section 62-2-901		$10.00	$10.00
Certifying Appeal Record		$10.00	$10.00
Marriage Fees			
Marriage License - Domestic Violence Fund Fee/Each Marriage Application (State)		$20.00	$20.00
Marriage Ceremony Fee - Oconee County Resident		$10.00	$10.00
Marriage Ceremony Fee - Out of County Resident		$25.00	$25.00
Marriage License Fee - (Total Cost) - Oconee County Resident		$30.00	$30.00
Marriage License Fee - (Total Cost) - Out of County Resident		$45.00	$45.00
Certified Copy of Marriage License		$5.00	$5.00
Filing Marriage License Affidavit		$1.00	$1.00
Reforming or Correcting Marriage Record		$6.75	$6.75
Issuing Duplicate Marriage License		$6.75	$6.75
Newspaper Advertisement Fees			
Keowee Courier/Westminster News		$25.00	$25.00
Daily Journal		$75.00	$75.00
Notice to Creditor - Daily Journal			$20.00
Notice to Creditor - Keowee Courier/Westminster News			$20.00

Oconee County, South Carolina
Fees Schedule
2017-2018

Description	Rate	FY 2017 Fees	FY 2018 Fees
Register of Deeds			
Deeds and Mortgages		$10.00 more than 4 pages $1.00 per additional	$10.00 more than 4 pages $1.00 per additional
Deed Stamps		$3.70 per $1,000 rounded up to next $500	$3.70 per $1,000 rounded up to next $500
Instrument Which Assigns, Transfers, or Releases Real Estate Mortgage		$6.00 for first page $1.00 for each additional	$6.00 for first page $1.00 for each additional
Affidavit of Missing Assignment		$10.00	$10.00
Lease, Contract of Sale, or Trust Indenture		$10.00 more than 4 pages $1.00 per additional	$10.00 more than 4 pages $1.00 per additional
Satisfaction of Real Estate Mortgage		$5.00	$5.00
Plat Larger Than 8.5 X 14		$10.00	$10.00
Plat of "Legal Size" Dimensions or Smaller		$5.00	$5.00
Plats Larger Than 17 X 24		$20.00	$20.00
Any Other Paper Affecting Title or Possession of Real Estate or Personal Property and Required by Law To Be Recorded, Except Judicial Records		$10.00 more than 4 pages $1.00 per additional	$10.00 more than 4 pages $1.00 per additional
Power of Attorney, Trustee Qualification, or Other Appointment		$15.00 more that 4 pages $1.00 per additional	$15.00 more that 4 pages $1.00 per additional
Mechanics Liens		$10.00 more than 4 pages $1.00 per additional	$10.00 more than 4 pages $1.00 per additional
Cancellation of Mechanics Lien		$5.00	$5.00
Uniform Commercial Code (UCC) Financing Statement Filing - UCC1 or UCC3		$8.00; more than 2 pages $10.00; more than two debtors $10.00; each additional debtor more than two $2.00; continuations $8.00; amendments $8.00;assignments $8.00; partial release $8.00	$8.00; more than 2 pages $10.00; more than two debtors $10.00; each additional debtor more than two $2.00; continuations $8.00; amendments $8.00;assignments $8.00; partial release $8.00
Public Finance Transaction and Manufactured Home Transactions		$20.00	$20.00
Copies Mailed $1.00 to Certify		$5.00 for 4 pages then $.25 per additional page	$5.00 for 4 pages then $.25 per additional page
Copies - 8.5 X 11	Per Page	$0.25	$0.25
Copies - 8.5 X 14	Per Page	$0.25	$0.25
Copies - 11 X 17	Per Page	$0.50	$0.50
Roads and Bridges			
Sign Fee - Municipalities		materials cost	materials cost
Sign Fee - Other		2.5 times the materials cost	2.5 times the materials cost
Encroachment Fee - Residential/Commercial		$60.00	$60.00
Encroachment Fee - Pavement Cut Fee (Contractor Only)		$250.00 + $10.00 per sq. ft.	$250.00 + $10.00 per sq. ft.
Encroachment Fee - Permit Extension		$10.00	$10.00
Encroachment Fee - Re-Inspection		$60.00	$60.00
Encroachment Fee - Longitudinal Work in ROW		$60.00 + $0.10 per linear ft.	$60.00 + $0.10 per linear ft.
Encroachment Fee - Annual Blanket Permit		$1,000.00	$1,000.00
Road Inspection Fee		$1.50 per foot minimum $600	$1.50 per foot minimum $600
Storm Water Fees		2.5 times the materials cost	2.5 times the materials cost

Oconee County, South Carolina
Fees Schedule
2017-2018

Description	Rate	FY 2017 Fees	FY 2018 Fees
Rock Quarry			
# 1 Crusher Run 1 1/2"		$9.50	$10.10
# 2 Crusher Run (Sap Rock)		$7.75	$8.35
# 3 Surge 2" x 3"		$11.75	$12.35
# 4 Screenings		$5.00	$5.60
# 5 57: 1"		$11.50	$12.10
# 6 789: 3/8" x 1/2"		$11.00	$11.60
# 7 Class A Rip Rap 4" x 8"		$13.25	$13.85
# 8 Class B Rip Rap 9" x 15"		$13.50	$14.10
# 9 Asphalt Sand		$8.75	$9.35
#13 Class E Rip Rap (Boulders Larger than 27")		$18.75	$19.35
#14 Flat Boulders		$21.75	$22.35
#15 Class C Rip Rap 15" x 21"		$13.75	$14.35
#16 Class D Rip Rap 21 1/2" x 27"		$14.00	$14.60
#17 Dirt Sales per Ton **(New)**		$0.00	**$0.50**
Sheriff			
Civil Fees			
Mechanics Liens	Each	$10.00	$10.00
Subpoenas	Each	$10.00	$10.00
Foreclosures	Each	$25.00	$25.00
Judgments	Each	$25.00	$25.00
Writs	Each	$25.00	$25.00
Trespass Notice	Each	$15.00	$15.00
Other	Each	$15.00	$15.00
Miscellaneous			
Incident Reports	Each	$2.00	$2.00
Record Check	Each	$5.00	$5.00
Executions	Each	$25.00	$25.00
Solid Waste			
MSW Transfer Station Tipping Fee	Per Ton	$48.00	$48.00
C and D Landfill Tipping Fee (Rate was last set in 1998.)	Per Ton	$30.00	$30.00
Mulch	Per Scoop	$10.60	$10.60
Solicitor			
Worthless Check Fee		$50 for checks up to $500; $100 dollars for checks $500 to $1000 and $150 for checks $1000 or greater	$50 for checks up to $500; $100 dollars for checks $500 to $1000 and $150 for checks $1000 or greater
Treasurer			
Decal Fee	Each	$1.00	$1.00
Bad Check Fee	Each	$30.00	$30.00
Replacement Check Fee	Each	$30.00	$30.00

PLANNED ADMINISTRATORS, INC.
ADMINISTRATIVE SERVICES ONLY (ASO) AGREEMENT

This Agreement, dated this 1st day of May 2017, effective for the Administrative Service Period of 12 months beginning May 1, 2017 and ending April 30, 2018 is entered into by and among the Plan Sponsor/Administrator, Oconee County, and the Plan Supervisor, Planned Administrators, Inc. ("PAI").

WITNESSETH:

Whereas, The Plan Sponsor/Administrator identified above has adopted an Employee Health and Welfare Benefit Plan known as the Oconee County Employee Health and Welfare Benefit Plan ("Plan"), which is set forth in the Plan Document, for certain employees and their dependents (hereinafter referred to as "covered persons"); and

Whereas, PAI has been designated by the Plan Sponsor/Administrator as the Third Party Administrator (TPA) to provide administration and claims services for the establishment and operation of the Plan; and

Whereas, the Plan Sponsor/Administrator has requested that PAI perform the services that are specified in the Agreement and PAI has agreed to do same upon the terms and conditions hereinafter set forth.

Now therefore, in consideration of the mutual promises and covenants contained herein, it is hereby agreed as follows:

SECTION 1. ADMINISTRATIVE SERVICES

1.1 To the extent specified in Exhibits A, B, C & D attached hereto, PAI shall provide the services for, and shall assist the Plan Sponsor/Administrator in, the administration of the Plan.

1.2 PAI shall follow the terms and provisions of the Plan Document in accordance with the Plan Sponsor/Administrator's intent and directions in carrying out the terms and purposes of this Agreement.

1.3 To the extent set forth in Exhibits A, B, C & D, PAI shall assist the Plan Sponsor/Administrator in the preparation of any report, or similar papers, required by a state or federal authority, for the Plan.

SECTION 2. PLAN SPONSOR/ADMINISTRATOR OBLIGATIONS

2.1 It is understood that the effective performance of all obligations hereunder by PAI will require that the Plan Sponsor/Administrator furnish to PAI certain timely reports and information in a form and manner specified by PAI, and such shall be as follows:

A. Previous Plan Document and Health Insurance Contract;

B. Plan Summary Booklet;

C. Copy of previous Carrier's billing for month preceding the effective date of coverage of the new Plan;

D. Complete, legible, and accurate enrollment forms on all covered employees and timely submission of Employee Data Change Forms and Health Questionnaires when appropriate;

E. Any and all necessary information regarding any Excess Loss (Stop Loss) Insurance ("Excess Loss (Stop Loss) Insurance" means the insurance procured by the Plan Sponsor/Administrator that insures against claims made in excess of certain amounts); and

F. Other information or documentation as may be required from time to time, within 30 days of request.

If applicable, items A through C shall be delivered to PAI within 15 days of the effective date of this Agreement. Item D shall be delivered to PAI no later than the 20th of each month for enrollments, changes, and questionnaires completed during the prior calendar month.

2.2 PAI shall not be responsible for delay in the performance of the claim and administrative and billing services caused by failure of the Plan Sponsor/Administrator to furnish any required information on a timely basis.

Form Rev.4/25/2017

2.3 The Plan Sponsor/Administrator shall comply with all requirements of the Employee Retirement Income Security Act of 1974 and any other laws and regulations covering self-funded employee benefits programs.

2.4 The Plan Sponsor/Administrator shall be responsible for determining which covered persons are eligible for benefits under the Plan and shall certify this eligibility to PAI. Eligibility determinations shall be made by the Plan Sponsor/Administrator in compliance with the terms of the Plan Document. The Plan Sponsor/Administrator is responsible for ensuring that any member (employees or employees' dependents who Plan Sponsor/Administrator determines are eligible to participate in the Plan and who have elected to participate in the Plan) coverage rescissions reported to PAI are due to fraud, intentional misrepresentation of material fact or non-payment of premium contribution amounts. Any member notices required by law due to rescissions of coverage are also the Plan Sponsor/Administrator's responsibility. The Plan Sponsor/Administrator is responsible for reconciling its employment records to the lists of covered employees on PAI's monthly invoices, and reporting any discrepancies to PAI.

2.5 The Plan Sponsor/Administrator shall open and maintain a separate checking account at the bank of its choice, from which claims payments will be issued. The Plan Sponsor/Administrator shall provide PAI with bank account documentation, i.e. signature card, MICR encoded bank specifications sheet. Claims checks will be issued from this account on a twice-weekly basis. The Plan Sponsor/Administrator shall be responsible for timely deposit of sufficient funds for claims checks to be mailed two business days following the date of the check issuance (check date). Escheat/Unclaimed Funds reporting and compliance shall be the responsibility of the Plan Sponsor/Administrator.

2.6 The Plan Sponsor/Administrator is responsible for timely payment of all premiums for any insurance purchased by or for the benefit of the Plan. The Plan Sponsor/Administrator has the final authority to decide the insurance company(s) that will provide any such insurance.

2.7 If the Plan Sponsor/Administrator purchases COBRA services from PAI, Plan Sponsor/Administrator shall:

A. Complete a COBRA initial notification form (which shall be provided by PAI or its designee within ninety (90) days of any new employees and within thirty (30) days of a member's Qualifying Event (as defined in the Plan Document);

B. Determine the amount of contributions required for COBRA continuation coverage and notify PAI or its designee of such amount;

C. Inform PAI or its designee of continuation rights, by use of the COBRA notification form or other electronic means upon the occurrence of a Qualifying Event;

D. Notify PAI or its designee upon receipt of notification of any second Qualifying Event.

If the Plan Sponsor/Administrator does not purchase COBRA services from PAI, then this section is not applicable.

2.8 Internal Revenue Code Section 125 Plan ("125 Plan") Services: If applicable and if the Plan Sponsor/Administrator purchases 125 Plan Services from PAI, then the Plan Sponsor/Administrator shall:

A. Sponsor and encourage employee support of the 125 Plan.

B. Provide PAI or its designee (in a format reasonably acceptable to PAI or its designee) any necessary employee payroll, census, benefit information and any other information reasonably requested from time to time by PAI or its designee.

C. Be responsible for creation of any 125 Plan documents.

D. At all times be responsible for contributions to the 125 Plan and funds held by the 125 Plan.

E. Report participant terminations and changes of family status to PAI or its designee.

F. Reconcile payroll amounts redirected to the 125 Plan.

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G. Complete and file form(s) 5500 with the IRS each plan year.

H. Initiate any action required in the event 125 Plan becomes discriminatory.

I. Distribute funds according to the requirements of the 125 Plan and PAI's or its designee's direction.

If the Plan Sponsor/Administrator does not purchase 125 Plan Services from PAI, then this section is not applicable.

2.9 Summary of Benefits and Coverage (SBC): The Plan Sponsor/Administrator agrees:

A. To promptly provide to PAI the information necessary to complete the SBC;

B. There is an understanding and agreement that the Plan Sponsor/Administrator's failure to provide information in a timely manner may substantially delay and/or jeopardize the timely delivery of the SBC;

C. To distribute the SBC required under the Patient Protection and Affordable Care Act (PPACA) to members;

D. To ensure that electronic access shall be restricted to a "read-only" or similar basis;

E. To replace any hard-copy SBC that is modified by PAI;

F. That the hard-copy SBC on file with PAI shall control in the event of any discrepancy; and

G. That the Plan Sponsor/Administrator remains solely responsible for the content of the SBC and all other legal requirements related to the SBC. To the extent that PAI incurs any liability as a result of the preparation or distribution of the SBCs to Plan Sponsor/Administrator's members, Plan Sponsor/Administrator shall fully indemnify PAI.

SECTION 3. PAYMENTS

3.1 **Monthly Billing** - Monthly billings reflecting Fixed Costs (all Plan Costs except Claim Costs) will be provided to the Plan Sponsor/Administrator to arrive approximately seven (7) calendar days prior to the first day of the month in which it is due. This bill will reflect all written changes received by PAI prior to the 10th day of the previous month. Payment is due on the 1st day of each month, and will be delinquent if not received prior to the 10th. All claims adjudication will be curtailed on delinquent accounts until such time as the account is brought current. If payment is not received within 30 days following the due date, PAI Administrative and Claims Services may be cancelled. If life insurance premiums are included on the billing, that coverage will also be cancelled. The Plan Sponsor/Administrator is required to pay as billed and accept reasonable or appropriate retroactive additions or terminations, if applicable, on the subsequent month's billing.

3.2 If during the operation of the Plan, any tax (other than state or federal income taxes), or any other assessment or premium charge shall be assessed against the Plan, or if PAI is required to pay such tax, PAI shall report the payment to the Plan Sponsor/Administrator and the Plan Sponsor/Administrator shall reimburse PAI for the same, to exclude any expenses or taxes that are not appropriately allocable to the operation of the Plan.

3.3 In addition to monthly administrative, claims, and handling fees, the Plan Sponsor/Administrator shall pay PAI additional charges for any special request items or services not specifically covered in Exhibits A, B, C & D. Such items may be:

A. Printing and supplies expenses incurred after exhausting the supplies provided under the initial set-up fee for Plan inserts, Plan Document changes, ID cards, etc.;

B. Special statistical reports other than customary or annual reports, (See Exhibit B, paragraph F). Unusual or extraordinary expenses for services or support that PAI and the Plan Sponsor/Administrator mutually agreed upon.

3.4 All charges incurred as a result of paragraph 3.3 will be submitted for payment on the next Plan monthly billing statement and subject to payment in full with that billing remittance.

3.5 All charges incurred for services to be rendered for an administrative run-out of claims at termination of a contract will be billed and remitted as set forth in Section 9, Termination of Agreement, paragraph 9.5.

3.6 PAI has the right to change the monthly Fixed Costs charges, in the following circumstances. PAI will, to the extent possible, give the Plan Sponsor/Administrator no less than thirty (30) days advance written notice of the change. The portion of the Fixed Costs representing policy premiums (if any) may be changed at any time the policy premiums are changed by the insurer(s). The administrative service fees of PAI may be changed once every twelve months. PAI may also change the administrative service fees (1) on the date a substantive change is made to the Plan which increases the responsibilities of PAI or (2) on the date the number of employees covered by the Plan has changed by 25% or more since the date the then current administrative services fees were effective. If Fixed Costs charges change during the term of this Agreement, an amended Schedule D will be prepared, agreed upon and initialed by both parties to the Agreement.

SECTION 4. MISCELLANEOUS PROVISIONS

4.1 PAI in performing its obligations under this Agreement is acting only as an agent of the Plan Sponsor/Administrator. For the purposes of the Employee Retirement Income Security Act of 1974, as amended from time to time, and any applicable state legislation of similar nature, the Sponsor shall be the Administrator of the Plan, unless the Sponsor by action of its Board of Directors designates an individual or committee to act as Administrator. In no instance shall PAI be deemed to be, or be, the Sponsor or the Administrator of the Plan for purposes of the Employee Retirement Income Security Act of 1974, as amended from time to time. Both parties acknowledge and agree that all documents and records generated by PAI in performance of its obligations under this Agreement are owned by the Plan Sponsor/Administrator, and that PAI serves as the custodian of such documents and records on behalf of the Plan Sponsor/Administrator.

4.2 PAI shall not be liable, nor advance its funds, for the payment of claims under the Plan or insurance or other premiums or monies owed to other providers of goods or services that are the responsibility of the Plan Sponsor/Administrator. PAI shall not be considered the Insurer or Underwriter of the liability of the Plan Sponsor/Administrator to provide benefits for the Plan's covered persons and the Plan Sponsor/Administrator shall have final responsibility and liability for payment of claims in accordance with the provisions of the Plan.

4.3 To the extent permitted pursuant to applicable law, the Plan Sponsor/Administrator agrees to defend, indemnify and hold harmless PAI from any and all claims, lawsuits, settlements, judgments, costs, penalties, liabilities and expenses ("Damages"), including a reasonable attorneys' fee (for attorneys chosen by PAI), resulting from, or related to any third party claim relating to this Agreement or the Plan Sponsor/Administrator's Plan or the Plan Document unless such Damages are the direct consequence of criminal conduct, fraud, or willful misconduct on the part of PAI. The Plan Sponsor/Administrator agrees to hold PAI harmless for any claims amounts that are not reimbursed by any Excess Loss (Stop Loss) carrier, provided that PAI has processed the claims pursuant Section 8.

4.4 PAI agrees to indemnify and hold harmless the Plan Sponsor/Administrator from any and all claims, lawsuits, settlements, judgments, costs, penalties, liabilities and expenses, including a reasonable attorney's fee (for attorneys chosen by The Plan Sponsor/Administrator), arising out of or related to the Plan, Plan Document or this Agreement, but only if resulting from PAI's criminal conduct, fraud, or willful misconduct.

4.5 The Plan Sponsor/Administrator also recognizes and agrees that Plan Sponsor/Administrator's failure to adhere to the check release process as outlined in Section 4.10, or Plan Sponsor/Administrator's failure to pay the Administrative Fee due to PAI under this Agreement, may result in PAI incurring significant costs and has the potential to result in a delay in the release of the claims checks, Provider Vouchers and Explanation of Benefits Statements beyond the time frames for such release as set forth in the U.S. Department of Labor claims regulations. In the event that the Plan Sponsor/Administrator delays the release of any claims checks, or fails to pay the Administrative Fee, PAI will be entitled to indemnification for any and all claims, lawsuits, settlements, judgments, costs, penalties, liabilities and expenses, including attorneys' fees (for attorneys chosen by PAI), resulting from, or arising out of, based on, or in connection with such delay or non-payment.

4.6 PAI may secure the services of actuaries, computer service firms and any other firms it deems necessary in

performing its duties under this Agreement.

4.7 Both parties acknowledge and agree that pursuant to this Agreement, PAI is an independent contractor under South Carolina State law. Personnel performing services under this Agreement will remain employees of their respective parties and no such employee of either party shall be considered in any way to be an agent, officer, representative, or employee of the other party, or have binding authority as an agent, officer, representative, or employee of the other party.

4.8 A. If PAI becomes aware of an excess payment or overpayment made under the Plan in excess of $50.00, PAI shall use its standard overpayment collection processes and procedures to attempt to recover any overpayment; PAI will not attempt to recover overpayments in the amount of $50.00 or less. PAI's services for its standard overpayment collection processes are included in the Administrative Charge. In the event PAI uses the services of a Medical Provider Audit Firm ("MPAF"), the fee for such MPAF services shall be based on a percentage of the amount recovered and is listed on Exhibit D. PAI, in its sole discretion, shall settle and resolve overpayments on any basis it determines is reasonable (provided that PAI may only pursue litigation in accordance with this Section 4.8), including payment of less than the entire overpayment amount. Notwithstanding the foregoing, PAI is not required to initiate court proceedings to comply with this Section 4.8; however, if PAI determines that litigation is necessary to collect the overpayment, PAI will notify Plan Sponsor/Administrator, and Plan Sponsor/Administrator will be solely responsible for the decision to pursue litigation and funding all litigation costs and expenses, including attorney's fees; PAI shall deliver any related files to the Plan Sponsor/Administrator for the Plan Sponsor/Administrator to pursue such amount. PAI shall notify the Plan Sponsor/Administrator whenever attempted recovery of overpayments is unsuccessful, and the Plan Sponsor/Administrator shall hold PAI harmless for any overpayment not recovered.

B. If PAI becomes aware of a subrogation claim in excess of $50.00, PAI shall use its standard processes and procedures to attempt to recover the subrogation claim; PAI will not attempt to recover overpayments in the amount of $50.00 or less. PAI shall charge an additional fee based on a percentage of the subrogation amount recovered (hereinafter the "Subrogation Fee"). The Subrogation Fee is listed on Exhibit D and is not included in the Administrative Charge or any other fee described herein. PAI, in its sole discretion, shall settle and resolve all such claims on any basis it determines as reasonable, including collection of less than the entire amount of such claim and contributions to the Member's attorney's fees. Notwithstanding the foregoing, PAI is not required to initiate court proceedings to comply with this Section 4.8. In the event PAI determines litigation is necessary to recover a subrogation claim, PAI will notify Plan Sponsor/Administrator, and Plan Sponsor/Administrator will be solely responsible for the decision to pursue litigation and funding all litigation costs and expenses, including attorney's fees; PAI shall deliver any related files to the Plan Sponsor/Administrator, for the Plan Sponsor/Administrator to pursue such amount. PAI shall notify the Plan Sponsor/Administrator whenever attempted recovery of subrogation claims is unsuccessful, and the Plan Sponsor/Administrator shall hold PAI harmless for any subrogation claim not recovered. If the Plan Sponsor/Administrator separately contracts with an outside vendor for subrogation services, references to subrogation recovery in this paragraph are not applicable.

4.9 The Plan Sponsor/Administrator acknowledges that PAI may receive rebates and/or other amounts ("credits") from drug manufacturers and/or through a Pharmacy Benefit Manager ("PBM"). These financial credits are paid directly from drug manufacturers or from other providers through the PBM. Except as otherwise provided herein, credits are not payable to the Plan Sponsor/Administrator or members and will be retained by PAI to help stabilize overall rates and to offset expenses. Amounts paid to pharmacies, or discounted prices charged at pharmacies, are not affected by these credits. Any coinsurance that a member must pay for prescription drugs is based upon the allowable charge at the pharmacy, and does not change due to receipt of any credit by PAI. Copayments are not affected by any credit. Pharmacy rates may vary and the proposed retail rates do not necessarily reflect the actual contracted rate between the PBM and the pharmacy chain. The Plan Sponsor/Administrator acknowledges that the amount paid to the pharmacy may not be equal to the amount billed to the Plan Sponsor/Administrator. If the Plan Sponsor/Administrator independently contracts with a Pharmacy Benefit Manager that does not electronically exchange member level claims data with PAI, then PAI is not responsible for (1) integrating pharmaceutical claims payment information into members' maximum out-of-

pocket accumulators, or (2) inclusion of pharmaceutical claims payment information in stop loss claims submissions for reimbursement. This section does not apply if Plan Sponsor/Administrator does not offer coverage for prescription drugs as part of its Plan Document or if the Plan Sponsor/Administrator has separately contracted with a PBM. If the Plan Sponsor/Administrator has separately contracted with a PBM, PAI shall be entitled to rely on any information provided to it by the Plan Sponsor/Administrator's PBM vendor. PAI shall base certain eligibility, coverage and other determinations in the performance of its responsibilities under this Agreement in reliance on the information so provided, and shall not be required to confirm or verify the accuracy, authenticity or completeness of any information so provided. PAI shall not be liable for any damages that may result from its reliance on and/or utilization of inaccurate or incomplete information received from the Plan Sponsor/Administrator's PBM vendor.

4.10 The Plan Sponsor/Administrator agrees to operate under the prescribed procedures for auto-release of their claims checks. Checks will be mailed two business days after the date of the checks. Failure of the Plan Sponsor/Administrator to comply with prescribed auto-release procedures may result in immediate placement of claims processing on administrative hold.

4.11 PAI shall not be bound by any notice, or directive or request unless and until it is received in writing at its office in Columbia, South Carolina, addressed to Planned Administrators, Inc., Post Office Box 6927, Columbia, South Carolina 29260.

4.12 This Agreement, including any attached Exhibit, Schedule, Attachment or Supplement, contains the entire agreement between the parties with respect to the subject matter hereof and it supersedes all prior oral or written agreements, commitments or understandings with respect to such matters. Unless otherwise provided in this Agreement, no modification or waiver of any of the provisions, or any future representation, promise, or addition, shall be binding upon the parties unless made in writing and signed by both parties.

SECTION 5. LAWS GOVERNING AGREEMENT

This Agreement shall be construed and enforced according to the laws of the State of South Carolina, except to the extent such laws are preempted by the Employee Retirement Income Security Act of 1974 and any other federal law in which such federal law shall apply.

SECTION 6. AGREEMENT COUNTERPARTS

This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, and said counterpart shall constitute but one of the same instrument.

SECTION 7. MODIFICATION OF AGREEMENT

This Agreement and any attachments thereto constitute the entire Agreement between the parties. Changes in the Agreement or in any attachments must be mutually agreed to, in writing, signed and delivered to the respective parties.

SECTION 8. TIME LIMIT FOR FILING CLAIMS

8.1 It is understood that the Plan Sponsor/Administrator has implemented a self-funded health benefit plan and that all provisions of the Plan must be described in a Plan Document.

8.2 The Plan Sponsor/Administrator understands that if it purchases Excess Loss (Stop Loss) coverage to reimburse it for some losses sustained under the Plan, the coverage contract will contain a time limit within which covered and complete claims must be filed by persons covered under the Plan in order for the loss to be reimbursable to the Plan Sponsor/Administrator.

8.3 It is understood that the Plan Sponsor/Administrator is responsible for the Plan Document and for all provisions in the Plan Document including, but not limited to, a description of any time limits within which complete claims must be filed. It is understood, further, that if the Plan Document provides for a longer time period to pay claims than the Excess Loss (Stop Loss) coverage provides, there could be claims payable under the Plan which will not be reimbursed by the Excess Loss (Stop Loss) contract, which otherwise might have been reimbursable. In all

cases where claims are submitted to PAI for payment, PAI is responsible for processing and presenting claims for payment to the Plan Sponsor/Administrator in a time and manner as specified in Exhibit B, and within a reasonable timeframe to secure reimbursement under the Excess Loss (Stop Loss) contract. If PAI receives a claim after the deadline for reimbursement under the Excess Loss (Stop Loss) contract, PAI will promptly notify the Plan Sponsor/Administrator. PAI will not disrupt the standard flow of the adjudication process, but will follow its standard processing procedures.

Claims must be filed with PAI within the time requirements as set forth in the Plan Document, unless it was not reasonably possible to do so. PAI will determine if enough information has been submitted to enable proper consideration of the claim.

8.4 For purposes of claims processing, a complete claim is one that includes all information necessary for PAI to properly adjudicate the claim. If PAI receives incomplete claims or if the claim is considered incomplete due to any other information being needed, PAI will request the needed information and the Plan Sponsor/Administrator shall be notified in writing, via a monthly "LPR-Claim Letter Listing" report, which informs the Plan Sponsor/Administrator about any claims received by PAI that are pending additional information. This report provides information regarding all letters PAI has sent out to subscribers on behalf of the Plan Sponsor/Administrator, requesting additional information necessary to complete the adjudication of the claim in question. PAI will use reasonable means to secure the information needed for the incomplete claim to become complete. It is ultimately, however, the responsibility of the Plan Sponsor/Administrator to secure any information needed by PAI.

8.5 If PAI receives any claim which is incomplete, as described in paragraph 8.4 and the information needed to make the claim complete is not received within the claim filing and payment time limit in the Excess Loss (Stop Loss) contract, that claim if subsequently paid under the Plan may not be reimbursed to the Plan Sponsor/Administrator by the carrier providing the Excess Loss (Stop Loss) coverage.

SECTION 9. TERMINATION OF AGREEMENT

9.1 This Agreement may be terminated by either party by written notice of intention to terminate given to the other party, to be effective as of a certain date set forth in the written notice which shall not be less than thirty (30) days from the date of such notice. Failure by the Plan Sponsor/Administrator to render written notice of at least thirty (30) days will result in the equivalent of one month's administrative service fees being due to the Plan Supervisor, payable immediately. Failure of the Plan Sponsor/Administrator to remit said amount will void and invalidate any further obligation of PAI to furnish materials or data as outlined in Section 9, paragraph 9.5, item C.

9.2 This Agreement shall automatically terminate in the event of:

A. Bankruptcy or insolvency of the Plan Sponsor/Administrator or PAI;

B. Failure by the Plan Sponsor/Administrator to deliver to PAI on a timely basis the reports and information set forth in Section 2, paragraph 2.1;

C. Merger, sale or consolidation of Plan Sponsor/Administrator, unless the surviving entity, as new Plan Sponsor/Administrator, and PAI agree to continue this Agreement;

D. Merger, sale or consolidation of PAI, unless the surviving entity, as new Plan Supervisor, and Plan Sponsor/Administrator agree to continue this Agreement;

E. The enactment of any law or the promulgation of any regulation, which makes illegal the continuance of this Agreement or the performance of any obligations hereunder;

F. Failure of the Plan Sponsor/Administrator to deposit funds for the payment of claims within a two week time period from the date of the checks.

Provided, however, in the event of any termination of this Agreement pursuant to items A through F of this Section 9.2, such termination shall not occur and shall not be effective until the 15th day after the terminating party notifies the other party in writing that the Agreement is being terminated. As to items B and F above, there

shall be a right to cure the default during the first 7 days of this 15-day notice period.

9.3 In the event of termination of this Agreement, PAI shall complete the processing of all fully documented requests for claim payments under the Plan that were received by it and are due and payable prior to the termination of this Agreement, but it shall have no obligation:

A. To complete the processing of any such requests upon its determination that the Plan Sponsor/Administrator has failed to provide funds for the payment of benefits due;

B. To process requests for claim payments that were received by it after termination of this Agreement;

C. To process requests for claims payment for which full documentation does not arrive at PAI until after the termination of the Agreement;

D. To issue checks after the termination date for requests for claim payment relative to conditions existing on or after such date.

9.4 All checks issued by PAI, which are outstanding upon the termination of this Agreement or issued thereafter in accordance with Section 9, paragraph 9.3, shall continue to be the responsibility and liability of the Plan Sponsor/Administrator. The Plan Sponsor/Administrator shall continue to be responsible and liable for the payment of all benefits and expenses under the Plan after the termination of this Agreement.

9.5 Notwithstanding anything herein to the contrary, if the Agreement is terminated for any reason the following applies:

A. Termination of this Agreement will result in cessation of all administrative and claims services, upon the date of termination. However, when mutually agreeable the Plan Sponsor/Administrator can request an Administrative and Claims Service Agreement only, to allow for the orderly resolution of the incurred but not paid, pending claims (runout). This in no way will be construed as an extension of any insurance contracts that may exist. Such an agreement can be arranged for three months at a time (up to a total of 12 months), and the runout fees will be based on the administrative rates and number of enrollees on the invoice of the final month of the contract. The monthly runout fees will be determined at the time of contract termination. The monthly runout fees will be equal to 100% of the last contract month's administrative fees for the first three months, 50% of the last contract month's administrative fees for the fourth through sixth months, and 25% of the last contract month's administrative fees for the seventh through twelfth months. Any runout PPO network fees are not reduced quarterly in the same manner as the administrative fees. The runout fees will be payable in advance, unless otherwise agreed upon.

B. PAI will deliver to the Plan Sponsor/Administrator, for a standard end-of-contract reporting fee of $500.00, the following items after the termination of this Service Agreement:

1. The Plan year-end closing documentation;
2. A final accounting of all reimbursements made by the Excess Loss (Stop Loss) Carrier;
3. All unused check stock;
4. Copies of paperwork on outstanding reimbursements which was forwarded to Excess Loss (Stop Loss) Carrier;
5. Claims submitted but not processed;
6. All claims documentation and other materials utilized to process claims;
7. A listing of all deductible and out-of-pocket accumulations;
8. Any other documents or records for which PAI is responsible pursuant to the terms of this Agreement.

C. The delivery of those items in the paragraph above to the Plan Sponsor/Administrator or its representative will release PAI of all further administrative, legal, financial and consultative responsibility of any ongoing or future actions that may be taken by claimants or providers of services, etc.

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In Witness whereof, the Plan Sponsor/Administrator and PAI have executed this Agreement as of the day and year first above written.

For:	**OCONEE COUNTY**	For:	**PLANNED ADMINISTRATORS, INC. (PAI)**
By:	*(Signature)*	By:	*(Signature)*
Name:	T. Scott Moulder *(Print)*	Name:	PJ Rescigno *(Print)*
Title:	County Administrator	Title:	AVP Sales and Service
Date:	4/26/17 *(Please enter exact date signed.)*	Date:	*(Please enter exact date signed.)*

This Agreement shall be effective on the earlier of the Effective Date or, if Plan Sponsor/Administrator shall not return an executed copy prior to the Effective Date, the first date the Plan Sponsor/Administrator receives Services. If Plan Sponsor/Administrator has not returned an executed copy of this Agreement prior to the receipt of Services, then the version of this Agreement initially provided to the Plan Sponsor/Administrator shall control.

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EXHIBIT A

General Administrative Services

1. PAI will provide technical assistance, guidance and administrative support in the preparation for approval by the Plan Sponsor/Administrator of the following:
   A. Standard Plan Document with the Schedule of Benefits (Benefit Booklet);
   (If Plan Sponsor/Administrator has not returned an approved and executed copy of the Plan Document prior to the receipt of Services, then the version of the Plan Document initially provided to the Plan Sponsor/Administrator shall control.)
   B. Billing format;
   C. Checks for any bank account.
2. PAI will provide the following:
   A. Enrollment/Change Forms;
   B. Claim Forms (medical, dental, and disability);
   C. Health Questionnaires;
   D. Drug Forms;
   E. Monthly billing;
   F. Explanation of benefit forms (EOB);
   G. Standard PAI identification cards.
3. PAI may perform the marketing function to obtain quotes and coordinate the procurement process for any Stop Loss Insurance Contracts.
4. PAI will furnish information to the Plan Sponsor/Administrator necessary for the Plan Sponsor/Administrator to complete 5500 filings (if applicable), within the prescribed deadline of 120 days from end of Plan year. It is the Plan Sponsor/Administrator's responsibility to determine whether the Plan is required to file Form 5500.
5. PAI will print and mail 1099s to the appropriate recipients at the end of each calendar year. PAI's actual cost will be billed to the Plan Sponsor/Administrator. PAI will also electronically file the 1099 information returns with the appropriate governmental authorities, on behalf of the Plan Sponsor/Administrator.
6. If Plan Sponsor/Administrator purchases COBRA Services from PAI, PAI or its designee shall:
   A. Mail the initial COBRA rights notice (as approved by the Department of Labor) to the member or dependent under the Plan. A separate COBRA rights notice will be mailed to the covered spouse if applicable.
   B. Send the appropriate COBRA notice and election forms to the qualified beneficiaries and monitor the election period for the COBRA beneficiaries upon notice of a qualified member. (Forms must be completed in its entirety; incomplete elections will be treated as elected as offered.)
   C. Bill and collect the initial premium payment covering the period during which coverage would have normally ended to the date the beneficiary elects COBRA continuation.
   D. Bill and collect the monthly premiums from the COBRA beneficiaries who elected continuation of coverage beginning with the first monthly premium due after notice of continuation coverage is made by the beneficiary.
   E. Monitor the appropriate continuation of coverage period for each beneficiary and disenroll the beneficiary at the end of the period of continued coverage.
   F. Send conversion notices to eligible COBRA beneficiaries to the extent and within the period prescribed by applicable law, provided that a conversion option is included in their Plan Document.
   G. Not be responsible for giving notice to the COBRA continuants of any open enrollment periods as well as the available benefit plan options and applicable premium rates for the periods.

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H. Provide reports as follows:

1) a monthly report summarizing the following items for the preceding month: coverage elections and terminations; premium payment status; eligibility expirations; and all changes related to coverage and/or demographics that have been affected;

2) a daily report indicating: receipt of initial premium, notice of election (including type of coverage chosen) and notice of termination (including date of and reason for termination);

3) additional reports may be available upon mutual agreement and for an additional fee.

I. Forward contributions received for the preceding month to Plan Sponsor/Administrator on a monthly basis, less any amount due as payment for COBRA Services furnished pursuant to this Agreement.

Neither PAI or its designee shall be responsible for providing notice of any open enrollment periods, available benefit plan options, and/or applicable premium rates for such periods.

PAI or its designee shall rely upon any information provided to it by the Plan Sponsor/Administrator, shall base certain eligibility, coverage and other determinations in the performance of its responsibilities under this Agreement in reliance on the information so provided, and shall not be required to confirm or verify the accuracy, authenticity or completeness of any information so provided. PAI's or its designee's only obligation hereunder shall be to compile such information accurately and to utilize such information in performing its responsibilities under this Agreement.

If the Plan Sponsor/Administrator does not purchase COBRA services from PAI, then this section is not applicable.

7. If Plan Sponsor/Administrator purchases 125 Plan Services from PAI, PAI or its designee shall:

A. Provide sample announcement letters, sample communications materials for employee education and annual enrollment materials as requested by the Plan/Administrator.

B. Process employee reimbursement requests as directed by the Employer's Section 125 Plan, 125 Plan Master Application and IRS guidelines.

C. Provide toll-free customer service access via telephone.

D. Provide 125 Plan discrimination reports at the beginning and end of the year.

E. Provide standard monthly reports for reconciling amounts redirected to the 125 Plan. Standard monthly reports include:

1) Reports detailing the monthly administrative fees;

2) Reports detailing billing for employees; and,

3) Reports detailing employees' elections and participation.

F. Not have any obligation or duty to maintain any accounts or handle funds on behalf of the Plan Sponsor/Administrator.

If the Plan Sponsor/Administrator does not purchase 125 Plan Services from PAI, then this section is not applicable.

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EXHIBIT B

Claim Payment Services

1. PAI shall, in accordance with the terms of the Plan Document or other written agreements, as originally stated or as subsequently amended, do the following:

   A. Promptly process claims with respect to covered persons and calculate the amounts due and payable in accordance with the Plan Document.

   B. Prepare for signature by the authorized party, process and distribute payment checks drawn on the Plan's checking account.

   C. Prepare and submit all reports and notices of claims to the reinsurer in a time and manner required by the Excess Loss Insurance Policy; maintain records reasonably required by the reinsurer and furnish to the reinsurer upon request, all pertinent data with respect to Covered Persons as required by the Excess Loss Insurance Policy; or perform any other duty in a time and manner as specified in the Excess Loss Insurance Policy. PAI shall promptly notify Plan Sponsor/Administrator of any notices received by PAI from the reinsurer, and promptly forward Excess Loss Insurance reimbursements received from the reinsurer to the Plan Sponsor/Administrator.

   D. Maintain current and complete records and files of claim payments for each covered person in accordance with PAI's current practices.

   E. Request, as needed, any Medical Records necessary with which to process claims and file claims reimbursements with the Excess Loss (Stop Loss) carrier on behalf of the Plan Sponsor/Administrator. The Plan Sponsor/Administrator shall be responsible for any expenses incurred in obtaining these Medical Records. This expense will be charged against the Plan Sponsor/Administrator's claims account.

   F. Submit the following claims related reports to the Plan Sponsor/Administrator:

      1. Check register;

      2. Monthly Individual Specific Analysis (policy year); Benefit Analysis (month-to-date) and Coverage Analysis;

      3. Loss Ratio Report and Benefit Analysis (year-to-date);

      4. The reports in items 1 through 3 above, if requested at intervals other than specified above, will be provided for an additional fee. Non-standard reports such as Cost Containment, Lag Studies, or other program reports, can also be provided for an additional fee. Any such additional fees will be pre-approved by the Plan Sponsor/Administrator.

   G. Conduct reviews of all written appeals of claim decisions. Claims appeal findings and determinations are subject to the Plan Sponsor/Administrator's right for final approval or denial.

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EXHIBIT C

Agreement Regarding Disclosure of Group Claim Information

HIPAA

1. HIPAA. For purposes of this Section 1, any reference to Plan Sponsor/Administrator shall include any group health plan administrated pursuant to the Administrative Services Agreement (the "Agreement").

   A. Privacy of Protected Health Information.

      i. PAI is permitted or required to use or disclose Protected Health Information ("PHI") it creates or receives for or from Plan Sponsor/Administrator's health plan or to request PHI on Plan Sponsor/Administrator's health plan's behalf as follows:

         a. PAI is permitted to request the PHI on Plan Sponsor/Administrator's health plan's behalf, and to use and to disclose the Minimum Necessary PHI to perform functions, activities, or services for or on behalf of Plan Sponsor/Administrator's health plan, as specified in this Agreement.

         b. PAI may use or disclose PHI it creates for or receives from Plan Sponsor/Administrator as necessary for data aggregation purposes. PAI may use the PHI for PAI's proper management and administration or to carry out PAI's legal responsibilities. PAI may disclose the PHI for PAI's proper management and administration or to carry out PAI's legal responsibilities only if:

            1) The disclosure is required by law; or

            2) PAI obtains reasonable assurances, in the form of a written contract, from any person or organization to which PAI will disclose PHI that the person or organization will hold such PHI in confidence and use or further disclose it only for the purpose for which PAI disclosed it to the person or organization or as required by law, and promptly notify PAI of any instance of which the person or organization becomes aware in which the confidentiality of such PHI was breached.

      ii. PAI will develop, document, implement, maintain, and use appropriate administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Plan Sponsor/Administrator's Electronic Protected Health Information that PAI creates, receives, maintains, or transmits on Plan Sponsor/Administrator's behalf as required by the HIPAA Security Rule and as required by the HITECH Act. PAI also shall develop and implement policies and procedures and meet the HIPAA Security Rule documentation requirements as required by the HITECH Act. PAI agrees to mitigate, to the extent practicable, any harmful effect that is known to PAI of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

      iii. PAI will require any of its subcontractors and agents to provide reasonable assurance that such subcontractor or agent will comply with the same privacy and security obligations as PAI with respect to such PHI.

      iv. PAI's use, disclosure or request of PHI shall utilize a limited data set if practicable. Otherwise, PAI will, in its performance of the functions, activities, services, and operations allowed or required by this Agreement, make reasonable efforts to use, to disclose, and to request of a covered entity only the minimum amount of Plan Sponsor/Administrator's PHI reasonably necessary to accomplish the intended purpose of the use, disclosure or request.

      v. PAI will neither use nor disclose PHI except as permitted or required by this Exhibit, or as required by law.

   B. Individual Rights.

      i. PAI will, within a reasonable time after Plan Sponsor/Administrator's request, make available to Plan Sponsor/Administrator or, at Plan Sponsor/Administrator's direction, to the individual (or the individual's personal representative) for inspection and obtaining copies, any PHI about the individual that is in PAI's custody or control, so that Plan Sponsor/Administrator may meet its access obligations under 45 C.F.R. § 164.524.

      ii. PAI will, upon receipt of notice from Plan Sponsor/Administrator, promptly amend any applicable portion of the PHI under 45 C.F.R. § 164.526.

Form Rev.4/25/2017

iii. Disclosure Accounting.

a. PAI will record information concerning each disclosure of PHI, not excepted from disclosure tracking under Section 1(b)(iii)(b) below, that PAI makes to Plan Sponsor/Administrator or a third party. For repetitive disclosures made by PAI to the same person or entity for a single purpose, PAI may provide (i) the disclosure information for the first of these repetitive disclosures; (ii) the frequency, periodicity or number of these repetitive disclosures; and (iii) the date of the last of these repetitive disclosures. PAI will make this disclosure information available to Plan Sponsor/Administrator within a reasonable time after Plan Sponsor/Administrator's request.

b. PAI need not record disclosure information or otherwise account for disclosures of PHI that this Agreement or Plan Sponsor/Administrator in writing permits or requires: (i) for purposes of treating the individual who is the subject of the PHI disclosed, payment for that treatment, or for the healthcare operations PAI; (ii) to the individual who is the subject of the PHI disclosed or to that individual's personal representative; (iii) pursuant to a valid authorization by the person who is the subject of the PHI disclosed; (iv) to persons involved in that individual's healthcare or payment related to that individual's healthcare; (v) for notification for disaster relief purposes, (vi) for national security or intelligence purposes; (vii) as part of a limited data set; or (viii) to law enforcement officials or correctional institutions regarding inmates or other persons in lawful custody.

c. PAI must have available for Plan Sponsor/Administrator the disclosure information required by Section 1(b)(iii)(a) above for the six (6) years preceding Plan Sponsor/Administrator's request for the disclosure information (except PAI need have no disclosure information for disclosures occurring before the effective date of the Agreement).

iv. PAI will comply with any reasonable requests for restriction requests or confidential communications of which it is aware and to which Plan Sponsor/Administrator agrees pursuant to 45 C.F.R. § 164.522 (a) or (b).

v. In addition to the obligations described above, PAI will provide such additional individual rights to access and accounting as mandated by and, where applicable, the HITECH Act. Specifically, PAI shall make such access information available in an electronic format where directed by Plan Sponsor/Administrator. In addition, PAI shall include within its accounting, disclosures for payment and health care operations purposes where such recording or accounting is required by the HITECH Act. PAI further shall provide any additional information to the extent required by the HITECH Act and any accompanying regulations.

vi. Where PAI is contacted directly by an individual based on information provided to the individual by Plan Sponsor/Administrator and where so required by the HITECH Act and/or any accompanying regulations, PAI shall make such disclosure information available directly to the individual.

vii. PAI will make its internal practices, books, and records, relating to its use and disclosure of PHI, available to the U.S. Department of Health and Human Services to determine Plan Sponsor/Administrator's compliance with 45 C.F.R. Parts 160-64 or the Agreement.

C. Other Plan Sponsor/Administrator Responsibilities.

i. Plan Sponsor/Administrator shall promptly provide PAI with Plan Sponsor/Administrator's health plan's notice of privacy practices and any changes to such notice.

ii. Plan Sponsor/Administrator shall provide PAI with any changes to, or revocation of, authorization by an individual to use or disclose PHI, to the extent such changes affect PAI's permitted or required uses and disclosures.

D. Breach of Privacy Obligations.

i. PAI agrees to report to Plan Sponsor/Administrator any use or disclosure of PHI not provided for by this Agreement of which it becomes aware.

ii. In the event Plan Sponsor/Administrator determines that PAI has materially breached this Section 1, Plan Sponsor/Administrator may terminate the Agreement upon thirty (30) days prior written notice to PAI and PAI fails to cure the breach within such thirty (30) day period.

Form Rev.4/25/2017

iii. Obligations upon Termination. Upon termination, cancellation, expiration or other conclusion of this Agreement, PAI will, at its sole discretion and if feasible, return to Plan Sponsor/Administrator or destroy all PHI. If PAI agrees to return Plan Sponsor/Administrator's PHI, all costs related to the return of such PHI will be paid by Plan Sponsor/Administrator. PAI may identify any PHI that cannot feasibly be returned to Plan Sponsor/Administrator or destroyed. PAI will limit its further use or disclosure of that PHI that is not returned or destroyed.

iv. If for any reason Plan Sponsor/Administrator determines that PAI has breached these terms and such breach has not been cured, but Plan Sponsor/Administrator determines that termination of the Agreement is not feasible, Plan Sponsor/Administrator may report such breach to the U.S. Department of Health and Human Services.

v. PAI will have the right to terminate this Agreement if Plan Sponsor/Administrator has engaged in a pattern of activity or practice that constitutes a material breach or violation of Plan Sponsor/Administrator's obligations regarding Plan Sponsor/Administrator's PHI and, on notice of such material breach or violation from PAI, fails to take reasonable steps to cure the breach or end the violation. If Plan Sponsor/Administrator fails to cure the material breach or end the violation within thirty (30) days after receipt PAI's notice, PAI may terminate this Agreement by providing Plan Sponsor/Administrator written notice of termination, stating the uncured material breach or violation that provides the basis for the termination and specifying the effective date of the termination. If for any reason PAI determines that Plan Sponsor/Administrator has breached the terms of this Section 1 and such breach has not been cured, but PAI determines that termination of this Agreement is not feasible, PAI may report such breach to the U.S. Department of Health and Human Services.

E. The Plan Sponsor/Administrator, as the plan sponsor of its self-funded group health plan, has amended the plan document to comply with the requirements of 45 CFR Sections 164.314(b) and 164.504(f)(2).

F. Security Incident. If PAI becomes aware of any Security Incident, PAI shall report the same in writing to Plan Sponsor/Administrator as provided below. PAI agrees to mitigate, to the extent practicable, any harmful effect resulting from such Security Incident.

i. In determining how and how often PAI shall report to Plan Sponsor/Administrator in writing the Security Incidents required above, both Plan Sponsor/Administrator and PAI agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur would outweigh any potential benefit gained from reporting them. Consequently, both Plan Sponsor/Administrator and PAI agree that this Agreement shall constitute the documentation, notice and written report of such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C and that no further documentation, notice or report of such attempts will be required. By way of example (and not limitation in any way), the Parties consider the following to be illustrative (but not exhaustive) of Unsuccessful Security Incidents when they do not result in unauthorized access, use, disclosure, modification, or destruction of e-PHI or interference with an information system:

a. Pings on a Party's firewall,

b. Port scans,

c. Attempts to log on to a system or enter a database with an invalid password or username,

d. Denial-of-service attacks that do not result in a server being taken off-line, and

e. Malware (e.g., worms, viruses).

ii. Otherwise, PAI will document as required by 45 C.F.R. Part 164, Subpart C and report to Plan Sponsor/Administrator any successful unauthorized access, use, disclosure, modification, or destruction of Plan Sponsor/Administrator's Electronic Protected Health Information of which PAI becomes aware if such security incident either (a) results in a breach of confidentiality; (b) results in a breach of integrity but only if such breach results in a significant, unauthorized alteration or destruction of Plan Sponsor/Administrator's Electronic Protected Health Information; or (c) results in a breach of availability of Plan

Sponsor/Administrator's Electronic Protected Health Information, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing within ten (10) business days after PAI becomes aware of the impact of such Security Incident upon Plan Sponsor/Administrator's Electronic Protected Health Information.

G. In addition to any reporting obligations in this Agreement, PAI will report, following discovery and without unreasonable delay, but in no event later than sixty (60) days following discovery, any "Breach" of "Unsecured Protected Health Information" as these terms are defined by the HITECH Act and any implementing regulations. PAI agrees to mitigate, to the extent practicable, any harmful effect it knows to have resulted from Breach. Any such report shall include, to the extent possible, the identification (if known) of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by PAI to have been, accessed, acquired, or disclosed during such Breach, along with any other information required to be reported under the HITECH Act and any accompanying regulations.

H. Plan Sponsor/Administrator represents and certifies that it is solely responsible for and has obtained consent from all members authorizing the release of PHI by PAI to Plan Sponsor/Administrator or, the Plan Sponsor/Administrator otherwise has the legal authority to review, access, and /or use such information.

I. Plan Sponsor/Administrator will only use claims information provided by PAI to administer the Plan Sponsor/Administrator's group health plan. This may include auditing, monitoring and evaluating the costs and performance PAI and the Plan Sponsor/Administrator's health plan. Plan Sponsor/Administrator will not use any information provided by PAI for any improper or illegal or unauthorized purpose.

J. PAI is prohibited from releasing alcohol and drug abuse patient information protected under 42 U.S.C. § 290dd-2(a) to Plan Sponsor/Administrator.

K. If the Plan Sponsor/Administrator accesses the Benefit Coordinator features of the PAI website, it will ensure that Protected Health Information is only accessed while the individual whose information is being accessed is present or such individual has otherwise consented to such access.

L. Plan Sponsor/Administrator will protect and safeguard the integrity, privacy and confidentiality of all Protected Health Information in accordance with all federal and state laws, regulations and guidelines governing and applicable to Protected Health Information. Plan Sponsor/Administrator will only use or further disclose Protected Health Information for the purpose for which PAI disclosed it to the Plan Sponsor/Administrator or as required by law, and will promptly notify PAI of any instance of which the person or organization becomes aware in which the confidentiality of such PHI was breached.

M. If Plan Sponsor/Administrator requests that PAI disclose Protected Health Information to a third party, Plan Sponsor/Administrator agrees that it will indemnify and hold PAI harmless from any consequences from such disclosure. Plan Sponsor/Administrator will not require PAI to disclose information to any third party until such third party has executed PAI's disclosure agreement.

2. Compliance with Standard Transactions. For purposes of this Section 2, any reference to Plan Sponsor/Administrator shall include any group health plan administrated pursuant to this Agreement. If Plan Sponsor/Administrator conducts, in whole or part, Standard Transactions for or on behalf of Plan Sponsor/Administrator's health plan, Plan Sponsor/Administrator will comply, and will require any subcontractor or agent involved with the conduct of such Standard Transactions to comply, with 45 C.F.R. Part 162. All Standard Transactions submitted by the Plan Sponsor/Administrator or its subcontractors must be in a format that is acceptable to PAI.

EXHIBIT D - Administrative Services Only Agreement

Rate Schedule - Disclosure of Charges Billed by PAI

GROUP NAME: Dooley County GROUP # 817

FOR THE PERIOD FROM 3/1/2017 TO: 4/30/2018

(Rates are based on "Per Employee Per Month" unless otherwise stated.)

ADMINISTRATIVE SERVICE FEES:		SINGLE	FAMILY
Medical (may include broker commission, if applicable)		$13.84	$13.84
Dental	Delta Dental Billing Fee	$0.10	$0.10
Vision		$0.00	$0.00
Short Term Disability (STD)(PAI In-house)		$0.00	$0.00
HIPAA Eligibility Pre-Existing/Creditable Coverage Services		$0.00	$0.00
HIPAA Privacy Services		$0.75	$0.75
COBRA Services		$1.35	$1.35
MyCatalyst.it Broker Fee		$1.85	$1.85
NY-HCRA Services		$0.00	$0.00
(Monthly NY-HCRA assessment fees will also apply if any subscribers are NY residents)			
PPO NETWORK ACCESS FEES:			
Preferred Blue		10% of savings	10% of savings
First Health		25% of savings	25% of savings
First Health		$5.25 pepm	$5.25 pepm
		$0 pepm	$0 pepm

PRE-CERTIFICATION, MEDICAL REVIEW + MANAGED CARE ACCESS FEE			
Managed Care Services	included	included	
Managed Care Services	2.50	2.50	
Maternity Care	n/a		
Health Management	n/a	n/a	
Health Management	n/a		
Domicile Care - ongoing fees per patient	n/a		
24 hour Nurse Advisor - pepm	n/a	n/a	
Smoking Cessation	n/a		
Weight Management	n/a		
Diet for Life	n/a		
Cholesterol Management	n/a		
Back Pain Management	n/a		
Stress Management	n/a		
Autism Management	n/a		
PRESCRIPTION DRUG PROGRAM:			
Applicable Fee Schedule:	PBM: MagellanRx		
Per employee per month		$0.00	$0.00
ELECTRONIC ELIGIBILITY ELIG Download Vendor	ELIG Download Vendor	$0.00	$0.00
DATA WAREHOUSE FEES	Doorkwalk	0	0
OTHER CHARGES: Description:	Description	$0.00	$0.00

STOP LOSS PREMIUMS: (Contract is between Group and Stop Loss Carrier. Not a PAI Contract)

Medical Specific per employee per month	$05.70	$361.94
Medical Specific Marketing Fee - PAI	$3.50	$0.00
Medical Specific Marketing Fee - Broker	$7.00	$19.05
Rating Aggregate (medical) per employee per month	$0.00	$0.00
Medical Aggregate per employee per month	$0.51	$0.51
Medical Aggregate Marketing Fee - PAI	$0.21	$0.21
Medical Aggregate Marketing Fee - Broker	$0.41	$0.41

OTHER STOP LOSS INFORMATION ** Note: Please refer to your Stop Loss contract for information concerning:

- Specific Contract Basis
- Specific Deductible
- Aggregate Contract Basis
- Aggregate Attachment Point
- Maximum Claim Liability Funding Factors
- Any individuals or whom the Stop Loss carrier elected "lasers" or other limitations
- All other stop loss contract terms and conditions.

** Note: Aggregate attachment point will be determined after final enrollment.

** Note: Contract ending dates may be processed several working days prior to the end of the contract period, to enable proper and timely year-end closeout under Stop Loss requirements.

SYSTEM GENERATED REPORTS:

- Standard monthly reports
- Custom reports (per hour of programming time)

ONE-TIME SETUP FEE

- Includes the initial production and printing of Plan Document 0
- Plan Building and Design (to include loading of benefit maximums if applicable)

PRINTING CHARGES:

- Employee Booklets: Actual Vendor Cost + 10% Processing Fee

Group ID Cards:

No charge for initial printing. If ID cards reproduced by PAI, Quote will be provided, based on group size to include printing and mailing costs.

* If plastic cards produced by PBM: Initial and Subsequent Printings = Actual Vendor Cost

PPO Directories: Actual Vendor Cost Plus Postage

Check Printing Charges: $.16 per check

Sponsor/Administrator Initials _____ PAI Initials _____ Exhibit D, Page 1

EXHIBIT D - Administrative Services Only Agreement

Division of Responsibilities

This Exhibit is a Disclosure of (1) All Charges Billed by PAI, and (2) Responsibilities of Parties to this Agreement.

GROUP NAME: Oconee County GROUP #: 817

FOR THE PERIOD FROM: 5/1/2017 TO: 4/30/2018

DIVISION OF RESPONSIBILITIES

	Plan Sponsor/ Administrator	PAI
Production of Plan Document Draft	☐	☑
Approval of the Final Plan Design and Plan Document	☐	☑
Final Approval of Plan Document	☑	☐
Cost of Printing Employee Booklets:	☑	☐
Cost of Group I.D. Cards		
a) Initial Plastic ID Cards, new group or bulk reprinting	☐	☑
b) Subsequent ID Cards, due to membership enrollment changes	☐	☑
Cost of Printing or Copying PPO Directories (Initial and Subsequent Orders)	☑	☐
Cost of Printing of Membership Applications and Enrollment Forms		
Standard PAI Forms	☐	☑
Custom Forms Requested by Plan Sponsor/Administrator	☑	☐
Banking:		
a) Claims Checking Account Owned and Maintained By	☑	☐
b) Reconciliation of Claims Checking Account	☑	☐
c) Escheat/Unclaimed Funds compliance and reporting	☑	☐
d) Signature of Claims Checks	☐	☑
e) Cost of Printing Plan Sponsor Claims Check Stock	☑	☐
Plan Sponsor/Administrator Audit Fees, Bank Fees, Attorney + Other Legal Expenses	☑	☐
Fees for Medical Information	☑	☐
Fees for Discounts Obtained and Applied to Non-Network Claims	☑	☐
Reconciliation of PAI's monthly fixed cost invoice to employment records	☑	☐
Preparation and Filing of Form 5500	☑	☐
(PAI will furnish summary information to assist PAI Sponsor/Administrator with Form 5500)		
1099 Forms:		
Preparation, printing, and mailing	☐	☑
Filing of Forms 1099 and other related information returns with governmental authorities	☐	☑
Responsibility for Obtaining Prior Claim Files, Billings and/or Other Required Reports	☑	☐
Refunds:		
* If refund due to Plan Sponsor/Administrator is identified by and obtained through a Medical Provider Audit Firm (MPAF), MPAF's fee is to be paid by the Plan Sponsor/Administrator. (MPAF fees range from 10% to 15% of the refund secured for the Plan Sponsor/Administrator)	☑	☐
* If subrogation refund due to the Plan Sponsor/Administrator is obtained through the efforts of the BCBSSC Subrogation Research Department, BCBSSC's 30% fee is to be paid by the Plan Sponsor/Administrator.	☑	☐
* All refunds identified by PAI, will be sought by PAI.	☐	☑
Out of Network Claims Negotiation Fee: 25% of savings to be paid by the Plan Sponsor/Administrato	☑	☐

Sponsor/Administrator Initials: _____ PAI Initials: _____

AMENDMENT 2016 01
Oconee County
Effective: May 1, 2016

As of the effective date above, the following changes will be implemented:

The following items in the **ELIGIBILITY** section will be updated as follows:

Eligibility:	
Dependent Child, in addition to meeting the requirements contained in the Plan of Benefits; the maximum age limitation to qualify as a Dependent Child is:	An Employee may cover a Dependent Child up to the end of the calendar month during which the Dependent Child reaches age 26 for medical Benefits.

DEFINITIONS

The following items will be added to the **DEFINITIONS** section:

The following items in the **DEFINITIONS** section will be updated as follows:

Excepted Benefits:

1. Coverage only for accident, or disability income insurance, or any combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics;
8. Other similar insurance coverage specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
9. If offered separately:
   a. Limited scope dental or vision benefits;
   b. Benefits for long-term care, nursing home care, Home Health Care, community-based care, or any combination thereof;
   c. Such other similar, limited benefits as specified in regulations.
10. If offered as independent, non-coordinated benefits:
   a. Coverage only for a specified disease or illness;
   b. Hospital indemnity or other fixed indemnity insurance.
11. If offered as a separate insurance policy:
   a. Medicare supplemental health insurance (as defined under Section 1882(g)(1) of the Social Security Act);

b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code;

c. Similar supplemental coverage under a group health Plan.

Out-of-Pocket Maximum: the maximum amount (if listed on the Schedule of Benefits) of otherwise Covered Expenses incurred during a Benefit Year that a Participant will be required to pay.

The following items will be removed from the **DEFINITIONS** section:

Certificate of Creditable Coverage: a document from a group health Plan or insurer that states that a Participant had prior Creditable Coverage with that group health Plan or insurer.

Creditable Coverage: benefits or coverage provided under any of the following (each capitalized term as defined under HIPAA unless defined in this Plan of Benefits):

1. A group health Plan;
2. Health Insurance Coverage;
3. Medicare Part A or Part B, Title XVIII of the Social Security Act;
4. Medicaid: Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;
5. Title 10 United States Code Chapter 55 (i.e. medical and dental care for members and certain former members of the uniformed forces and their Dependents);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool, including South Carolina Health Insurance Pool (SCHIP);
8. A state Children's Health Insurance Program (S-CHIP);
9. A health Plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Act);
10. A public health Plan, including that of the U.S. Federal Government as well as that of a foreign country or its political subdivision; or
11. A health benefit Plan under Section 5(e) of 22 United States Code 2504(e), the Peace Corps Act.

Creditable Coverage does not include coverage consisting solely of Excepted Benefits (as defined within the definition of Health Insurance Coverage).

Signature

Title

T. Scott Moulder

Typed/Printed Name

5/9/16

Date

Disclaimer:

In order for amendments to your plan to take effect, a signature is required from the person authorized to oversee your benefit plan. Requests for amendment should be signed within 30 days. Please sign and return to PAI on or before [redacted]

AMENDMENT 2015 02
Oconee County
Effective: July 1, 2015

As of the effective date above, the following changes will be implemented:

The following item will be added in the **MEDICAL SCHEDULE OF BENEFITS, WELLNESS SERVICES** section as follows:

WELLNESS SERVICES: **Co-pay only applies if office visit is billed**	**PPO:**	**Non-PPO:**
Adult and Child Immunizations based on CDC guidelines including administration fees (except those required for travel)	*100%	*60%

The following item in the **MEDICAL SCHEDULE OF BENEFITS, WELLNESS SERVICES** section will be updated as follows:

WELLNESS SERVICES: **Co-pay only applies if office visit is billed**	**PPO:**	**Non-PPO:**
Well-Child Care: Immunizations are covered at 100%, not subject to Benefit Year deductible or co-pay.	$25 co-pay, then *100%	*60%

Signature

County Administrator
Title

T. Scott Moulder
Typed/Printed Name

10/1/2015
Date

Disclaimer:

In order for amendments to your plan to take effect, a signature is required from the person authorized to oversee your benefit plan. Requests for amendment should be signed within 30 days. Please sign and return to PAI on or before October 31, 2015.

AMENDMENT 2015 01
Oconee County
Effective: May 1, 2015

As of the effective date above, the following changes will be implemented:

PRE-AUTHORIZATION

The second paragraph in the **PRE-AUTHORIZATION** section will be updated as follows:

All Admissions and some Benefits (as indicated herein or on the Schedule of Benefits) require Pre-Authorization to determine the Medical Necessity of such Admission or Benefit. The Group Health Plan reserves the right to add or remove Benefits that are subject to Pre-Authorization. Each Participant is responsible for obtaining Pre-Authorization and the appropriate review. If Pre-Authorization is not obtained for an Admission or outpatient services and the Participant is still admitted, Benefits may be reduced (up to and including denial of all or a portion of the room and board charges associated with the Admission) as listed on the Schedule of Benefits. If a PPO fails to obtain Pre-Authorization, they are required to write off this reduced amount and cannot bill the Participant for this amount. The Participant is responsible for obtaining Pre-Authorization for Admission to a Non-PPO Provider facility, and the Participant will be responsible for any penalty or reduction in payable charges as stated in the Schedule of Benefits if approval is not obtained. Pre-Authorization is obtained through the following procedures:

1. For all Admissions that are not the result of an Emergency Medical Condition, Pre-Authorization is granted or denied in the course of the Pre-Admission Review.
2. For all Admissions that result from an Emergency Medical Condition, Pre-Authorization is granted or denied in the course of the Emergency Admission Review.
3. For Admissions that are anticipated to require more days than approved through the initial review process, Pre-Authorization is granted or denied for additional days in the course of the Continued Stay Review.
4. For specific Benefits that require Pre-Authorization, Pre-Authorization is granted or denied in the course of the Pre-Authorization process.
5. For items requiring Pre-Authorization, the Medical Review Department or CBA must be called at the numbers listed below or on the Identification Card.

Items requiring Pre-Authorization are listed on the Schedule of Benefits.

The following item in the **MEDICAL SCHEDULE OF BENEFITS, INPATIENT HOSPITAL SERVICES** section will be added as follows:

INPATIENT HOSPITAL SERVICES: Pre-Authorization required	**PPO:**	**Non-PPO:**
Residential Treatment Facility:	80%	60%

MEDICAL BENEFITS

The following item will be added to the **MEDICAL BENEFITS** section:

Covered Expenses at a **Residential Treatment Center.**

MEDICAL EXCLUSIONS AND LIMITATIONS

The following items in the **MEDICAL EXCLUSIONS AND LIMITATIONS** section will be updated as follows:

42. Admissions or portions thereof for **custodial care or long-term care** including:
    A. Rest cures;
    B. Long-term acute or chronic psychiatric care;
    C. Care to assist a Participant in the performance of activities of daily living (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication);
    D. Care in a sanitarium;
    E. Custodial or long-term care; or
    F. Psychiatric or Substance Abuse residential treatment when provided at therapeutic schools; wilderness/boot camps; therapeutic boarding homes; halfway houses; and therapeutic group homes.

ELIGIBILITY FOR COVERAGE

The following item in the **ELIGIBILITY** section will be removed in its entirety:

Eligibility:	
Pre-Existing Condition Exclusion Period: Applies only to claims with dates of service prior to June 1, 2014.	Each Participant age 19 or older may serve a twelve-month Pre-Existing Condition Exclusion Period, less any Creditable Coverage the Participant can provide. Any Participant who is a Late Enrollee will serve an eighteen-month Pre-Existing Condition Exclusion Period. See the Eligibility for Coverage section for information on qualifying for Special Enrollment.

DEFINITIONS

The following items will be added to the **DEFINITIONS** section:

Residential Treatment Center: a licensed institution, other than a Hospital, which meets all six of these requirements:

1. Maintains permanent and full-time Facilities for bed care of resident patients; and
2. Has the services of a Psychiatrist (Addictionologist, when applicable) or Physician extender available at all times and is responsible for the diagnostic evaluation, provides face-to-face evaluation services with documentation a minimum of once/week and PRN as indicated; and
3. Has a Physician or registered nurse (RN) present onsite who is in charge of patient care along with one or more registered nurses (RNs) or licensed practical nurses (LPNs) onsite at all times (24/7); and
4. Keeps a daily medical record for each patient; and
5. Is primarily providing a continuous structured therapeutic program specifically designed to treat behavioral health disorders and is not a group or boarding home, boarding or therapeutic school, half-way house, sober living residence, wilderness camp or any other facility that provides Custodial Care; and
6. Is operating lawfully as a residential treatment center in the area where it is located.

The following items in the **DEFINITIONS** section will be updated as follows:

Dependent: an individual who is:

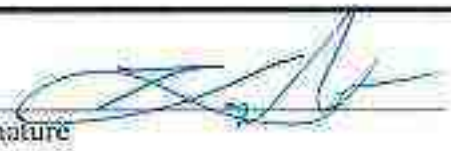
1. An Employee's spouse, which is any individual who is legally married under any state law; or
2. A Child under the age set forth in the Eligibility for Coverage section; or
3. An Incapacitated Dependent.

The following items will be removed from the **DEFINITIONS** section:

Mental Health Conditions: certain psychiatric disorders or conditions defined in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and are not otherwise excluded by the terms and conditions of this Plan of Benefits. The conditions as mandated by the State of South Carolina are:

1. Bipolar Disorder;
2. Major Depressive Disorder;
3. Obsessive Compulsive Disorder;
4. Paranoid and Other Psychotic Disorder;
5. Schizoaffective Disorder;
6. Schizophrenia;
7. Anxiety Disorder;
8. Post-traumatic Stress Disorder; and
9. Depression in childhood and adolescence.

Pre-Existing Condition(s): a physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was received or recommended during the six (6) month period preceding the Enrollment Date, if applicable. Genetic Information may not be treated as a Pre-Existing Condition in the absence of a diagnosis of the specific condition related to the Genetic Information. Pre-Existing Condition applies only to Participants age 19 or older for claims with dates of service prior to June 1, 2014.



Signature

County Administrator

Title

T. Scott Moulder

Typed/Printed Name

April 27, 2015

Date

Disclaimer:

In order for amendments to your plan to take effect, a signature is required from the person authorized to oversee your benefit plan. Requests for amendment should be signed within 30 days. Please sign and return to PAI on or before May 21, 2015.

SELF-FUNDED
PLAN DOCUMENT
FOR

GROUP MEDICAL PLAN

Effective Date: May 1, 2014

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Capitalized terms are defined in the Definitions section of this Plan Document.

ABOUT YOUR PLAN

Because of the dramatic increase in the cost of medical care, group health Plans encourage and reward those covered individuals who are selective in their purchase of medical services.

Please review this booklet, which describes your health Plan. Be a selective medical consumer and assume the major role in keeping the cost of medical services at a minimum.

Your Plan Sponsor has established a comprehensive Group Health Plan ("Plan") for its Employees. In connection with the Plan, your Plan Sponsor has retained the services of *Planned Administrators, Inc.* ("PAI") (a third-party administrator) to process and pay health claims and to provide administrative services in connection with the operation of this Plan of Benefits. PAI has contracted with **Blue Cross and Blue Shield of South Carolina Preferred Blue, First Health and First Health Travel** as the Preferred Provider Organizations ("PPOs").

You will receive maximum Benefits when you use Providers who participate in the PPO Program (the term "PPO Providers" is explained further below) and when you obtain authorization (when required) for services. You will pay more if you do not use PPO Providers or if you do not obtain prior authorization (unless it is an emergency). The following information explains how to obtain authorization for services or supplies covered under this Plan.

It is your responsibility to ensure that your Provider is a PPO Provider. You should verify your Provider's status before services are rendered. To verify whether your Provider is a PPO Provider, you may:

- Ask the Provider if they participate in the PPO program referenced above.
- See the appropriate website for Provider information. Link available on www.paisc.com.
- Call PAI.*

* The methods of verifying PPO participation may have timing differences between when a Provider is participating in the PPO or terminating from the PPO. The preferable method of obtaining the most correct information is to ask your Provider.

For South Carolina Employees, the Blue Cross and Blue Shield Preferred Blue Network is the PPO for this Group Health Plan. For Employees living outside of South Carolina, the PPO is First Health. Employees traveling outside of their home networks, will have access to First Health Travel.

PPO Providers include Hospitals, Skilled Nursing Facilities, Home Health Agencies, hospices, doctors and other Providers of medical services and supplies (as listed in the Definitions section) that have a written agreement with the PPO. Under their agreement with the PPO, PPO Providers will do the following:

- File all claims for Benefits or supplies with PAI;
- Ask you to pay only the Deductible, per occurrence Co-payments and Coinsurance amounts, if any, for Benefits;
- Accept the preferred allowance as payment in full for Covered Expenses; and
- Make sure that all necessary approvals are obtained from the Medical Services Department.

Non-PPO Providers include Hospitals, Skilled Nursing Facilities, Home Health Agencies, hospices, doctors and other Providers of medical services and supplies that are not under contract with the PPO. Non-PPO Providers can bill you their total charge. They may ask you to pay the total amount of their charges at the time you receive services or supplies, or to file your own claims, and you will need to obtain any necessary approvals for benefits to be paid. In addition to Deductibles and Coinsurance, you are responsible for the difference between the Non-PPO Provider's charge and the Allowed Amount for Covered Expenses.

Although Benefits typically are reduced when you use a Non-PPO Provider, Benefits provided by a Non-PPO Provider will be covered at the PPO Provider level under the following circumstances:

- In the event treatment is for an Emergency Medical Condition as defined in this Plan of Benefits and PPO Provider care is not available;
- For Dependents living out of state;
- For treatment by a Specialist when a PPO Provider Specialist is not available;
- For Non-PPO Provider ancillary services rendered in a PPO Provider Hospital, and/or
- The Participant requires a transplant and the transplant is performed at a Centers of Excellence (COE) facility.

Out-of-area Emergency Provision—If a Participant receives care for an Emergency Medical Condition from a Non-Participating Provider, the Plan will pay for Benefits at a PPO Provider level of Benefits if all of these conditions are met:

- You were traveling for reasons other than seeking medical care when the Emergency Medical Condition occurred.
- You were treated for an Accidental injury or new Emergency Medical Condition.

Benefits under this provision are subject to the Deductibles or Co-payments, Coinsurance and all Plan of Benefits maximums, limits and exclusions.

If you have claims that meet all of these conditions, write or call PAI. PAI will review your claims to determine if additional Benefits can be provided.

Customer Service

PAI is committed to helping you understand your coverage and obtain maximum Benefits on your claims. If you have questions about your coverage, you may call or write PAI at the following:

Planned Administrators, Inc.
Attn: Claims
P.O. Box 6927
Columbia, SC 29260
1-800-768-4375
www.paisc.com

Once a claim has been processed, you will have access to an Explanation of Benefits (EOB) at www.paisc.com or by contacting customer service. An EOB also will be mailed to you. The EOB explains who provided the care, the kind of service or supply received, the amount billed, the Allowed Amount, the Coinsurance rate and the amount paid. It also shows Benefit Year Deductible information and the reasons for denying or reducing a claim.

Time Limits to File a Claim

Claims should be filed within 180 days of the date charges were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date will be decline unless:

a. it is not reasonably possible to submit the claim in that time; and
b. the claim is submitted within one year from the incurred date. This one year period will only apply when the person is not legally capable of submitting the claim, and the Plan Administrator has final authority to decide whether there is sufficient cause for a claim to be considered beyond the 180 day filing limit.

Authorized Representatives and Representatives designated under Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Unless expressly permitted by law, you and your Dependent's PHI generally cannot be released to any other person without your or your Dependent's consent. However, there are instances when you may want someone to discuss your PHI with PAI or receive an Explanation of Benefits etc. to manage your care. In order to comply with applicable laws and also to comply with your request, you must sign a written authorization form. To obtain a copy of the form, please visit the PAI website at www.paisc.com and then select "forms." You can print this form and mail to the PAI address, or you can call 1-800-768-4375 for a copy of the form.

A Provider may be considered a Participant's authorized representative without a specific designation by the Participant when the claim request is for an Urgent Care Claim. A Provider may be a Participant's authorized representative with regard to non-Urgent Care Claims for Benefits or an appeal of an Adverse Benefit Determination only when the Participant gives the Plan supervisor a specific written designation in a format that is reasonably acceptable to PAI to act as an authorized representative. All information and notifications will continue to be directed to the Participant unless the Participant gives contrary directions.

This Plan Sponsor believes this Plan of Benefits is a "grandfathered health Plan" under the Affordable Care Act ("ACA"). As permitted by ACA, a grandfathered health Plan can preserve certain basic health coverage that already was in effect when that law was enacted. Being a grandfathered health Plan means that this Plan of Benefits may not include certain consumer protections of ACA that apply to other Plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health Plans must comply with certain other consumer protections in ACA; for example, the elimination of lifetime limits on Benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health Plan and what might cause a Plan to change from grandfathered health Plan status can be directed to the Plan Administrator at the number on the back of your Identification Card. For ERISA Plans, the Participant also may contact the Employee Benefits Security Administration, U.S. Department of Labor, at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health Plans.

PRE-AUTHORIZATION

To receive the maximum Benefits, certain types of services and equipment and all Admissions require Pre-Authorization in order to be covered under the Plan. Depending on the type of service, either the Blue Cross Blue Shield of South Carolina Medical Review Department or Companion Benefit Alternatives, Inc. ("CBA") must give advance authorization for the services and equipment that require Pre-Authorization and for all Admissions.

All Admissions and some Benefits (as indicated herein or on the Schedule of Benefits) require Pre-Authorization to determine the Medical Necessity of such Admission or Benefit. The Group Health Plan reserves the right to add or remove Benefits that are subject to Pre-Authorization. Each Participant is responsible for obtaining Pre-Authorization and the appropriate review. If Pre-Authorization is not obtained for an Admission or outpatient services and the Participant is still admitted, Benefits may be reduced (up to and including denial of all or a portion of the room and board charges associated with the Admission) as listed on the Schedule of Benefits. If a PPO fails to obtain Pre-Authorization, they are required to write off this reduced amount and cannot bill the Participant for this amount. The Participant is responsible for obtaining Pre-Authorization for Admission to a Non-PPO Provider facility, and the Participant will be responsible for any penalty or reduction in payable charges as stated in the Schedule of Benefits if approval is not obtained. Specific penalties for Mental Health Services, Mental Health Conditions and Substance Abuse Services are listed on the Schedule of Benefits. Pre-Authorization is obtained through the following procedures:

1. For all Admissions that are not the result of an Emergency Medical Condition, Pre-Authorization is granted or denied in the course of the Pre-Admission Review.
2. For all Admissions that result from an Emergency Medical Condition, Pre-Authorization is granted or denied in the course of the Emergency Admission Review.
3. For Admissions that are anticipated to require more days than approved through the initial review process, Pre-Authorization is granted or denied for additional days in the course of the Continued Stay Review.
4. For specific Benefits that require Pre-Authorization, Pre-Authorization is granted or denied in the course of the Pre-Authorization process.
5. For items requiring Pre-Authorization, the Medical Review Department or CBA must be called at the numbers listed below or on the Identification Card.

Items requiring Pre-Authorization are listed on the Schedule of Benefits.

Who to Call for Pre-Authorization

For Pre-Authorization for medical care, call the Blue Cross and Blue Shield of South Carolina Medical Review Department at 1-800-652-3076.

For Pre-Authorization for Mental Health Services, Mental Health Conditions or Substance Abuse Services, call CBA at 1-800-868-1032. CBA is a Mental Health and Substance Abuse subsidiary of Blue Cross and Blue Shield of South Carolina.

If you are unsure if Pre-Authorization is required, call PAI customer service. However, customer service representatives cannot give approval for services.

These numbers also are on the back of your Identification Card. Be sure to keep your Identification Card with you at all times, since you never know when you may need to reach us.

When you call for Pre-Authorization, you will be asked for the following information:

- Your name and ID number
- Participant's Employer
- The patient's name and relationship to you
- The Provider's name, address and phone number
- If applicable, the Hospital or Skilled Nursing Facility's name, address and phone number

- The reason the requested service, supply or Admission is necessary

After careful review, your Physician and Hospital will be notified whether the service, supply or Admission is approved as Medically Necessary and how long the approval is valid.

If you are or a Dependent is undergoing a human organ and/or tissue Transplant, written approval must be obtained in advance [and the procedure must be done at a facility that PAI designates]. **If PAI does not pre-approve these services in writing** [or they are not done by a Provider PAI designates], then this Plan will not pay any Benefits.

If your Physician recommends services and supplies for you or your Dependent for any reason, make sure you tell your Physician that your health insurance Plan requires Pre-Authorization. Participating Providers will be familiar with this requirement and will get the necessary approvals.

Please note that if your claim for services or Benefits is denied, you may request further review under the guidelines set out in the Claims Filing and Appeal Procedures section of this booklet. Remember that a denial of a Pre-Authorization is a denied claim for purposes of an appeal.

CLAIMS FILING AND APPEAL PROCEDURES

A. CLAIMS FILING PROCEDURES

1. Where a Participating Provider renders services, generally the Participating Provider should either file the claim on a Participant's behalf or provide an electronic means for the Participant to file a claim while the Participant is in the Participating Provider's office. However, the Participant is responsible for ensuring that the claim is filed.

2. Written notice of receipt of services on which a claim is based must be furnished to PAI, at its address listed in this booklet, within twenty (20) days of the beginning of services, or as soon thereafter as is reasonably possible. Failure to give notice within the time does not invalidate nor reduce any claim if the Participant can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible. Upon receipt of the notice, PAI will furnish or cause a claim form to be furnished to the Participant. If the claim form is not furnished within fifteen (15) days after PAI receives the notice, the Participant will be deemed to have complied with the requirements of this Plan of Benefits as to proof of loss. The Participant must submit written proof covering the character and extent of the services within this Plan of Benefits' time fixed for filing proof of loss.

3. For Benefits not provided by a Participating Provider, the Participant is responsible for filing claims with PAI. When filing the claims, the Participant will need the following:

   a. A claim form for each Participant. Participants can get claim forms from PAI at the telephone number indicated on the Identification Card or via the website, www.paisc.com.

   b. Itemized bills from the Provider(s). These bills should contain all the following:

      i. Provider's name and address;

      ii. Participant's name and date of birth;

      iii. Participant's Identification Card number;

      iv. Description and cost of each service;

      v. Date that each service took place; and

      vi. Description of the illness or injury and diagnosis.

   c. Participants must complete each claim form and attach the itemized bill(s) to it. If a Participant has other insurance that already paid on the claim(s), the Participant also should attach a copy of the other Plan's Explanation of Benefits notice.

   d. Participants should make copies of all claim forms and itemized bills for the Participant's records, since they will not be returned. Claims should be mailed to PAI's address listed on the claim form.

4. PAI must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Participant shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. Except in the absence of legal capacity, claims must be filed no later than twelve (12) months following the date services were received.

5. Receipt of a claim by PAI will be deemed written proof of loss and will serve as written authorization from the Participant to PAI to obtain any medical or financial records and documents useful to the Plan of Benefits. The Plan of Benefits, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to PAI in support of a Participant's claim will be deemed to be acting as the agent of the Participant. If the Participant desires to appoint an Authorized Representative in connection with such Participant's claims, the Participant should contact PAI for an Authorized Representative form.

6. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims, and Concurrent Care Claims. The Group Health Plan will make a determination for each type of claim within the following time periods:

   a. Pre-Service Claim

      i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.

      ii. If a Pre-Service Claim is improperly filed, or otherwise does not follow applicable procedures, the Participant will be sent notification within five (5) days of receipt of the claim.

      iii. An extension of fifteen (15) days is permitted if PAI (on behalf of the Group Health Plan) determines that, for reasons beyond the control of PAI, an extension is necessary. If an extension is necessary, PAI will notify the Participant within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension, and the date PAI expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Participant will have at least forty-five (45) days to provide the required information. If PAI does not receive the required information within the forty-five (45) day time period, the claim will be denied. PAI will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If PAI receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first-level appeal. Reference the Claims Filing and Appeal Procedures section, B. Appeal Procedures for an Adverse Benefit Determination, for details regarding the appeals process.

   b. Urgent Care Claim

      i. A determination will be sent to the Participant in writing or in electronic form as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.

      ii. If the Participant's Urgent Care Claim is determined to be incomplete, the Participant will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Participant then will have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.

      iii. If the Participant requests an extension of Urgent Care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Participant will be notified within twenty-four (24) hours of receipt of the request for an extension.

   c. Post-Service Claim

      i. A determination will be sent within a reasonable time period, but no later than thirty (30) days from receipt of the claim.

      ii. An extension of fifteen (15) days may be necessary if PAI (on behalf of the Group Health Plan) determines that, for reasons beyond the control of PAI, an extension is necessary. If an extension is necessary, PAI will notify the Participant within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension, and the date PAI expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Participant will have at least forty-five (45) days to provide the required information. If PAI does not receive the required information within the forty-five (45) day time period, the claim will be denied. PAI will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information. If PAI receives the requested information after the forty-five (45) days, but within two hundred twenty-five (225) days, the claim will be reviewed as a first-level appeal. Reference the Claims Filing and Appeal Procedures section, B. Appeal Procedures for an Adverse Benefit Determination, for details regarding the appeals process.

d. Concurrent Care Claim

The Participant will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow the Participant time to appeal the decision before the Benefits are reduced or terminated.

7. Notice of Determination

a. If the Participant's claim is filed properly, and the claim is in part or wholly denied, the Participant will receive notice of an Adverse Benefit Determination. This notice will:

i. State the specific reason(s) for the Adverse Benefit Determination;

ii. Reference the specific Plan of Benefits provisions on which the determination is based;

iii. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;

iv. Describe the claims review procedures and the Plan of Benefits and the time limits applicable to such procedures, including a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;

v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request); and,

vi. If the reason for denial is based on a lack of Medical Necessity, or Experimental or Investigational services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

b. The Participant will also receive a notice if the claim is approved.

B. APPEAL PROCEDURES FOR AN ADVERSE BENEFIT DETERMINATION

1. The Participant has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:

a. An appeal must be in writing; and,

b. An appeal must be sent (via U.S. mail or FAX) at the address or FAX number below:

Planned Administrators, Inc.

Attention: Appeals

P.O. Box 6927

Columbia, SC 29260

FAX 1-803-870-8012

c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,

d. An appeal must include the Participant's name, address, identification number and any other information, documentation or materials that support the Participant's appeal.

2. The Participant may submit written comments, documents, or other information in support of the appeal, and will (upon request) have access to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.

3. If the appealed claim involves an exercise of medical judgment, the Plan Sponsor will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.

4. The final decision on the appeal will be made within the time periods specified below:

   a. Pre-Service Claim

      PAI (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than thirty (30) days after receipt of the appeal.

   b. Urgent Care Claim

      The Participant may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and the Plan Sponsor will communicate with the Participant by telephone or facsimile. The Plan Sponsor will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.

   c. Post-Service Claim

      PAI (on behalf of the Group Health Plan) will decide the appeal within a reasonable period of time, but no later than sixty (60) days after receipt of the appeal.

   d. Concurrent Care Claim

      The Plan Sponsor will decide the appeal of Concurrent Care Claims within the time frames set forth in the Claims Filing and Appeal Procedures section, B. Appeal Procedures for an Adverse Benefit Determination, item 4 a.-c., depending on whether such claim also is a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

5. Notice of Final Internal Appeals Determination

   a. If a Participant's appeal is denied in whole or in part, the Participant will receive notice of an Adverse Benefit Determination.

      i. State specific reason(s) for the Adverse Benefit Determination;

      ii. Reference specific provision(s) of the Plan of Benefits on which the Benefit determination is based;

      iii. State that the Participant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;

      iv. Disclose and provide any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination

      v. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, or Experimental or Investigational services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request); and

      vi. Include a statement regarding the Participant's right to bring an action under section 502(a) of ERISA.

   b. The Participant will also receive a notice if the claim on appeal is approved.

6. The Plan Sponsor may retain PAI to assist the Plan Sponsor in making the determination on appeal. Regardless of its assistance, PAI is acting only in an advisory capacity and is not acting in a fiduciary capacity. The Plan Sponsor at all times retains the right to make the final determination.

CASE MANAGEMENT

Case management is provided through a contract between PAI and Blue Cross Blue Shield of South Carolina.

COMPREHENSIVE CASE MANAGEMENT

In the event of a serious or catastrophic illness or injury, this Plan of Benefits provides for a comprehensive case management program. The comprehensive case management program is a patient-centered approach to developing a comprehensive plan of cost-effective health care. The services provided under the case management program include:

A. Evaluation and assistance for the Participant to help develop a plan of services to meet specific needs;

B. Assistance with obtaining unusual equipment or supply needs;

C. Assistance in home care planning and implementation;

D. Arrangements for needed nursing/caregiver services;

E. Providing help with assessment of rehabilitation needs and Provider arrangements;

F. Offering appropriate and effective alternative care/therapy suggestions for Mental Health Services and/or Substance Abuse Services as determined by medical care review;

G. Monitoring and assuring treatment programs and interventions for Mental Health Services and/or Substance Abuse Services; and

H. Functioning as an effective resource for information on treatment facilities and available care for Mental Health Services and/or Substance Abuse Services.

The case management program is voluntary and will not provide Benefits in excess of those ordinarily available under the Plan.

ALTERNATIVE TREATMENT PLAN UNDER CASE MANAGEMENT

In the course of the case management program, the Plan Administrator shall have the right to alter or waive the normal provisions of this Plan of Benefits when it is reasonable to expect a cost-effective result without a sacrifice to the quality of patient care.

Benefits provided under this section are subject to all other Plan of Benefits provisions. Alternative care will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that Participant or any other Participant. Nothing contained in this Plan of Benefits shall obligate the Plan Administrator to approve an alternative treatment plan.

MEDICAL SCHEDULE OF BENEFITS

This Schedule of Benefits and the Benefits described herein are subject to all terms and conditions of the Plan of Benefits. In the event of a conflict between the Plan of Benefits and this Schedule of Benefits, the Schedule of Benefits shall control. Capitalized terms used in this Schedule of Benefits have the meaning given to such terms in the Plan of Benefits. Percentages stated are those paid by the Group Health Plan. Covered Expenses will be paid only for Benefits that are Medically Necessary.

Benefit Year is from January 1st – December 31st.

Deductibles:	
Benefit Year Deductible: Benefits with an "*" indicate that the Benefit Year Deductible is waived.	$300 per Participant per Benefit Year at a Participating Provider, limited to $900 per family $550 per Participant per Benefit Year at a Non-Participating Provider, limited to $1,650 per family
Benefit Year Deductible and any Co-payments must be met before any Covered Expenses are paid. The Co-payment for each Hospital Admission is $250 at a Participating Provider and $500 at a Non-Participating Provider.	

Maximums:	
Annual Out-of-Pocket Maximum:	$3,000 per Participant and $6,000 per family at a Participating Provider $6,500 per Participant and $13,000 per family at a Non-Participating Provider Allowed Amounts are paid at 100% after the Out-of-Pocket Maximum is met. Covered Expenses that are applied to the Out-of-Pocket Maximum shall contribute to both the Participating and Non-Participating Provider Out-of-Pocket Maximums. Benefit Year Deductibles, Penalties and Co-payments do not contribute to the Out-of-Pocket Maximum determination, nor does the percentage of reimbursement change from the amount indicated on the Schedule of Benefits.

Pre-Authorization Requirements:
♦ **All Admissions require Pre-Authorization—**If Pre-Authorization is not obtained for services at a Participating Provider, room and board charges will be denied. Pre-Authorization for services at a Non-Participating Provider is your responsibility, and you will be responsible for the first $1,000 if it is not obtained.

INPATIENT HOSPITAL SERVICES: Pre-Authorization required	**PPO:**	**Non-PPO:**
Room and Board: Semi-private room rate: Private room rate:	 80% 90%	60%
Skilled Nursing Facility: Limited to 100 days per Benefit Year—Per Admission Co-pay does not apply	80%	60%
Physical Rehabilitation Facility:	80%	60%
Intensive Care Unit, Cardiac Care Unit, Burn Unit:	80%	60%
Newborn Nursery:	80%	60%
Physician Expenses:	80%	60%
Radiology/Pathology Charges:	80%	60%
Mental Health or Substance Abuse:	80%	60%
Anesthesia:	80%	60%
Inpatient Prescription Drugs Only:	80%	60%

OUTPATIENT SERVICES:	**PPO:**	**Non-PPO:**
Hospital Surgical Services:	80%	60%
Hospital and Physician Charges:	80%	60%
Emergency Room Charges: Co-pay waived if admitted	$100 co-pay per visit, then 80%	$100 co-pay per visit, then 60%
Pre-Admission Testing:	80%	60%
Anesthesia:	80%	60%
Cardiac Rehabilitation:	80%	60%
Mental Health or Substance Abuse:	80%	60%
Diagnostic X-ray, Laboratory, Pathology, and Radiology:	80%	60%

PHYSICIAN OFFICE SERVICES:	**PPO:**	**Non-PPO:**
Surgery:	$25 co-pay, then *100%	60%
Physician Office Visit: Including Lab, X-ray, Pathology, Radiology, Supplies, Mental Health, Substance Abuse, Injections, MRI, CT Scans or Allergy Services	$25 co-pay, then *100%	60%
Allergy Injections: Co-pay applies with or without Office Visit	$25 co-pay, then *100%	60%
Birth Control Device Surgery: Includes Implanon, IUD and Norplant	$25 co-pay, then *100%	60%
Radiology, Pathology, X-ray, Labs, Supplies , MRI, CT Scans and Injections (other than Allergy Injections) billed separate from Office Visit: Note: Office Visit co-pay applies to all services rendered in a physician's office **and billed by the physician**. Lab, X-ray or other services billed by another entity will be subject to applicable deductible and coinsurance provisions.	80%	60%
Diagnostic Hearing Exam:	$25 co-pay, then *100%	60%

OTHER SERVICES:	PPO:	Non-PPO:
Chiropractic Care: Limited to 24 visits per Benefit Year	80%	60%
Hospice Care:	80%	60%
Bereavement Counseling: Limited to 3 visits within 12 months of death	*80%	80%
Home Health Care:	80%	60%
Durable Medical Equipment (DME):	80%	60%
Prosthetics:	80%	60%
Second Surgical Opinion (not mandatory)**:**	*100%	*100%
Human Organ/Tissue Transplants: Pre-Authorization required	80%	60%
Ambulance:	*80%	*80%
Physical /Occupational/Speech Therapy:	80%	60%
Radiation Therapy and Chemotherapy:	80%	60%
Diagnostic Colonoscopies:	80%	60%
Orthotics: Limited to initial appliance only	80%	60%
Maternity Care:	80%	60%
Private Duty Nursing:	80%	60%
Refractive Eye Surgery: Includes Lasik, PRK, Radial Keratotomy and any similar procedures Limited to lifetime maximum of $1,000 per eye	50%	50%
Wig after Chemotherapy:	*80%	*80%
All Other Benefits:	80%	60%

WELLNESS SERVICES: Co-pay only applies if office visit is billed	PPO:	Non-PPO:
Annual Physical Exam:	$25 co-pay, then *100%	*60%
Annual Gynecological Exam or Prostate Exam:	$25 co-pay, then *100%	*60%
Well-Child Care: Immunizations are covered at 100%, not subject to Benefit Year deductible or co-pay up to age 6—Flu shots are **not** included	$25 co-pay, then *100%	*60%
Routine Mammograms: Limited to one every 2 years for women age 40-50; one per year for women over age 50; and one per year upon Physician's orders for women at risk.	*100%	*60%
Routine Colonoscopies: Limited to one every 10 years for Participants age 50 or over	$25 co-pay, then *100%	*60%
Routine Hearing Exams:	$25 co-pay, then *100%	*60%
Blue Cross and Blue Shield of S.C. Mammography Network Provider:		
Routine Mammogram: Limited to one every 2 years for women age 40-50; one per year for women over age 50; and one per year upon Physician's orders for women at risk.	*100%	

PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits are subject to all of the Prescription Drug Exclusions listed in this document.

Prescription Drugs are provided through the Magellan Rx Prescription Drug Program. Partners Rx uses the Medispan defined drug/therapeutic classification for product coverage and exclusion. Prescription Drugs will be covered in the following manner:

Participating Pharmacies:

Co-pay per prescription (30-day supply maximum per prescription):

Brand Name Drug	30% up to a maximum of $250 per prescription
Generic Drug	$3 co-pay, then 100%

Participating Pharmacies:

Co-pay per prescription (90-day supply maximum available for **Maintenance Drugs** at **all retail locations**):

Brand Name Drug	20% up to a maximum of $250 per prescription
Generic Drug	$6 co-pay, then 100%

Mail Service Pharmacy:

Co-pay per prescription (90-day supply maximum per prescription):

Brand Name Drug	20% up to a maximum of $250 per prescription
Generic Drug	$6 co-pay, then 100%

All Specialty Drugs require Pre-Authorization. (limited to 30-day supply at retail and mail order locations)

***Over the counter Smoking deterrents are covered at the Generic co-pay.**

***Anti-Obesity prescription drugs are covered.**

***Contraceptives are covered to include injectables, orals, patches and IUDs.**

A Participant will pay the difference in price between the Brand Name Drug and its generic equivalent when a brand name drug is dispensed (up to a maximum of $225). This differential is in addition to the Brand Name co-payment. However, if there is no Generic bioequivalent available, there will be no additional cost of the Participant (other than the Brand Name co-payment).

MEDICARE PART D NOTICE

The prescription benefits offered by this Benefit Plan are considered "Creditable" for purposes of the CMS/Medicare Part D drug benefit option. This means that the Benefits offered by this Plan are generally the same as, or better than, what would be available under an approved Part D drug option plan. The determination that this Plan's drugs coverage is "Creditable" is important. As such, if you participate in this Plan's prescription drug Benefit program, and are also eligible for CMS/Medicare coverage but do not elect a CMS/Medicare Part D option, CMS/Medicare will not penalize you with higher premiums should you elect to participate in such a program in the future.

It is important to note that the "Creditable" coverage provided by this Plan could be forfeited in the event there is a break in coverage of 63 days or more before enrolling in an approved Part D plan.

MEDICAL BENEFITS

A. Payment

The payment of Covered Expenses for Benefits is subject to all terms and conditions of the Plan of Benefits and the Schedule of Benefits. In the event of a conflict between the Plan of Benefits and the Schedule of Benefits, the Schedule of Benefits controls. Covered Expenses will be paid only for Benefits:

1. Performed or provided on or after the Participant Effective Date; and
2. Performed or provided prior to termination of coverage; and
3. Provided by a Provider, within the scope of his or her license; and
4. For which the required Pre-Admission Review, Emergency Admission Review, Pre-Authorization and/or Continued Stay Review has been requested and Pre-Authorization was received from PAI (the Participant should refer to the Schedule of Benefits for services that require Pre-Authorization); and
5. That are Medically Necessary; and
6. That are not subject to an exclusion of this Plan of Benefits; and
7. After the payment of all required Benefit Year Deductibles, Coinsurance and Co-payments.

B. Specific Covered Benefits

If all of the following requirements are met, the Group Health Plan will provide the Benefits described in this section:

1. All of the requirements of this Benefits Section must be met; and
2. The Benefit must be listed in this section; and
3. The Benefit (separately or collectively) must not exceed the dollar amount or other limitations contained on the Schedule of Benefits; and
4. The Benefit must not be subject to one or more of the exclusions set forth in the Exclusions and Limitations Section.

The Group Health Plan will provide the following Benefits:

1. Covered Expenses for **ambulance transportation** (including air ambulance when necessary) when used:
   A. Locally to or from a Hospital providing Medically Necessary services in connection with an accidental injury or that is the result of an Emergency Medical Condition; and
   B. To or from a Hospital in connection with an Admission.

   In some cases, emergency transportation by an Air Ambulance may qualify as ambulance service. Air Ambulance service must be Medically Necessary. Medical Necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. All Air Ambulance services will be individually considered for Medical Necessity, and prior authorization should be obtained if possible.
2. Covered Expenses made by an **Ambulatory Surgical Center** or minor emergency medical clinic.
3. Covered Expenses for the cost and administration of an **anesthetic**; however, anesthesia rendered by the attending surgeon or his/her assistant is excluded.
4. Covered Expenses for **artificial limbs or breast prosthesis**, to replace body parts when the replacement is necessary because of physiological changes.
5. When an **assistant surgeon** is required to render technical assistance at an operation, the eligible expense for such services shall be limited to 20% of the Allowed Amount of the surgical procedure.

6. Covered Expenses incurred for the treatment of **Autism.**
7. **Blood transfusions**, including cost of blood, blood plasma, blood plasma expanders and other blood products not donated or replaced by a blood bank.
8. Phase II **cardiac rehabilitation** (to improve a patient's tolerance for physical activity or exercise) will be covered under a medically supervised and controlled reconditioning program.
9. Covered Expenses for **chiropractic care**.
10. Initial **contact lenses or** one pair of **eyeglasses** required following cataract surgery;
11. Covered Expenses for **cosmetic surgery**, only for the following situations:
    A. When the malappearance or deformity is due to a congenital anomaly; or
    B. When due solely to surgical removal of all or part of the breast tissue because of an injury or illness to the breast; or
    C. When required for the medical care and treatment of a cleft lip and palate.

    Coverage for the proposed cosmetic surgery or treatment must be Pre-Authorized by the Medical Review Department prior to the date of that surgery or treatment.
12. Charges for **CRNAs and Supervising Medical Doctors** will be a Covered Charge subject to the following provisions:
    A. The Allowed Amount for a CRNA will be 50% of the PPO re-priced amount for the MD Anesthesiologist, subject to all other Plan and modifier limitations.
    B. If the MD Anesthesiologist is not a PPO, then the CRNA Allowed Amount will be equal to 50% of the UCR for the MD Anesthesiologist, subject to all other Plan and modifier limitations.
    C. Charges for the Supervising MD will be limited to 50% of the PPO re-priced amount for the MD Anesthesiologist working independently.
13. Covered Expenses for Prescription **Drugs** requiring a written prescription of a licensed Physician; such drugs must be necessary for the treatment of an illness or injury.
14. Covered Expenses for **Durable Medical Equipment** (such as renal dialysis machines, resuscitators or Hospital-type beds), required for temporary therapeutic use in the Participant's home by an individual patient for a specific condition when such equipment ordinarily is not used without the direction of a Physician. If such equipment is not available for rent, the monthly payments toward the purchase of the equipment may be approved by the Plan supervisor. Benefits will be reduced to standard equipment allowances when deluxe equipment is used. The rental or purchase Benefits cannot exceed the purchase price of the equipment.
15. Covered Expenses for **electrocardiograms**, electroencephalograms, pneumoencephalograms, basal metabolism tests or similar well-established diagnostic tests generally approved by Physicians throughout the United States.
16. Covered Expenses for Pre-Authorized **Home Health Care** when rendered to a homebound Participant in the Participant's current place of residence.
17. Covered Expenses for Pre-Authorized **Hospice Care** provided in an inpatient or outpatient setting. Bereavement counseling covered for up to three visits for any combination of family members within 12 months of death.
18. **Hospital Covered Expenses** for:
    A. Daily room and board charges in a Hospital, not to exceed the daily semiprivate room rate (charges when a Hospital private room has been used will be reimbursed at the average semiprivate room rate in the facility). Hospitals with all private rooms will be allowed at 100% of the prevailing private room rate;
    B. The day on which a Participant leaves a Hospital or Skilled Nursing Facility, with or without permission, is treated as the discharge day and will not be counted as an inpatient care day, unless he returns to the Hospital by midnight of the same day. The day the Participant returns to the Hospital or Skilled Nursing Facility is treated as the Admission day and is counted as an inpatient care day. The days during which the Participant is not physically present for inpatient care are not counted as inpatient days;

C. Confinement in an intensive care unit, cardiac care unit or burn unit;

D. Miscellaneous Hospital services and supplies during Hospital confinement if such charges should not have been included in the underlying Hospital charge (as determined by the Plan);

E. Inpatient charges for well Newborn Care for nursery room and board and for professional service. Eligible expenses will be subject to the fee schedule rates for pediatric services and circumcision; and

F. Outpatient Hospital services and supplies and emergency room treatment.

19. Charges for **Human Organ or Tissue Transplants** subject to the following limits:

    A. The transplant must be performed to replace an organ or tissue of the participant.

    B. If the organ or tissue donor is a participant and the recipient is not, then the Plan will cover donor organ or tissue charges for:

        i. Evaluating the organ or tissue;

        ii. Removing the organ or tissue from the donor.

    The Plan will always pay secondary to any other coverage for the organ or tissue donor, however, if no coverage is available for the donor then benefits will be considered under the recipient's coverage and subject to the recipient's deductible and coinsurance. If the donor and recipient are both covered under this Plan the donor's charge will be considered as incurred by the recipient.

    This Plan will **not** pay benefits for Travel or Lodging expenses.

    Transplant arrangements are often assisted by Utilization Review, and at times Transplant facilities may or may not participate in one of the approved Preferred Provider Organizations (PPO). If the Utilization Review Coordinator assists in arranging services with an out-of-network facility (and usually is able to negotiate a discount in the process) then network benefit levels will be utilized when benefit payments are issued. If, however, Utilization review approves the Transplant procedure, but the patient chooses to have the service rendered in a non-network facility that is other than that recommended by Utilization review, then the benefits will be paid at the out-of-network benefit level.

    Pre-Authorization by Cost Management/Utilization Review is <u>mandatory</u> for Transplant Coverage to be in effect (except for Cornea transplants).

20. Routine **mammograms**. Non-routine mammograms are covered when Medically Necessary.

21. Expenses for **maternity care** for Employee and covered Dependents.

22. Any expenses incurred in obtaining **medical records** in order to substantiate Medical Necessity.

23. Covered Expenses for dressings, sutures, casts, splints, trusses, crutches, pacemakers, braces (not dental braces) or other **Medical Supplies** determined by the Plan to be appropriate for treatment of an illness or injury.

24. Covered Expenses for **Mental Health Services** if rendered by a licensed medical Physician (M.D.), licensed psychologist (Ph.D.), clinical psychologist, licensed masters social worker or licensed professional counselor. Expenses for Psychological Testing are also covered.

25. Covered Expenses for **newborn care**. The Plan of Benefits will comply with the terms of the Newborns' and Mothers' Health Protection Act of 1996. The Plan of Benefits will not restrict Benefits for any length of Hospital stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery (not including the day of delivery), or less than ninety-six (96) hours following a cesarean section (not including the day of surgery). Nothing in this paragraph prohibits the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than the specified time frames or from requesting additional time for hospitalization. In any case, PAI may not require that a Provider obtain authorization from PAI for prescribing a length of stay not in excess of forty-eight (48) or ninety-six (96) hours as applicable. However, Pre-Authorization is required to use certain Providers or facilities, or to reduce out-of-pocket costs.

26. Covered Expenses for the treatment and services rendered by an **occupational therapist** in a home setting, at a facility or institution whose primary purpose is to provide medical care for an illness or injury, or at a free-standing outpatient facility.

27. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Expenses only if that care is for the following **oral surgical procedures**:

    A. Emergency repair due to Injury to sound natural teeth;

    B. Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth; and

    C. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when a lab exam is required; excision of benign bony growths of the jaw and hard palate; external incision and drainage of cellulitis and incision of sensory sinuses, salivary glands or ducts.

28. The initial purchase and fitting of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness that occurred while covered under the plan. Replacement or repair will be covered only if it is necessary due to a change in the person's physical condition or it is less costly to buy a replacement rather than repair the existing equipment or rent like equipment.

29. Covered Expenses for **oxygen** and other gases and their administration.

30. Covered Expenses incurred for Admission in a **physical rehabilitation facility or Skilled Nursing Facility**, for participation in a multidisciplinary team-structured rehabilitation program following severe neurologic or physical impairment. The Participant must be under the continuous care of a Physician, and the attending Physician must certify that the individual requires nursing care 24 hours a day. Nursing care must be rendered by a registered nurse or a licensed vocational or practical nurse. The confinement cannot be primarily for domiciliary, custodial, personal-type care, care due to senility, alcoholism, drug abuse, blindness, deafness, mental deficiency, tuberculosis or Mental Disorders.

31. Covered Expenses for the treatment or services rendered by a **physical therapist** in a home setting, a facility or institution whose primary purpose is to provide medical care for an illness or injury, or at a free-standing duly licensed outpatient therapy facility.

32. Covered Expenses for the services of a **Physician** for medical care and/or surgical treatments including office, home visits, Hospital inpatient care, Hospital outpatient visits/exams, clinic care, and surgical opinion consultations, subject to the following:

    In-Hospital medical service consists of a Physician's visit or visits to a Participant who is a registered bed-patient in a Hospital or Skilled Nursing Facility for treatment of a condition other than that for which surgical service or obstetrical service is required, as follows:

    A. In-Hospital medical Benefits will be provided, limited to one visit per specialty per day;

    B. In-Hospital medical Benefits in a Skilled Nursing Facility;

    C. When two or more Physicians, within the same study, render in-Hospital medical services at the same time, payment for such service will be made only to one Physician; and

    D. Concurrent medical/surgical care Benefits for in-Hospital medical service in addition to Benefits for surgical service will be provided only:

        i. When the condition for which in-Hospital medical service requires medical care not related to Surgical or obstetrical service and does not constitute a part of the usual, necessary and related pre-operative and postoperative care but requires supplemental skills not possessed by the attending surgeon or his assistant; or

        ii. When a Physician other than a surgeon admits a Participant to the Hospital for medical treatment and it later develops that surgery becomes necessary, such Benefits cease on the date of surgery for the admitting Physician and become payable under the surgeon only; or

        iii. When the surgical procedure performed is designated by the Plan supervisor as a "warranted diagnostic procedure" or as a "minor surgical procedure."

33. **Pre-Admission testing** for a scheduled Admission when performed on an outpatient basis prior to such Admission. The tests must be in connection with the scheduled Admission and are subject to the following:

A. The tests must be made within seven (7) days prior to Admission; and

B. The tests must be ordered by the same Physician who ordered the Admission and must be Medically Necessary for the illness or injury for which the Participant is subsequently admitted to the Hospital.

34. Covered Expenses for **Private Duty Nursing Care** by a licensed nurse (R.N., L.P.N. or L.V.N.) as follows:

A. Inpatient Nursing Care: Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

B. Outpatient Nursing Care: Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those covered under Home Health Care and does not include outpatient private duty nursing care on a 24 hour shift basis.

35. Covered Expenses for **radiation therapy** or treatment, and **chemotherapy**.

36. Expenses for a **Second Opinion** (Not Mandatory). The Second Opinion must be rendered by a board-certified surgeon who is not professionally or financially associated with the Physician or the surgeon who rendered the first surgical opinion. The surgeon who gives the second surgical opinion may not perform the surgery. If the Second Opinion is different from the first, a third opinion also will be payable, provided the opinion is obtained before the procedure is performed. The conditions that apply to a Second Opinion also apply to any third surgical opinion.

37. Fees of a licensed **speech therapist** for restorative speech therapy for speech loss or impairment due to:

A. Surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenulectomy); or

B. An injury or illness.

38. Covered Expenses for **Substance Abuse** treatment will be payable if rendered by a licensed medical Physician (M.D.), licensed psychologist (Ph.D.), clinical psychologist, licensed masters social worker or licensed professional counselor. Services or charges for Detoxification are also covered.

39. Covered Expenses for **surgical procedures**, subject to the following:

A. If two or more operations or procedures are performed at the same surgical approach, the total amount covered for the operations or procedures will be payable for the major procedure only, or Benefits will be payable according to the recommendations of the Medical Review Department;

B. If two or more operations or procedures are performed at the same time, through different surgical openings or by different surgical approaches, the total amount covered will be paid according to the Allowed Amount for the operation or procedure bearing the highest allowance, plus one half of the Allowed Amount for all other operations or procedures performed;

C. If an operation consists of the excision of multiple skin lesions, the total amount covered will be paid according to the Allowed Amount for the procedure bearing the highest allowance, 50 percent (50%) for procedures bearing the second- and third-highest allowance, 25 percent (25%) for procedures bearing the fourth- through the eighth-highest allowance, and 10 percent (10%) for all other procedures;

D. If an operation or procedure is performed in two or more steps or stages, coverage for the entire operation or procedure will be limited to the allowance for such operation or procedure;

E. If two or more Physicians perform operations or procedures in conjunction with one another, other than as an assistant at surgery or anesthesiologist, the allowance, subject to the above paragraphs, will be prorated between them by the Plan supervisor when so required by the Physician in charge of the case; and

F. Certain surgical procedures, which are normally exploratory in nature, are designated as "independent procedures" by the Plan supervisor, and the Allowed Amount is covered when such a procedure is performed as a separate and single entity. However, when an independent procedure is performed as an integral part of another surgical service, the total amount covered will be paid according to the Fee Schedule for the major procedure only.

40. Covered Expenses for hyperalimentation or **total parenteral nutrition** (TPN) for person recovering from or preparing for surgery.

41. Covered Expenses for services for **voluntary sterilization** for Participants.
42. Charges associated with the initial purchase of a **wig after chemotherapy.**
43. Covered Expenses for **x-rays**, microscopic tests, and **laboratory tests**.

MEDICAL EXCLUSIONS AND LIMITATIONS

Notwithstanding any provision of the Plan to the contrary, if the Plan generally provides Benefits for a type of injury, then in no event shall a limitation or exclusion of Benefits be applied to deny coverage for such injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions), even if the medical condition is not diagnosed before the injury.

1. Any service or supply that is not **Medically Necessary**.
2. Charges incurred as a **result of declared or undeclared war or any act of war** or caused during service in the armed forces of any country.
3. **Professional services** billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
4. **Travel expenses**, whether or not recommended by a Physician.
5. Any medical **social services, recreational or Milieu Therapy, education testing or training**, except as part of Pre-Authorized Home Health Care or Hospice Care program.
6. **Nutritional counseling or vitamins, food supplements, and other dietary supplies** even if the supplements are ordered or prescribed by a Physician. Exceptions to this exclusion are noted under the Medical Schedule of Benefits and the Prescription Drug Benefits section.
7. Services, supplies or charges for **pre-marital and pre-employment physical examinations**.
8. Any service or supply for which a Participant is entitled to receive payment or Benefits (whether such payment or Benefits have been applied for or paid) under any law (now existing or that may be amended) of the United States or any state or political subdivision thereof, except for Medicaid. These include, but may not be limited to, Benefits provided by or payable under **workers' compensation laws**, the Veteran's Administration for care rendered for service-related disability, or any state or federal Hospital services for which the Participant is not legally obligated to pay. This exclusion applies if the Participant receives such Benefits or payments in whole or in part, and is applied to any settlement or other agreement regardless of how it is characterized and even if payment for medical expenses is specifically excluded.
9. Services to the extent that the Participant is entitled to payment or Benefits under any **state or federal** program that provides health care benefits, including Medicare, but only to the extent that Benefits are paid or are payable under such programs.
10. Charges incurred for which the Participant is not in the absence of this coverage **legally obligated** to pay or for which a charge would not ordinarily be made in the absence of this coverage.
11. Any illness you get or injury you receive while committing or attempting to **commit a crime, felony or misdemeanor** or while engaging or attempting to engage in an illegal act or occupation.
12. Any service (other than Substance Abuse Services), medical supplies, charges or losses resulting from a Participant being **Legally Intoxicated or under the influence of any drug or other substance**, or taking some action the purpose of which is to create a euphoric state or alter consciousness. The Participant, or Participant's representative, must provide any available test results showing blood alcohol and/or drug/substance levels upon request. If the Participant refuses to provide these test results, no Benefits will be provided.

    Legal Intoxication or Legally Intoxicated means the Participant's blood alcohol level was at or in excess of the amount established under applicable state law to create a presumption and/or inference that the Participant was under the influence of alcohol, when measured by law enforcement or medical personnel.
13. Services and supplies received as the result of any intentionally **self-inflicted injury** that does not result from a medical condition or domestic violence.
14. Charges incurred for services or supplies that constitute **personal comfort or beautification items**, such as television or telephone use.

15. All **cosmetic procedures** and any related **medical supplies,** in which the purpose is improvement of appearance or correction of deformity without restoration of bodily function. Examples of services that are cosmetic and are not covered are: rhinoplasty (nose); mentoplasty (chin), rhytidoplasty (face lift); surgical planing (dermabrasion); and blepharoplasty (eyelid).

16. Charges for **custodial care,** including sitters and companions**.**

17. Charges for **services, supplies, or treatment** not commonly and customarily recognized throughout the Physician's profession or by the American Medical Association as generally accepted and Medically Necessary for the Participant's diagnosis and/or treatment of the Participant's illness or injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value.

18. Any Medical Supplies or services rendered by a Participant to himself or herself or by a Participant's **immediate family** (parent, Child, spouse, brother, sister, grandparent or in-law).

19. Charges for inpatient confinement, primarily for x-rays, laboratory, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent, custodial or rest care, or any medical examination or test **not connected with an active illness or injury**, unless otherwise provided under any preventable care covered under this Plan of Benefits.

20. Charges incurred for treatment on or to the **teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes**.

21. Treatment of **infertility** (including the reversal of voluntary sterilization).

22. **Experimental or Investigational** services, including surgery, medical procedures, devices or drugs. The Group Health Plan reserves the right to approve, upon medical review, non-labeled use of chemotherapy agents that have been approved by the Federal Drug Administration (FDA) for cancer.

23. Charges incurred for treatment or supplies of weak, strained, or **flat feet**, instability or imbalance of the feet, treatment of any tarsalgia, metatarsalgia or bunion (other than operations involving the exposure of bones, tendons or ligaments), cutting or removal by any method of toenails or superficial lesions of the feet, including treatment of corns, calluses and hyperkeratoses, unless needed in treatment of a metabolic or peripheral-vascular disease.

24. Charges for **custom molded inserts and/or orthotics, other than the initial appliance, unless needed in treatment of a metabolic or peripheral-vascular disease.**

25. Charges for **maintenance care**. Unless specifically mentioned otherwise, the Plan of Benefits does not provide benefits for services and supplies intended primarily to maintain a level of physical or mental function.

26. Any service or supply rendered to a Participant for the treatment of **obesity** or for the purpose of weight reduction. This includes all procedures designed to restrict the Participant's ability to assimilate food; for example, gastric bypass, the insertion of gastric bubbles, the wiring shut of the mouth, and any other procedure the purpose of which is to restrict the ability of the Participant to take in food, digest food or assimilate nutrients. Also excluded are services, supplies or charges for the correction of complications arising from weight control procedures, services, supplies or charges, such as procedures to reverse any restrictive or diversionary procedures and such reconstructive procedures as may be necessitated by the weight loss produced by these non-covered restrictive or diversionary procedures, except as specified on the Schedule of Benefits. Examples of such reconstructive procedures include, but are not limited to, abdominal panniculectomy and removal of excessive skin from arms, legs or other areas of the body. Membership fees to weight control programs are also excluded.

27. Any service or treatment for complications resulting from any **non-covered procedures**.

28. Any service or supply rendered to a Participant for the diagnosis or treatment of **sexual dysfunction** (including impotence) except when Medically Necessary due to an organic disease. This includes, but is not limited to, drugs, laboratory and x-ray tests, counseling, transsexual procedures or penile prostheses necessary due to any medical condition.

29. Any charges for **elective abortions,** except for abortion performed in accordance with federal Medicaid guidelines.

30. No charge will be covered under Medical Benefits for **dental and oral surgical procedures** involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.
31. Charges not included as part of a Hospital bill for autologous **blood donation** that involves collection and storage of a patient's own blood prior to elective surgery.
32. Charges incurred for **take-home drugs** upon discharge from the Hospital.
33. **Spare items** of the nature of braces of the leg, arm, back and neck, artificial arms, legs or eyes, lenses for the eye, or hearing aids, unless needed due to physiological changes.
34. Care and treatment of **hair loss**.
35. **Exercise programs** for treatment of any condition.
36. Air conditioners, air-purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, wigs, non-Prescription Drugs and medicines, first aid supplies and non-Hospital adjustable beds.
37. **Acupuncture or hypnosis**, except when performed by a Physician in lieu of anesthesia.
38. Care and treatment for **sleep apnea**, unless Medically Necessary.
39. Treatment of **dysfunctional conditions** related to the muscles of mastication, malpositions or deformities of the jaw bone(s), orthognathic deformities, or temporomandibular joint (TMJ) disorders.
40. Charges that exceed any **Benefit limitations** stated in the Medical Schedule of Benefits of this Plan document.
41. Admissions or portions thereof for **custodial care or long-term care** including:
    A. Rest cares;
    B. Long-term acute or chronic psychiatric care;
    C. Care to assist a Participant in the performance of activities of daily living (including, but not limited to: walking, movement, bathing, dressing, feeding, toileting, continence, eating, food preparation and taking medication);
    D. Care in a sanitarium;
    E. Custodial or long-term care; or
    F. Psychiatric or Substance Abuse residential treatment, including: residential treatment centers; therapeutic schools; wilderness/boot camps; therapeutic boarding homes; halfway houses; and therapeutic group homes.
42. **Counseling and psychotherapy services** for the following conditions are not covered:
    A. Feeding and eating disorders in early childhood and infancy;
    B. Tic disorders, except when related to Tourette's disorder;
    C. Elimination disorders;
    D. Mental disorders due to a general medical condition;
    E. Sexual function disorders;
    F. Sleep disorders;
    G. Medication-induced movement disorders; or
    H. Nicotine dependence, unless specifically listed as a covered Benefit in the Plan of Benefits or on the Medical Schedule of Benefits.
43. Medical supplies, services or charges for the diagnosis or treatment of sexual and gender identity disorders, personality disorders, learning disorders, dissociative disorders, developmental speech delay, communication disorders, developmental coordination disorders, mental retardation or vocational rehabilitation.

44. **Error**. Charges for care, supplies, treatment, and/or services that are required to treat injuries that are sustained or an illness that is contracted, including infections and complications, while the Participant was under, and due to , the care of a Provider wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.
45. Charges for services that are not reasonable, not Medically Necessary, are not Usual and Customary, and/or are in excess of the **Maximum Allowable Charge** (See definition of Maximum Allowable Charge for application when utilizing PPO network discounts).
46. **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services (unless Medically Necessary as determined by the Plan Administrator and approved in advance).
47. Charges for care, supplies, treatment, and/or services for expenses actually **incurred by other persons.**
48. Charges for care, supplies, treatment, and/or services for Injuries resulting from **negligence**, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.
49. All charges in connection with treatments or medications where the patient either is in **non-compliance** with or is discharged form a Hospital or Skilled Nursing Facility against medical advice.
50. Care, treatment, services or supplies **not recommended and approved by a Physician;** or treatment, services or supplies when the Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
51. Treatments and supplies which are **not specified as covered** under this Plan.
52. Care and treatment billed by a Hospital for **non-medical emergency admissions** on a Friday or Saturday. This does not apply if surgery is performed within 24 hours of admission.
53. Charges for **Orthognathic surgery**.
54. **Subrogation, Reimbursement, and/or Third Party Responsibility.** Charge for care, supplies, treatment, and /or services of an Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.
55. Excision of wholly or partly unerupted **impacted teeth.**
56. **Prescription Drug Exclusions**. The following are not covered under this Plan of Benefits:
    A. Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, ostomy supplies and non-medical substances regardless of intended use;
    B. Any over-the-counter medication, unless specified otherwise;
    C. Prescription Drugs that have not been prescribed by a Physician;
    D. Prescription Drugs not approved by the Food and Drug Administration;
    E. Prescription Drugs for non-covered therapies, services, or conditions;
    F. Prescription Drug refills in excess of the number specified on the Physician's prescription order or Prescription Drug refills dispensed more than one (1) year after the original prescription date;
    G. Unless different time frames are specifically listed on the Schedule of Benefits more than a thirty (30) day supply for Prescription Drugs (ninety (90) day supply for Prescription Drugs obtained through a Mail Service Pharmacy);
    H. Any type of service or handling fee (with the exception of the dispensing fee charged by the pharmacist for filling a prescription) for Prescription Drugs, including fees for the administration or injection of a Prescription Drug;
    I. Dosages that exceed the recommended daily dosage of any Prescription Drug as described in the current Physician's Desk Reference or as recommended under the guidelines of the Pharmacy Benefit Manager, whichever is lower;

J. Prescription Drugs administered or dispensed in a Physician's office, Skilled Nursing Facility, Hospital or any other place that is not a Pharmacy licensed to dispense Prescription Drugs in the state where it is operated;

K. Prescription Drugs for which there is an over-the-counter equivalent and over-the-counter supplies or supplements;

L. Prescription Drugs that are being prescribed for a specific medical condition that is not approved by the Food and Drug Administration for treatment of that condition (except for Prescription Drugs for the treatment of a specific type of cancer, provided the drug is recognized for treatment of that specific cancer in at least one standard, universally accepted reference compendia or is found to be safe and effective in formal clinical studies, the results of which have been published in peer-reviewed professional medical journals);

M. Prescription Drugs that are not consistent with the diagnosis and treatment of a Participant's illness, injury or condition, or are excessive in terms of the scope, duration, dosage or intensity of drug therapy that is needed to provide safe, adequate and appropriate care;

N. Prescription Drugs to enhance physical growth or athletic performance or appearance;

O. Prescription Drugs that are immunization agents or biological sera;

P. Prescription Drugs or services that require Pre-Authorization by PAI and Pre-Authorization is not obtained;

Q. Prescription Drugs for injury or disease that are paid by workers' compensation benefits (if a workers' compensation claim is settled, it will be considered paid by workers' compensation benefits); and

R. Prescription Drugs that are not Medically Necessary.

57. **Home Health Care Exclusions**. The following are excluded from coverage under the Home Health Care Benefit:

A. Services and supplies not included in the Medical Schedule of Benefits, but not limited to, general housekeeping services and services for custodial care; and

B. Services of a person who ordinarily resides in the home of the Participant, or is a Participant's immediate family member (parent, Child, spouse, brother, sister, grandparent or in-law); and

C. Transportation services.

Notwithstanding the above exclusions, in the event that, after review of the medical records, other documentation, and case notes, the health care management medical director (or similarly titled position) of PAI, deems a plan of treatment and procedures are appropriate care for a Participant, the Plan shall deem the cost of the plan of treatment and procedures a Covered Expense.

ELIGIBILITY FOR COVERAGE

Eligibility:	
Waiting Period:	Coverage for new Employees will commence on the first day of the month following 60 days of continuous employment.
Annual Enrollment:	Month of March for a May 1st effective date
Actively at Work: Minimum hours per week:	At least 30 full-time hours per week
Pre-Existing Condition Exclusion Period: Applies only to claims with dates of service prior to June 1, 2014	Each Participant age 19 or older may serve a twelve-month Pre-Existing Condition Exclusion Period, less any Creditable Coverage the Participant can provide. Any Participant who is a Late Enrollee will serve an eighteen-month Pre-Existing Condition Exclusion Period. See the Eligibility for Coverage section for information on qualifying for Special Enrollment.
Dependent Child, in addition to meeting the requirements contained in the Plan of Benefits; the maximum age limitation to qualify as a Dependent Child is:	An Employee may cover a Dependent Child up to age 26. Coverage will end for the Dependent Child on their 26th birthday.
The column to the right identifies other group classifications, as defined by the Plan Sponsor, that also may participate in the Plan of Benefits:	Council Members (not subject to the 30 full-time hours per week minimum) Retirees subject to the provisions below in Item B. **Note:** Retirees and their dependents who are under age 65, and not eligible for Medicare, will be subject to the same benefit levels as active employees and their dependents. **Note: Retirees hired after July 1, 2010 will not be eligible to participate in this Plan except through COBRA.**
The column to the right identifies other group classifications, as defined by the Plan Sponsor, that may not participate in the Plan of Benefits:	Seasonal or Temporary Employees Post 65 Retirees and Medicare Eligible Individuals
Coverage for Participants will terminate the last day of the month in which employment is terminated or the end of the period for which the required premium has been paid.	

A. ELIGIBILITY

1. Every Employee who is Actively at Work and who has completed the Waiting Period on or after the Plan Sponsor Effective Date is eligible to enroll (and to enroll his or her Dependents) for coverage under this Plan of Benefits.
2. If an Employee is not Actively at Work or has not completed the Waiting Period, such Employee is eligible to enroll (and to enroll his or her Dependents) beginning on the next day that the Employee is:
   a. Actively at Work; and
   b. Has completed the Waiting Period.
3. Dependents are not eligible to enroll for coverage under Plan of Benefits without the sponsorship of an Employee who is enrolled under this Plan of Benefits.
4. Probationary periods and/or contribution levels will not be based on any factor that discriminates in favor of higher-wage employees as required under the ACA.

B. ELIGIBLE CLASSES OF EMPLOYEES

All Active and Retired Employees of the Plan Sponsor. Employees at Oconee County will be eligible to receive retiree coverage as follows:

1. For Retirees who leave employment prior to May 1, 2007:

    a. The employee must have been employed with Oconee County at least five years, but less than 10 and accepted by the SC State Retirement System as disabled. Further, the retiree will be required to pay the full cost of the insurance premiums to the county at the time of retirement. If an employee is accepted as disabled with the SC Retirement System and Social Security, the employee and spouse (if covered under the county plan) must elect, and keep in force, Medicare Parts A & B. If the employee is not accepted as disabled by Social Security within 25 months, coverage under the County insurance plan will be cancelled. However, coverage under the County plan may be reinstated if accepted by Social Security as disabled within a 36 month period of the original disability claim date, relating to the original cause of disability, and coverage was maintained under COBRA for any period beyond the initial 25 months.

    b. An employee retiring from Oconee County with at least 10 year of service with Oconee County and age 60, but less than 28 years of service with the County and the SC Retirement Service may retain the County insurance plan at the reduced premium of the County at the time of retirement, however, the employee and spouse (if covered under the county plan), must elect, and keep in force, both Medicare Parts A&B when eligible.

    c. An employee retiring from Oconee County with 28 years of service with the County and the SC Retirement System or at least 25 years of service with Oconee County and the SC Police Officers Retirement System shall retain the County insurance benefits (employee only) at reduced cost to the employee, however, the employee and spouse (if covered under the county plan), must elect, and keep in force, both Medicare Parts A & B when eligible.

    d. All current retirees (disabled and regular) listed before December 1, 2001, are hereby granted "grandfather status". Additionally, as of May 1, 2005 there were several retirees with Dependent Children covered under the Plan. These retiree dependents are "grandfathered" for this coverage. However, from this point forward, no other Dependent Children will be eligible for coverage, and once the Dependent Children currently covered are no longer on the Plan, they will not be eligible to become covered again as Dependents.

2. For retirees who leave employment on or after May 1, 2007:

    Retirees will be eligible to continue participation with the Plan (including their spouses) under the following circumstances:

    a. The employee must have been employed with Oconee County for at least 20 years. To remain covered the retiree must pay all applicable premiums and elect Medicare Parts A & B as soon as eligible.

    b. If disabled (as determined by Social Security and/or the SC State Retirement System) an employee may qualify with 10 years of County employment. To remain covered the retiree must elect Medicare Parts A & B as soon as eligible, but in no event longer than 29 months from the date deemed disabled by Social Security, and pay all applicable premiums.

3. Retirees hired after July 10, 2010 will not be eligible to participate in this plan except through COBRA:

    Retirees who otherwise qualify for retiree benefits under the eligibility provisions of this Plan will be eligible to continue coverage until their entitlement to Medicare, either through attainment of the age of eligibility or because of disability. Spouses with coverage in effect at the time of the employee's retirement may continue to be covered as long as the retiree is eligible under the Plan and all applicable premiums are paid. The spouse will no longer be eligible once they become entitled to Medicare.

For ALL Retirees: Should the qualified retiree terminate coverage for any reason, or predecease the spouse, the spouse's coverage will then terminate at the end of that month that the retiree's coverage is terminated under this Plan. Spousal coverage for a retiree is effective only if the spouse is covered at the time of retirement. Should coverage on the spouse be terminated at any time after the date of retirement of the retired employee, the spouse will not be eligible for reenrollment; however COBRA continuation coverage may be available. If the retired employee elects to drop coverage, on himself or spouse, no option of reelection is available.

C. ELECTION OF COVERAGE

Any Employee may enroll for coverage under the Group Health Plan for such Employee and such Employee's Dependents by completing and filing a Membership Application with the Plan Sponsor. Dependents must be enrolled within thirty-one (31) days of the date on which they first become Dependents. Employees and Dependents also may enroll if eligible under the terms of any late enrollment or Special Enrollment procedure.

D. COMMENCEMENT OF COVERAGE

Coverage under the Group Health Plan will commence as follows:

1. Employees and Dependents eligible on the Plan Sponsor Effective Date

   For Employees who are Actively at Work prior to and on the Plan Sponsor Effective Date, coverage will generally commence on the Plan of Benefits Effective Date.

2. Employees and Dependents Eligible After the Plan of Benefits Effective Date

   Employees and Dependents who become eligible for coverage after the Plan of Benefits Effective Date and have elected coverage will have coverage after they have completed the Waiting Period.

3. Dependents Resulting from Marriage

   Dependent(s) resulting from the marriage of an Employee will have coverage effective on the date of marriage provided they have enrolled for coverage within thirty-one (31) days after marriage and the coverage has been paid for under this Plan of Benefits.

4. Newborn Children

   A newborn Child will have coverage from the date of birth provided he or she has been enrolled for coverage within thirty-one (31) days after the Child's birth and the coverage has been paid for under this Plan of Benefits.

5. Adopted Children

   For an adopted Child of an Employee, coverage shall commence as follows:

   a. Coverage shall be retroactive to the Child's date of birth when a decree of adoption is entered within thirty-one (31) days after the date of the Child's birth.

   b. Coverage shall be retroactive to the Child's date of birth when adoption proceedings have been instituted by the Employee within thirty-one (31) days after the date of the Child's birth, and if the Employee has obtained temporary custody of the Child.

   c. For an adopted Child other than a newborn, coverage shall begin when temporary custody of the Child begins. However, such coverage shall only continue for one (1) year unless a decree of adoption is entered, in which case coverage shall be extended so long as such Child is otherwise eligible for coverage under the terms of this Plan of Benefits.

6. Special Enrollment

   In addition to enrollment under Eligibility for Coverage Section (E)(2-5) above, the Group Health Plan shall permit an Employee or Dependent who is not enrolled to enroll if each of the following is met:

   a. The Employee or Dependent was covered under a group health Plan or had Creditable Coverage at the time coverage was previously offered to the Employee or Dependent; and

b. The Employee stated in writing at the time of enrollment that the reason for declining enrollment was because the Employee or Dependent was covered under a group health Plan or had Creditable Coverage at that time. This requirement shall apply only if the Plan Sponsor required such a statement at the time the Employee declined coverage and provided the Employee with notice of the requirement and the consequences of the requirement at the time; and

c. The Employee or Dependent's coverage described above:

i. Was under a COBRA continuation provision and the coverage under the provision was exhausted; or

ii. Was not under a COBRA continuation provision described in section 6(c)(i), above, and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the Plan), death, termination of employment) or reduction in the number of hours of employment), or if the Plan Sponsor's contributions toward the coverage were terminated; or

iii. Was one of multiple Plans offered by a Plan Sponsor and the Employee elected a different Plan during an open enrollment period or when a Plan Sponsor terminates all similarly situated individuals; or

iv. Was under a HMO that no longer serves the area in which the Employee lives, works or resides; or

v. Was under a Plan where the Participant incurred a claim that met or exceeded a lifetime limit on all benefits. The Special Enrollment period is continued until at least thirty (30) days after a claim is denied due to the operation of the lifetime limit on all benefits;

vi. Under the terms of the Plan, the Employee requests the enrollment not later than thirty-one (31) days after date of exhaustion described in 6(c)(i) above, or termination of coverage or Plan Sponsor contribution described in 6(c)(ii) above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

The above list is not an all-inclusive list of situations when an Employee or Dependent loses eligibility. For situations other than those listed above, see the Plan Sponsor.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

a. in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;

b. in the case of a Dependent's birth, as of the date of birth; or

c. in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Medicaid or State Children's Health Insurance Program Coverage

A. The Employee or Dependent was covered under a Medicaid or State Children's Health Insurance Program Plan and coverage was terminated due to loss of eligibility; or

B. The Employee or Dependent becomes eligible for assistance under a Medicaid or State Children's Health Insurance Program Plan; and

C. The Employee or Dependent requests such enrollment not more than sixty (60) days after either:

i. the date of termination of Medicaid or State Children's Health Insurance Program coverage; or

ii. determination that the Employee or Dependent is eligible for such assistance.

E. DEPENDENT CHILD'S ENROLLMENT

1. A Dependent's eligibility for or receipt of Medicaid assistance will not be considered in enrolling that Dependent for coverage under this Plan of Benefits.

2. Absent the sponsorship of an Employee, Dependents are not eligible to enroll for coverage under this Plan of Benefits.

F. CHANGE IN FAMILY STATUS

The Plan permits you to change your benefit election during the Plan Year if a qualified change in family status occurs. Enrollment Application forms are available from your Human Resources Department. A qualified change in family status can occur for many reasons such as:

Type of Event	You need to...
Birth or Adoption	complete an Enrollment Application and indicate name of Dependent and date of birth or adoption.
Marriage	complete an Enrollment Application and indicate name of Spouse and date of marriage.
Divorce	complete an Enrollment Application and indicate the date of divorce and submit a copy of divorce decree.
Legal Separation	complete an Enrollment Application and indicate the date of separation and submit a copy of the separation agreement.
Death	complete an Enrollment Application and indicate the name of deceased and date of death.
Child reaches dependent age limit of 26.	complete an Enrollment Application and indicate the names of the family members who will continue to be covered.
Termination of employment	review section entitled Termination of Coverage in this booklet.
Loss of Spouse's employment	review section entitled Special Enrollment Periods. If enrolling new Plan members, complete an Enrollment Application and submit HIPAA certificate.

In order to effect a change in your Benefits, you must complete and return an Enrollment Application form to your Human Resources Department within 31 days following the qualifying event. Please note that the requested change in Benefits must be consistent with your change in family status (i.e. change from a single to family coverage due to marriage).

If you have (or expect to have) a change in family status or if you are unsure about your rights and responsibilities when applying for coverage, please contact the Human Resources Department to discuss your options and the necessary enrollment procedures.

G. PARTICIPANT CONTRIBUTIONS

The Participant is solely responsible for making all payments for any Premium.

H. DISCLOSURE OF MEDICAL INFORMATION

By accepting Benefits or payment of Covered Expenses, the Participant agrees that the Group Health Plan (and including Blue Cross on behalf of the Group Health Plan) may obtain claims information, medical records, and other information necessary for the Group Health Plan to consider a request for Pre-Authorization, a Continued Stay Review, an Emergency Admission Review, a Pre-Admission Review or to process a claim for Benefits.

TERMINATION OF THIS PLAN OF BENEFITS

A. TERMINATION OF THIS PLAN OF BENEFITS

Termination of an Employee's coverage and all of such Employee's Dependents' coverage will occur on the earliest of the following dates:

1. The date the Group Health Plan is terminated pursuant to Sections (B)-(E) below.
2. The date an Employee retires unless the Group Health Plan covers such individual as a retiree.
3. The date an Employee ceases to be eligible for coverage as set forth in the Eligibility Section.
4. The last day of the month in which an Employee is no longer Actively at Work or the end of the period for which the required premium has been paid, except that a qualified Employee (as qualified under the Family and Medical Leave Act of 1993) may be considered Actively at Work during any leave taken pursuant to the Family and Medical Leave Act of 1993.
5. In addition to terminating when an Employee's coverage terminates, a Dependent spouse's coverage terminates on the date of entry of a court order ending the marriage between the Dependent spouse and the Employee regardless of whether such order is subject to appeal.
6. In addition to terminating when an Employee's coverage terminates, a Child's coverage terminates when that individual no longer meets the definition of a Dependent under the Group Health Plan.
7. In addition to terminating when an Employee's coverage terminates, an Incapacitated Dependent's coverage terminates when that individual no longer meets the definition of an Incapacitated Dependent.
8. Death of the Employee.

B. TERMINATION FOR FAILURE TO PAY PREMIUMS

1. If a Participant fails to pay the Premium during the Grace Period, such Participant shall automatically be terminated from participation in the Group Health Plan, without prior notice to such Participant.
2. In the event of termination for failure to pay Premiums, Premiums received after termination will not automatically reinstate the Employee in participation under the Group Health Plan absent written agreement by the Plan Sponsor. If the Employee's participation in the Group Health Plan is not reinstated, the late Premium will be refunded to the Employee.

C. TERMINATION WHILE ON LEAVE

During an Employee's leave of absence that is taken pursuant to the Family and Medical Leave Act, the Plan Sponsor must maintain the same health Benefits as provided to Employees not on leave. The Employee must continue to pay his or her portion of the Premium. If Premiums are not paid by an Employee, coverage ends as of the due date of that Premium contribution.

D. TERMINATION DUE TO A RESCISSION OF COVERAGE

In the event that a Participant:

1. Performs an act, practice, or omission that constitutes fraud; or
2. Makes an intentional misrepresentation of material fact,

The Participant's coverage under this Plan of Benefits will terminate retroactively at one of the following times:

1. If event occurs upon application for participation in the Plan, the Participant's coverage will be void from the time of his/her effective date; or
2. If event occurs at any other time, the Participant's coverage will terminate retroactively to the date of the event occurrence, as outlined above.

In the event your coverage is rescinded, you will be given 30 days' advance written notice of the Rescission as well as the retroactive effective date. Any Premiums paid will be returned once the Plan Administrator deducts

the amount for any claims paid.

E. NOTICE OF TERMINATION TO PARTICIPANTS

Other than as expressly required by law, if the Group Health Plan is terminated for any reason, the Plan Sponsor is solely responsible for notifying all Participants of such termination and that coverage will not continue beyond the termination date.

F. REINSTATEMENT

The Group Health Plan in its sole discretion (and upon such terms and conditions as any stop-loss carrier or the Plan Sponsor may determine) may reinstate coverage under the Group Health Plan that has been terminated for any reason. If a Participant's coverage (and including coverage for the Participant's Dependents) for Covered Expenses under the Group Health Plan terminates while the Participant is on leave pursuant to the Family and Medical Leave Act because the Participant fails to pay such Participant's Premium, the Participant's coverage will be reinstated without new probationary periods if the Participant returns to work immediately after the leave period, re-enrolls and, within thirty-one (31) days following such return, pays all such Employee's portion of the past due amount and then current Premium.

G. PLAN SPONSOR IS AGENT OF PARTICIPANTS

By accepting Benefits, a Participant agrees that the Plan Sponsor is the Participant's agent for all purposes of any notice under the Group Health Plan. The Participant further agrees that notifications received from, or given to, the Plan Sponsor by PAI are notification to the Employees except for any notice required by law to be given to the Participants by PAI.

H. PERSONNEL POLICIES

Except as required under the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act, the Plan Sponsor's current personnel policies regarding Waiting Periods, continuation of coverage, or reinstatement of coverage shall apply during the following situations: Plan Sponsor-certified disability, leave of absence, layoff, reinstatement, hire or rehire.

I. RETURN TO WORK

An Employee who returns to work **within six (6) months** of a layoff or an approved leave of absence will retain the same insurance status as prior to the said date, provided any required contributions have been paid in full. No new eligibility Waiting Period will apply unless these conditions were still to be met at the time of layoff or leave of absence.

An Employee who returns to work **after six (6) months** of an approved leave of absence or layoff will be considered a new Employee and will be subject to all eligibility requirements, including all requirements relating to the Effective Date of coverage (except as provided under the provision entitled "status change").

J. STATUS CHANGE

If an Employee or Dependent has a status change while covered under this Plan of Benefits (i.e. Employee to Dependent, COBRA to active) and no interruption in coverage has occurred, the Plan of Benefits will allow continuity of coverage with respect to any Waiting Period.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

In the case of a Participant who is receiving Covered Expenses in connection with a mastectomy, the Group Health Plan will pay Covered Expenses for each of the following (if requested by such Participant):

A. Reconstruction of the breast on which the mastectomy has been performed;

B. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

C. Prosthesis and physical complications at all stages of mastectomy, including lymphedemas.

The Plan of Benefits' Benefit Year Deductible and Co-payment will apply to these Benefits.

FAMILY AND MEDICAL LEAVE ACT ("FMLA")

The Group Health Plan must comply with FMLA as outlined in the regulations issued by the U.S. Department of Labor. During any leave taken under the FMLA, the Plan Sponsor will maintain coverage under this Plan of Benefits on the same basis as coverage would have been provided if the Employee had been continuously employed during the entire leave period.

In general, eligible Employees may be entitled to:

Twelve workweeks of leave in a 12-month period for:

- the birth of a Child and to care for the newborn Child within one year of birth;
- the placement with the Employee of a Child for adoption or foster care and to care for the newly placed Child within one year of placement;
- to care for the Employee's spouse, Child, or parent who has a serious health condition;
- a serious health condition that makes the Employee unable to perform the essential functions of his or her job;
- any qualifying exigency arising out of the fact that the Employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" or

Twenty-six workweeks of leave in a single 12-month period to care for a covered service member with a serious injury or illness of a service member spouse, son, daughter, parent, or next of kin to the Employee (military caregiver leave).

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires that Plan Sponsors allow the following categories of eligible people continue coverage under the Group Health Plan after such individuals would ordinarily not be eligible.

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

If you decide to continue this coverage, it is available for a period of up to 18, 29 or 36 months, depending on the circumstances:

A. 18 months for Employees whose working hours are reduced – during a non-FMLA leave of absence or when an Employee changes from full-time to part-time – and any family members who also lose coverage for this reason;

B. 18 months for Employees who voluntarily quit work and any family members who also lose coverage for this reason;

C. 18 months for Employees who are part of a layoff and any family members who also lose coverage for this reason;

D. 18 months for Employees who are fired, unless the firing is due to gross misconduct of the Employee, and any family members who also lose coverage for this reason;

E. 29 months for Employees and all covered Dependents who are determined to be disabled under the Social Security Act before or during the first sixty (60) days after termination of employment or reduction of hours of employment. Notice of the Social Security Disability determination must be given to the Plan Sponsor within 60 days of the determination of disability and before the end of the first 18 months of continuation of coverage. However, if the determination was prior to termination, the Notice can be provided with COBRA election form in order to secure the extension;

F. 36 months for Employees' widows or widowers and their Dependent Children;

G. 36 months for separated (in states where legal separation is recognized) or divorced husbands or wives of the Employee and their Dependent Children;

H. 36 months for Dependent Children who lose coverage under the Plan of Benefits because they no longer meet the Plan's definition of a Dependent Child;

I. 36 months for Dependents who are not eligible for Medicare when the Employee is eligible for Medicare and no longer has coverage with the Plan Sponsor;

J. For Plans providing coverage for retired Employees and their Dependents, a special rule applies for such persons who would lose coverage due to the Plan Sponsor filing for Title 11 Bankruptcy. (Loss of coverage includes a substantial reduction of coverage within a year before or after the bankruptcy filing.) Upon occurrence of such an event, retired Employees and their eligible Dependents may continue their coverage under the Plan of Benefits until the date of death of the retiree. If a retiree dies while on this special continued coverage, surviving Dependents may elect to continue coverage for up to 36 additional months.

Except for items E, G, and H, above, the Plan Administrator is responsible for getting the proper form(s) to the Participant so continuation of coverage can be applied for.

For items E, G, and H, the Participant is responsible for notifying the Plan Administrator within sixty (60) days that the qualifying event has occurred. The notice must be given in writing to the Plan Administrator and should contain the following information: (1) name of benefit Plan, (2) covered Employee's name, (3) your name and address, and (4) the type of qualifying event and the date it occurred. Upon receipt of notice, the Plan Sponsor will then forward the COBRA application form to the Participant or the appropriate Dependent.

The Participant or the appropriate Dependent must complete a COBRA application form and return it to the Plan Administrator no later than 60 days (called the election period) from the later of: (1) the date the Participants coverage ends, or (2) the date the Participant receives notice of the right to apply for continuation coverage.

An application by the Participant or their spouse for continuation of coverage also applies to any other family members who also lose coverage for the same reason. However, each family member losing coverage for the same reason is entitled to make a separate application for continuation of coverage. If there is a choice among types of coverage under the Plan of Benefits, each family member can make a separate selection from the available types of coverage.

During an 18-month continuation of coverage period, some persons may have another situation occur to them from among items B, C, D, and F through I. They will be entitled to continuation of coverage for an overall total of up to **36** months. For items G and H, the Participant must notify the Plan Administrator within **60** days that the situation has occurred.

Premiums for continuation of coverage should be paid to the Plan Administrator or their designated party. The Plan Administrator has the right to require you to pay the entire Premium, even if active employees pay only part of the Premium. The Plan Administrator also has the right to charge and keep an extra two percent administration fee each month. For disabled employees who have applied for the 29-month COBRA continuation period, the Plan Administrator has the right to charge 150% of the applicable Premium each month for the 19th month through the 29th month of coverage.

For those Participants electing COBRA continuation of coverage, the first Premium payment must be postmarked and mailed to the Plan Administrator by the 45th day after the Participant elects continuation coverage. Thereafter, Premium payments are due on the first of each month. There is a 31-day grace period for payment of the monthly Premiums.

COBRA Continuation of Coverage ends earlier than the maximum continuation period under the following circumstances:

A. When Premiums are not paid on time.

B. When the Participant who has continuation of coverage becomes covered under another group health Plan or Medicare, after the date of the COBRA election, through employment or otherwise.

C. When a disabled person covered under the extended 29-month COBRA continuation period has been determined by the Social Security Administration to be no longer disabled, coverage ends for the disabled person and any covered family members on the later of 30 days after the determination or 18 months. (Notification must be given to the Company within 30 days of final determination.)

D. The termination of the Group Health Plan.

Uniformed Services Employment and Re-employment Rights Act (USERRA)

A. In any case in which an Employee or any of such Employee's Dependents has coverage under the Plan of Benefits, and such Employee is not Actively at Work by reason of active duty service in the uniformed services, the Employee may elect to continue coverage under the Plan of Benefits as provided in this section. The maximum period of coverage of the Employee and such Employee's Dependents under such an election shall be the lesser of:

   i The twenty-four (24) month period beginning on the date on which the Employee's absence from being Actively at Work by reason of active duty service in the uniformed services begins; or

   ii The day after the date on which the Employee fails to apply for or return to a position of employment, as determined under USERRA.

   The continuation of coverage period under USERRA will be counted toward any continuation of coverage period available under COBRA.

B. An Employee who elects to continue coverage under this section of the Group Health Plan must pay one hundred and two percent (102%) such Employee's normal Premium. Except that, in the case of an Employee who performs service in the uniformed services for less than thirty-one (31) days, such Employee will pay the normal contribution for the thirty-one (31) days.

C. An Employee who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under the Group Health Plan upon re-employment. Except as otherwise provided in this Article upon re-employment and reinstatement of coverage no new exclusion or Probationary Period will be imposed in connection with the reinstatement of such coverage if an exclusion or Waiting Period normally would have been imposed. This Article applies to the Employee who is re-employed and to a Dependent who is eligible for coverage under the Group Health Plan by reason of the reinstatement of the coverage of such Employee.

D. This Section shall not apply to the coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

National Defense Authorization Act—Military Leave Entitlements

A. Permits a "spouse, son, daughter, parent or next of "kin" to take up to 26 workweeks of leave to care for a "member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy and is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness".

B. Permits an Employee to take FMLA leave for "any qualifying exigency (as the Secretary of Labor shall, by regulation, determine) arising out of the fact that the spouse, or a son, daughter, or parent of the Employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation".

SUBROGATION / RIGHT OF REIMBURSEMENT

In the event Benefits are provided to or on behalf of a Participant under the terms of this Plan of Benefits, the Participant agrees, as a condition of receiving Benefits under the Plan of Benefits, to transfer to the Group Health Plan all rights to recover damages in full for such Benefits when the injury or illness occurs through the act or omission of another person, firm, corporation, or organization. The Group Health Plan shall be subrogated, at its expense, to the rights of recovery of such Participant against any such liable third party.

If, however, the Participant receives a settlement, judgment, or other payment relating to an injury or illness from another person, firm, corporation, organization or business entity for the injury or illness, the Participant agrees to reimburse the Group Health Plan in full, and in first priority, for Benefits paid by the Group Health Plan relating to the injury or illness. The Group Health Plan's right of recovery applies regardless of whether the recovery, or a portion thereof, is specifically designated as payment for, but not limited to, medical Benefits, pain and suffering, lost wages, other specified damages, or whether the Participant has been made whole or fully compensated for his/her injuries.

The Group Health Plan's right of full recovery may be from the third party, any liability or other insurance covering the third party, the insured's own uninsured motorist insurance, underinsured motorist insurance, any medical payments (Med-Pay), no fault, personal injury protection (PIP), malpractice, or any other insurance coverages that are paid or payable.

The Group Health Plan will not pay attorney's fees, costs, or other expenses associated with a claim or lawsuit without the expressed written authorization of the Group Health Plan.

The Participant shall not do anything to hinder the Group Health Plan's right of subrogation and/or reimbursement. The Participant shall cooperate with the Group Health Plan and execute all instruments and do all things necessary to protect and secure the Group Health Plan's right of subrogation and/or reimbursement, including assert a claim or lawsuit against the third party or any insurance coverages to which the Participant may be entitled. Failure to cooperate with the Group Health Plan will entitle the Group Health Plan to withhold Benefits due the Participant under the Plan of Benefits document. Failure to reimburse the Group Health Plan as required will entitle the Group Health Plan to deny future Benefit payments for all Participants under this policy until the subrogation/reimbursement amount has been paid in full.

It is further agreed that the Participant will sign a written agreement to repay the Group Health Plan in full out of any money that the Participant receives from a negligent person or organization. If the Participant fails to sign such an agreement, the Group Health Plan reserves the right to withhold payment of the Participant's claims, which relate to the negligence of another person or organization, until such time as the Participant signs the agreement to repay.

WORKERS' COMPENSATION PROVISION

This policy does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained by a Participant that arises out of, in connection with, or as the result of any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Participant. Benefits will not be provided under this Plan if coverage under the Workers' Compensation Act or similar law would have been available to the Participant but the Participant elects exemption from available Workers' Compensation coverage; waives entitlement to Workers' Compensation benefits for which he/she is eligible; fails to timely file a claim for Workers' Compensation benefits; or seeks treatment for the injury or illness from a provider that is not authorized by the Participant's Plan Sponsor.

If the Group Health Plan, or its designee, including PAI (hereinafter referred to as "the Plan") pays Benefits for an injury or illness and the Plan determines the Participant also received Workers' Compensation benefits by means of a settlement, judgment, or other payment for the same injury or illness, Participant shall reimburse the Plan in full all Benefits paid by the Plan relating to the injury or illness.

The Plan's right of recovery will be applied even if: the Workers' Compensation benefits are in dispute or are made by means of a compromised, doubtful and disputed, clincher or other settlement; no final determination is made that the injury or illness was sustained in the course of or resulted from the Participant's employment; the amount of Workers' Compensation benefits due to medical or health care is not agreed upon or defined by the Participant or the Workers' Compensation carrier; or the medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

As a condition of receiving Benefits under this Plan of Benefits, the Participant agrees to notify the Plan of any Workers' Compensation claim he/she may make and agrees to reimburse the Plan as described herein. The Participant shall not do anything to hinder the Plan's right of recovery. The Participant shall cooperate with the Plan, execute all documents, and do all things necessary to protect and secure the Plan's right of recovery, including assert a claim or lawsuit against the Workers' Compensation carrier or any other insurance coverages to which the Participant may be entitled. Failure to cooperate with the Plan will entitle the Plan to withhold Benefits due the Participant under this Plan of Benefits. Failure to reimburse the Plan as required under this Section will entitle the Plan to invoke the Workers' Compensation Exclusion and deny payment for all claims relating to the injury or illness and/or deny future Benefit payments for any such Participant until the reimbursement amount has been paid in full.

COORDINATION OF BENEFITS

Coordination of benefits rules apply when a Participant is covered by this Plan of Benefits and also covered by any other Plan or Plans. When more than one coverage exists, one Plan normally pays its benefits in full and the other Plan pays a reduced benefit. This Plan of Benefits will always pay either its Benefits in full or a reduced amount that, when added to the benefits payable by the other Plan or Plans, will not exceed 100% of Allowed Amounts. Only the amount paid by the Plan of Benefits will be included for purposes of determining the maximums in the Schedule of Benefits. Through the coordination of benefits, a Participant or Dependent will not receive more than the Allowed Amounts for a loss.

The coordination of benefits provision applies whether or not a claim is filed under the other Plan or Plans. The Participant agrees to provide authorization to this Plan of Benefits to obtain information as to benefits or services available from any other Plan or Plans, or to recover overpayments. All Benefits contained in the Plan of Benefits are subject to this provision.

When this Plan of Benefits is primary, Benefits are determined before those of the other Plan. The benefits of the other Plan are not considered. When this Plan of Benefits is secondary, Benefits are determined after those of the other Plan. Benefits may be reduced because of the other Plan's benefits. When there are more than two Plans, this Plan of Benefits may be primary as to one and may be secondary as to another.

ORDER OF DETERMINATION

If a Participant covered hereunder is also covered for comparable benefits or services under another Plan that is the Primary Plan, Benefits applicable under this Plan of Benefits will be reduced so that, for benefits incurred, benefits available under all Plans shall not exceed the Allowed Amounts of such benefits.

This Plan of Benefits determines its order of Benefits using the first of the following that applies:

A. **General** - A Plan that does not coordinate with other Plans is always the Primary Plan;

B. **Non-Dependent/Dependent** - The benefits of the Plan that covers the person as an Employee (other than a Dependent) is the Primary Plan; the Plan that covers the person as a Dependent is the Secondary Plan;

C. **Dependent Child/Parents Not Separated or Divorced** - Except as stated in (D) below, when this Plan of Benefits and another Plan cover the same Child as a Dependent of different parents:

   1. The Primary Plan is the Plan of the parent whose birthday (month and day) falls earlier in the year. The Secondary Plan is the Plan of the parent whose birthday falls later in the year; but

   2. If both parents have the same birthday, the benefits of the Plan that covered the parent the longer time is the Primary Plan; the Plan that covered the parent the shorter time is the Secondary Plan;

   3. If the other Plan does not have the birthday rule, but has the gender rule and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

D. **Dependent Child/Separated or Divorced Parents** - If two or more Plans cover a person as a Dependent Child of divorced or separated parents, benefits for the Child are determined in this order:

   1. First, the Plan of the parent with custody of the Child;

   2. Then, the Plan of the spouse of the parent with custody;

   3. Finally, the Plan of the parent without custody of the Child.

   However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the Child, then that parent's Plan is the Primary Plan. If a court decree exists stating that the parents shall share joint custody, without stating that one of the parents is financially responsible for the health care of the Child, the order of liability will be determined according to the rules for Dependent Children whose parents are not separated or divorced. Anyone who legally adopts the Child will assume natural parent status.

E. **Active/Inactive Employee** - The Primary Plan is the Plan that covers the person as an Employee who is neither laid off nor retired (or as that Employee's Dependent). The Secondary Plan is the Plan that covers that person as

a laid off or retired Employee (or as that Employee's Dependent). If the other Plan does not have this rule, and if, as result the Plans do not agree on the order of benefits, this rule does not apply.

F. **Longer/Shorter Length of Coverage** - If none of the above rules determines the order of benefits, the Primary Plan is the Plan that covered an Employee longer. The Secondary Plan is the Plan that covered that person the shorter time.

G. In the case of a Plan that contains order of benefit determination rules that declare that Plan to be excess to or **always secondary to all other Plans**, this Plan of Benefits will coordinate benefits as follows:

1. If this Plan of Benefits is Primary, it will pay or provide Benefits on a Primary basis;
2. If this Plan of Benefits is secondary, it will pay or provide Benefits first, but the amount of Benefits payable will be determined as if this Plan of Benefits were the Secondary Plan. The liability of this Plan of Benefits will be limited to such payment;
3. If the Plan does not furnish the information needed by this Plan of Benefits to determine Benefits within a reasonable time after such information is requested, this Plan of Benefits shall assume that the benefits of the other Plan are the same as those provided under this Plan of Benefits, and shall pay Benefits accordingly. When information becomes available as to the actual benefits of the other Plan, any Benefit payment made under this Plan of Benefits will be adjusted accordingly.

H. **Right To Coordination of Benefits Information**

The Plan Administrator and PAI have the right:

1. To obtain or share information with any insurance company or other organization regarding coordination of benefits without the claimant's consent; and
2. To require that the claimant provide the Plan Administrator with information on such other Plans so that this provision may be implemented;
3. To pay over the amount due under this Plan of Benefits to an insurer or other organization if this is necessary, in the Plan Administrator or PAI's opinion, to satisfy the terms of this provision.

I. **Facility of Payment**

Whenever payments that should have been made under this Plan of Benefits in accordance with this provision have been made under any other Plan or Plans, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organizations or person making such other payments any amount it will determine in order to satisfy the intent of this provision, and amount so paid will be deemed to be Benefits paid under this Plan of Benefits and to the extent of such payment, the Plan Administrator will be fully discharged from liability under this Plan of Benefits. The Benefits that are payable will be charged against any applicable Maximum Payment or Benefit of this Plan of Benefits rather than the amount payable in the absence of this provision.

J. **Medicare**

Individuals Age 65 or Older

If you are a Participant and are age 65 or older, this Plan is the primary payer. Medicare will be the secondary payer.

If you are a retiree and are age 65 or older and are eligible to participate in this Plan, Medicare will be the primary payer and this Plan will pay secondary.

If you are not a Participant and are age 65 or older, Medicare will be your only medical coverage.

Disabled Participants*

If you are a Participant who is disabled, this Plan is the primary payer and Medicare is the secondary payer.

*This applies for Plans with 100 or more employees. (If the Plan has less than 100 employees, Medicare is primary for disabled individuals).

End-Stage Renal Disease

If you have End-Stage Renal Disease and are a Participant, this Plan is the primary payer and Medicare is the secondary payer for the first 30 months of eligibility or entitlement to Medicare. After 30 months, Medicare will be the primary payer, and this Plan will be the secondary payer.

COBRA - Age 65 or Older or Disabled

If you are age 65 or older or disabled, and covered by Medicare and COBRA, Medicare will be the primary payer and the COBRA coverage will pay secondary.

Coordination:

When Medicare is primary and the Plan is secondary, Medicare (Parts A and B) will be considered a Plan for the purposes of coordination of benefits. The Plan will coordinate benefits with Medicare whether or not the Participant or their Dependents is/are actually receiving Medicare benefits.

ERISA RIGHTS

As a Participant in this Group Health Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA") provided the Plan Sponsor is subject to ERISA regulations. ERISA provides that all Participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Group Health Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration ("EBSA").

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Group Health Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The Plan Administrator may assess a reasonable charge for the copies.

Receive, upon request, a summary of the Group Health Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself and your Dependents if there is a loss of coverage under the Group Health Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such continuation coverage. You should review the documents governing COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee welfare benefit plan. The people who administer an employee welfare benefit plan are called "fiduciaries" and have a duty to do so prudently and in the interest of the Participants. The Plan Sponsor is the fiduciary of the Group Health Plan.

Enforce Your Rights

If your claim for a Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits that is denied or ignored, in whole or in part, you may file suit in state or federal court. In addition, if you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, you may file suit in federal court. If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

No one, including your Plan Sponsor, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Benefit or exercising your rights under ERISA.

Assistance with Your Questions

If you have any questions about the Group Health Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

The Group Health Plan will disclose (or require PAI to disclose) Participant's PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions for the Group Health Plan not inconsistent with the requirements of HIPAA. Any disclosure to and use by the Plan Sponsor will be subject to and consistent with the provisions of the sections below.

1. Disclosure of Protected Health Information to Plan Sponsor.

    a. The Group Health Plan and any health insurance issuer or business associate servicing the Group Health Plan will disclose PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions for the Group Health Plan not inconsistent with the requirements of the HIPAA and its implementing regulations, as amended. Any disclosure to and use by the Plan Sponsor of PHI will be subject to and consistent with the provisions of paragraphs 2 and 3 of this section.

    b. Neither the Group Health Plan nor any health insurance issuer or business associate servicing the Plan of Benefits will disclose Participant's PHI to the Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to the Participants.

    c. Neither the Group Health Plan nor any health insurance issuer or business associate servicing the Plan of Benefits will disclose Participant's PHI to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

2. Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information.

    a. The Plan Sponsor will neither use nor further disclose Participant's PHI, except as permitted or required by the Plan documents, as amended, or required by law.

    b. The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Participant's PHI, agrees to the restrictions and conditions of the Plan of Benefits, with respect to PHI.

    c. The Plan Sponsor will not use or disclose Participant PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

    d. The Plan Sponsor will report to the Group Health Plan any use or disclosure of Participant PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

    e. The Plan Sponsor will make PHI available to the Participant who is the subject of the information in accordance with HIPAA.

    f. The Plan Sponsor will make PHI available for amendment, and will on notice amend Participant PHI, in accordance with HIPAA.

    g. The Plan Sponsor will track disclosures it may make of Participant PHI so that it can make available the information required for the Group Health Plan to provide an accounting of disclosures in accordance with HIPAA.

    h. The Plan Sponsor will make available its internal practices, books, and records, relating to its use and disclosure of Participants' PHI, to the Group Health Plan and to the U.S. Department of Health and Human Services to determine compliance with HIPAA.

    i. The Plan Sponsor will, if feasible, return or destroy all Participant PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control), received from the Group Health Plan, including all copies of and any data or compilations derived from and allowing identification of any Participant who is the subject of the PHI, when the Participants' PHI is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Participant PHI, the Plan Sponsor will limit the use or disclosure of any Participant PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

3. Adequate Separation Between the Plan Sponsor and the Group Health Plan.

   a. Certain classes of employees or other workforce members under the control of the Plan Sponsor may be given access to Participant PHI received from the Group Health Plan or business associate servicing the Group Health Plan:

   b. These employees will have access to PHI only to perform the Plan administration functions that the Plan Sponsor provides for the Group Health Plan.

   c. These employees will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Participant PHI in breach or violation of or noncompliance with the provisions of this section of the Plan of Benefits. The Plan Sponsor will promptly report such breach, violation or noncompliance to the Group Health Plan, and will cooperate with the Group Health Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.

   d. Plan Sponsor shall ensure that the separation required by the above provisions will be supported by reasonable and appropriate security measures.

4. Plan Sponsor Obligations to the security of Electronic Protected Health Information ("ePHI"):

   Where ePHI will be created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the Group Health Plan, the Plan Sponsor shall reasonably safeguard the ePHI as follows:

   a. Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Group Health Plan. Plan Sponsor will ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect this information;

   b. The Plan Sponsor shall report any security incident of which it becomes aware to the Group Health Plan as provided below.

      i. In determining how and how often Plan Sponsor shall report security incidents to Group Health Plan, both Plan Sponsor and Group Health Plan agree that unsuccessful attempts at unauthorized access or system interference occur frequently and that there is no significant benefit for data security from requiring the documentation and reporting of such unsuccessful intrusion attempts. In addition, both parties agree that the cost of documenting and reporting such unsuccessful attempts as they occur outweigh any potential benefit gained from reporting them. Consequently, both Plan Sponsor and Group Health Plan agree that this Agreement shall constitute the documentation, notice and written report of any such unsuccessful attempts at unauthorized access or system interference as required above and by 45 C.F.R. Part 164, Subpart C, and that no further notice or report of such attempts will be required. By way of example (and not limitation in any way), the Parties consider the following to be illustrative (but not exhaustive) of unsuccessful security incidents when they do not result in unauthorized access, use, disclosure, modification, or destruction of ePHI or interference with an information system:

         - Pings on a Party's firewall,
         - Port scans,
         - Attempts to log on to a system or enter a database with an invalid password or username,
         - Denial-of-service attacks that do not result in a server being taken off-line, and
         - Malware (e.g., worms, viruses)

ii. Plan Sponsor shall, however, separately report to Group Health Plan (i) any successful unauthorized access, use, disclosure, modification, or destruction of the Group Health Plan's ePHI of which Plan Sponsor becomes aware if such security incident either (a) results in a breach of confidentiality; (b) results in a breach of integrity but only if such breach results in a significant, unauthorized alteration or destruction of Group Health Plan's ePHI; or (c) results in a breach of availability of Group Health Plan's ePHI, but only if said breach results in a significant interruption to normal business operations. Such reports will be provided in writing within ten (10) business days after Plan Sponsor becomes aware of the impact of such security incident upon Group Health Plan's ePHI.

GENERAL INFORMATION

Whereas Plan Sponsor establishes this Group Health Plan and the applicable Benefits, rights and privileges that shall pertain to participating employees, hereinafter referred to as "Employees" and the eligible Dependents of such Employees, as herein defined, for which Benefits are provided through a fund established by the Plan Sponsor and hereinafter referred to as the "Plan of Benefits":

ADMINISTRATIVE SERVICES ONLY
PAI provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The Group Health Plan is a self-funded health Plan, and the Plan Sponsor assumes all financial risk and obligation with respect to claims.

CLERICAL ERRORS
Clerical errors by PAI or the Plan Sponsor will not cause a denial of Benefits that should otherwise have been granted, nor will clerical errors extend Benefits that should otherwise have ended.

GOVERNING LAW
The Group Health Plan may be governed by and subject to ERISA and any other applicable federal law. If ERISA or another federal law does not apply, the Group Health Plan is governed by and subject to the laws of the State of South Carolina. If federal law conflicts with any state law, then such federal law shall govern. If any provision of the Group Health Plan conflicts with such law, the Group Health Plan shall automatically be amended solely as required to comply with such state or federal law.

IDENTIFICATION CARD
A Participant must present their Identification Card prior to receiving Benefits.

Having an Identification Card creates no right to Benefits or other services. To be entitled to Benefits, the cardholder must be a Participant whose Premium has been paid. Any person receiving Covered Expenses to which the person is not entitled will be responsible for the charges.

INFORMATION AND RECORDS
PAI and the Plan Sponsor are entitled to obtain such medical and Hospital records as may reasonably be required from any Provider incident to the treatment, payment and health-care operations for the administration of the Benefits hereunder and the attending Physician's certification as to the Medical Necessity for care or treatment.

LEGAL ACTIONS
No action at law or in equity can be brought under the Group Health Plan until such Participant has exhausted the administrative process (including the exhaustion of all appeals) as described in this booklet. No such action may be brought after the expiration of any applicable period prescribed by law.

MISSTATEMENT OF AGE
If age is a factor in determining eligibility or amount of coverage and there has been a misstatement of age, the coverage or amounts of Benefits, or both, for which the person is covered shall be adjusted in accordance with the covered individual's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force. Contributions and Benefits will be adjusted on the contribution due date next following the date of the discovery of such misstatement.

NEGLIGENCE OR MALPRACTICE
PAI and the Plan Sponsor do not practice medicine. Any medical treatment, service or Medical Supplies rendered to or supplied to any Participant by a Provider is rendered or supplied by such Provider and not by PAI or the Plan Sponsor. PAI and the Plan Sponsor are not liable for any improper or negligent act, inaction or act of malfeasance of any Provider in rendering such medical treatment, service, Medical Supplies or medication.

NOTICES
Except as otherwise provided in this Plan of Benefits, any notice under the Group Health Plan may be given by United States mail, postage paid and addressed:

1. To PAI:
   Planned Administrators, Inc.
   Post Office Box 6927
   Columbia, South Carolina 29260
2. To a Participant: To the last known name and address listed for the Employee on the membership application. Participants are responsible for notifying PAI of any name or address changes within thirty-one (31) days of the change.
3. To the Plan Sponsor: To the name and address last given to PAI. The Plan Sponsor is responsible for notifying PAI and Participants of any name or address change within thirty-one (31) days of the change.

NO WAIVER OF RIGHTS
On occasion, PAI (on behalf of the Group Health Plan) or the Plan Sponsor may, at their discretion, choose not to enforce all of the terms and conditions of this Plan of Benefits. Such a decision does not mean the Group Health Plan or the Plan Sponsor waives or gives up any rights under this Plan of Benefits in the future.

OTHER INSURANCE
Each Participant must provide the Group Health Plan (and its designee, including PAI) and the Plan Sponsor with information regarding all other Health Insurance Coverage to which such Participant is entitled.

PAYMENT OF CLAIMS
Except for the Participant's Provider, a Participant is expressly prohibited from assigning any right to payment of Covered Expenses or any payment related to Benefits. The Group Health Plan may pay Covered Expenses directly to the Employee or to the Non-Participating Provider upon receipt of due proof of loss for services provided by a Non-Participating Provider. Where a Participant has received Benefits from a Participating Provider or Contracting Provider, the Group Health Plan will pay Covered Expenses directly to such Participating Provider or Contracting Provider.

PHYSICAL EXAMINATION
The Group Health Plan has the right to examine, at their own expense, a Participant whose injury or sickness is the basis of a claim (whether Pre-Service, Post-Service, Concurrent or Urgent Care). Such physical examination may be made as often as the Group Health Plan (through its designee, including PAI) may reasonably require while such claim for Benefits or request for Pre-Authorization is pending.

PLAN AMENDMENTS
Upon thirty (30) days prior written notice, the Plan Sponsor may unilaterally amend the Group Health Plan. Increases in the Benefits provided or decreases in the Premium are effective without such prior notice. Notice of an amendment will be effective when addressed to the Plan Sponsor. PAI has no responsibility to provide individual notices to each Participant when an amendment to the Group Health Plan has been made.

PLAN IS NOT A CONTRACT
This Plan of Benefits constitutes the entire Group Health Plan. The Plan of Benefits will not be deemed to constitute a contract of employment or give any employee of the Plan Sponsor the right to be retained in the service of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge or otherwise terminate the employment of any employee.

PLAN INTERPRETATION
The Plan Administrator has full discretionary authority to interpret and apply all Plan of Benefits provisions, including, but not limited to, all issues concerning eligibility and determination of Benefits. The Plan Administrator may contract with an independent administrative firm to process claims, maintain Group Health Plan data, and perform other Group Health Plan-connected services; however, final authority to construe and apply the provisions

of the Plan of Benefits rests exclusively with the Plan Administrator. Decisions of the Plan Administrator, made in good faith, shall be final and binding.

REPLACEMENT COVERAGE

If the Group Health Plan replaced the Plan Sponsor's prior Plan, all eligible persons who were validly covered under that Plan on its termination date will be covered on the Plan of Benefits Effective Date of the Group Health Plan, provided such persons are enrolled for coverage as stated in the Eligibility for Coverage Section.

TERMINATION OF PLAN

The Plan Administrator reserves the right at any time to terminate the Group Health Plan by a written instrument to that effect. All previous contributions by the Plan Administrator shall continue to be issued for the purpose of paying Benefits under the provisions of this Plan of Benefits with respect to claims arising before such termination, or shall be used for the purpose of providing similar health Benefits to covered Employees, until all contributions are exhausted.

ADMINISTRATIVE INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health and disability Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Oconee County Employee Health Plan

PLAN NUMBER: 501-9030512

TAX ID NUMBER: 57-6000391

PLAN EFFECTIVE DATE: 5/1/2014

PLAN YEAR ENDS: April 30

EMPLOYER INFORMATION

Oconee County
415 South Pine Street
Walhalla, SC 29691
(864) 638-4244

PLAN ADMINISTRATOR

Oconee County
415 South Pine Street
Walhalla, SC 29691
(864) 638-4244

NAMED FIDUCIARY

Oconee County
415 South Pine Street
Walhalla, SC 29691
(864) 638-4244

AGENT FOR SERVICE OF LEGAL PROCESS

Oconee County
415 South Pine Street
Walhalla, SC 29691
(864) 638-4244

CLAIMS ADMINISTRATOR

Planned Administrators, Inc.
P.O. Box 6927
Columbia, SC 29260
1-800-768-4375
www.paisc.com

DEFINITIONS

Capitalized terms that are used in this Plan of Benefits shall have the following defined meanings:

Active Employee: an Employee who is on the regular payroll of the Plan Sponsor and who has begun to perform the duties of his/her job with the Plan Sponsor on a full-time or part-time basis.

Actively at Work: a permanent, full-time employee who works at least the minimum number of hours per week and the minimum number of weeks per year (each as set forth in the ELIGIBILITY section) and who is not absent from work during the initial enrollment period because of a leave of absence or temporary layoff. An absence during the initial enrollment period due to a Health Status Related Factor will not keep an employee from qualifying for Actively at Work status.

Admission: the period of time between a Participant's entry as a registered bed-patient into a Hospital or Skilled Nursing Facility and the time the Participant leaves or is discharged.

Adverse Benefit Determination: any denial, reduction or termination of, or failure to provide or make (in whole or in part) payment for a claim for Benefits, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in a Plan, and including a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for a Benefit that results from the application of any utilization review as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Allowed Amount: the amount the Plan Sponsor agrees to pay a Participating Provider or Non-Participating Provider as payment in full for a service, procedure, supply or equipment. For a Non-Participating Provider, (i) the Allowed Amount shall not exceed the Maximum Payment and (ii) in addition to the Member's liability for deductibles, co-payments and/or co-insurance, the Participant may be balanced billed by the Non-Participating Provider for any difference between the Allowed Amount and the billed charges.

Ambulatory Surgical Center: a licensed facility that:

1. has permanent facilities equipped and operated primarily for the purpose of performing surgical procedures on an outpatient basis; and
2. has continuous Physician services and registered professional nursing service whenever a patient is in the facility; and
3. does not provide accommodations for patients to stay overnight; and
4. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician or oral surgeon.

Ambulatory Surgical Center includes an endoscopy center.

Benefit Year: the period of time set forth on the Schedule of Benefits. The initial Benefit Year may be more or less than twelve (12) months.

Benefit Year Deductible: the amount, if any, listed on the Schedule of Benefits that must be paid by the Participant each Benefit Year before the Group Health Plan will pay Covered Expenses. The Benefit Year Deductible is subtracted from the Allowed Amount before Coinsurance is calculated. Participants must refer to the Schedule of Benefits to determine if the Benefit Year Deductible applies to the Out-of-Pocket Maximum.

Benefits: medical services or Medical Supplies that are:

1. Medically Necessary; and
2. Pre-Authorized (when required under this Plan of Benefits or the Schedule of Benefits); and

3. Included in this Plan of Benefits; and
4. Not limited or excluded under the terms of this Plan of Benefits.

Birthing Center: any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

Brand Name Drug: a Prescription Drug that is manufactured under a registered trade name or trademark.

Calendar Year: January 1st through December 31st of the same year.

Certificate of Creditable Coverage: a document from a group health Plan or insurer that states that a Participant had prior Creditable Coverage with that group health Plan or insurer.

Child: An Employee's child, whether a natural child, adopted child, foster child, stepchild, or child for whom an Employee has custody or legal guardianship. The term "Child" also includes an Incapacitated Dependent, or a child of a divorced or divorcing Employee who, under a Qualified Medical Child Support Order, has a right to enroll under the Group Health Plan. The term "Child" does not include the spouse of an eligible child.

Under ACA and the Health Care and Education Reconciliation Act, "Child" does not include an individual who is eligible for other employer-sponsored coverage if the Group Health Plan is a grandfathered Plan for Plan years beginning before January 1, 2014.

Clean Claim: one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

Filing a Clean Claim—A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitutes covered expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amendment.

Coinsurance: the sharing of Covered Expenses between the Participant and the Group Health Plan. After the Participant's Benefit Year Deductible requirement is met, the Group Health Plan will pay the percentage of Allowed Amounts as set forth on the Schedule of Benefits. The Participant is responsible for the remaining percentage of the Allowed Amount. Coinsurance is calculated after any applicable Benefit Year Deductible or Co-payment is subtracted from the Allowed Amount based upon the network charge or lesser charge of the Provider.

For Prescription Drug Benefits, Coinsurance means the amount payable by the Participant, calculated as follows:

1. The percentage listed on the Schedule of Benefits; multiplied by
2. The amount listed in the Participating Provider's schedule of allowance for that item calculated at the time of sale;
3. Without regard to any Credit or allowance that may be received by PAI.

Concurrent Care Claim: an ongoing course of treatment to be provided over a period of time or number of treatments.

Continued Stay Review: the review that must be obtained by a Participant (or the Participant's representative) regarding an extension of an Admission to determine if an Admission for longer than the time that was originally Pre-Authorized is Medically Necessary (when required).

Co-payment: the amount specified on the Schedule of Benefits that the Participant must pay directly to the Provider each time the Participant receives Benefits.

Cosmetic Dentistry: unnecessary dental procedures ("cosmetic" dental procedures may be covered if necessary due to an accident while covered under this Plan).

Cosmetic Surgery: medically unnecessary surgical procedures, usually, but not limited to plastic surgery directed toward preserving beauty or correction scars, burns or disfigurements ("cosmetic" procedures may be covered if necessary due to a disfiguring procedure while covered under this plan.

Covered Charge(s): those Medically Necessary services or supplies that are covered under this Plan.

Covered Expenses: the amount payable by the Group Health Plan for Benefits. The amount of Covered Expenses payable for Benefits is determined as set forth in this Plan of Benefits and at the percentages set forth in the Schedule of Benefits. Covered Expenses are subject to the limitations and requirements set forth in the Plan of Benefits and on the Schedule of Benefits. Covered Expenses will not exceed the Allowed Amount.

Credit: financial credits (including rebates and/or other amounts) to PAI directly from drug manufacturers or other Providers through a Pharmacy Benefit Manager (PBM). Credits are used to help stabilize overall rates and to offset expenses and may not be payable to Plan Sponsor or Participants.

Reimbursements to a Participating Pharmacy, or discounted prices charged at Pharmacies, are not affected by these credits. Any Coinsurance that a Participant must pay for Prescription Drugs is based on the Allowed Amount at the Pharmacy and does not change due to receipt of any Credit received by PAI. Co-payments are not affected by any Credit.

Creditable Coverage: benefits or coverage provided under any of the following (each capitalized term as defined under HIPAA unless defined in this Plan of Benefits):

1. A group health Plan;
2. Health Insurance Coverage;
3. Medicare: Part A or Part B, Title XVIII of the Social Security Act;
4. Medicaid: Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;
5. Title 10 United States Code Chapter 55 (i.e. medical and dental care for members and certain former members of the uniformed forces and their Dependents);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool, including South Carolina Health Insurance Pool (SCHIP);
8. A state Children's Health Insurance Program (S-CHIP);
9. A health Plan offered under Chapter 89 of Title 5, United States Code (Federal Employees Health Benefits Act);
10. A public health Plan, including that of the U.S. Federal Government as well as that of a foreign country or its political subdivision; or
11. A health benefit Plan under Section 5(e) of 22 United States Code 2504(e), the Peace Corps Act.

Creditable Coverage does not include coverage consisting solely of Excepted Benefits (as defined within the definition of Health Insurance Coverage).

Custodial Care: care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding, or supervision over medication which could normally be self-administered.

Dependent: an individual who is:

1. An Employee's spouse (NOT to include an individual of the same sex as the Employee); or
2. A Child under the age set forth in the Eligibility for Coverage section; or
3. An Incapacitated Dependent.

The following persons are excluded as Dependents:

1. Other individuals living in the covered Employee's home, but are not eligible as defined;
2. The divorced former spouse of the Employee;
3. Any person who is on active duty in any military service of any country; or
4. Any person who is covered under the Plan as an Employee.

Detoxification: a Hospital service providing treatment to diminish or remove from a Patient's body the toxic effects of chemical substances, such as alcohol or drugs, usually as an initial step in the treatment of a chemical-dependent person.

Discount Services: services (including discounts on services) that are not Benefits but may be offered to Participants from time to time as a result of being a Participant.

Durable Medical Equipment: equipment that:

1. Can stand repeated use; and
2. Is Medically Necessary; and
3. Is customarily used for the treatment of a Participant's illness, injury, disease or disorder; and
4. Is appropriate for use in the home; and
5. Is not useful to a Participant in the absence of illness or injury; and
6. Does not include appliances that are provided solely for the Participant's comfort or convenience; and
7. Is a standard, nonluxury item (as determined by the Group Health Plan); and
8. Is ordered by a medical doctor, oral surgeon, podiatrist or osteopath.

Prosthetic Devices, Orthopedic Devices and Orthotic Devices are considered Durable Medical Equipment. Items such as air conditioners, dehumidifiers, whirlpool baths, and other equipment that have nontherapeutic uses are not considered Durable Medical Equipment.

Emergency Admission Review: the review that must be obtained by a Participant (or the Participant's representative) within twenty-four (24) hours of or by the end of the first working day after the commencement of an Admission to a Hospital to treat an Emergency Medical Condition.

Emergency Medical Condition: a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the Participant, or with respect to a pregnant Participant, the health of the Participant or her unborn child, in serious jeopardy; or
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Employee: any employee of the Employer (also known as Plan Sponsor) who is eligible for coverage as provided in the eligibility section of this Plan of Benefits, and who is so designated to PAI by the Employer (also known as Plan Sponsor).

Employer: the entity providing this Plan of Benefits, also known as Plan Sponsor.

Employer Effective Date: the date PAI begins to provide services under this Plan of Benefits, also known as Plan Sponsor Effective Date.

Enrollment Date: the date of enrollment in the Group Health Plan or the first day of the Waiting Period for enrollment, whichever is earlier.

ERISA: The Employee Retirement income Security Act of 1974, as amended.

Experimental or Investigational: surgical procedures or medical procedures, supplies, devices or drugs that, at the time provided, or sought to be provided, are in the judgment of PAI not recognized as conforming to generally accepted medical practice, or the procedure, drug or device:

1. Has not received required final approval to market from appropriate government bodies; or
2. Is one about which the peer-reviewed medical literature does not permit conclusions concerning its effect on health outcomes; or
3. Is not demonstrated to be as beneficial as established alternatives; or
4. Has not been demonstrated to improve net health outcomes; or
5. Is one in which the improvement claimed is not demonstrated to be obtainable outside the experimental or investigational setting.

Excepted Benefits: benefits or coverage that does not constitute Creditable Coverage:

1. Coverage only for accident, or disability income insurance, or any combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics;
8. Other similar insurance coverage specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

<u>If offered separately</u>:

1. Limited scope dental or vision benefits;
2. Benefits for long-term care, nursing home care, Home Health Care, community-based care, or any combination thereof;
3. Such other similar, limited benefits as specified in regulations.

<u>If offered as independent, non-coordinated benefits</u>:

1. Coverage only for a specified disease or illness;

2. Hospital indemnity or other fixed indemnity insurance.

If offered as a separate insurance policy:

1. Medicare supplemental health insurance (as defined under Section 1882(g)(1) of the Social Security Act);
2. Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code;
3. Similar supplemental coverage under a group health Plan.

Family Unit: the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

Formulary: a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Foster Child: an unmarried child under the limiting age shown in the Eligibility for Coverage section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met:

1. the child is being raised as the covered Employee's;
2. the child depends on the covered Employee for primary support;
3. the child lives in the home of the covered Employee; and
4. the covered Employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic Drug: a Prescription Drug that has a chemical structure that is identical to and has the same bioequivalence as a Brand Name Drug but is not manufactured under a registered brand name or trademark or sold under a brand name. The Pharmacy Benefit Manager has the discretion to determine if a Prescription Drug is a Generic Drug.

Genetic Information: information about genes, gene products (messenger RNA and transplanted protein) or genetic characteristics derived from a Participant or family member of the Participant. Genetic Information includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes. However, Genetic Information shall not include routine physical measurements, chemical, blood, and urine analyses unless conducted to diagnose a genetic characteristic; tests for abuse of drugs; and tests for the presence of human immunodeficiency virus.

Grace Period: a period of time as determined by the Plan Sponsor that allows for the Participant to pay any Premium due.

Group Health Plan: an employee welfare benefit plan adopted by the Plan Sponsor to the extent that such Plan provides health benefits to employees or their dependents, as defined under the terms of such Group Health Plan, directly or through insurance, reimbursement or otherwise. This Plan of Benefits is a Group Health Plan.

Health Insurance Coverage: benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any Hospital or medical service policy or certificate, Hospital or medical service Plan contract, or health maintenance organization contract offered by a health insurance issuer. Health Insurance Coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

Health Status Related Factor: information about a Participant's health, including health status, medical conditions (including both physical and mental illnesses), claims experience, receipt of health care, medical history, Genetic Information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

HIPAA: the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care Agency: an agency or organization licensed by the appropriate state regulatory agency to provide Home Health Care.

Home Health Care Plan: must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must sate the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies: part-time or intermittent nursing care, health aide services, or physical, occupational, or speech therapy provided or supervised by a Home Health Agency and provided to a homebound Participant in such Participant's private residence.

Hospice Agency: an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan: a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies: those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit: a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital: a short-term, acute-care facility licensed as a hospital by the state in which it operates. A Hospital is engaged primarily in providing medical, surgical, or acute behavioral health diagnosis and treatment of injured or sick persons, by or under the supervision of a staff of licensed Physicians, and continuous twenty-four (24) hour-a-day services by licensed, registered, graduate nurses physically present and on duty. The term Hospital does not include Long Term Acute Care Hospitals, chronic care institutions or facilities that principally provide custodial, rehabilitative or long-term care, whether or not such institutions or facilities are affiliated with or are part of a Hospital. A Hospital may participate in a teaching program. This means medical students, interns, or residents participating in a teaching program may treat Participants.

Identification Card: the card issued by PAI to a Participant that contains the Participant's identification number.

Incapacitated Dependent: a Dependent who is incapable of financial self-sufficiency by reason of mental or physical disability.

Independent Review Organization: An external review organization approved by the South Carolina Department of Insurance and accredited by a nationally recognized private accrediting organization, and not affiliated with the health carrier.

Illness: a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury: an accidental physical Injury to the body caused by unexpected means.

Intensive Care Unit: a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit". It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee: an Employee who enrolls under this Group Health Plan other than during:

1. The first period in which the Employee or Dependent is eligible to enroll if such initial enrollment period is a period of at least thirty (30) days; or
2. A Special Enrollment period (as set forth in the Eligibility for Coverage section).

Legal Guardian: a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime: a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of a Participant.

Mail Service Pharmacy: a Pharmacy maintained by the Pharmacy Benefit Manager that fills prescriptions and sends Prescription Drugs by mail.

Maternity Management Program: the voluntary program offered by the Group Health Plan to Participants who are pregnant.

Maximum Allowable Charge: is the lesser of:

- The Usual and Customary amount,
- The allowable charge specified under the terms of the Plan,
- The negotiated rate established in a contractually arrangement with a provider, or
- The actual billed charges for the covered services.

In the event a PPO network provider is utilized, the network scheduled allowance may be utilized in lieu of the Usual and Customary charge. **This does not, however, remove the Plan Administrator's discretionary authority to decide whether a charge should be subject to Usual and Customary guidelines, regardless of the network schedule allowance. The Plan Administrator also retains the discretionary authority to decide if a charge is a Medically Necessary and Reasonable service.**

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, upcoding, duplicate charges, and charges for services not performed.

Maximum Payment: the maximum amount the Group Health Plan will pay for a particular Benefit. The Maximum Payment will not be affected by any Credit. The Maximum Payment will be one of the following:

1. The actual charge submitted to the Plan Supervisor for the service, procedure, supply or equipment by a Provider; or
2. An amount based upon the reimbursement rates established by the Plan Sponsor in its Benefits Checklist; or
3. An amount that has been agreed upon in writing by a Provider and the network used by the Plan Sponsor based upon factors including but not limited to, (i) governmental reimbursement rates applicable to the service, procedure, supply or equipment, or (ii) reimbursement for a comparable or similar service, procedure, supply or equipment, taking into consideration the degree of skill, time and complexity involved, geographic location and the circumstances giving rise to the need for the service, procedure, supply or equipment; or
4. The lowest amount of reimbursement allowed for the same or similar services, procedure, supply or equipment when provided by a Participating Provider.

Medical Care Facility: a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Child Support Order: any judgment, decree or order (including an approved settlement agreement) issued by a court of competent jurisdiction or a national medical support notice issued by the applicable state agency that:

1. Provides child support with respect to a child or provides for health benefit coverage to a child, is made pursuant to a state domestic relations law (including a community property law), and relates to the Plan of Benefits;
2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health Plan.
3. A Medical Child Support Order must clearly specify:
    a. The name and the last known mailing address (if any) of each participant employee and the name and mailing address of each alternate recipient covered by the order; and
    b. A reasonable description of the type of coverage to be provided by the group health Plan to each such alternate recipient or the manner in which such type of coverage is to be determined; and
    c. The period to which such order applies; and
    d. Each group health Plan to which such order applies.
4. If the Medical Child Support Order is a national medical support notice, the order must also include:
    a. The name of the issuing agency; and
    b. The name and mailing address of an official or agency that has been substituted for the mailing address of any alternate recipient; and
    c. The identification of the underlying Medical Child Support Order.
5. A Medical Child Support Order meets the requirement of this definition only if such order does not require a group health Plan to provide any type or form of the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section of 13822 of the Omnibus Budget Reconciliation Act of 1993).

Medical Emergency: a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care: chare which can safely and adequately be provided other than in a Hospital.

Medically Necessary/Medical Necessity/Medical Care Necessity: health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
3. not primarily for the convenience of the patient, Physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

    For the purposes of this definition, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Medical Record Review: in the event that the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the plan Administrator may determine the Maximum Allowable Charge according to the medical record review and audit results.

Medical Supplies: supplies that are:

1. Medically Necessary; and

2. Prescribed by a Physician acting within the scope of his or her license (or are provided to a Participant in a Physician's office); and
3. Are not available on an over-the-counter basis (unless such supplies are provided to a Participant in a Physician's office and should not (in PAI's discretion) be included as part of the treatment received by the Participant); and
4. Are not prescribed in connection with any treatment or benefit that is excluded under this Plan of Benefits.

Medicare: the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Health Conditions: certain psychiatric disorders or conditions defined in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and are not otherwise excluded by the terms and conditions of this Plan of Benefits. The conditions as mandated by the State of South Carolina are:

1. Bipolar Disorder;
2. Major Depressive Disorder;
3. Obsessive Compulsive Disorder;
4. Paranoid and Other Psychotic Disorder;
5. Schizoaffective Disorder;
6. Schizophrenia;
7. Anxiety Disorder;
8. Post-traumatic Stress Disorder; and
9. Depression in childhood and adolescence.

Mental Health Parity: Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies the terms **uniformly** and enforces parity between covered health care Benefits and covered mental health and substance disorder Benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Mental Health Services: treatment (except Substance Abuse Services) for a condition that is defined, described or classified **as** a psychiatric disorder or condition in the most current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association and is not otherwise excluded by the terms and conditions of this Plan of Benefits.

Midwife: a person who is certified or licensed to assist women in the act of childbirth.

Milieu Therapy: type of treatment in which the patient's social environment is manipulated for his/her benefit.

Morbid Obesity: a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Participant.

Natural Teeth: teeth that:

1. Are free of active or chronic clinical decay; and
2. Have at least 50% bony support; and
3. Are functional in the arch; and

4. Have not been excessively weakened by multiple dental procedures; or
5. Teeth that have been treated for one (1) or more of the conditions referenced in 1-4 above and, as a result of such treatment, have been restored to normal function.

No-fault Auto Insurance: basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Participating Provider: any Provider who does not have a current, valid contract with one of the networks used by this Plan of Benefits.

Non-Preferred Brand Name Drug: a Prescription Drug that bears a recognized brand name of a particular manufacturer but does not appear on the list of Preferred Brand Name Drugs and has not been chosen by PAI or its designated Pharmacy Benefit Manager to be a Preferred Brand Name Drug, including any Brand Name Drug with an "A" rated Generic Drug available.

Orthognathic surgery: surgery performed on the bones of the jaws to change their positions. Orthognathic surgery is corrective facial surgery where deformities of the jaw exist. It may be indicated for functional, cosmetic , or health reasons. It is surgery commonly done on the jaws in conjunction with orthodontic treatment, which straightens the teeth**.**

Orthopedic Device: any rigid or semirigid leg, arm, back or neck brace and casting materials that are used directly for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.

Orthotic Device: any device used to mechanically assist, restrict, or control function of a moving part of the Participant's body.

Other Plan: includes, but is not limited to:

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy covering the Participant;
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Worker's compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Outpatient Care and/or Services: treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, and Ambulatory Surgical Center, or the patient's home.

Out-of-Pocket Maximum: the maximum amount (if listed on the Schedule of Benefits) of otherwise Covered Expenses incurred during a Benefit Year that a Participant will be required to pay. The Out-of-Pocket Maximum is Coinsurance payable by the Participant. Co-payments and Benefit Year Deductibles may not apply toward the Out-of-Pocket Maximum (as set forth on the Schedule of Benefits).

Over-the-Counter Drug: a drug that does not require a prescription.

Paid Claim: for contractual purpose of this Plan, means a claim will be deemed Paid on the date a check is cut for the services rendered.

Partial Hospitalization: an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is a reasonable expectation for improvement or when it is necessary

to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours a day and no charge is made for room and board.

Participant: an Employee or Dependent who has enrolled (and qualifies for coverage) under this Plan of Benefits. A Participant may also include individuals who meet the criteria under the "other eligible group classifications" as defined in the Eligibility section of this document.

Participant Effective Date: the date on which a Participant is covered for Benefits under the terms of this Plan of Benefits.

Participating Provider: a Physician, Hospital or other Provider who has a signed contract with one of the networks used by this Plan of Benefits and who has agreed to provide Benefits to a Participant and submit claims to PAI and to accept the Allowed Amount as payment in full for Benefits. The participating status of a Provider may change.

Pharmacy: a licensed establishment where Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices.

Physician: a person who is:

1. Not an:
    a. Intern; or
    b. Resident; or
    c. In-house physician; and
2. Duly licensed by the appropriate state regulatory agency as a:
    a. Medical doctor; or
    b. Oral surgeon; or
    c. Osteopath; or
    d. Podiatrist; or
    e. Chiropractor; or
    f. Optometrist; or
    g. Psychologist with a doctoral degree in psychology; and
3. Legally entitled to practice within the scope of his or her license; and
4. Customarily bills for his or her services.

Physician Services: the following services, performed by a Physician within the scope of his or her license, training and specialty and within the scope of generally acceptable medical standards as determined by PAI:

1. Office visits, which are for the purpose of seeking or receiving care for an illness or injury; or
2. Basic diagnostic services and machine tests;
3. Physician Services includes the following services when performed by a medical doctor, osteopath, podiatrist or oral surgeon, but specifically excluding such services when performed by a chiropractor, optometrist, or licensed psychologist with a doctoral degree:
    a. Benefits rendered to a Participant in a Hospital or Skilled Nursing Facility; or
    b. Benefits rendered in a Participant's home; or
    c. Surgical Services; or

d. Anesthesia services, including the administration of general or spinal block anesthesia; or

e. Radiological examinations; or

f. Laboratory tests; or

g. Maternity services, including consultation, prenatal care, conditions directly related to pregnancy, delivery and postpartum care, and delivery of one or more infants. Physician Services also include maternity services performed by certified nurse midwives.

Plan: any program that provides benefits or services for medical or dental care or treatment including:

1. Individual or group coverage, whether insured or self-insured. This includes, but is not limited to, prepayment, group practice or individual practice coverage; and
2. Coverage under a governmental Plan or coverage required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage is a separate Plan for purposes of this Plan of Benefits. If a Plan has two (2) or more parts and the coordination of benefits rules apply only to one (1) of the parts, each part is considered a separate Plan.

Plan Administrator: the entity charged with the administration of the Plan of Benefits. The Plan Sponsor is the Plan Administrator of this Plan of Benefits.

Plan of Benefits: This Plan of Benefits including, the membership application, the Schedule of Benefits, and all endorsements, amendments, riders or addendums.

Plan of Benefits Effective Date: 12:01 AM on the date listed on the Schedule of Benefits.

Plan Sponsor: also known as the Employer.

Plan Year: the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Post-Service Claim: any claim that is not a Pre-Service Claim.

Pre-Admission Review: the review that must be obtained by a Participant (or the Participant's representative) prior to all Admissions that are not related to an Emergency Medical Condition.

Pre-Authorized/Pre-Authorization: the approval of Benefits based on Medical Necessity prior to the rendering of such Benefits to a Participant. Pre-Authorization means only that the Benefit is Medically Necessary. Pre-Authorization is not a guarantee of payment or a verification that Benefits will be paid or are available to the Participant. Notwithstanding Pre-Authorization, payment for Benefits is subject to a Participant's eligibility and all other limitations and exclusions contained in this Plan of Benefits. A Participant's entitlement to Benefits is not determined until the Participant's claim is processed.

Pre-Existing Condition(s): a physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was received or recommended during the six (6) month period preceding the Enrollment Date, if applicable. Genetic Information may not be treated as a Pre-Existing Condition in the absence of a diagnosis of the specific condition related to the Genetic Information. Pre-Existing Condition applies only to Participants age 19 or older for claims with dates of service prior to June 1, 2014.

Preferred Brand Drug: a Prescription Drug that bears a recognized brand name of a particular manufacturer and appears on the list of Preferred Brand Drugs.

Preferred Brand Name Drug: a Prescription Drug that has been reviewed for cost effectiveness, clinical efficacy and quality that is preferred by the Pharmacy Benefit Manager for dispensing to Participants. Preferred Brand Name Drugs are subject to periodic review and modification by PAI, or its designated Pharmacy Benefit Manager, and include Brand Name Drugs and Generic Drugs.

Pregnancy: childbirth and conditions associated with Pregnancy, including complications.

Premium: the monthly amount paid to the Plan Sponsor by the Participant for coverage under this Plan of Benefits. Payment of Premiums by the Participant constitutes acceptance by the Participant of the terms of this Plan of Benefits.

Prescription Drugs: a drug or medicine that is:

1. Required to be labeled that it has been approved by the Food and Drug Administration; and
2. Bears the legend "Caution: Federal Law prohibits dispensing without a prescription" or "Rx Only" prior to being dispensed or delivered, or labeled in a similar manner; or
3. Insulin.

Additionally, to qualify as a Prescription Drug, the drug must:

1. Be ordered by a medical doctor or oral surgeon as a prescription; and
2. Not be entirely consumed at the time and place where the prescription is dispensed; and
3. Be purchased for use outside a Hospital.

Prescription Drugs also include the following, which otherwise may not meet the definition of Prescription Drugs:

1. DESI drugs – These drugs are determined by the FDA (Food and Drug Administration) as lacking substantial evidence of effectiveness. The DESI drugs do not have studies to back up the medications' uses, but since they have been used and accepted for many years without any safety problems, they continue to be used in today's marketplace.
2. Controlled substance 5 (CV) OTC's are covered. (Examples: Robitussin AC syrup and Naldecon-CX) Federal law designates these medications as OTC. However, depending on certain state Pharmacy laws, the medications may be considered prescription medications and are, therefore, all covered.
3. Single entity vitamins – These vitamins have indications in addition to their use as nutritional supplements. For this reason, Plan supervisor recommends covering these medications. Single entity vitamins are used for the treatment of specific vitamin deficiency diseases. Some examples include: vitamin B12 (cyanocobalamin) for the treatment of pernicious anemia and degeneration of the nervous system; vitamin K (phytonadione) for the treatment of hypoprothrombinemia or hemorrhage; and folic acid for the treatment of megaloblastic and macrocytic anemias.

Prescription Drug Co-payment: the amount payable, if any, set forth on the Schedule of Benefits, by the Participant for each Prescription Drug filled or refilled. This amount will not be applied to the Benefit Year Deductible or the Out-of-Pocket Maximum.

Pre-Service Claim: any claim or request for a Benefit where prior authorization or approval must be obtained from BlueCross Medical Review Department before receiving the medical care, service or supply.

Primary Plan: a Plan whose benefits must be determined without taking into consideration the existence of another Plan.

Prior to Effective Date or After Termination Date: dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges incurred prior to the effective date of coverage under the Plan or after coverage is terminate, unless Extension of Benefits applies.

Protected Health Information (PHI): Protected Health Information as that term is defined under HIPAA.

Prosthetic Device: any device that replaces all or part of a missing body organ or body member, except a wig, hairpiece or any other artificial substitute for scalp hair.

Provider: any person or entity licensed by the appropriate state regulatory agency and legally engaged within the scope of such person or entity's license in the practice of any of the following:

- Medicine
- Dentistry
- Optometry
- Podiatry
- Chiropractic Services
- Physical Therapy
- Behavioral Health
- Oral Surgery
- Speech Therapy
- Occupational Therapy

Provider includes a long-term-care Hospital, a Hospital, a rehabilitation facility, Skilled Nursing Facility, and nurses practicing in expanded roles (such as pediatric nurse practitioners, family practice nurse practitioners and certified nurse midwives) when supervised by a medical doctor or oral surgeon. The term Provider does not include physical trainers, lay midwives or masseuses.

Qualified Medical Child Support Order (QMCSO): a Medical Child Support Order that:

1. Creates or recognizes the existence of an Alternate Recipient's right to enroll under this Plan of Benefits; or
2. Assigns to an Alternate Recipient the right to enroll under this Plan of Benefits.

Qualifying Event: for continuation of coverage purposes, a Qualifying Event is any one of the following:

1. Termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked that renders the Employee no longer Actively at Work and therefore ineligible for coverage under the Plan of Benefits;
2. Death of the Employee;
3. Divorce or legal separation of the Employee from his or her spouse;
4. A Child ceasing to qualify as a Dependent under this Plan of Benefits.
5. Entitlement to Medicare by an Employee, or by a parent of a Child;
6. A proceeding in bankruptcy under Title11 of the United States Cod with respect to an Employer from whose employment an Employee retired at any time.

Reasonable and/or Reasonableness: in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating Provider. Determination that fee(s) or services are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitation the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The national Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must e in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or service(s) are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on behalf of the right to review charges processed and/or paid y the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Rescission: a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a Rescission if the cancellation or discontinuance of coverage:

1. Has only a prospective effect; or
2. Is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

A Rescission retroactively canceling coverage is permitted if an individual performs an act, practice or omission that constitutes fraud or if the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan or coverage.

Retired Employee: a former Active Employee of the Plan Sponsor who was retired while employed by the Plan Sponsor under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Schedule of Benefits: the pages of this Plan of Benefits so titled that specify the coverage provided and the applicable Co-payments, Coinsurance, Benefit Year Deductibles and Benefit limitations.

Second Opinion: an opinion from a Physician regarding a service recommended by another Physician before the service is performed, to determine whether the proposed service is Medically Necessary and covered under the terms of this Plan of Benefits.

Secondary Plan: the Plan that has secondary responsibility for paying a Participant's claim as determined through the coordination of benefits provisions of this Plan of Benefits.

Sickness: For a covered Employee and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness or disease.

Skilled Nursing Facility: a facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an inpatient basis to person convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. It services are provided for compensation and under the full-time supervision of a Physician.
3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally challenged, Custodial or education care or care of Mental Disorders.
7. It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Special Enrollment: the time period during which an Employee or eligible Dependent who is not enrolled for coverage under this Plan of Benefits may enroll for coverage due to the involuntary loss of other coverage or under circumstances described in the Eligibility For Coverage section of this Plan of Benefits.

Specialist: a Physician who specializes in a particular branch of medicine.

Specialty Drugs: Prescription Drugs that treat a complex clinical condition and/or require special handling such as refrigeration. They generally require complex clinical monitoring, training and expertise. Specialty Drugs include, but are not limited to, infusible Specialty Drugs for chronic diseases, injectable and self-injectable drugs for acute and chronic diseases, and specialty oral drugs. Specialty Drugs are used to treat acute and chronic disease states (e.g. growth deficiencies, hemophilia, multiple sclerosis, rheumatoid arthritis, Gaucher's Disease, hepatitis, cancer, organ transplantation, Alpha 1-antitrypsin disease and immune deficiencies).

Spinal Manipulation/Chiropractic Care: skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or sublaxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or sublaxation of, or in, the vertebral column.

Substance Abuse: the continued use, abuse and/or dependence on legal or illegal substance(s), despite significant consequences or marked problems associated with the use (as defined, described or classified in the most current version of *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association).

Substance Abuse Services: services or treatment relating to Substance Abuse.

Totally Disabled: means the complete inability of the Participant to perform the important daily duties of the Participant's occupation, for which the Participant is reasonably suited by education, training or experience. As applied to a Participant who is a Dependent, the term means the Dependent is prevented solely because of a non-occupational injury or non-occupational disease from engaging in all of the normal activities of a person in good health and of like age. The Participant must provide a Physician's statement of disability upon periodic request by the Group Health Plan.

Transplant: The transfer of organs or tissues, including bone marrow, stem cells and cord blood, from human to human. Transplants are covered only at facilities approved by PAI in writing and include only those procedures that otherwise are not excluded by this Plan of Benefits. Pre-Authorization is required. Transplant Physician Charges are subject to the Benefit Year Deductible.

Transplant Benefit Period: the period of time that for Transplant of:

1. an organ, the period that begins one day prior to the Admission date for Transplant and continues for a 12-month period. Anti-rejection drugs are not subject to the Transplant Benefit Period; or
2. bone marrow, the period that begins one day prior to the date marrow ablative therapy begins, or one day prior to the day the preparative regimen for non-myeloablative Transplant begins and continues for a twelve (12) month period. Mobilization therapy and stem-cell harvest are also included. Anti-rejection drugs are not subject to the Transplant Benefit Period.

Urgent Care: treatment required in order to treat an unexpected illness or injury that is life-threatening and required in order to prevent a significant deterioration of the Participant's health if treatment were delayed.

Urgent Care Claim: any claim for medical care or treatment where making a determination under other than normal time frames could seriously jeopardize the Participant's life or health or the Participant's ability to regain maximum function; or, in the opinion of a medical doctor or oral surgeon with knowledge of the Participant's medical condition, would subject the Participant to severe pain that could not be managed adequately without the care or treatment that is the subject of the claim.

Usual and Customary (U & C): Only Usual and Customary charges are covered expenses. When determining whether an expense is Usual and Customary, the Plan Administrator will take into consideration the fee(s) which the provider most frequently charges the majority of patients for the service or supply, and the prevailing range of fees charged in the same "area" by provider of similar training and experience for the service or supply. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is

necessary to obtain a representative cross-section of providers, person or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and has the discretionary authority to decide whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may alternatively be determined and established by the Plan using normative data such as Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices. In the event a PPO network provider is utilized, the network scheduled allowance may be utilized in lieu of the Usual and Customary Charge. This does not, however, remove the Plan Administrator's discretionary authority to decide whether a charge is Usual and Customary.

Waiting Period: a period of continuous employment with the Plan Sponsor that an Employee must complete before becoming eligible to enroll in the Plan of Benefits.

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Oconee Countv
Employee Medical Benefits Plan
Effective Date: May I, 2014

Plan Document Signature Page

Employer hereby amends and restates by this Plan Document an employee welfare benefit plan. It is *intended that this Plan Document will* serve *to describe the nature, funding and benefits of the Plan.*

By

OCONEE COUNTY ADMINISTRATOR

Title

T. SCOTT MOULDER

Typed/Printed Name

6/18/14

Date

Oconee County
Plan Sponsor
OconeeCountyPD201 4

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Oconee County Ordinance 2016-24
EXHIBIT A

MODIFICATIONS TO THE OCONEE COUNTY HEALTH INSURANCE PLAN - RETIREE HEALTH INSURANCE PLAN PROVISIONS

THESE RETIREE HEALTH INSURANCE PLAN (THE "PLAN") PROVISIONS ARE SUBJECT TO CHANGE, AND THE COUNTY'S ABILITY TO FUND THIS BENEFIT CAN BE IMPACTED BY FISCAL CHALLENGES AND LEGISLATIVE CHANGES. DUE TO THE RISK OF UNKNOWN CIRCUMSTANCES, THIS PLAN, AS DESCRIBED HEREIN, MAY BE DEEMED UNSUSTAINABLE AT SOME FUTURE TIME. THE RETIREE HEALTH INSURANCE GUIDELINES DESCRIBED HEREIN, OR OTHERWISE, ARE DISCRETIONARY ON THE PART OF THE COUNTY AND THE EMPLOYEE AND DO NOT CREATE ANY EXPRESS OR IMPLIED CONTRACT OF THIS BENEFIT BEING PROVIDED IN THE FUTURE OR IN ANY PARTICULAR AMOUNT AT ANY PARTICULAR TIME. NO PAST PRACTICES OR PROCEDURES, PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, FORM ANY EXPRESS OR IMPLIED AGREEMENT TO CONTINUE SUCH PRACTICES OR PROCEDURES. IT IS EXPLICITLY STATED AND RECOGNIZED BY THE COUNTY AND EVERY EMPLOYEE OR OTHER PERSON ACCEPTING BENEFITS UNDER THE PLAN THAT ALL EMPLOYMENT IN OCONEE COUNTY (EXCEPT FOR THE OCONEE COUNTY ADMINISTRATOR) IS "AT WILL" AND THAT NO OCONEE COUNTY EMPLOYEE (EXCEPT FOR THE OCONEE COUNTY ADMINISTRATOR) HAS AN EMPLOYMENT AGREEMENT OR CONTRACT, AND THAT ALL PROVISIONS OF ANY AND ALL EMPLOYMENT BENEFITS, INCLUDING, WITHOUT LIMITATION, THOSE DESCRIBED IN THIS PLAN ARE ALWAYS SUBJECT TO ANNUAL APPROPRIATION BY THE OCONEE COUNTY COUNCIL, WHICH IS NEVER GUARANTEED AND NEVER WILL BE GUARANTEED.

1. To the extent there are any inconsistencies between the provisions contained herein and the provisions of "ATTACHMENT C" to Ordinance 2016-01, the provisions herein supersede and replace such provisions, which are hereby revoked and repealed.

2. Oconee County (the "County") acting by and through the Oconee County Council ("County Council") currently pays a percentage of the total cost of health benefits for certain retirees of Oconee County and desires to share cost increases of such benefits with current and future retirees who are qualified by twenty (20) or more years of consecutive full-time employment with Oconee County.

3. All current retirees will continue with their current retiree health insurance / plan benefits, with no changes at this time; however, such benefits are subject to change in the future.

4. **Grandfathered Employees**:

    a. "Grandfathered Employees" are those employees of Oconee County who had at least twenty (20) consecutive years of full-time employment for Oconee County as of December 31, 2013.
    b. Upon retirement, Grandfathered Employees will remain on the Oconee County Health Care Plan, under the same terms and conditions as when they were

actively employed, until age 65 or when they become Medicare eligible, whichever occurs first. Spouses of Grandfathered Employees are eligible for the same coverage as Grandfathered Employees, provided the spouse is on the Grandfathered Employee's County Health Care Plan at the time of his or her retirement.

c. Once a retired Grandfathered Employee reaches age 65, he or she is required to enroll in Medicare parts A & B in order to receive the Subsidy, as defined and described in Section 4.d. below,
d. The Subsidy:
    i. The County desires to contribute a monthly subsidy to all Grandfathered Employees upon retirement, when they reach 65 years of age or when they become Medicare eligible, whichever occurs first.
    ii. Current Oconee County paid health benefit coverage for Grandfathered Employees under the Oconee County Employee Health Care Plan shall cease when the Grandfathered Employee retires (becoming a "Grandfathered Retiree") and reaches age 65 or becomes Medicare eligible, whichever occurs first. Discontinuance of County paid health benefit coverage for spouses of Grandfathered Employees / Retirees will also occur when the spouse reaches age 65 or becomes Medicare eligible, whichever occurs first. Effective January 1, 2016 the County began contributing a monthly subsidy of $158 per Grandfathered Retiree, or $316 per month if married and the spouse is covered. This subsidy is solely for the purpose of assisting the Grandfathered Retiree and spouse, if applicable, in purchasing a Medicare supplemental insurance plan.
    iii. Increases to the cost of the Oconee County Employee Health Care Plan will depend upon actual costs; increases to the Subsidy will change annually by the lower of CPI (Consumer Price Index) or 3% per year. The CPI increase will be determined using September over September time frame
    iv. Grandfathered Employees / Retirees may choose to decline coverage under the Plan at any time, but they will not be allowed to re-enroll in the Plan in the future, (with the exception of 2 prior grandfathered employees with special circumstances).

5. "**Non-grandfathered Employees**" are those employees hired prior to July 1, 2005, who complete 20 years of consecutive employment for Oconee County but who do not qualify as Grandfathered Employees.

    a. Non-grandfathered Employees will remain eligible for Oconee County Employee Health Care Plan benefits upon their retirement, subject to the conditions stated therein, and otherwise provided by law.
    b. Spouses of Non-grandfathered Employees will not be eligible for Oconee County Employee Health Care Plan coverage upon retirement of the Non-grandfathered Employee.
    c. Once a Non-grandfathered Employee retires and attains the age of 65 or becomes Medicare eligible, whichever occurs first, Oconee County Employee Health Care Plan Coverage will cease.
    d. No Subsidy will be provided Non-grandfathered Employees or their spouses.

6. For all groups (Grandfathered and Non-grandfathered), identified in these guidelines, only actual Oconee County employment time is considered for the purpose of determining contributions by Oconee County. No purchased service time of any kind will be considered for any group for purposes of retiree health benefits from Oconee County.

7. Employees hired after June 30, 2005 are ineligible for both retiree health care coverage and the Subsidy

Summary:

Grandfathered Employees

- Must have 20 consecutive years of County employment as of December 31, 2013.
- Retiree and Spouse will remain on the Oconee County Health Care Plan until they reach age 65 or become Medicare eligible, whichever occurs first.
- At age 65 or upon Medicare eligibility, (whichever occurs first) a subsidy in the amount of $158 for Retiree or $316 for Retiree/Spouse will be offered in calendar year 2016. Subsidy increases over time by the lesser of 3% per year or the prevailing CPI rate increase each year.

Non-Grandfathered Employees

- Must have 20 consecutive years County employment and hired before July 1, 2005.
- If retired prior to age 65, Retiree will remain on the Oconee County Health Care Plan until the retiree reaches age 65 or becomes Medicare eligible, whichever occurs first.
- No coverage will be provided for spouse upon retirement of the Non-Grandfathered Employee.
- No Subsidy will be provided Non-grandfathered Employees or their spouses.

Employees hired on or after July 1, 2005

- Oconee County provides no retiree health care coverage or Subsidy.

Current Retirees

- Will continue with the current retiree health insurance / Plan benefits being received, with no changes at this time; however, the Plan is subject to change in the future.