McDuffie County Board of Commissioners
Regular Commission Meeting
Regular Session, Wednesday 4, 2023, 10:00 am
Government Center Meeting Room

AGENDA

PUBLIC HEARING

1. Consideration Concerning a Determination to Abandon portions of Ferrous Road no longer utilized by the General Public.

WELCOME & CALL TO ORDER

Chairman Newton

INVOCATION & PLEDGE OF ALLEGIANCE

APPROVALS

Agenda	**Current**
Minutes	**Regular Meeting**- *September 19, 2023*

INFORMATION & ANNOUNCEMENTS

- **ACCG Legislative Conference: October 10th – 13th, Jekyll Island**
- **Camellia City Festival and Pink Ribbon One Mile Walk, Saturday, October 21, 2023**
- **ACCG Lifelong Learning Academy November 2023 Leadership Institute November 16-17, 2023**

APPOINTMENT/REAPPOINTMENT

- Reappointment of David Holt to Tax Assessor Board – See Resolution 23-15.
- Appointment of Stephanie Walker to CSRA EOA Board

OLD BUSINESS

NEW BUSINESS

1) Consideration Concerning a Determination to Abandon portions of Ferrous Road no longer utilized by the General Public.
2) Consideration to Approve Resolution 23-15 to reappoint David Holt for Board of Assessors.
3) Consideration to Approve Emergency repair through Utility Asset Management to Stagecoach and Folly Lake.
4) Consideration to Enter Contract with CSRA Regional Commission for the for Administration of Paul Bruhn Subgrant Program for DTRP and Enter into Agreement with the CSRA RC to Assure Effective Management of the Project.
5) Consideration to Adopt Resolution 23-14, to Temporarily Suspend the Issuance of Alcoholic Beverage Licenses within McDuffie County, Georgia and for Other Purposes.
6) Consideration to Approve second reading to Amend the Fire Fee Ordinance to include Dearing as part of the fire service area.
7) Consideration to approve UniFirst Customer Service Agreement.
8) Consideration to Approve Meritain Administrative Services Agreement.

9) Consideration Concerning the Purchase of Civic Plus Management and Meeting software for McDuffie County.
10) Consideration Concerning Purchase of Cameras for Animal Services at the Animal Shelter.
11) Consideration to Approve Fall Trash Amnesty Day
12) Presentation of Schedule of Fees.
13) Presentation of 2024 Proposed Budget.
14) Presentation of September ACO Report.

ADJOURNMENT

MCDUFFIE COUNTY BOARD OF COMMISSIONERS
Regular Commissioner Meeting
Wednesday, September 19, 2023 | 6:30 PM
Government Center Meeting Room

COMMISSIONERS PRESENT:
Charles G Newton, Chairman
Sammie Wilson, Vice Chairman
Gloria Thompson, Commissioner
William "Bill" Jopling, Commissioner
Reverend Fred Favors, Commissioner

COUNTY REPRSENTATION:
David Crawley, County Manager
Carrie Edwards, County Clerk
Stacey Thomas, Tax Commissioner
Pam Workman, Finance Director
Stephanie Walker, Senior Center/Transit
Ruthie Thomas, HR Director
Jason Smith, Community Development
Stephen Sewell, Fire EMS
Robert Spurlin, IT Director

PUBLIC

MEDIA: McDuffie Progress
Members of the Public

HEARING

1. **FY 2023 Millage Rate**

   County Manager Crawley presented the proposed FY23 millage rate. He advised the process for millage and what is required for the county to operate. Governor Kemp's one time additional $18,000 in Homestead Exemptions was discussed.

WELCOME & CALL TO ORDER

Chairman Newton called the meeting to order at 6:30 pm, acknowledged quorum of commissioners' present and welcomed everyone in attendance.

INVOCATION AND PLEDGE OF ALLEGIANCE

PUBLIC INPUT

Darrick Brown requested to speak regarding the Land Bank property and his property that are connected.

APPROVALS

APPROVALS

Agenda
Current
Chairman Newton asked if there were any corrections to the Current Agenda.
There were none. Vice Chairman Wilson made a motion to approve the agenda. The motion was seconded by Commissioner Jopling. The motion carried unanimously.

Minutes	**Regular Meeting**	September 6, 2023
	Executive Session	September 6, 2023
	Special Called	September 7, 2023 | 10:00 am

MCDUFFIE COUNTY BOARD OF COMMISSIONERS
Regular Commissioner Meeting
Wednesday, September 19, 2023 | 6:30 PM
Government Center Meeting Room

Special Called September 7, 2023 | 6:30 pm

Chairman Newton requested motion to approve August 15, 2023 minutes. Commissioner Jopling made the motion to approve minutes. The motion was seconded by Vice Chairman Wilson.
The motion carried unanimously.

INFORMATION AND ANNOUNCEMENTS

Chairman Newton reminded everyone of the upcoming Blind Willie Blues Festival weekend being held in Thomson, Saturday, September 23, 2023.

APPOINTMENT/REAPPOINTMENTS None
OLD BUSINESS None

NEW BUSINESS

1. **Consideration to Approve Resolution 23-11 for FY23 Millage.**

County Manager Crawley provided a brief summary on the previously discussed Millage Rate Public Hearings. Chairman Newton opened the floor for discussion and the recommendation to roll back the rate to 7.50. The rate was discussed in length with Commissioner Thompson providing input on the recommendation to remain at 7.809 due to the $18k additional homestead exemption by the state. Chairman Newton opened the floor for voting. Commissioner Thomspon made a motion to approve the Millage Rate at 7.809. Commissioner Jopling seconded the motion. The motion was motion carried 3-2. Opposed: Chairman Charlie Newton, Commissioner Fred Favors.

2. **Consideration to Approve Alcohol License for SAI KRUPA HOTEL LLC.**

Community Development Director, Jason Smith provided an update on the alcohol license request. Chairman Newton requested motion to approve. Commissioner Thompson made a motion to approve. The motion was seconded by Commissioner Jopling. The motion carried unanimously.

3. **Consideration to Approve the Resolution 23-12 for the Wrightsboro Road Sewer Expansion.**

County Manager Crawley provided an update on the Wrightsboro Road Sewer Expansion. Chairman Newton requested motion to approve. Commissioner Favors made a motion to approve. The motion was seconded by Commissioner Jopling. The motion carried unanimously.

4. **Consideration to Approve Transmittal Letter for FY25 5311 (Transit) Grant.**

Chairman Newton requested a motion to approve. Commissioner Thompson made a motion to approve. The motion was seconded by Vice Chair Wilson. The motion carried unanimously.

5. **Consideration to Approve Resolution 23-13 Authorizing the Filing of an Application with the Department of Transportation for FY25.**

County Manager Crawley provided an overview of Resolution 23-13. Chairman Newton requested a motion to approve. Vice Chair Wilson made a motion to approve. The motion was seconded by Commissioner Thompson. The motion carried unanimously.

6. **Consideration to Approve Supplemental Agreement with DOT Concerning Additional Funding for the West Bypass Project.**

County Manager Crawley provided an update to request for additional dollars for West Bypass. Chairman Newton requested motion to approve. Commissioner Jopling made a motion to approve. The motion was seconded by Commissioner Thompson. The motion carried unanimously.

7. **Consideration to Approve McDuffie County Education Salary Increase.**

   County Manager Crawley, along with HR Director, Ruthie Thomas provided a summary to approve educational salary increase. After thorough discussion regarding two separate employees Chairman Newton requested motion to approve. Commissioner Jopling made a motion to approve one employee based on discussion. Commissioner Thompon seconded the motion. The motion carried unanimously. The second was tabled for further information. Vice Chair Vice Chair Wilson made a motion to approve. The motion was seconded by Commissioner Jopling. The motion carried unanimously. Tabled until further information from employee is obtained.

8. **Monthly Budget Report.**

   County Manager Crawley provided an overview of the monthly budget. No motion required.

9. **Monthly Financial Report.**

   Finance Director, Pam Workman provided an update of the monthly financial report. No motion required.

ADJOURNMENT

A motion was made by Vice Chairman Wilson to adjourn the regular meeting. The motion was seconded by Commissioner Jopling. The motion carried unanimously.

MCDUFFIE COUNTY BOARD OF COMMISSIONERS

_____ **ATTEST:** _____
Charles G Newton, IV, Chairman Carrie Edwards, County Clerk

MCDUFFIE COUNTY BOARD OF COMMISSIONERS

Regular Commissioner Meeting

Wednesday, September 19, 2023 | 6:30 PM

Government Center Meeting Room

STAFF REPORT

BOARD OF COMMISSIONER MEETING: October 4, 2023

DATE: September 29, 2023
TO: McDuffie County Board of Commissioners
FROM: Carrie Edwards
ISSUE: Abandon Portions of Ferrous Road no longer utilized by the General Public.

BACKGROUND: Public Notice in McDuffie Progress. Public Hearing held Wednesday, October 4, 2023.

FACTS AND FINDINGS: Ferrous Road initial Resolution 23-09 has been executed.

STAFF RECOMMENDATION: Staff recommends the approval of the request.

ATTACHMENTS:

1. Executed Resolution 23-09 Determination to Abandon Portions of Ferrous Road, 09.06.2023/Plat
2. Public Hearing Notice
3. Public Hearing Notice Published Thursday, September 21, 2023
4. Public Hearing Notice Published Thursday, September 28, 2023
5. Public Hearing Letter to Property Owner

Thomson mcduffie County, Georgia

McDuffie County Board of Commissioners

RESOLUTION OF THE BOARD OF COMMISSIONERS OF MCDUFFIE COUNTY, GEORGIA CONCERNING A DETERMINATION TO ABANDON THOSE PORTIONS OF FERROUS ROAD NO LONGER UTILIZED BY THE GENERAL PUBLIC

RESOLUTION 23-09 | Dated: September 6, 2023

THIS RESOLUTION adopted by the Board of Commissioners of McDuffie County.

WHEREAS, it has been proposed that the Board of Commissioners make a determination that removing from the County road system those portions of the right-of-way known as Ferrous Road ("Road") no longer utilized by the general public shown and depicted as Parcel "A" and on that plat attached hereto as Exhibit "A," ("Property"), is in the public's best interest.

NOW, THEREFORE, be it resolved by the Board of Commissioners of McDuffie County and it is hereby resolved by the authority of same as follows:

1. That a public hearing be held on this issue and that a notice of such public hearing be published in the *McDuffie Progress*, which is the newspaper in which Sheriff's advertisements for McDuffie County are published, once a week for a period of two weeks prior to the date of the holding of such public hearing.

2. That following the holding of such public hearing, the County Manager shall report on this issue to the Board of Commissioners at its next meeting following the holding of such public hearing.

3. That the Clerk of the Board of Commissioners of McDuffie County promptly mail by certified mail, return receipt requested, to all of the property owners whose land fronts on said road as shown on the tax records of McDuffie County, a copy of the notice of the public hearing.

4. This resolution shall become effective immediately upon its adoption.

Adopted September 6, 2023.

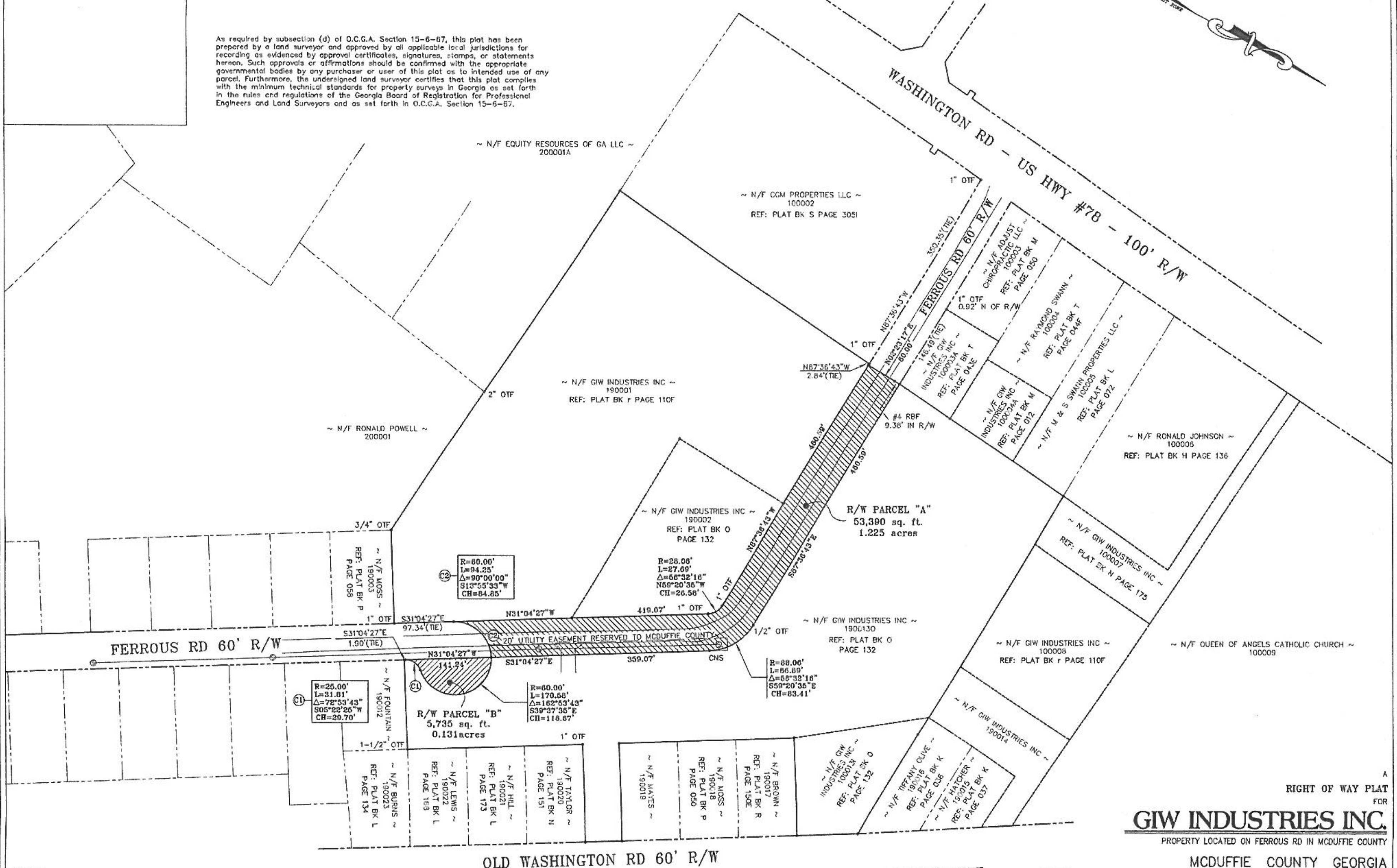
BOARD OF COMMISSIONERS OF MCDUFFIE COUNTY, GEORGIA (Seal)

By: _____
Chairman

Attest: Carrie R Fowlkes
Clerk

NOTE:
THIS SURVEY WAS PREPARED IN CONFORMITY WITH THE TECHNICAL STANDARDS FOR PROPERTY SURVEY IN GEORGIA AS SET FORTH IN CHAPTER 180-7 OF THE RULES OF THE GEORGIA BOARD OF REGISTRATION FOR PROFESSIONAL ENGINEERS AND LAND SURVEYORS AND AS SET FORTH IN THE GEORGIA PLAT ACT O.C.G.A. 15-6-67.

As required by subsection (d) of O.C.G.A. Section 15-6-67, this plat has been prepared by a land surveyor and approved by all applicable local jurisdictions for recording as evidenced by approval certificates, signatures, stamps, or statements hereon. Such approvals or affirmations should be confirmed with the appropriate governmental bodies by any purchaser or user of this plat as to intended use of any parcel. Furthermore, the undersigned land surveyor certifies that this plat complies with the minimum technical standards for property surveys in Georgia as set forth in the rules and regulations of the Georgia Board of Registration for Professional Engineers and Land Surveyors and as set forth in O.C.G.A. Section 15-6-67.



WASHINGTON RD - US HWY #78 - 100' R/W
FERROUS RD 60' R/W
OLD WASHINGTON RD 60' R/W
~ N/F EQUITY RESOURCES OF GA LLC ~ 200001A
~ N/F CGM PROPERTIES LLC ~ 100002 REF: PLAT BK S PAGE 3051
~ N/F GIW INDUSTRIES INC ~ 190001 REF: PLAT BK r PAGE 110F
~ N/F RONALD POWELL ~ 200001
~ N/F GIW INDUSTRIES INC ~ 190002 REF: PLAT BK O PAGE 132
~ N/F GIW INDUSTRIES INC ~ 190D130 REF: PLAT BK O PAGE 132
R/W PARCEL "A" 53,390 sq. ft. 1.225 acres
R/W PARCEL "B" 5,735 sq. ft. 0.131acres
20' UTILITY EASEMENT RESERVED TO MCDUFFIE COUNTY
~ N/F ADJUST CHIROPRACTIC LLC ~ 100003 REF: PLAT BK M PAGE 050
~ N/F RAYMOND SWANN ~ 100004 REF: PLAT BK T PAGE 044F
~ N/F GIW INDUSTRIES INC ~ 100003A REF: PLAT BK T PAGE 043E
~ N/F GIW INDUSTRIES INC ~ 100004A REF: PLAT BK M PAGE 012
~ N/F M & S SWANN PROPERTIES LLC ~ 100005 REF: PLAT BK L PAGE 072
~ N/F RONALD JOHNSON ~ 100006 REF: PLAT BK H PAGE 136
~ N/F GIW INDUSTRIES INC ~ 100007 REF: PLAT BK N PAGE 175
~ N/F GIW INDUSTRIES INC ~ 100008 REF: PLAT BK r PAGE 110F
~ N/F QUEEN OF ANGELS CATHOLIC CHURCH ~ 100009
~ N/F GIW INDUSTRIES INC ~ 190014
~ N/F GIW INDUSTRIES INC ~ 190013 REF: PLAT BK O PAGE 132
~ N/F TIFFANY OLIVE ~ 190016 REF: PLAT BK K PAGE 036
~ N/F HATCHER ~ 190015 REF: PLAT BK K PAGE 037
~ N/F BROWN ~ 190017 REF: PLAT BK R PAGE 150E
~ N/F MOSS ~ 190018 REF: PLAT BK P PAGE 050
~ N/F MAYES ~ 190019
~ N/F TAYLOR ~ 190020 REF: PLAT BK N PAGE 151
~ N/F HILL ~ 190021 REF: PLAT BK L PAGE 173
~ N/F LEWIS ~ 190022 REF: PLAT BK L PAGE 163
~ N/F BURNS ~ 190023 REF: PLAT BK L PAGE 134
~ N/F FOUNTAIN ~ 190012
~ N/F MOSS ~ 190003 REF: PLAT BK P PAGE 058
1" OTF
0.92' N OF R/W
2" OTF
3/4" OTF
1/2" OTF
1-1/2" OTF
CNS
N87°36'43"W 2.84'(TIE)
#4 RBF 9.38' IN R/W
N02°23'17"E 60.00'
N87°36'43"W 146.49'(TIE)
350.35'(TIE)
460.59'
N87°36'43"W
S87°36'43"E
419.07'
359.07'
N31°04'27"W
S31°04'27"E 97.34'(TIE)
S31°04'27"E 1.90'(TIE)
N31°04'27"W 141.24'
S31°04'27"E
R=60.00' L=94.25' Δ=90°00'00" S13°55'33"W CH=84.85'
R=28.00' L=27.69' Δ=56°32'16" N59°20'36"W CH=26.56'
R=88.00' L=86.89' Δ=56°32'16" S59°20'36"E CH=83.41'
R=60.00' L=170.58' Δ=162°53'43" S39°37'35"E CH=118.67'
R=25.00' L=31.81' Δ=72°53'43" S05°22'25"W CH=29.70'
C1
C2

NOTES:

1. THIS SURVEY WAS PERFORMED WITH A 5 SEC. THEODOLITE, AN E.D.M., AND A 200' STEEL TAPE.
2. THIS PROPERTY DOES NOT LIE WITHIN A DESIGNATED 100 YR. FLOOD PLAIN AS PER THE FLOOD INSURANCE STUDY FOR McDUFFIE COUNTY, GEORGIA COMMUNITY PANEL NUMBER 13189C0135B, DATED 9/29/2010.
3. DATE OF SURVEY: 5/18/2023.
4. FIELD CLOSURE: 1/32,505.
   ANGULAR ERROR: 1" PER STATION. COMPASS RULE ADJUSTED.
   PLAT CLOSURE: 1/90,503.
5. REFERENCE PLAT FOR G I W THOMSON, INC., BY JOHN MCGILL, DATED FEBRUARY 9, 1987.

Such approvals or affirmations should be confirmed with the appropriate governmental bodies by any purchaser as to intended use of any parcel. As the Registered Land Surveyor, I further certify that this map, plot, or plan complies with the minimum standards and specifications of the State Board of Registration for Professional Engineers and Land Surveyors and the Georgia Superior Court Clerks Cooperative Authority.

G.F. "BO" SLAUGHTER GEORGIA REGISTERED LAND SURVEYOR 2614

GEORGIA REGISTERED No. 2614 PROFESSIONAL LAND SURVEYOR G.F. "BO" SLAUGHTER

A RIGHT OF WAY PLAT FOR

GIW INDUSTRIES INC.

PROPERTY LOCATED ON FERROUS RD IN MCDUFFIE COUNTY

MCDUFFIE COUNTY GEORGIA

SCALE: 1" = 100'

JUNE 21, 2023

100' 0 100'

PREPARED BY:

JAMES G. SWIFT & ASSOCIATES
CONSULTING ENGINEERS
1206 INTERSTATE PARKWAY - AUGUSTA, GA. - 30909
Phone: (706) 868-8803 Fax: (706) 868-5464

NOTICE OF A PUBLIC HEARING TO CONSIDER A PROPOSED DETERMINATION BY THE BOARD OF COMMISSIONERS OF MCDUFFIE COUNTY, GEORGIA TO ABANDON FERROUS ROAD FROM THE ROAD SYSTEM OF MCDUFFIE COUNTY

Notice is hereby given that the Board of Commissioners of McDuffie County, Georgia will consider whether the public has ceased to use a portion of that right of way known as Ferrous Road, County Road No. 321, (hereinafter the "Right-of-Way"), to the extent that no substantial public purpose is served by the Right-of-Way and whether, accordingly, the County should abandon the Right-of-Way and remove it from the County's road system.

A public hearing on the proposed abandonment of a portion of the Ferrous Road Right-of-Way as described above will be held by the County Manager of McDuffie County, on Wednesday, October 4, 2023 at 10:00 a.m. in the Government Center Meeting Room on the first floor of 210 Railroad Street, Thomson, Georgia, 30824. Anyone desiring to comment on this matter may do so by appearing at said public hearing or may submit written comments at or prior to the public hearing to David Crawley, County Manager at 210 Railroad Street, Thomson, Georgia 30824.

The foregoing Notice is provided in accordance with Resolution 23-09 of the McDuffie County Board of Commissioners, adopted Wednesday, September 6, 2023.

Community

Thomson Camellia Lions invite community to join organization

The Thomson Camellia City Lions Club is seeking civic-minded men and women to join them in making a difference in the community. The club is hosting a free membership drive dinner on October 9, 2023 for people who want to learn more about the club and its work.

"Our club gives members an opportunity to advance worthy causes, serve with friends, and become leaders in the community. The club means a lot to our Lions, but it means so much more to the people we serve," said Lions President Bonnie Martin.

The membership drive dinner will be held at the Queen of Angels Catholic Church on Monday, October 9, 2023 at 6:30 p.m. President Bonnie Martin and Membership Chairman Lion Pat Wylie encourage the public to come out and learn more about the club's work.

"We want to share the great things we're doing in the community, and let others know how they can help." said Martin.

The Lions' motto is "We Serve," and the Thomson Camellia City Lions Club has lived up to it since August 1995 when the club was charter. The club provides and pay for eye examinations and glasses for needy individuals in our community, donates to our schools, help sponsors participant to camp through donations to Georgia Lions Camp for the Blind, helps with information for eye surgeries for the needy, and makes donations to the world-wide Lions programs by funding humanitarian service projects.

Lions Clubs International is the largest service club organization in the world. Its 1.3 million members in more than 46,000 clubs are serving communities in 207 countries and geographical areas around the globe. Since 1917, Lions clubs have aided the blind and visually impaired, championed youth initiatives and strengthened local communities through hands-on service and humanitarian projects. In 2007, Lions Clubs International gave $10,000 to Thomson Camellia City Lions Club to distribute to the citizens in Thomson that were affected by the tornado that hit Thomson. For more information about Lions Clubs International, visit lionsclubs.org.

For information and reservations for the Thomson Camellia City Lions Club free membership drive dinner, call Lions President Bonnie Martin at 706-595-5176, or Membership Chairman Lion Pat Wylie at 706-595-0560.

Lion of the Year award presented

At the recent Thomson Camellia City Lions meeting, Lion Joanne Huff was presented with the 2022-23 Lion of the Year Award.

Huff has been an active member of Lions since 2005. She has served and is serving in many state and district programs through the years. She has served as Thomson Camellia City Lions Club president and serving now as secretary.

This award is voted on by the members. Members selected Huff for recognition for her outstanding service, loyalty and her devotion to Lions.

Work anniversary

Courtesy photo

Becky Jenkins recently celebrated 10 years of service with Georgia Farm Bureau.

Family Connection of Warren County prepares for Breast Cancer Awareness Month events

Family Connection of Warren County, Inc. in partnership with the Warren County Teens In Action are again launching its annual fundraising drive for cancer patients and caregivers in Warren County.

They want to get local residents involved in their efforts to support individuals in Warren County who are going back and forth to Augusta/Atlanta, etc. for chemotherapy, radiation and other treatments. They are hoping and asking the community to participate in the 14th annual "Circle of Care" cancer drive to support individuals facing breast cancer and all other cancers.

There are several events this year to raise the funds needed to support individuals going through treatment or who need transportation and other supports during the fight to survive.

On October 8, beginning at 5 p.m., right before the Gospel on the Green Event, they will host their annual cancer prevention walk around the city park located near the Chamber of Commerce.

On October 14, they will be celebrating the tenth year breast cancer survivorship of Emma Sinkfield along with the tenth memorial year for Johnathan Bernard Ficklin.

October 22 through October 31, several events will be held in Warren County during the governor's Annual Red Ribbon Week. On October 24, the 15th Annual Community Health and Resource Fair along with the Mobile Mammogram Bus will be held uptown near the library and the Community Service Building. The 15th annual Circle of Care celebration will be held on October 26, in the Warren County High School Auditorium.

All proceeds from these events and celebrations go to the Circle of Care Cancer Fund for Warren County citizens. The closest treatment centers are located at least 100 miles round trip from the county. They hope to touch the hearts of the community to get involved in this much-needed effort to help create hope in this fight. They realize that we are strong alone but can be unstoppable united when they can boldly say that no one has to bear cancer alone.

The organization also welcomes financial gifts and donations to the cause because the need in Warren County is dire.

The group is are grateful to the citizens, churches and companies who have supported the efforts of the local Circle of Care Cancer Support initiative. During the last six years, they have assisted several individuals in Warren County with going back and forth to receive chemotherapy and radiation treatment.

October is recognized as Breast Cancer Prevention month but, in the Circle of Care, they changed their focus to assist in fighting against and praying for individuals with all types of cancers.

You may make a donation to the Circle of Care at PO box 468, Warrenton, GA 30828 or you can Cash App to $FCWarren1006.

For more information, please call Emma Sinkfield, ICPS, at 706-465-1006 or Louise Hadden at 706-465-3368.

Our theme for this year is "Encouraging the Fighters, Supporting the Survivors and Remembering the Warriors. To purchase a luminary for the Cancer Prevention Walk on October 8, call Tanisha Wilson at 706-466-0038. To purchase a t-shirt call Chranda Baker at 706-513-3554. To participate in the 10th Survivorship for Emma Sinkfield on October 14, call Bobbie Russell at 706-465-1006.

Community calendar

September 29 and 30
Annual yard sale
Queen of Angels Catholic Church, 1326 Washington Road in Thomson, will hold their annual yard sale on Friday, Sep. 29 and Saturday, Sep. 30, from 8 a.m. to 3 p.m. each day. All are welcome.

Sundays and Wednesdays- Ongoing
Thomson Church of God services
You are invited to the Thomson Church of God, 1354 Wrens Highway, which holds Sunday school at 9:55 a.m. and worship at 10:55 a.m. each Sunday. Evening services are at 6 p.m. each Wednesday with Bible study at 7 p.m. Songs from the Red Back Hymnal and Southern Gospel Chorus and songs.

Ongoing
Senior craft store
"Grandma's Craft & Ceramic Store" at the Thomson-McDuffie Senior Center is open to the public from 8 a.m. until 5 p.m. Monday through Friday. For more information, please call 706-595-7502.

Ongoing
Thomson-McDuffie Museum
The Thomson-McDuffie Museum has a vast stockpile of local historic treasures available for inspection and enjoyment located in a local historic landmark. Surrounding area residents have donated one-of-a-kind items that provide a time capsule of life in this area. The museum is free to the public, located at 121 Main St., and is open Friday and Saturday from noon to 5 p.m. Want to bring a group? Call (706) 990-8784.

Ongoing
Alanon meeting
If you have family or friends who are addicted to drugs or alcohol, there is help and support for you. The Thomson Serenity Seekers Alanon Family Group meets each Tuesday evening at 7 p.m. at the Young Memorial United Methodist Church which is located at 1711 Washington Road. Please join us if you need help.

NOTICE OF A PUBLIC HEARING TO CONSIDER A PROPOSED DETERMINATION BY THE BOARD OF COMMISSIONERS OF MCDUFFIE COUNTY, GEORGIA TO ABANDON FERROUS ROAD FROM THE ROAD SYSTEM OF MCDUFFIE COUNTY

Notice is hereby given that the Board of Commissioners of McDuffie County, Georgia will consider whether the public has ceased to use a portion of that right of way known as Ferrous Road, County Road No. 321, (hereinafter the "Right-of-Way"), to the extent that no substantial public purpose is served by the Right-of-Way and whether, accordingly, the County should abandon the Right-of-Way and remove it from the County's road system.

A public hearing on the proposed abandonment of a portion of the Ferrous Road Right-of-Way as described above will be held by the County Manager of McDuffie County, on Wednesday, October 4, 2023 at 10:00 a.m. in the Government Center Meeting Room on the first floor of 210 Railroad Street, Thomson, Georgia, 30824. Anyone desiring to comment on this matter may do so by appearing at said public hearing or may submit written comments at or prior to the public hearing to David Crawley, County Manager at 210 Railroad Street, Thomson, Georgia 30824.

The foregoing Notice is provided in accordance with Resolution 23-09 of the McDuffie County Board of Commissioners, adopted Wednesday, September 6, 2023.

PUBLIC NOTICE

Logic & Accuracy (L&A) testing of all equipment to be used for Advance Voting and Election Day for the upcoming November 7, 2023 General Municipal Election will begin at 10AM on Wednesday, October 3 and continue until completion. All testing will be done in the old THS Gym, 525 Main Street, Thomson, GA. (across from the Brickyard). QUESTIONS: 706/595-2105.

PUBLIC NOTICE

The McDuffie County Board of Commissioners proposes to amend Chapter 78 of the Code of Ordinances of McDuffie County, Article VII, entitled "Fire Protection Utility;" to provide for the inclusion of the Town of Dearing; to adjust the composition of the Fire Protection Utility Commission; and to adjust the Fire Utility Service Area to include the Town of Dearing.

For additional information contact Carrie Edwards, County Clerk, at (706) 597-7300.

Education

Dearing Elementary School news

Courtesy of McDuffie County School District

Students with perfect attendance for the month of August enjoyed lunch on the stage and a RingPop treat. There were 196 students present every day for the month of August.

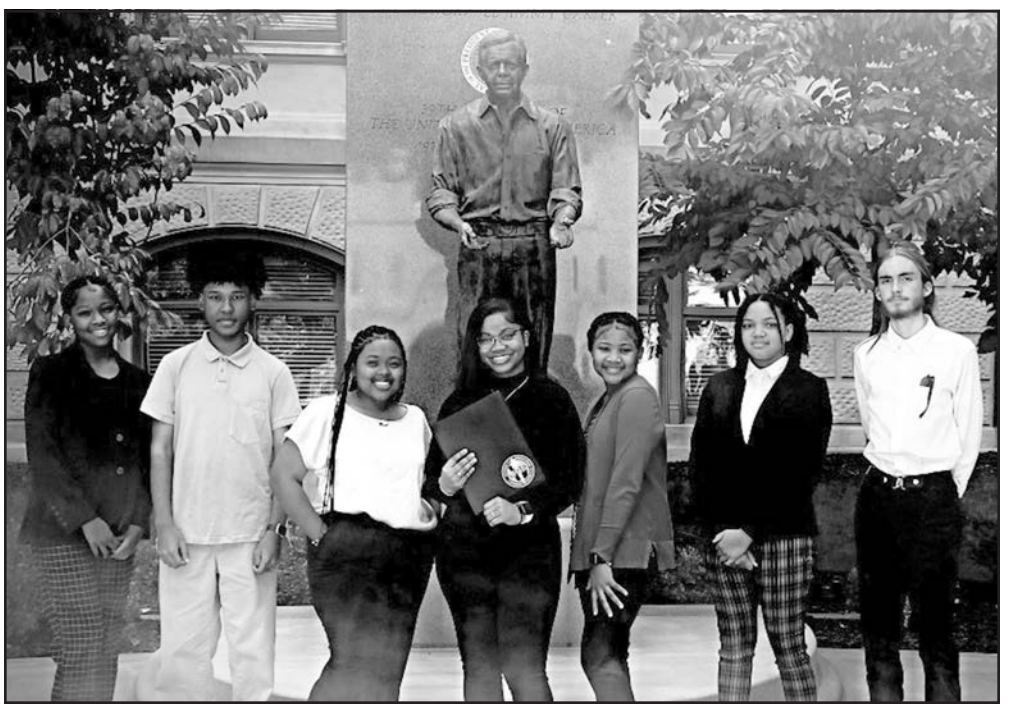
Courtesy of McDuffie County School District

Kindergarten students learned during rotation through multiple centers, including reading and writing in small groups, as well as I-Ready on the computers.

Thomson High School news

Courtesy of McDuffie County School District

THS Student Council leaders attended the Georgia Association of Student Council Leadership Summit at the State Capitol in Atlanta on Sept. 18. Students engaged in workshops to discover their personality



Norris Elementary School news

Courtesy of McDuffie County School District

Fifth graders created an edible model of the Earth's crust in science lab, simulating the movements of tectonic plates with graham crackers and Cool Whip. By carefully breaking and rearranging the crackers, they simulated the movement and interactions of these plates. As they manipulated the crackers, they observed how different types of plate boundaries form and the geological features that result from their collisions.

PUBLIC NOTICE

Logic & Accuracy (L&A) testing of all equipment to be used for Advance Voting and Election Day for the upcoming November 7, 2023 General Municipal Election will begin at 10AM on Wednesday, October 3 and continue until completion. All testing will be done in the old THS Gym, 525 Main Street, Thomson, GA. (across from the Brickyard). QUESTIONS: 706/595-2105.

PUBLIC NOTICE

The McDuffie County Board of Commissioners proposes to amend Chapter 78 of the Code of Ordinances of McDuffie County, Article VII, entitled "Fire Protection Utility;" to provide for the inclusion of the Town of Dearing; to adjust the composition of the Fire Protection Utility Commission; and to adjust the Fire Utility Service Area to include the Town of Dearing.

For additional information contact Carrie Edwards, County Clerk, at (706) 597-7300.

NOTICE OF MUNICIPAL GENERAL ELECTION
TO THE QUALIFIED ELECTORS OF THE CITY OF THOMSON, GEORGIA

Notice is hereby given that a Municipal General Election will be held on Tuesday, November 7, 2023. **ALL City of Thomson voters** will vote at the designated City of Thomson polling location, namely **Precinct on Main,** 525 Main Street **(old THS Gym).** This is the only City of Thomson polling location. The polling location shall be open from 7AM until 7PM on Election Day.

This election is for the purpose of electing one (1) Mayor, and five (5) Council Members.

In-Person Early/Advance Voting will be available at the polling location beginning at 9:00AM on Monday, October 16, 2023, and ending on Friday, November 3, 2023, 5:30PM, **including** Saturday, October 21 and Saturday, October 28. Additional times may be added.

Voting by mail will also be available to any registered voter of the City of Thomson.

The last day to submit an application for an absentee ballot shall be October 27.

Deadline to register/change name/change address for this election shall be October 10, 2023.

VOTING WILL STILL BE IN THE GYM!!

This the 28th day of September 2023
//Phyllis Brooks
Elections Director
McDuffie County, GA
706/595-2105

NOTICE OF A PUBLIC HEARING TO CONSIDER A PROPOSED DETERMINATION BY THE BOARD OF COMMISSIONERS OF MCDUFFIE COUNTY, GEORGIA TO ABANDON FERROUS ROAD FROM THE ROAD SYSTEM OF MCDUFFIE COUNTY

Notice is hereby given that the Board of Commissioners of McDuffie County, Georgia will consider whether the public has ceased to use a portion of that right of way known as Ferrous Road, County Road No. 321, (hereinafter the "Right-of-Way"), to the extent that no substantial public purpose is served by the Right-of-Way and whether, accordingly, the County should abandon the Right-of-Way and remove it from the County's road system.

A public hearing on the proposed abandonment of a portion of the Ferrous Road Right-of-Way as described above will be held by the County Manager of McDuffie County, on Wednesday, October 4, 2023 at 10:00 a.m. in the Government Center Meeting Room on the first floor of 210 Railroad Street, Thomson, Georgia, 30824. Anyone desiring to comment on this matter may do so by appearing at said public hearing or may submit written comments at or prior to the public hearing to David Crawley, County Manager at 210 Railroad Street, Thomson, Georgia 30824.

The foregoing Notice is provided in accordance with Resolution 23-09 of the McDuffie County Board of Commissioners, adopted Wednesday, September 6, 2023.

Thomson mcduffie County, Georgia

McDuffie County Board of Commissioners

September 28, 2023

Attention Jonathan Samuels
5000 Wrightsboro Road
Grovetown, Georgia 30813

Re: Abandonment of a Portion of Ferrous Road, County Road No. 321

Dear Property Owner:

The McDuffie County Board of Commissioners at their meeting held Wednesday, September 6, 2023 adopted *Resolution 23-09* in response to a proposal for the abandonment of a portion of Ferrous Road, County Road No. 321. The Resolution authorizes the holding of a public hearing pursuant O.C.G.A. §32-7-2 to obtain public input for the Board to determine whether the identified portion of road has ceased to be used by the public to the extent that no substantial public purpose is served and that its removal from the county road system is otherwise in the interest of the public.

You are receiving this letter because you are the owner of property which abuts the road right of way which is proposed to be abandoned.

The public hearing is scheduled to be held by the County Manager of McDuffie County, on Wednesday, October 4, 2023 at 10:00 am, in the Meeting Room on the first floor of the McDuffie County Government Center, 210 Railroad Street, Thomson, Georgia, 30824.

Anyone desiring to comment on this matter may do so by appearing at said public hearing or may submit written comments at or prior to the public hearing to:

David Crawley, County Manager
210 Railroad Street
Thomson, Georgia 30824.

Should you have any questions regarding the legal process, you may contact me at the addresses and phone numbers listed herein.

Sincerely,

Carrie R Edwards

Carrie R Edwards
McDuffie County Board of Commissioners
County Clerk

1870 150 2020

{01866775-1}

Thomson mcduffie County, Georgia

McDuffie County Board of Commissioners

Frederick D. Favors
Wm. (Bill) M. Jopling

Charles (Charlie) G. Newton IV, Chairman
David R. Crawley, Jr., County Manager

Gloria A. Thompson
Sammie Wilson, Sr.

RESOLUTION 23-15

WHEREAS, the McDuffie County Board of Commissioners does hereby reappoint **David Holt** to the Board of Tax Assessors.

NOW THEREFORE, BE IT RESOLVED that the McDuffie County Board of Commissioners does hereby appoint Butch Stadler to the Board of Tax Assessors to fulfill a six-year term, October 4, 2023 to October 4, 2029.

SO, RESOLVED the 4th day of October, 2024.

_____

Charles G. Newton, IV, Chairman
McDuffie County Board of Commissioners

ATTEST:

_____

Carrie R Edwards, County Clerk

UTILITY ASSET MANAGEMENT, INC.
Applied Trenchless Solutions

Quote No: GA23224

October 3, 2023

To: Thomson – McDuffie Co.
Attn: Charlie Newton

Re: 2372 Stagecoach Road – Thomson GA
48-inch Culvert Restoration

Scope of Work:
Furnish materials, equipment, labor, and supervision to restore the structural integrity of approximately 60 LF of existing 48-inch corrugated metal storm drain pipe by spincast or nozzle application of an 8000 PSI fiber reinforced engineered pipe repair mortar, applied at a minimum finished thickness of 1-inch. This method of repair provides an expected service life of 75 to 100 years.

Cost of Work: $26,698.00 / LS

Notes:

1. Our proposal includes:
    a. Lining / tie-in of the standpipe (approx. 6 VF).
    b. Flow control during normal conditions with max. pump size of 4-inch.
    c. Removal of debris from culvert if less than 25% full.
    d. Invert repairs as needed.
    e. Infiltration control with chemical grout up to 5 gallons.
    f. Pre/Post video with GoPro camera.
2. Others to provide:
    a. Reasonable access to pipe ends through headwall or junction box.
    b. Access to a potable water supply for materials mixing and equipment cleaning.
    c. Permits / right of entry if needed.
    d. A nearby location to stage materials and equipment.
    e. Traffic control for the duration of repair operation (approximately 4 days).
    f. All other ancillary work associated with the project.

Sincerely,

Anita Clyne – President
Utility Asset Management, Inc.

Corporate Office:
2025 US Hwy 41 S. ♦ Perry, Georgia, 31069
Office: 478-847-2301 ♦ E-Fax: 678-623-0282
www.uamonline.com

Metro Atlanta Office:
1902 Tucker Ind. Rd. ♦ Tucker, Georgia, 30084
Office: 678-691-1558
www.uamonline.com

STAFF REPORT

BOARD OF COMMISSIONER MEETING: October 4, 2023

DATE: September 29, 2023
TO: McDuffie County Board of Commissioners
FROM: Carrie Edwards
SUBJECT: Contractual Agreement with CSRA RC for Downtown Thomson Revitalization Program (DTRP)

BACKGROUND: McDuffie County applied for and received a grant of funds providing for financial aid under the FY2022 Historic Preservation Fund – Paul Bruhn Historic Revitalization Subgrant Program, National Park Service, U.S. Department of the Interior;

FACTS AND FINDINGS:

- CSRA RC will administer the above described Paul Bruhn Subgrant Program
- CSRA RC will assure the effective management of the project

STAFF RECOMMENDATION: Staff recommends the approval of the request.

ATTACHMENTS:

1. CSRA RC Contractual Agreement with McDuffie County

CONTRACTUAL AGREEMENT
Between
THE CENTRAL SAVANNAH RIVER AREA REGIONAL COMMISSION
(hereafter referred to as "RC")
and
MCDUFFIE COUNTY BOARD OF COMMISSIONERS
(hereafter referred to as "CONTRACTOR")

PROJECT NAME
DOWNTOWN THOMSON REVITALIZATION PROGRAM (DTRP)

For Official Use Only:		
Effective Date:	**Expiration Date:** Upon the issuance of a Conditional Closeout by the National Park Service, U.S. Dept. of the Interior.	**Contract Number:**

WITNESSETH THAT:

WHEREAS, the CONTRACTOR has applied for and received a grant of funds from the United States of America providing for financial aid to the CONTRACTOR under the FY2022 Historic Preservation Fund - Paul Bruhn Historic Revitalization Subgrant Program, National Park Service, U.S. Dept. of the Interior (Paul Bruhn Subgrant Program); and

WHEREAS, the National Park Service has awarded the CONTRACTOR the above-mentioned grant funds under the **FY2022 Historic Preservation Fund - Paul Bruhn Historic Revitalization Subgrant Program** for purposes of providing subgrants to support economic development through the preservation of historic buildings in rural communities across the country. Preservation activities will be conducted on properties listed in or eligible for the National Register of Historic Places in the commercial historic district of Thomson, Georgia, that are selected through a competitive process; and

WHEREAS, the CONTRACTOR desires to engage the RC to render certain services related to the administration of the above described Paul Bruhn Subgrant Program; and

WHEREAS, the CONTRACTOR desires to enter into an agreement with the RC as hereinafter provided to assure the effective management of the project;

SECTION 1 – SCOPE OF SERVICES

The RC as grant administrator for the CONTRACTOR's Paul Bruhn Subgrant Program grant award will comply with and adhere to the applicable Historic Preservation Fund Grants Manual, State, Tribal, Local, Plans & Grants Division, of the National Park Service, U.S. Department of the Interior, rules and regulations as set forth and referenced in the manual (as updated) to implement the grant. The RC will also comply with and adhere to other directives issued by the National Park Service pertaining to the CONTRACTOR's grant award.

1. The RC certifies that it has registered and does participate in the E-Verify program.

2. The RC, as grant administrator, will comply with and adhere to O.C.G.A. §50-36-1(e) which states that an agency or political subdivision providing or administering a public benefit shall require every applicant for such benefit to execute a signed and sworn affidavit verifying the applicant's lawful presence in the United States.

3. The RC shall advise and assist the CONTRACTOR with the following program functions in order to assure full compliance with the applicable Historic Preservation Fund Grants Manual Regulations:
    - Program Management
    - Grant Administration
    - Environmental Review
    - Equal Opportunity, Fair Housing Standards
    - Six-month Reporting Requirements
    - Close-out Requirements
    - Citizen Education and Participation
    - Labor Standards
    - Compliance with GA Local Government Public Works Construction Requirements
    - Financial Management working with McDuffie County Finance Dept.
    - Monitoring Liaison with NPS

4. Report regularly to the CONTRACTOR on the status of the grant program both in terms of funding and activity and make such recommendations as are deemed necessary to the continuous effective operation of the program.

5. Prepare required reports and assist in monitoring inspections, audits, and liaison with the National Park Service and McDuffie County and such other agencies, entities, and persons whose involvement might be necessary for proper function of the program.

SECTION 2 – MILESTONES AND PROJECT SCHEDULE

SEE EXHIBIT A – Scope of Work

SECTION 3 - COMPENSATION

In consideration of the services rendered by the RC under the provisions of this contract, the CONTRACTOR shall compensate the RC with a fee of **$45,000**. Such fee will cover the RC's costs associated with the fulfillment of the obligations of this contract. No legal, architectural, or engineering services shall be a part of this Contract.

Compensation shall be made by the CONTRACTOR for services rendered by the RC within thirty (30) days after a statement shall have been received by the CONTRACTOR from the RC requesting such compensation.

SECTION 4 - TERMINATION FOR CAUSE

If, through any cause, the RC shall fail to fulfill in a timely and proper manner its obligation under this agreement, or if the RC shall violate any of the covenants, agreements, or stipulations of this agreement, the CONTRACTOR shall have the right to terminate this agreement by giving written notice to the RC of such termination and specifying the effective date thereof, at any time, at least thirty (30) days prior to the effective date of such termination. In that event, all finished or unfinished documents, data, or other materials as described in **Section 1 - Scope of Work,** shall become the property of the CONTRACTOR.

The RC shall be entitled to receive just and equitable compensation for any satisfactory work completed and any outstanding obligations on such documents (calculated by adding the RC's staff time, fringe benefits and indirect costs up to the end of the contract). Also, the CONTRACTOR shall be entitled to receive a pro-rated refund of payment for any work not completed at time of termination if such overpayment has been made.

SECTION 5 - TERMINATION FOR THE CONVENIENCE OF THE CONTRACTOR AND/OR RC

If through any cause, either party shall fail to fulfill in a timely and proper manner its obligations under this agreement, or if the either party shall violate any of the covenants, agreements, or stipulations of this agreement, either party shall have the right to terminate this agreement by giving written notice to said party such termination and specifying the effective date thereof, at any time, at least (30) days prior to the effective date of such termination. In that event, all finished or unfinished documents, data, or other materials as described in **Section 1 – Scope of Work,** shall become the property of the CONTRACTOR. The RC shall be entitled to receive just and equitable compensation for any satisfactory work completed and any outstanding obligations on such documents (calculated by adding the RC's staff time, fringe benefits and indirect costs up to the end of the contract). Also, the CONTRACTOR shall be entitled to receive a pro-rated refund of payment for any work not completed at time of termination.

SECTION 6 -- PROVISIONS FOR REMEDIES FOR BREACH OF CONTRACT

Any violation or breach of contract terms shall cease this agreement and the RC shall be entitled to receive just and equitable compensation for any services satisfactorily performed and work completed.

SECTION 7- COMPLIANCE WITH LAWS, RULES, AND REGULATIONS

The RC, its officers, agents, employees, and subcontractors, in the performance of this Agreement shall comply with all applicable statutes and laws of the United States and the State of Georgia, and the applicable rules and regulations of the agencies of the United States and the State of Georgia. The RC and the CONTRACTOR will adhere to all requirements referenced in the Historic Preservation Fund Grants Manual, State, Tribal, Local, Plans & Grants Division, of the National Park Service, U.S. Department of the Interior as well as to other directives issued by the National Park Service.

SECTION 8 - SPECIAL PROVISIONS & EXHIBITS

This contract is subject to the following special provisions and exhibits are attached to and made part of this contract:

1) EEO Clause
2) Drug and Smoke-Free Workplace Free
3) Georgia Security and Immigration Compliance Act (GSICA)

SECTION 9 - ACCEPTANCE OF CONTRACT AND TERMS

This Agreement shall become effective with the signatures of the authorized parties and shall remain in effect until the National Park Service, U.S. Dept. of the Interior, issues a conditional closeout for the grant. Any revisions to the deadline date for the completion of the work shall be mutually agreed upon in writing by both parties.

This Agreement, entered into by and between the parties whose signatures appear below, representing their respective organizations, this_____ day of _____, _____.

CSRA Regional Commission
3626 Walton Way Ext., Suite 1
Augusta, GA 30909
PH: 706-210-2000

Name: Charlie Newton, Chairman
Title: McDuffie County Board of Commissioners

Andy Crosson
Executive Director

Date

Date

Witness

Witness

EEO CLAUSE

During the performance of this contract, the RC agrees as follows:

1. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. The Contractor will take affirmative action to ensure that applicants are employed, and the employees are treated during employment without regard to their race, color, religion, sex, or national origin. Such action shall include, but not be limited to the following: Employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided setting forth the provisions of this nondiscrimination clause.

2. The Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex or national origin.

3. The Contractor will send to each labor union or representative of workers with which he has a collective bargaining agreement or other contract or understanding, a notice to be provided advising the said labor union or workers' representative of the Contractor's commitments under this section and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

4. The Contractor will comply with all provisions of Executive Order 11246 of September 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.

5. The Contractor will furnish all information and reports required by Executive Order 11246 of September 24, 1965, and by rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to his books, records and accounts by the administering agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

6. In the event of the Contractor's noncompliance with the non-discrimination clauses of this contract or with any of the said rules, regulations, or orders, this contract may be canceled, terminated or suspended in whole or in part and the Contractor may be declared ineligible for further Government contracts or federally assisted construction contracts in accordance with procedures authorized in Executive Order 11246 of September 24, 1965, and such other sanctions may be imposed and remedies invoked as provided in Executive Order 11246 of September 24, 1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

7. The Contractor will include the portion of the sentence immediately preceding paragraph (1) and the provisions of paragraphs (1) through (7) in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the administering agency may direct as a means of enforcing such provisions, including sanctions for noncompliance. Provided, however, that in the event a Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the

administering agency the contractor may request the United States to enter into such litigation to protect the interests of the United States.

DRUG AND SMOKE-FREE WORKPLACE

The RC hereby certifies that it will not engage in the unlawful manufacture, sale, distribution, possession, or use of a controlled substance or marijuana during the performance of this Agreement. The RC may be suspended, terminated, or debarred if it is determined that:

1. The RC has made false certification herein above; or
2. The RC has violated such certification by failure to carry out the requirements of Official Code of Georgia 50-24-3.

Georgia Department of Community Affairs
GEORGIA SECURITY AND IMMIGRATION COMPLIANCE ACT: E-VERIFY AND SAVE PROGRAM OVERVIEW

I. Federal Work Authorization Program Registration

As of July 1,2007, the Georgia Security and Immigration Compliance Act (GSICA) requires counties and other public employers, along with contractors and subcontractors doing business with public agencies, to register and participate in a federal work authorization program to verify work eligibility of all new employees. [OCGA § 13-10-91 (a)]

Registration/Access. According to regulations of the Georgia Department of Labor, the applicable federal work authorization program is the "E-Verify Program" operated by the U.S. Citizenship and Immigration Services Bureau (USCIS) and the Department of Homeland Security (DHS). An employer's participation in E-Verify is currently free to employers. Users can access the web-based program at https://e-verify.uscis.gov/enroll/StartPage.aspx?JS=YES. To participate, an employer must register online and accept the electronic Memorandum of Understanding (MOU). If you need assistance in completing the registration process or need additional information relating to E-Verify, call the USCIS Verification Office toll free at 1-888-464-4218. [Georgia Department a/Labor Rules, §§ 300-10-1-.01 and.02}

Certification of Registration and Participation. Each county and other public employer must certify that it has registered and in participating in the E-Verify Program. For counties, certification is accomplished by transmitting a copy of all documents required for registration and participation including the required Memorandum of Understanding and the E-Verify Program ID number to the chairman/CEO/mayor of the county or consolidated government. [Georgia Department a/Labor Rules, § 300-10-1-. 04}

Monitoring New Employee Work Eligibility. Each county and other pubic employer must designate an individual to monitor compliance with the employee eligibility verification requirements of the new law and maintain necessary records. [Georgia Department a/Labor Rules, § 300-10-1-.05}

II. Agreements between Public Employers and Contractors/Subcontractors

The GSICA also phases in a requirement that bars counties and other public employers from entering into agreements with contractors/subcontractors for the "physical performance of services" unless the contractor/subcontractor registers and participates in a federal work authorization program to verify work eligibility. Under GSICA, a subcontractor is defined to include subcontractors, contract employees, staffing agencies, or contractors. [OCGA § 13-10-91 (b) (1) and (2) and Georgia Department a/Labor Rules, § 300-10-1-.02]

Phase-In Schedule. The contracting requirements of the GSICA are to be implemented as follows:

(a) Beginning July 1, 2007, public employers, contractors and subcontractors with 500 or more employees.
(b) Beginning July l, 2008, public employers, contractors and subcontractors with 100 or more employees.
(c) Beginning July 1, 2009, all public employers, contractors and subcontractors.
[OCGA § 13-10-91 (b) (3) and Georgia Department a/Labor Rules, § 300-10-1- .02]

Evidence of Contractor/Subcontractor Compliance. Each agreement between a public employer and a contractor/ subcontractor for the physical performance of services will have to include a provision that compliance with OCGA § 13- I0-91 is a condition of the contract. In addition, each contact must include a requirement that the contactor/subcontractor execute an affidavit verifying compliance with OCGA § 13- I091. The affidavit must be in a form consistent with the sample affidavits included in the Georgia

Department of Labor Rules. [Georgia Department a/Labor Rules, §§ 300-10-1-.03 and .07]

Public Transportation Contracts. The Georgia Department of Labor Rules applies generally to contracts between a public employer and a contractor/subcontractor. Exception: Rules and forms related to agreements relating to "public transportation" are to be promulgated by GDOT. [OCGA § 13-10-91 (d)]

III. Access to Federal, State and Local Benefits

Counties and other public agencies must verify that a person who applies for federal, state or local benefits (as defined in 8 U.S.C. Sections 161 I and 1621) is lawfully within the United States by requiring the applicant to sign an affidavit specifying that he or she is a citizen, legal permanent resident, or a qualified alien or nonimmigrant. [OCGA § 50-36-1]

Verification. For aliens seeking benefits that claim to be lawfully present in the U.S., eligibility for benefits must be determined through the Systematic Alien Verification of Entitlement (SAVE) program operated by the U.S. Citizenship and Immigration Services (USCIS) and Department of Homeland Security (DHS). To join the SAVE Program and acquire access to the VIS-CPS (Verification Information System (VIS), Customer Processing System (CPS) to perform immigration status verification, an agency must first establish a Memorandum of Understanding (MOU) with the SAVE Program, and then establish a purchase order with the SAVE Program contractor to pay for VIS-CPS transaction fees. Access to SAVE is subject to USCIS resource limitations or other legal or policy criteria. To request participation in SAVE and to begin the MOU process, please access the following website to register: https://www.vis- dhs.com/agency registration. For more information on the SAVE Program, please call 1-888-464-4218.

Public Benefits Defined. Generally, public benefits are defined to include any grant, contract, loan, professional license, or commercial license provided by federal, state, or local government; and, any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment assistance or similar benefit. [8 U.S.C. Sections 1611 and 1621]

Benefits Excluded. Generally, the verification requirements do not apply when the following public benefits are applied for:

(1) Treatment of emergency medical conditions;
(2) Short term, non-cash emergency disaster relief;
(3) Immunizations;
(4) Certain in-kind programs or services (such as soup kitchens and crisis counseling) delivered by public and nonprofit agencies that are necessary for the protection of life or safety when approved by the U.S. Attorney General;
(5) Prenatal care;
(6) Postsecondary education under specified circumstances;
(7) Certain community development assistance or financial assistance programs administered by HUD; and
(8) Other Federal programs including certain social security and Medicare benefits under specified conditions. [OCGA § 50-36-1 (c) and 8 U.S.C. Sections 1611 and 1621]

Note that it is unlawful for a county or other public agency to provide any federal, state, or local benefit in violation of OCGA § 50-36-1. An annual report is to be prepared regarding the requirements of the new law. Regarding the details of the verification requirements, benefits covered, and exclusions please see the Federal statutes cited above.

EXHIBIT A – SCOPE OF WORK

FY2022 Historic Preservation Fund – Paul Bruhn Historic Revitalization Subgrant Program
Downtown Thomson Revitalization Program (DTRP)
Awarded: McDuffie County Board of Commissioners
Budget: Award $700,000, Matching $315,000, TPC $1,015,000

Purpose: The DTRP will fund rehabilitation projects to drive economic redevelopment within downtown Thomson. The program will offer 8 to 12 grants ranging from $50,000 to $75,000 with a required minimum 50% match from subgrantees. The subgrant area will be the Thomson Commercial Historic District, as amended, which encompasses 51 contributing buildings. All properties must be contributing buildings within the National Register of Historic Places amended district and rehabilitation must meet the Secretary of the Interior's Standards. Design Guidelines for the district will be used.

	TASK	Responsible	Timeline
1	Application Materials Formalized (County attorney reviews all) 1) Policies and Procedures 2) Subgrant Application from Owner to McDuffie County Selection Committee 3) Work with architect/engineer as needed 4) Agreement/Contract between Contractor and Owner 5) Subgrant Agreement between McDuffie County and Owner 6) Preservation Easement regulations 7) Preservation Easement agreement with owner	CSRA RC	January 2024
2	Submit all documents to National Park Service for approval	CSRA RC	February 2024
3	Advertising and Marketing Materials Developed • 12 large signs advertising the project • Design, production, and distribution of marketing materials to owners of 51 contributing buildings in the amended Thomson DT Commercial HD (NR-listed) • Logo Development • QR Code and Development of Digital Forms • Interior website creation within County/City website (clearing house)	McDuffie County, CSRA RC	March-April 2024

	• PowerPoint		
4	Submit all documents to National Park Service for approval	NPS	May -June 2024
5	Website Posting -- County and City	County and City	April 2024
6	Promotion & Priorities Discuss program with Individuals/Groups who have expressed interest but lack funds for rehab, etc.	Thomson Planning Dept. and Downtown Development Authority (DDA)	April 2024
7	Information Sessions	DDA, McDuffie Co, CSRA RC	August 2024
8	Process (First Round Selection) 1) Subgrant Application submitted to DDA for completeness 2) Review Committee: Forward McDuffie Directors (5) and 2 CDIIWG and Archway 3) Forward McDuffie provides technical assistance to subgrantees *4)* Subgrantees submit their project for COA approval with the Thomson HPC. Fill out COA application Planning Dept. Use Design Guidelines. Must meet *Secretary of Interior's Standards* 5) Subgrantee coordinates with CSRA RC for compliance. 6) Preservation Easement	DDA Forward McDuffie, CDIIWG, Archway Forward McDuffie Planning Dept. Thomson HPC CSRA RC CSRA RC, City Attorney, Owner	August – October 2024
9	Building Inspector—inspects work in progress and completed	McDuffie County Planning Dept.	Ongoing
10	Financial Processing Invoices from Contractor sent to DDA for approval Invoices sent to CSRA RC	DDA, McDuffie County, CSRA RC	Ongoing
11	Interim 6-month reports in Grant Solutions	CSRA RC	Ongoing
12	Final NPS Reporting	CSRA RC	By August 30, 2026

STAFF REPORT

BOARD OF COMMISSIONER MEETING: October 4, 2023

DATE: September 29, 2023
TO: McDuffie County Board of Commissioners
FROM: Carrie Edwards
ISSUE: Moratorium Resolution 23-14 to Temporarily Suspend the Issuance of Alcoholic Beverage Licenses, excluding one day event permits, within McDuffie County, Georgia and for Other Purposes

BACKGROUND: County and Commission to review the current Alcoholic Beverage Ordinance to consider amendments and modifications for the health, safety, and general welfare of its citizens;

FACTS AND FINDINGS: City of Thomson Administration to also present to the City Council to ensure locations, rezoning, etc. align with the future development of the city.

STAFF RECOMMENDATION: Staff recommends the approval of the request.

ATTACHMENTS:

1) Moratorium Resolution 23-14

Thomson mcduffie County, Georgia

McDuffie County Board of Commissioners

Frederick D. Favors
Wm. (Bill) M. Jopling

Charles (Charlie) G. Newton IV, Chairman
David R. Crawley, Jr., County Manager

Gloria A. Thompson
Sammie Wilson, Sr.

MORATORIUM RESOLUTION

Resolution 23-14 | October 4, 2023

A MORATORIUM RESOLUTION TO TEMPORARILY SUSPEND THE ISSUSANCE OF ALCOHOLIC BEVERAGE LICENSES WITHIN McDUFFIE COUNTY, GEORGIA; AND FOR OTHER PURPOSES.

WHEREAS, the County Commission is an elected legislative and deliberative public body, serving the citizens of McDuffie County, Georgia; and,

WHEREAS, the County Commission desires to review the current Alcoholic Beverage Ordinance to consider amendments and modifications thereto for purposes of the health, safety, and general welfare of its Citizens; and

WHEREAS, the County Commission desires to suspend the further issuance of alcoholic beverage license for the sale of alcohols, excluding one day event permits, until such time as a review of the Alcoholic Beverage Ordinance can be completed and changes, if any, are made thereto; and

WHEREAS, such suspension of issuance of alcohol licenses must be accomplished by resolution.

NOW THEREFORE, BE IT RESOLVED, by the County Commission of McDuffie County, Georgia, that the County Commission does hereby suspend the future issuance of all alcoholic beverage licenses within McDuffie County, Georgia, for 120 days.

PASSED AND ADOPTED by the County Commission of McDuffie County, Georgia, on this, the 4th day of October 2023.

CHARLIE NEWTON
Chairman

ATTEST:

CARRIE R. EDWARDS
County Clerk

1870 150 2020

ORDINANCE NO. 23-04

AN ORDINANCE TO AMEND CHAPTER 78 OF THE CODE OF ORDINANCES OF MCDUFFIE COUNTY, ~~TO PROVIDE FOR A NEW ARTICLE, TO BE~~ KNOWN AS ARTICLE VII ENTITLED "FIRE PROTECTION UTILITY;" TO ~~PROVIDE FOR DEFINITIONS~~PROVIDE FOR THE INCLUSION OF THE TOWN OF DEARING; ~~TO PROVIDE FOR AN ENTERPRISE FUND; TO PROVIDE FOR FIRE PROTECTION UTILITY CUSTOMER CLASSES; TO PROVIDE FOR FIRE PROTECTION FEE CHARGES; TO PROVIDE FOR FIRE PROTECTION FEE CHARGE EXEMPTIONS; TO PROVIDE FOR FIRE PROTECTION FEE CHARGE CREDITS; TO PROVIDE FOR FIRE PROTECTION FEE BILLING, DELINQUENCIES, COLLECTIONS, AND ADJUSTMENTS~~ TO ADJUST THE COMPOSITION OF THE FIRE PROTECTION UTILITY COMMISSION; ~~TO PROVIDE FOR APPEALS; TO PROVIDE FOR AN EFFECTIVE DATE~~TO ADJUST THE FIRE UTILITY SERVICE AREA; TO PROVIDE FOR REPEAL OF CONFLICTING ORDINANCES; AND FOR OTHER PURPOSES

BE IT ORDAINED BY the Board of Commissioners of McDuffie County, Georgia, and it is hereby ordained by the authority thereof that Chapter 78 of the Code of Ordinances of McDuffie County is hereby amended by adding thereto a new Article, to be known as Article VII, which Article shall provide as follows:

Section 78: Article VII and Chapter 78 of the McDuffie County Code, as amended, relating to fire protection services is amended by adding the following pertaining to the establishment of the Fire Protection Utility:

ARTICLE VII.
FIRE PROTECTION UTILITY ORDINANCE

Sec. 78-200. Purpose

This ordinance shall serve the purpose of establishment and set up of the Fire Protection Utility and establishment of the Fire Protection Enterprise Fund and Fire Protection Fee.

Sec. 78.201. Findings of Fact

The McDuffie County Board of Commissioners make the following findings of fact:

(a) McDuffie County, Georgia is authorized by the Georgia Constitution of 1983, including, without limitation, Article IX, Section II, Paragraph 111 thereof, to provide fire protection service.

(b) McDuffie County, Georgia is authorized by the Georgia Constitution of 1983, including, without limitation, Article IX, Section II, Paragraph VI thereof, to create special service districts for the provision of services within such districts, and to levy and collect within such districts fees and assessments to pay, wholly or partially, the cost of providing such services therein.

(c) In accordance with O.C.G.A. § 36-70-20, areas of McDuffie County that are serviced by Dearing-Thomson-McDuffie County Fire, EMS and Emergency Management/Homeland Security Agency (collectively, "DTMCF") are defined in the Service Delivery Strategy ("SOS"), most recently certified on ~~January 19, 2021~~September __, 2023.

(d) A system for fire protection provides benefits to all properties within the County and surrounding areas, through increased value and marketability, heightened use and enjoyment of the property, reduced risk to life and property due to fire, and reduced insurance premiums.

(e) The cost of maintaining a constant state of availability, readiness and preparedness, which is the primary function of DTMCF, should, to the extent practicable, be allocated in relationship to the services made available to the property serviced by the DTMCF. Initial fire response to a particular property, and the cost to the DTMCF to be prepared to provide such a response, is affected by building size, land use, and the risk (i.e. the probability and/or the consequence) of a fire occurring at a particular property.

(f) The financing analysis and related documents prepared by DTMCF properly assesses and defines the County's fire protection needs, goals, and priorities, as well as the DTMCF funding strategy for delivery of those services. The professional financing analysis document entitled: Fire Fee Revenue Projection (dated July 23, 2019), Fire Fee Revenue Projection Updates (dated August 6, 2020), Fire Fee Rate Methodology Comparison (dated June 6, 2021), Fire Fee Rate Model Update (Dated June 21, 2021) and applicable supporting, project-related documents are incorporated herein by reference.

(g) Given the County's fire protection program service delivery needs, goals, priorities and funding strategy, it is appropriate to authorize the formation of an organizational and accounting entity dedicated specifically to the management, maintenance, protection, regulation, use, and enhancement of fire protection services, systems and facilities within the County.

(h) It is practical and equitable to allocate the cost of maintaining a constant state of availability, readiness and preparedness to provide fire protection services among the owners of property in proportion to the demands the properties impose on DTMCF which result in benefits to such properties and the owners thereof. The fair and equitable apportionment of costs via the service fee charge should correlate to the fire protection services made available to properties.

(i) The fire protection services provided by the County include, but are not limited to: protection of the public health, safety, and welfare of the community. Provision of fire protection services renders and/or results in both a service and a benefit to all properties, property owners, citizens, and residents of the County.

(j) The most equitable means to fund fire protection services within the County is through fire protection service fee charges and other mechanisms.

(k) Fire protection service fee charges may be supplemented by other types of fees and charges, including, but not limited to, special service fees, special assessments, revenue bonds, use of proceeds from special purpose local option sales taxes (SPLOST) and other forms of revenue, as deemed appropriate by the Board of Commissioners.

(l) McDuffie County reserves the right to consider the existence of privately owned and maintained on-site fire protection facilities or systems which reduce, or otherwise

mitigate, the impact of a particular property on the County's fire protection program, and the Fire Protection Utility's cost of providing fire protection services, conditioned upon continuing provision of such facilities in a manner complying with the standards and codes as determined the Fire Protection Utility.

(m) It is imperative that the proceeds from all service fee charges for fire protection services, systems or facilities, together with any other supplemental revenues raised or otherwise allocated specifically to fire protection services, systems or facilities, be dedicated solely to those purposes, and such proceeds of service fee charges and supplemental revenues shall therefore be deposited into the Fire Protection Enterprise Fund and shall remain in that fund and be dispersed only for fire protection capital, operating and non-operating costs, lease payments and debt service of bonds or other indebtedness for fire protection purposes.

(n) In order to protect the health, safety and welfare of the public, the Board of Commissioners of McDuffie County, Georgia hereby concludes a Fire Protection Utility, funded by a dedicated Fire Protection Service Fee, is warranted as the best available means of addressing the foregoing needs.

Sec. 78-202. Definitions

The following words, terms and phrases, when used in this article, shall have the meanings ascribed to them in this section, except where the context clearly indicates a different meaning:

Customers of the Fire Protection Utility shall include all persons, properties, and entities serviced by and/or benefiting from the services provided by DTMCF and the Fire Protection Utility. These services include, but are not necessarily limited to, the utility's administration, management, and operation of fire protection systems for the purposes of fire protection.

Dwelling Unit shall mean a structure, regardless of the type or method of construction, which contains one (1) or more bedrooms, a bathroom, and cooking facilities, designed for occupancy by one or more person(s) regardless of relationship, living as a single-family unit.

Fire Protection Services mean all services provided by the County which directly or indirectly relate to the following:

a. Fire safety prevention and protection;

b. Management and operation of the fire protection program;

c. Maintenance, repair and replacement of existing fire protection facilities and equipment;

d. Planning, development, design and construction of additional fire protection facilities to meet the current and anticipated future needs;

e. Emergency management services;

f. Regulation and enforcement of fire safety prevention and protection services and facilities; and

g. Compliance with applicable State and Federal fire protection regulations and permit requirements.

Fire Protection Personnel and Facilities means all personnel, equipment, physical works, and properties which are used to provide fire protection services.

Fire Department means the Dearing-Thomson-McDuffie County Fire, EMS and Emergency Management/Homeland Security Agency.

Fire Protection Fee means the periodic service fee charge imposed pursuant to this Article, and other applicable Articles, by the McDuffie County Fire Protection Utility for providing fire protection services. This term shall exclude special charges to the owners of particular properties for services or facilities related to fire protection, including, but not limited to, charges for fire inspections for which a corresponding fee may be collected for the service rendered.

McDuffie County Fire Utility Service Area means the entire land area within McDuffie County, as defined in the Service Delivery Strategy most recently certified on September ___, 2023.

Fire Protection Utility Manager means the person appointed by the County Manager to administer and oversee the DTMCF operations and the provisions of this Article.

Non-Single Family Residential (NSFR) Property shall mean a developed parcel of land that consists of various non-single family residential land uses including, but not limited to: (1) multi-family, commercial (including mixed commercial & residential), office/institutional, public, transportation, industrial, manufacturing and storage buildings and facilities; (2) government facilities, public and private schools, universities and hospitals; (3) houses of worship, and (4) any other form of use not specifically defined as a single family residential property (SFR).

Non-Single Family Residential (NSFR) Customer shall mean a utility customer whose property meets the definition of NSFR whether such customer is the owner of the parcel or a tenant of the owner.

Risk Response Factor is based on the relative cost of responding to high- risk commercial/industrial fire calls versus residential or small NSFR property calls. This user fee rate reflects the additional cost born by the TMCF to stand ready to respond to high-risk fires that require additional equipment, personnel, and time.

Single-Family Residential (SFR) Property means developed property containing one residential structure or manufactured home with no more than two dwelling units in or attached thereto, situated upon a single lot of record. Improved property may be classified as SFR even if supplemental accessory structures are present such as garages, carports, storage buildings, guesthouses, servants or caretakers' quarters, cottages or barns, or the presence of a commercial use within the residence, as long as such use does not materially alter the single-family residential structure or necessitate additional needed fire flow. SFR properties shall not include improved property containing structures used primarily for non-residential purposes and as defined herein; manufactured homes located within manufactured home parks where the land is owned by someone other than the owners of the manufactured homes; residential condominium developments with more than two units; or vacant/undeveloped property.

Single-family Residential (SFR) Customer means a utility customer of the County residing in a dwelling unit whether such customer is the owner of the dwelling unit, a tenant of the owner of the dwelling unit, or a resident of the dwelling unit.

DTMCF means Dearing-Thomson-McDuffie County Fire, EMS and Emergency Management/Homeland Security Agency.

Undeveloped Property means a parcel with no structures located within the parcel boundaries.

Undeveloped Property Customer shall mean a utility customer whose property meets the definition of an undeveloped property.

Sec. 78-203. Fire Protection Utility established.

(a) There is hereby established a Fire Protection Utility consisting of ~~six~~ seven (~~6~~7) members, two (2) of which shall be County Commissioners; ~~and~~ two (2) of which shall be City of Thomson Council ~~members~~Members; ~~and~~ two (2) of which shall be Town of Dearing Council Members; and one (1) which shall be appointed from the public at large by the other six (6) members, provided such member shall reside in the County. All members of the Fire Protection Utility shall live within the McDuffie County Fire Utility Service Area.

(b) It shall be the responsibility of the Fire Protection Utility to oversee and make recommendations to the governing body of the County regarding the management and operation of the Fire Protection Enterprise Fund, to oversee the provision of Fire Protection Services throughout the McDuffie County Fire Utility Service Area, and to fulfill all other duties and responsibilities as provided for in the Fire Protection Utility Ordinance. The governing body of the County shall be the final decision maker regarding all matters related to fire protection services, unless otherwise provided herein.

Sec. 78-204. Fire Protection Enterprise Fund established.

(a) There is hereby established a fire protection account within the general fund to be known as the Fire Protection Enterprise Fund which will help finance protection services throughout the McDuffie County Fire Utility Service Area, and which shall provide for the management and operations associated with the Fire Protection Services.

(b) All revenues and receipts of the Fire Protection Enterprise Fund shall be expended solely for the provision of Fire Protection Services; provided, however, that the County may allocate other revenues and/or resources not accounted for in the Fire Protection Enterprise Fund for Fire Protection Services as deemed appropriate by the County.

Sec. 78-205. Fire Protection Utility Customer Classes.

(a) The Fire Protection Utility shall recommend to the governing body of the County for approval specified customer classes within the service area to reflect differences in building structure and contents; fire risk; fire protection services provided by the County to the Fire Protection Utility customers; and the respective demand that those

customers' properties place on the DTMCF. All State, Federal, County, and City properties are subject to the user fee charges on the same basis as private properties. The Fire Protection Utility classes will encompass all developed and undeveloped properties within the County and are defined as follows:

(1) The Single Family Residential (SFR) Class shall consist of all developed properties classified as SFR Property per the applicable definition.
(2) The Non-Single Family Residential (NSFR) Class shall consist of all developed properties classified as NSFR Property per the applicable definition.
(3) The Undeveloped Class shall consist of properties classified as undeveloped per the applicable definition.

(b) Documentation pertaining to the Fire Protection Utility customer classes shall be kept on file in the office of the Fire Protection Utility Manager for public inspection.

Sec. 78-206. Fire Protection Fee Charge Rates

(a) The Fire Protection Utility shall recommend to the governing body of the County for approval a fire protection fee on all properties within the service area in a fair and equitable manner. The Fire Protection Utility recommendation shall apportion the cost of delivering fire protection services to all properties based on the demand the property places on the DTMDF and the fire protection services provided.

(b) Fire Protection fee charge rates shall be set and may be modified from time to time by the governing body of the County. A schedule of said rates shall be on file in the office of the County Clerk of McDuffie County. In setting or modifying such rates, it shall be the goal of the County to establish rates that are fair, equitable and reasonable, and together with other funding sources available to the McDuffie County Fire Protection Utility for services, systems, and/or facilities related to fire protection services are sufficient to support the cost of the DTMCF, including, but not limited to, the payment of principal and interest on debt obligations, lease payments, operating expenses, capital outlays, non-operating expenses, provisions for prudent reserves and other costs as deemed appropriate by the County.

(c) The basis for calculation of the fire protection fee charge to all property within the County is established in this Article. The County shall assign or determine the customer class, land use, building square footage, parcel acreage, risk and other pertinent factors as may be needed for the fair, reasonable and equitable allocation of the costs to deliver fire protection services and to calculate the fire protection fee charges for all properties in the County.

(d) Fire protection fee shall be reflective of the following three (3) important factors in the County's cost of providing fire protection services to individual properties, including: (1) the acreage of each parcel of land; (2) the square footage of structures on each property; and (3) the assigned risk response factor.

(e) The total fire protection fee for each property shall include two (2) charges, if applicable, as described below:

a. Wildfire Charge: This charge shall apply to all properties within the Fire Protection Service Area and shall be correlated to the cost to the DTMCF to respond to wildfires, which may occur on any property, developed or undeveloped. This charge shall be based upon the total acreage of the parcel.

b. Structure Charge: This charge shall be applied to all properties upon which any structure is built. This charge shall be based upon the square footage of all structures on the property.

(f) To ensure that the fire service fee is reasonably correlated to the cost to DTMCF to make service available to high risk properties within the Fire Protection Service Area, fire service fee charges shall be subject to a risk rate modifier, based upon the risk classification assigned to a parcel by the DTMCF. A risk modifier of 2.2 can be applied to the square footage calculation for each building identified as meeting the criteria for high risk.

Sec. 78-207. Fire Protection Fee Charge Exemptions.

(a) Except as provided in this section or otherwise provided by law, no public or private property located in the incorporated area of the County shall be exempt from the fire protection fee charges. The fire protection fee charge is not a tax and no exception, credit, offset, or other reduction in fire protection fee charges shall be granted based on age, tax status, economic status, race, religion, disability, or other condition unrelated to the Fire Protection Utility's cost of providing fire protection services and facilities.

(b) Exemptions to the fire protection fee charges are as follows:

(1) Linear rights-of-way (i.e. roads, tracks, rails, roadbed) outside of defined parcel limits shall be exempt from Fire Protection fee charges. This exemption is in recognition of the right of the DTMCF to collect emergency response fees for emergency response services provided within the right-of-way.

Sec. 78-208. Fire Protection Fee Charge Credits. (Reserved)

Sec. 78-209. Fire Protection Fee Charge Billing, Delinquencies, Collections, Adjustments.

The property owner or account holder, as identified from County Tax Assessor parcel GIS database information, Tax Digest and other public records of McDuffie County, shall be obligated to pay the applicable fire protection fee charge.

(a) Billing. Fire Protection user fee charges shall be billed on the customer's annual Ad Valorem Property Tax bill starting with the first billing cycle in September 2021 as provided in this Article.

(1) Customers that do not receive an Ad Valorem Property Tax bill from the County Tax Assessor shall be billed for fire protection services via another method and frequency established by the County.

(2) The property owner will be charged the fire fee for multi-family residential properties that are part of a larger common development such as apartment complexes or manufactured home parks.

(3) A bill for fire protection fee charges may be sent through the United States Postal Service or by alternative means, notifying the Fire Protection Utility customer of the following items (as a minimum): the fire protection fee charge amount (less any approved credits), the date the payment is due and the date when payment is past due.

(4) Failure to receive a bill shall not be justification for nonpayment. Regardless of the party to whom the bill is initially directed, the owner of each property subject to fire protection fee charges shall be ultimately obligated to pay fire protection fee charges and any interest at the rate of equal to the bank prime loan rate as posted by the Board of Governors of the Federal Reserve System in statically release H.15 or any publication that may supersede it, plus three (3%) percent to accrue monthly on delinquent fire protection fee charge payments.

(5) If a property is unbilled, or if no bill is sent for a particular tract of property, the Fire Protection Utility may back bill for a period of up to three (3) years, but shall not be entitled to any interest or any delinquency charges during the back billed period.

(b) Delinquencies and Collections

(1) Unpaid fire protection service fees shall be collected by any means allowed under law, including but not limited to filing suit to collect on an unpaid account and by using all methods allowed by Georgia law to collect on any judgment obtained thereby, including enforcement of any lien resulting from any such judgment. Unless reduced to a judgment and a writ of fieri facias issued, the unpaid user fee charge shall not constitute a direct lien against the owner or the property.

(2) A late charge shall be assessed against the customer for the unpaid balance of any fire protection fee charge that becomes delinquent in accordance with applicable State law and County ordinance provisions. In addition, the County shall assess all costs of collection, including attorney's fees and court costs, against the property owner.

(c) Adjustments. The Fire Protection Utility Manager shall administer the procedures and standards for the adjustment of the fire protection fee charge.

(1) If a customer believes their fire protection fee is incorrect, the customer may seek an adjustment of the fire protection fee charge allocated to a property at any time by submitting the request in writing to the Fire Protection Utility Manager and setting forth in detail the grounds upon which relief is sought. The customer's fire protection fee account must be paid and current prior to consideration of an adjustment request by the County.

(2) Customers requesting the adjustment shall be required, at their own expense, to provide accurate information to the Fire Protection Utility Manager, including, but not limited to, inspection reports from a certified fire protection professional or building construction plans certified by a registered architect or a professional engineer. Submittal of this information may be required if the County staff cannot make a determination based on field inspection and/or review of existing County information. Failure to provide the required information within the time limits established by the Fire Protection Utility Manager, as may be reasonably extended, may result in denial of the customer's adjustment request.

(3) Once a complete adjustment request and all required information are received by the Fire Protection Utility Manager, the Fire Protection Utility Manager shall within 30 calendar days render a written decision.

(4) In considering an adjustment request, the Fire Protection Utility Manager shall consider whether the calculation of the fire protection fee charge for the property is correct.

(5) The Fire Protection Utility Manager's decision shall be in writing and will be mailed to the address provided on the adjustment request, and service shall be complete upon mailing.

(6) If the result of an adjustment is that a refund is due the applicant, the refund will be applied as a credit on the applicant's next fire protection fee charge bill.

Sec. 78-210. Appeals and Hearings

(a) Appeals. An appeal to the County Manager may be taken by any property owner or customer aggrieved by any decision of the Fire Protection Utility Manager. The appeal shall be taken within 30 calendar days of the decision of the Fire Protection Utility Manager by filing with the County Manager a notice of appeal in writing specifying the grounds thereof. Upon the filing of the notice of appeal, the Fire Protection Utility Manager shall forthwith transmit to the County Manager all documentation constituting the record upon which the decision appealed from was taken.

(b) Hearings. The County Manager shall fix a reasonable time for hearing the appeal and give written notice to the appellant at least ten (10) calendar days prior to the hearing date. The notice shall indicate the place, date and time of the hearing. The County Manager shall affirm, reverse, affirm in part, or reverse in part the decision of the Fire Protection Utility Manager after hearing the evidence. If the decision of the Fire Protection Utility Manager is reversed in whole or in part, resulting in a refund or credit due to the property owner or customer, then such refund or credit shall be calculated retroactive to the date of the initial appeal. The decision of the County Manager shall be final, and there shall be no further administrative appeal. Any person aggrieved or dissatisfied with the decision of the County Manager may petition the Superior Court of McDuffie County for Writ of Certiorari.

Sec. 78-211. Severability

If the provisions of any article, section, subsection, paragraph, subdivision or clause of this ordinance shall be judged invalid by a court of competent jurisdiction, such order of judgment shall not affect or invalidate the remainder of any article, section, subsection, paragraph, subdivision or clause of this ordinance.

Sec. 78-212. Repealer

All ordinances or parts thereof which are in conflict with any provision or any section, subsection, paragraph, provision or clause of this ordinance are hereby repealed to the extent of the conflict.

Sec. 78-213- Sec. 78-220 (Reserved)

BE IT FURTHER ORDAINED that this Ordinance shall become effective as of the date of its approval by the governing body of the McDuffie County, Georgia.

SO ORDAINED, this the _____ day of _____, ~~2021~~2023.

McDuffie County, Georgia

By: _____

Chairman

Attest: _____

County Clerk

STAFF REPORT

BOARD OF COMMISSIONER MEETING: October 4, 2023

DATE: October 2, 2023
TO: McDuffie County Board of Commissioners
FROM: Carrie Edwards
ISSUE: UniFirst Customer Service Agreement

BACKGROUND: Agreement for Roads Department

FACTS AND FINDINGS: Ongoing

STAFF RECOMMENDATION: Staff recommends the approval of the request.

ATTACHMENTS:
1. Customer Service Agreement

UniFirst

Existing account [X]

Agreement No. 1003431

Customer No. 1678913

Customer Service Agreement

Company Name (Customer)	MCDUFFIE COUNTY	Loc. No.	298
Address	504 RAILROAD ST.	Route No.	MM4700
	THOMSON, GA 30824	Date	09/06/2023
Phone	7065952591	SIC/NAICS	9199

The undersigned (the "CUSTOMER") orders from UniFirst Corporation and/or UniFirst Holdings, Inc. d.b.a. UniFirst and/or UniFirst Canada LTD. ("UniFirst") the rental service(s) at the prices and upon the conditions outlined:

Merchandise Serviced

Item Description		Lost / Damaged Repl. Charge	Service Frequency	No. of Wearers	Total Inventory	Billing Quantity	Price per Change / Piece	Non-Standard	Total Full Service
010227	LSSHT-65/35 WORKSHIRT		1				0.3084	YES	
020227	SSSHT-65/35 WORKSHIRT		1				0.2816	YES	
03TOIF	LSSHT-65/35 TYPE O CL 1 RIPSTO		1	10	67		0.6971	YES	46.71
03UM09	LSSHT-UNIFIRST MICROCHECK		1	2	10		0.3084	YES	3.08
03UMFW	LSSHT-UNIFIRST MICROCHECK		1				0.3084	YES	
04MQHK	SSPOLO-100%PLY TRICLR WHT MESH		1	1	7		0.2279	YES	1.60
04MQKU	SSPOLO-100%PLY TRICLR WHT MESH		1	1	5		0.2279	YES	1.14
04TOIF	SSSHT-65/35 TYPE O CL 1 RIPSTO		1	13	104		0.6569	YES	68.32
04UM09	SSSHT-UNIFIRST MICROCHECK		1	2	12		0.2681	YES	3.22
06HXHT	SS TEE-POLY HIVIS CL3 PKT-BICE		1	1	6		0.6971	YES	4.18
07WW26	SS SHIRT-CANVAS WEAVE 60/40 CO		1	2	22		0.4290	YES	9.44
100205	PNT-65/35 SOFTWILL PLAIN FRONT		1	6	66		0.3084	YES	20.35
10AI05	PNT-65/35 W/CARGO PKT		1	1	6		0.4022	YES	2.41
10AI87	PNT-65/35 W/CARGO PKT		1	1	5		0.4022	YES	2.01
10DP05	PNT-65/35 CARGO PKTS-REFLEC (Y		1	13	144		0.6971	YES	100.38
10HD69	JEAN-100%COT.RELAX FIT UNIFIRS		1				0.4156	YES	
11WW31	PNT-60/40 COT/POL CARGO CANVS		1	2	17		0.5095	YES	8.66
12WW31	SHORT-60/40 COT/POL CARGO CANV		1	1	6		0.4960	YES	2.98
150631	JKT-65/35 PERMALINED SLASHPOCK		1	2	3		0.5898	YES	1.77
15EL05	JKT-65/35 P/C YSY REFL-PRMLND(		1	17	28		0.6167	YES	17.27
15ML12	JKT-100% POLY WATER RES. SOFT		1	1	1		0.5898	YES	0.59
15ML31	JKT-100% POLY WATER RES. SOFT		1	1	1		0.5898	YES	0.59
300205	COVERALL-65POLY 35COTTON		1	6	7		0.4960	YES	3.47
300231	COVERALL-65POLY 35COTTON		1	2	3		0.4960	YES	1.49
802310	WIPERS 18X18 BAGGED		1		120	60	0.0677		4.06
88AN03	FLOORSTAND-SOAP DISPN(EA)14"X5		1		1	1	1.4500		1.45
88UC00	UNIFIRST GEL SANIT-1000ML-USA		1				16.7800		

Other Charges	Amount
Garment preparation per piece	1.25
Name emblem per piece	1.00/ 1.35
Company emblem per piece	2.25
Direct Embroidery	
Garment Maintenance Program	YES
Loss protection Maint. Program	NO
Linen Maintenance Program	NO
Mat Protection Program	NO

Other Charges	Amount
Non-stock sizes per piece	20.00%
Special cuts per piece	3.00
Restock/Exchange per piece	3.00
Automatic Wiper Replacement	YES
Automatic Linen Replacement	NO
Ongoing Prep Program	NO
Ongoing Emblem Program	NO
DEFE Charge Fixed	10.50
DEFE Sliding Plus	
Energy Charge	

Payment Terms: C.O.D. [ ] E.F.T. [ ] Approved Charge[3] [X]

COMMENTS

Approved charge: CUSTOMER agrees to make payments within 30 days of invoice receipt. A late charge of 1½ % per month (18% per year) for any amount in arrears may be applied. [4]

The undersigned agrees to the attached Customer Service Agreement Terms and attests to have the authority to execute for the named CUSTOMER, and to approve use of any personalization - including logos or brand identities - that has been requested.

Sales Rep: _____ Sales Rep (Print Name) _____ Date

Accepted: [5] _____ Location Manager (Signature) _____ Date

_____ Location Manager (Print Name and Title)

Accepted _____ CUSTOMER (Signature) _____ Date

_____ CUSTOMER (Print Name and Title)

_____ Email

[1] Out-sizes of otherwise Standard Merchandise are deemed to be Non-Standard Merchandise
[2] Merchandise which is Val-U-Leased is not cleaned by UniFirst
[3] Charge status contingent upon continuing credit worthiness and may be revoked at UniFirst's discretion.
[4] All returned checks and declined credit/debit cards subject to $35 processing fee.
[5] This Agreement is effective only upon acceptance by UniFirst Location Manager

Print & Sign (2) copies on Legal-Size (8½" * 14") paper: [ ] **Local UniFirst copy** (scanned copy to corporate office) [ ] **Customer copy**

Existing account [X]

Agreement No. 1003431

Customer No. 1678913

Customer Service Agreement

Company Name (Customer) MCDUFFIE COUNTY

Address 504 RAILROAD ST.

THOMSON, GA 30824

Phone 7065952591

Loc. No. 298

Route No. MM4700

Date 09/06/2023

SIC/NAICS 9199

The undersigned (the "CUSTOMER") orders from UniFirst Corporation and/or UniFirst Holdings, Inc. d.b.a. UniFirst and/or UniFirst Canada LTD. ("UniFirst") the rental service(s) at the prices and upon the conditions outlined:

Merchandise Serviced

Item Description	Lost / Damaged Repl. Charge	Service Frequency	No. of Wearers	Total Inventory	Billing Quantity	Price per Change / Piece	Non-Standard	Total Full Service
88UE12 UNIFIRST DISPN-HANDS FREE		1		1	1	NC		NC

Minimum weekly charge applies, equal to 75% of the initial weekly value

Other Charges	Amount
Garment preparation per piece	1.25
Name emblem per piece	1.00/ 1.35
Company emblem per piece	2.25
Direct Embroidery	
Garment Maintenance Program	YES
Loss protection Maint. Program	NO
Linen Maintenance Program	NO
Mat Protection Program	NO

Other Charges	Amount
Non-stock sizes per piece	20.00%
Special cuts per piece	3.00
Restock/Exchange per piece	3.00
Automatic Wiper Replacement	YES
Automatic Linen Replacement	NO
Ongoing Prep Program	NO
Ongoing Emblem Program	NO
DEFE Charge Fixed	10.50
DEFE Sliding Plus	
Energy Charge	

Payment Terms: C.O.D. [ ] E.F.T. [ ] Approved Charge[3] [X]

COMMENTS

Approved charge: CUSTOMER agrees to make payments within 30 days of invoice receipt. A late charge of 1½ % per month (18% per year) for any amount in arrears may be applied. [4]

The undersigned agrees to the attached Customer Service Agreement Terms and attests to have the authority to execute for the named CUSTOMER, and to approve use of any personalization - including logos or brand identities - that has been requested.

Sales Rep: _____ Sales Rep (Print Name) _____ Date

Accepted: [5] _____ Location Manager (Signature) _____ Date

_____ Location Manager (Print Name and Title)

Accepted _____ CUSTOMER (Signature) _____ Date

_____ CUSTOMER (Print Name and Title)

_____ Email

[1] Out-sizes of otherwise Standard Merchandise are deemed to be Non-Standard Merchandise
[2] Merchandise which is Val-U-Leased is not cleaned by UniFirst
[3] Charge status contingent upon continuing credit worthiness and may be revoked at UniFirst's discretion.
[4] All returned checks and declined credit/debit cards subject to $35 processing fee.
[5] This Agreement is effective only upon acceptance by Uni First Location Manager

Customer Service Agreement Terms

REQUIREMENTS SUPPLIED. Customer orders from UniFirst Corp. ("UniFirst") the rental garments and/or other items of the type specified in this Agreement ("Merchandise") and related pickup/delivery and maintenance services (collectively with Merchandise, "Services") for all of Customer's requirements therefor, at the prices and upon the terms and conditions set forth herein. Additional Services requested by Customer, verbally or in writing, will also be covered by this Agreement. All rental Merchandise supplied to Customer remains the property of UniFirst. Customer warrants that it is not subject to, and that this Agreement does not interfere or conflict with, any existing agreement for the supply of the Merchandise or Services covered.

PERFORMANCE GUARANTEE. UNIFIRST GUARANTEES TO DELIVER HIGH-QUALITY SERVICE AT ALL TIMES. All items of Merchandise cleaned, finished, inspected, repaired and delivered by UniFirst will meet or exceed industry standards, or non-conforming items will be replaced by the next scheduled delivery day at no cost to Customer. Items of rental Merchandise requiring replacement due to normal wear and tear will be replaced at no cost to Customer, save for any applicable personalization and setup charges.

Customer expressly waives the right to terminate this Agreement during the initial term or any extension thereof for deficiencies in the quality of Services unless: (1) complaints are first made in writing to UniFirst which set forth the precise nature of any deficiencies; (2) UniFirst is afforded at least 60 days to correct any deficiencies complained of; and (3) UniFirst fails to correct those deficiencies complained of within 60 days. In the event Customer complies with the foregoing and UniFirst fails to correct such deficiencies, Customer may terminate this Agreement by written notice to UniFirst, providing that all previous balances due to UniFirst have been paid in full and that all other conditions to terminate have been satisfied. Any delay or interruption of the Services provided for in this Agreement by reason of acts of God, fires, explosions, strikes or other industrial disturbances, or any other cause not within the control of UniFirst, shall not be deemed a breach or violation of this Agreement.

TERM AND RENEWAL. This Agreement is effective when signed by both the Customer and UniFirst Location Manager and continues in effect for 60 months after installation of Merchandise (for new customers) or any renewal date. This Agreement will be renewed automatically and continuously for multiple successive 60-month periods unless Customer or UniFirst gives written notice of non-renewal to the other at least 90 days prior to the next expiration date.

PRICES AND PAYMENTS. Prices are based on 52 weeks of service per year. Any increase(s) to Service Frequency could result in additional charges. On an annual basis, the prices then in effect will be increased by the greater of the annual percent increase in the Consumer Price Index - All Urban Consumers, Series ID: CUUROOOOSAG, other goods and services, or by 5%. Additional price increases and other charges may be imposed by separate written notice or by notation on Customer's invoice. Customer may, however, decline such additional increases or charges by notifying UniFirst in writing within 10 days after receipt of such notice or notation. If Customer declines said additional price increases, UniFirst may terminate this Agreement. Customer also agrees to pay the other charges and minimum weekly charge herein specified. Charges relating to a wearer leaving Customer's employ can be terminated by (1) giving notice thereof to UniFirst and (2) returning or paying for any missing Merchandise issued to that individual. Any Merchandise payments required pursuant to this Agreement will be at the replacement price(s) then in effect hereunder. If an authorized Customer representative is not available to receive and acknowledge delivery of Merchandise, Customer authorizes UniFirst to make delivery and assumes responsibility for related charges/invoices.

If Customer fails to make timely payment, UniFirst may, at any time and in its sole discretion, terminate this Agreement by giving written notice to Customer, whether or not UniFirst has previously strictly enforced Customer's obligation to make timely payments. Customer agrees to pay, and will pay, all applicable sales, use, personal property and other taxes and assessments arising out of this Agreement.

DEFE CHARGE. Customer's invoices may also include a DEFE charge to cover all or portions of certain expenses including:
D = DELIVERY, or expenses associated with the actual delivery of Services and Merchandise to Customer's place of business, primarily Route Sales Representative commissions, management salaries, vehicle depreciation, equipment maintenance, insurance, road use charges and local access fees.
E = ENVIRONMENTAL, or expenses (past, present and future) UniFirst absorbs related to wastewater testing, purification, effluent control, solids disposal, supplies and equipment for pollution controls and energy conservation and overall regulatory compliance.
F = FUEL, or the gas, diesel fuel, oil and lubricant expenses associated with keeping UniFirst's fleet vehicles on the road and servicing its customers.
E = ENERGY, primarily the natural gas UniFirst uses to run boilers and gas dryers, plus other local utility charges.

MERCHANDISE. Customer acknowledges and agrees to notify all employees that Merchandise supplied is for general occupational use and, except as expressly specified below, affords no special user protections. Customer further acknowledges that: (1) Customer has unilaterally and independently determined and selected the nature, style, performance characteristics, number of changes and scope of all Merchandise to be used and the appropriateness of such Merchandise for Customer's specific needs or intended uses; (2) UniFirst does not have any obligation to advise, and has not advised, Customer concerning the fitness or suitability of the Merchandise for Customer's intended use; (3) UniFirst makes no representation, warranty or covenant regarding the performance of the Merchandise (including without limitation Flame Resistant and Visibility Merchandise); and (4) UniFirst shall in no way be responsible or liable for any injury or harm suffered by any Customer employees while wearing or using any Merchandise. Customer agrees to indemnify and hold harmless UniFirst and its employees and agents from and against all claims, injuries or damages to any person or property resulting from Customer's or Customer's employee use of the Merchandise, whether or not such claims, injuries or damages arise from any alleged defects in the Merchandise.

Flame Resistant ("FR") Merchandise supplied hereunder is intended only to prevent the ignition and burning of fabric away from the point of high heat impingement and to be self-extinguishing upon removal of the ignition source. FR items will not provide significant protection from burns in the immediate area of high heat contact due to thermal transfer through the fabric and/or destruction of the fabric in the area of such exposure. FR items are designed for continuous wear as only a secondary level of protection. Primary protection is still required for work activities where direct or significant exposure to heat or open flame is likely to occur.

Visibility Merchandise is intended to provide improved conspicuity of the wearer under daylight conditions and when illuminated by a light source of sufficient candlepower at night. It is Customer's responsibility to determine the level of conspicuity needed by wearers under specific work conditions. Further, Customer agrees that Visibility Merchandise alone does not ensure conspicuity of the wearer and that additional safety precautions may be necessary. The Visibility Merchandise supplied satisfied particular ANSI/ISEA standards only when they were new and unused and only if so labeled. Customer acknowledges that usage and laundering of Visibility Merchandise may adversely affect its conspicuity.

Healthcare/Food-Related Customer acknowledges that: (1) UniFirst does not guarantee or warrant that the Merchandise selected by Customer or that processed garments delivered by UniFirst will be appropriate or sufficient to provide a hygienic level adequate for individual Customer's needs; and (2) optional poly-bagging* is recommended to reduce the risk of cross-contamination of Merchandise, and the failure to utilize such service may adversely affect the efficacy of UniFirst's hygienic cleaning process.
(* Poly-bag services incur additional charges.)

If any Merchandise supplied hereunder is Merchandise that: (1) UniFirst does not stock for whatever reason (including due to style, color, size or brand); (2) consists of non-UniFirst manufactured or customized FR Merchandise; or (3) consists of Merchandise that has been permanently personalized (in all cases known as "Non-Standard Merchandise"), then, upon the discontinuance of any Service hereunder at any time for any reason, including expiration, termination, or cancellation of this Agreement, with or without cause, deletion of any Non-Standard Merchandise from Customer's Service Program, or due to employee reductions (in each case a "Discontinuance of Service"), Customer will purchase at the time of such Discontinuance of Service all affected Non-Standard Merchandise items then in UniFirst's inventory (in-service, shelf, as well as any manufacturer's supplies ordered for Customer's use), paying for same the replacement charges then in effect.

Customer agrees not to contaminate any Merchandise with asbestos, heavy metals, solvents, inks or other hazardous or toxic substances ("contaminants"). Customer agrees to pay UniFirst for all Merchandise that is lost, stolen, damaged or abused beyond repair. As a condition to the termination of this Agreement, for whatever reason, Customer will return to UniFirst all standard Merchandise in good and usable condition or pay for same at the replacement charges then in effect.

OBLIGATIONS AND REMEDIES. If Customer breaches or terminates this Agreement before the expiration date for any reason (other than for UniFirst's failure under the performance guarantee described above), Customer will pay UniFirst, as liquidated damages and not as a penalty (the parties acknowledging that actual damages would be difficult to calculate with reasonable certainty) an amount equal to 50 percent of the average weekly amounts invoiced in the preceding 26 weeks, multiplied by the number of weeks remaining in the current term. These damages will be in addition to all other obligations or amounts owed by Customer to UniFirst, including the return of Standard Merchandise or payment of replacement charges, and the purchase of any Non-Standard Merchandise items as set forth herein.

This Agreement shall be governed by Massachusetts law (exclusive of choice of law). If a dispute arises from or relates in any way to this Agreement or any alleged breach thereof at any time, the parties will first attempt to resolve the claim or dispute by negotiation at agreed time(s) and location(s). All negotiations are confidential and will be treated as settlement negotiations. Any matter not resolved through direct negotiations within 30 days shall be resolved exclusively by final and binding arbitration, conducted in the capital city of the state where Customer has its principal place of business (or some other location mutually agreed); pursuant to the Commercial Arbitration Rules of the American Arbitration Association; and, governed by the Federal Arbitration Act, to the exclusion of state law inconsistent therewith. The parties will agree upon one (1) Arbitrator to settle the controversy or claim. The successful or substantially prevailing party in any proceeding, including any appeals thereof (as determined by the Arbitrator/court) shall recover all of its costs and expenses including, without limitation, reasonable attorney fees, witness fees and discovery costs, all of which shall be included in and as a part of the judgment or award rendered hereunder. This provision for Arbitration is specifically enforceable by the parties; the Arbitrator shall have no power to vary or ignore the provisions hereof; and, the decision of the Arbitrator in accordance herewith, may be entered in any court having jurisdiction thereof. Customer acknowledges that, with respect to all such disputes, it has voluntarily and knowingly waived any right it may have to a jury trial or to participate in a class action or class litigation as a representative of any other persons or as a member of any class of persons, or to consolidate its claims with those of any other persons or class of persons. If this prohibition against class litigation is ruled to be unenforceable for any reason in any proceeding, then the prohibition against class litigation shall be void and of no force and effect in that proceeding.

MISCELLANEOUS. The parties agree that this Agreement represents the entire agreement between them. In the event Customer issues a purchase order to UniFirst at any time, none of the standard pre-printed terms and conditions therein shall have any application to this Agreement, or any transactions occurring pursuant hereto or thereto. UniFirst may, in its sole discretion, assign this Agreement. Customer may not assign this Agreement without the prior written consent of UniFirst. Customer agrees that in the event it sells or transfers its business, it will require the purchaser or transferee to assume all obligations and responsibilities under this Agreement; provided that such assumption shall not relieve Customer of its liabilities hereunder; and provided further that any failure by a purchaser or transferee to assume this Agreement shall constitute a breach and early termination of this Agreement resulting in the obligation to pay all amounts on account thereof as set forth in this Agreement. Neither party will be liable for any incidental, consequential, special or punitive damages. In no event shall UniFirst's aggregate liability to Customer for any and all claims exceed the sum of all amounts actually paid by Customer to UniFirst. In the event any portion of this Agreement is held by a court of competent jurisdiction or by a duly appointed arbitrator to be unenforceable, the balance will remain in effect. All written notices provided to UniFirst must be sent by certified mail to the attention of the Location Manager. In Texas and certain other locations, UniFirst's business is conducted by, and the term "UniFirst" as used herein means, UniFirst Holdings, Inc. d.b.a. UniFirst.

STAFF REPORT

BOARD OF COMMISSIONER MEETING: October 4, 2023

DATE: October 2, 2023
TO: McDuffie County Board of Commissioners
FROM: Carrie Edwards
ISSUE: Meritain Administrative Services Agreement

BACKGROUND: Agreement for New Insurance

FACTS AND FINDINGS:

STAFF RECOMMENDATION: Staff recommends the approval of the request.

ATTACHMENTS:

1. Administrative Services Agreement
2. Establishment of the Plan
3. Meritain Claim Processing Authorization

MCDUFFIE COUNTY BOARD OF COMMISSIONERS

Subject: Plan Document/Summary Plan Description effective July 1, 2023

As requested, enclosed you will find your Plan Document/Summary Plan Description (PD/SPD) effective July 1, 2023.

Your PD/SPD includes Meritain Health, Inc. standard language. If exclusions and definitions do not align after you compare your current stop loss contract and this PD/SPD, please do not execute the document. Please contact your Implementation Manager or Client Management Representative to provide information on the required language changes. If your current stop loss contract is not available until after your PD/SPD is executed, please compare the exclusions and definitions as soon as possible. Please provide information on the required language changes to your Client Management Representative.

If no changes are required, please sign the attached document, and return it to Meritain Health, Inc., retaining a copy for your records.

Thank you for your attention to this matter.

McDuffie County Board of Commissioners Employee Benefit Plan

Group No.: 20334

Plan Document
and
Summary Plan Description

Effective: July 1, 2023

P.O. Box 853921
Richardson, TX 75085-3921
(800) 925-2272
www.meritain.com

TABLE OF CONTENTS

ESTABLISHMENT OF THE PLAN

McDuffie County Board of Commissioners (the "Employer" or the "Plan Sponsor") has adopted this Plan Document and Summary Plan Description effective as of July 1, 2023 for the McDuffie County Board of Commissioners Employee Benefit Plan (hereinafter referred to as the "Plan" or "Summary Plan Description"), as set forth herein for the exclusive benefit of its Employees and their eligible Dependents.

Purpose of the Plan
The Plan Sponsor has established the Plan for your benefit and for the benefit of your eligible Dependents, on the terms and conditions described herein. The Plan Sponsor's purpose in establishing the Plan is to help to protect you and your family by offsetting some of the financial problems that may arise from an Injury or Illness. To accomplish this purpose, the Plan Sponsor must attempt to control health care costs through effective plan design and the Plan Administrator must abide by the terms of the Plan Document and Summary Plan Description, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to manage their healthcare costs.

The Plan is not a contract of employment between you and your Employer and does not give you the right to be retained in the service of your Employer.

The purpose of this Plan is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain health care expenses. This Plan is maintained by the Plan Administrator and may be inspected at any time during normal working hours by you or your eligible Dependents.

Adoption of this Plan Document and Summary Plan Description
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document and Summary Plan Description (SPD) as the written description of the Plan. This Plan represents both the Plan Document and the Summary Plan Description. This Plan Document and SPD amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document and Summary Plan Description to be executed as of the date set forth below.

McDuffie County Board of Commissioners

Dated:_____ By:_____

Name:_____

Title:_____

GENERAL OVERVIEW OF THE PLAN

The Plan Administrator has entered into an agreement that provides access to one or more networks of Participating Providers called "Networks". Available Networks are identified on the Employee identification card. These Networks offer your health care services at discounted rates. Using a Network provider will normally result in a lower cost to the Plan as well as a lower cost to you. There is no requirement for anyone to seek care from a provider who participates in the Network. The choice of provider is entirely up to you. You are also not required to designate a Primary Care Physician (PCP), but the Plan encourages you to designate a PCP to help manage your care.

Non-Participating Provider Exceptions
Unless otherwise described herein, covered services rendered by a Non-Participating Provider will be paid at the Participating Provider level subject to the Usual and Customary provision of the Plan when a:

(1) Covered Person has an Emergency Medical Condition requiring immediate care.*

(2) Covered Person receives services by a Non-Participating Provider who is under agreement with a Network facility.*

(3) Participating Provider submits a specimen to a Non-Participating Provider laboratory.

(4) Covered Person receives services from a Network surgeon who uses a non-Network Assistant Surgeon.

(5) Participating Provider is not available within a 75-mile radius of the Covered Person's residence.

***NOTE:** In the case of a Surprise Bill for covered services from a Non-Participating Provider who is under agreement with a Network facility and the Covered Person had no control of the Non-Participating Providers participation in their care or when a Covered Person seeks Emergency Services for an Emergency Medical Condition from a Non-Participating Provider, the cost share will be based on the median contract rate.

Not all providers based in Network Hospitals or medical facilities are Participating Providers. It is important when you enter a Hospital or medical facility that you request that ALL Physician services be performed by Participating Providers. By doing this, you will always receive the greater Participating Provider level of benefits.

A current list of Participating Providers is available, without charge, through the Third Party Administrator at www.meritain.com. If you do not have access to a computer at your home, you may contact your Employer or the Network at the phone number on the Employee identification card.

You have a free choice of any provider and you, together with your provider, are ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. Participating Providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any Participating Provider.

Transitional Care
Certain Covered Expenses may be paid at the applicable Participating Provider benefit level subject to the Usual and Customary provision of the Plan if the Covered Person is currently under a treatment plan by a Physician or other health care provider or facility that was a member of this Plan's previous Network but who is not a member of this Plan's current Network. In order to ensure continuity of care for certain medical conditions already under treatment, the Participating Provider benefit level may continue for 90 days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

(1) Cancer if under active treatment with chemotherapy and/or radiation therapy.

(2) Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).

(3) If the Covered Person is Inpatient in a Hospital on the effective date.

(4) Post-acute Injury or Surgery within the past 3 months.

(5) Pregnancy in the second or third trimester and up to 8 weeks postpartum.

(6) Behavioral Health – any previous treatment.

You or your Dependent must call the Plan Administrator prior to the effective date or within 4 weeks after the effective date to see if you or your Dependents are eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor Illnesses and elective Surgical Procedures will not be covered by transitional level benefits.

Continuity of Care (Keeping a provider you go to now)
You may have to find a new provider when:

(1) The Plan's Network changes and the provider you have now is not in the new Network; or

(2) You are already enrolled in the Plan and your provider stops participating in the Plan's Network.

However, in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery. Routine procedures, minor Illnesses and elective Surgical Procedures generally are not covered under this provision.

Contact the phone number on the back of your identification card to obtain further information on how to submit a request for continuity of care. If your request is approved to keep going to your current provider, you will be informed how long you can continue to see the provider. Reimbursement for approved continuity of care will be at the applicable Participating Provider benefit level subject to the Usual and Customary provision of the Plan.

Costs
You must pay for a certain portion of the cost of Covered Expenses under the Plan, including (as applicable) any Copay, Deductible and Coinsurance percentage that is not paid by the Plan, up to the Out-of-Pocket Maximum set by the Plan.

Coinsurance
Coinsurance is the percentage of eligible expenses the Plan and the Covered Person are required to pay. The amount of Coinsurance a Covered Person is required to pay is the difference from what the Plan pays as shown in the Medical Schedule of Benefits.

There may be differences in the Coinsurance percentage payable by the Plan depending upon whether you are using a Participating Provider or a Non-Participating Provider. These payment levels are also shown in the Medical Schedule of Benefits.

Copay
A Copay is the portion of the medical expense that is your responsibility, as shown in the Medical Schedule of Benefits. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible.

Deductible
NOTE: Deductible amounts satisfied with the Employer-sponsored plan immediately replaced by this Plan will be credited toward satisfaction of this Plan's Deductible requirements.

A Deductible is the total amount of eligible expenses as shown in the Medical Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan. The family Deductible maximum, as shown in the Medical Schedule of Benefits, is the maximum amount which must be Incurred by the covered family members during a Calendar Year. However, each individual in a family is not required to contribute more than one individual Deductible amount to a family Deductible.

Out-of-Pocket Maximum
NOTE: Out-of-Pocket amounts satisfied with the Employer-sponsored plan immediately replaced by this Plan will be credited toward satisfaction of this Plan's Out-of-Pocket Maximum requirements.

An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Plan increases to 100%.

The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Plan will pay 100% of additional eligible expenses for that individual during the remainder of that Calendar Year.

The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum is the maximum amount that must be satisfied by covered family members during a Calendar Year. The entire family Out-of-Pocket Maximum must be satisfied; however, each individual in a family is not required to contribute more than the single Out-of-Pocket amount to the family Out-of-Pocket Maximum before the Plan will pay 100% of Covered Expenses for any Covered Person in the family during the remainder of that Calendar Year.

Your Out-of-Pocket Maximum may be higher for Non-Participating Providers than for Participating Providers. Please note, however, that not all Covered Expenses are eligible to accumulate toward your Out-of-Pocket Maximum. The types of expenses, which are not eligible to accumulate toward your Out-of-Pocket Maximum, ("non-accumulating expenses") include:

(1) Charges over Usual and Customary Charges for Non-Participating Providers.

(2) Charges this Plan does not cover, including precertification penalties.

Reimbursement for any eligible non-accumulating expenses will continue at the percentage payable shown in the Schedule of Benefits, subject to the Plan maximums.

The Plan will not reimburse any expense that is not a Covered Expense. In addition, you must pay any expenses that are in excess of the Usual and Customary Charges for Non-Participating Providers. This could result in you having to pay a significant portion of your claim. None of these amounts will accumulate toward your Out-of-Pocket Maximum.

Once you have paid the Out-of-Pocket Maximum for eligible expenses Incurred during a Calendar Year, the Plan will reimburse additional eligible expenses Incurred during that year at 100%.

If you have any questions about whether an expense is a Covered Expense or whether it is eligible for accumulation toward your Out-of-Pocket Maximum, please contact your Plan Administrator for assistance.

Integration of Deductibles and Out-of-Pocket Maximums
If you use a combination of Participating Providers and Non-Participating Providers, your total Deductible amount and Out-of-Pocket Maximum amount required to be paid are separate amounts and do not integrate. In other words, you will be required to satisfy the Deductible amount and Out-of-Pocket Maximum amount for Participating Providers and Non-Participating Providers separately.

All other maximum amounts (e.g., Calendar Year or Lifetime) are combined.

Non-Essential Health Benefits
Essential Health Benefit has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as may be further defined by the Secretary of the United States Department of Health and Human Services. Essential Health Benefits includes the following general categories and the items and services covered within such categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); Prescription Drugs; rehabilitative and habilitative services and devices; laboratory service; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The Plan considers the following items or services to be non-Essential Health Benefits:

(1) Hearing aids

MEDICAL MANAGEMENT PROGRAM

Medical Management is a program designed to help ensure that you and your eligible Dependents receive necessary and appropriate healthcare while avoiding unnecessary expenses. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other healthcare provider. The Medical Management Program Administrator contact information for this Plan is identified on the Employee identification card and also on the General Plan Information page of this Plan.

Precertification
Before you or your eligible Dependents are admitted to a medical facility or receive items or services from the list below, the Medical Management Program Administrator will, based on clinical information from the provider or facility, certify the care according to the Medical Management Program Administrator's policies, procedures, and guidelines. Once an Inpatient setting has been precertified, working directly with your Physician, the Medical Management Program Administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses. The Medical Management Program Administrator will also assist and coordinate the initial implementation of any services you will need post hospitalization (called discharge planning) with the attending Physician and the facility. This could include registering you for specialized programs or case management when appropriate.

Case Management
Depending on the level of care needed, the case manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. All parties involved (e.g., the Plan, attending Physician, and patient) must all agree to the alternate individually tailored treatment plan. Each treatment plan is specific to that patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis. Case management is a voluntary service. There are no reductions of benefits or penalties if you or your eligible Dependents choose not to participate.

Important Timeframes to Know
You, your Physician, the facility, or someone acting on your behalf, must call the Medical Management Program Administrator (at the number listed on your Employee identification card or the General Plan Information page of this Plan) within the following time frames for a:

Non-emergency admission	48 hours before the scheduled admission
Non-emergency services	48 hours before you are scheduled to receive the services
Emergency admission	Within 48 hours or if later, the next business day after you are admitted

If the attending Physician feels that it is Medically Necessary for a patient to receive services for a greater length of time than initially precertified, the attending Physician or the medical facility must request the additional service or days as soon as reasonably possible, but no later than the final authorized day.

Penalty for Failure to Obtain Precertification
Your provider may precertify your treatment for you; however, you should verify prior to incurring Covered Expenses that your provider has obtained precertification. If your treatment is not precertified by you or your provider within the time periods described above, Medically Necessary Covered Expenses will be reduced as follows:

(1) Covered Expenses will be reduced by $500 per occurrence. The amount of the precertification penalty is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

If the Plan's required review procedures are not followed, a retrospective review will be conducted by the Medical Management Program Administrator to determine if the services provided met all other Plan provisions and requirements. If the review concludes the services were Medically Necessary and would have been approved had the required phone call been made, benefits will be considered subject to the penalty outlined above. However, any charges not deemed Medically Necessary will be denied.

List of Items and/or Services that Require Precertification
The below items and/or services, if Covered Expenses under the Plan, must be precertified before any medical services are provided. To determine whether a benefit is covered or excluded, please review the Eligible Medical Expenses and/or General Exclusions and Limitations sections of your Plan.

All Inpatient Admissions:
- Acute
- Long-Term Acute Care
- Rehabilitation Facility
- Mental Disorder / Substance Use Disorder
- Residential Treatment Facility
- Transplant
- Skilled Nursing Facility

Diagnostic Services (Outpatient and Physician):
- CT for non-orthopedic
- MRI for non-orthopedic
- PET
- Capsule endoscopy
- Genetic testing, including BRCA
- Sleep study

Surgery (including in a Physician's office):
- Breast and bone marrow biopsy
- Thyroidectomy, partial or complete
- Open prostatectomy
- Oophorectomy, unilateral and bilateral
- Back Surgeries and hardware related to Surgery
- Osteochondral Allograft, knee
- Hysterectomy (including prophylactic)
- Autologous chondrocyte implantation, Carticel
- Transplant (excluding cornea)
- Balloon sinuplasty
- Sleep apnea related Surgeries, limited to:
  - Radiofrequency ablation (Coblation, Somnoplasty)
  - Uvulopalatopharyngoplasty (UPPP), including laser-assisted procedures

Continuing Care Services (Outpatient and Physician):
- Chemotherapy (including oral)
- Radiation therapy
- Oncology and transplant related injections, infusions, and treatments (e.g., CAR-T, endocrine and immunotherapy), excluding supportive drugs (e.g., antiemetic and antihistamine)
- Hyperbaric oxygen
- Home health care
- Durable Medical Equipment, limited to electric/motorized scooters or wheelchairs and pneumatic compression devices
- Gene therapy

Important Notes:

❖ Precertification is recommended if a procedure could be considered Experimental and/or Investigational or potentially Cosmetic in nature (such as, but not limited to: abdominoplasty, cervicoplasty, liposuction/lipectomy, mammoplasty (augmentation and reduction - includes removal of implant), Morbid Obesity procedures, septoplasty, etc.).

❖ Precertification is NOT REQUIRED for a maternity delivery admission unless the stay extends past 48 hours for vaginal delivery or 96 hours for a cesarean section. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. If a newborn remains hospitalized beyond the time frames specified, the confinement must be precertified with the Medical Management Program Administrator or a penalty will be applied. Please refer to the penalty section above.

Recommended List of Items and/or Services for Prenotification
The below items and/or services, if Covered Expenses under the Plan, should be prenotified before any medical services are provided. To determine whether a benefit is covered or excluded, please review the Eligible Medical Expenses and/or General Exclusions and Limitations sections of this document.

- Biopsies (excluding skin)
- Vascular Access Devices for the infusion of chemotherapy (including, but not limited to, PICC and Central Lines)
- Creation and revision of Arteriovenous Fistula (AV Fistula) or Vessel to Vessel Cannula for dialysis
- Dialysis

Prenotification is used to inform the Medical Management program of upcoming services. It is a data-entry process and does not require judgment or interpretation for Medical Necessity. Prenotification is set in motion by a telephone call from you, the patient, or a representative acting on your behalf or on behalf of the patient. There are no reductions of benefits or penalties if prenotification is not performed.

Precertification Does Not Guarantee Payment
Precertification of the above benefits ensures the service being rendered is Medically Necessary and appropriate. All benefits/payments are subject to the patient's eligibility for benefits under the Plan. For benefit payment, services rendered must be considered a Covered Expense and are subject to all other provisions of the Plan.

To File a Complaint or Request an Appeal to a Non-Certification
If it is determined that the item and/or services are not Medically Necessary, the notification you receive will explain why. Verbal appeal requests and information regarding the appeal process should be directed to the Medical Management Program Administrator as identified on the General Plan Information page of this Plan.

HEALTHCARE BLUEBOOK PROGRAM

Employees and their Dependents can earn cash rewards by choosing a green provider for specific procedures available through Healthcare Bluebook. You may access the list of eligible services and green providers under Healthcare Bluebook at www.meritain.com or by contacting (800) 341-0504.

Go Green to Get Green!
Selecting a high value green provider for select procedures qualifies you for a reward. Healthcare Bluebook will identify your reward eligibility and the reward amount and send the reward directly to you. You do not have to submit any forms.

Eligible Rewards & Reward Amounts
The list of select procedures along with the incentive award for using a green provider can be found on the Healthcare Bluebook website, on the Healthcare Bluebook app or by calling Healthcare Bluebook at (800) 341-0504.

Bluebook CareConnect
Healthcare Bluebook can assist you in finding a high value provider on certain procedures. Simply call (800) 875-9717 and ask for Bluebook CareConnect help. Bluebook staff will assist you in locating a provider based on your needs, schedule appointments and assist with paperwork. The procedures eligible under the Bluebook CareConnect program are as follows:

(1) Outpatient Procedures

- Carpal Tunnel Surgery
- Cholecystectomy (laparoscopic)
- Complex Ear Drum Repair (Tympanoplasty)
- Ear Tube Replacement (Tympanostomy)
- Elbow Surgery
- Knee Surgery
- Hip Surgery
- Lithotripsy
- Nasal Passage Widening Surgery
- Nasal Septum Repair
- Removal of Adenoids
- Repair of Finger Tendon
- Shoulder Surgery
- Tonsillectomy

(2) Inpatient Procedures

- Benign Breast Tumor Removal
- Hysterectomy
- Spinal Fusion
- Total Hip Replacement
- Total Knee Replacement

Go Green Rewards Processing

(1) Healthcare Bluebook will determine eligibility.

(2) Rewards are processed minimally on a bi-monthly basis. Rewards usually arrive between 30 and 90 days after you have received a service. Rewards for services received at or near the end of the processing period may not appear until the following rewards cycle.

(3) Confidential: No information about individual rewards is disclosed to anyone.

(4) Rewards may be considered taxable income.

(5) Rewards are mailed to the Employee's address and are made payable to the Employee (including rewards earned by family members).

(6) Patients may receive multiple rewards for procedures rendered on the same day (e.g., if a patient needs 2 knee MRIs (left and right), he/she would receive 2 separate rewards for using a high value provider).

MEDICAL SCHEDULE OF BENEFITS

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE		
Single	$1,500	$4,500
Family	$3,000	$9,000
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card)		
Single	$5,000	$15,000
Family	$10,000	$30,000
MEDICAL BENEFITS		
Allergy Injections (Office)	$5 Copay then 100%; Deductible waived	70% after Deductible
Allergy Serums (Office)	100%; Deductible waived	70% after Deductible
Ambulance Services	80% after Deductible	Paid at the Participating Provider level of benefits
Cardiac Rehab (Outpatient)	80% after Deductible	60% after Deductible
Chemotherapy (Outpatient – includes all related charges)	80% after Deductible	60% after Deductible
Chiropractic Care/Spinal Manipulation	$55 Copay then 100%; Deductible waived	70% after Deductible
Calendar Year Maximum Benefit combined with Cognitive and Outpatient Therapies Maximum Benefit	60 visits*	10 visits*
*Participating Provider and Non-Participating Provider limits reduce each other.		
Cognitive Therapy (Outpatient)	$55 Copay then 100%; Deductible waived	70% after Deductible
Calendar Year Maximum Benefit combined with Chiropractic Care and Outpatient Therapies Maximum Benefit	60 visits*	10 visits*
*Participating Provider and Non-Participating Provider limits reduce each other.		
Diabetic Supplies	Paid based on place of service	Paid based on place of service
Diagnostic Testing, X-Ray, and Lab Services (Outpatient)	100%; Deductible waived	70% after Deductible
Advanced Imaging (MRI, MRA, CT and PET Scans, Bone Density, Scintimammography, Capsule Endoscopy, Nuclear Medicine)	80% after Deductible	60% after Deductible
Durable Medical Equipment (DME)	80% after Deductible	60% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Emergency Services/Emergency Room Services	$350 Copay then 100%; Deductible waived	Paid at the Participating Provider level of benefits
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.		
Genetic Testing	80% after Deductible	70% after Deductible
NOTE: Includes any item or service not otherwise covered under the preventive services provision.		
Hearing Aids (to age 19)	Paid based on place of service	Paid based on place of service
Maximum Benefit	1 aid per ear every 48 months up to $3,000 per aid	
Home Health Care	80% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	100 visits	
Hospice Care	80% after Deductible	60% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	80% after Deductible	60% after Deductible
Room and Board Allowance*	Semi-Private Room Rate*	Semi-Private Room Rate*
Intensive Care Unit	ICU/CCU Room Rate	ICU/CCU Room Rate
Miscellaneous Services & Supplies	80% after Deductible	60% after Deductible
Outpatient	80% after Deductible	60% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Infusion Therapy (Outpatient)	80% after Deductible	60% after Deductible
Injectables (not covered through the Prescription Drug Card Program)	$50 Copay then 100%; Deductible waived	60% after Deductible
Injectables (Physician administered)	$5 Copay then 100%; Deductible waived	70% after Deductible
Maternity (non-facility charges)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	70% after Deductible
Lactation Consultations	100%; Deductible waived	100%, Deductible waived
Initial Office Visit	$30 Copay then 100%; Deductible waived	70% after Deductible
All Other Prenatal and Postnatal Care	100%; Deductible waived	70% after Deductible
Delivery	80% after Deductible	60% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Mental Disorders and Substance Use Disorders		
Inpatient	80% after Deductible	60% after Deductible
Outpatient		
Office Visits	$30 Copay then 100%; Deductible waived	70% after Deductible
All Other Outpatient Care	80% after Deductible	60% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
MinuteClinic	100%; Deductible waived	Not Applicable
Morbid Obesity	80% after Deductible	60% after Deductible
Lifetime Maximum Benefit	1 Surgical Procedure	
Outpatient Therapies (physical, speech/hearing, occupational)	$55 Copay then 100%; Deductible waived	70% after Deductible
Combined Calendar Year Maximum Benefit with Chiropractic Care and Cognitive Therapy	60 visits*	10 visits*
*Participating Provider and Non-Participating Provider limits reduce each other.		
Physician's Services		
Inpatient/Outpatient Services	80% after Deductible	60% after Deductible
Office Visits:		
Primary Care Physician (PCP)	$30 Copay* then 100%; Deductible waived	70% after Deductible
Specialist	$55 Copay* then 100%; Deductible waived	70% after Deductible
All Other Services Rendered During the Office Visit	80% after Deductible	70% after Deductible
Physician Office Surgery:		
Primary Care Physician (PCP)	$30 Copay* then 100%; Deductible waived	70% after Deductible
Specialist	$55 Copay* then 100%; Deductible waived	70% after Deductible
*Copay applies to the Physician office visit component only.		
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%; Deductible waived	70% after Deductible
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)	100%; Deductible waived	70% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Radiation Therapy (Outpatient – includes all related charges)	80% after Deductible	60% after Deductible
Respiratory/Pulmonary Therapy (Outpatient)	80% after Deductible	60% after Deductible
Retail Clinic	$40 Copay* then 100%; Deductible waived	70% after Deductible
*Lab and x-rays are paid at 100% with no Deductible when performed in a Retail Clinic.		
Skilled Nursing Facility and Rehabilitation Facility	80% after Deductible	60% after Deductible
Combined Calendar Year Maximum Benefit	60 days	
Teladoc Network Providers	$30 Copay then 100%; Deductible waived	Not Applicable
Telemedicine		
Mental Disorders & Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders	Paid same as office visit benefit for Mental Disorders and Substance Use Disorders
All Other Provider Services	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)	Paid based on provider billing for telemedicine (subject to any applicable maximums and exclusions for the services provided)
Temporomandibular Joint Dysfunction (TMJ)	Paid based on place of service	Paid based on place of service
Transplants	80% after Deductible (Aetna IOE Program)* 60% after Deductible (All Other Network Providers)	60% after Deductible
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
Urgent Care Facility	$75 Copay* then 100%; Deductible waived	70% after Deductible
*Copay applies to the Physician office visit component only. All other services are paid subject to any Deductible and Coinsurance percentages.		
All Other Eligible Medical Expenses	80% after Deductible	60% after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	BENEFIT
NOTE: The Covered Person will be reimbursed the amount that would have been paid to a Participating Provider less the applicable Copay if Prescription Drugs are obtained from a Non-Participating Provider.	
CALENDAR YEAR DEDUCTIBLE	
Single	$250
Family	$500
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Copays – combined with major medical Out-of-Pocket)	
Single	$5,000
Family	$10,000
Retail Pharmacy: 30-day supply	
Generic Drug	$10 Copay; Deductible waived
Preferred Drug	Deductible, then $40 Copay
Non-Preferred Drug	Deductible, then $70 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid; Deductible waived)
Preventive Maintenance Drug (Generic Drugs Only)	$0 Copay (100% paid; Deductible waived)
Immunization / Vaccination	$0 Copay (100% paid; Deductible waived)
Specialty Pharmacy Program: 30-day supply	
Generic Drug	25% Copay; Deductible waived
Preferred Drug	Deductible, then 25% Copay
Non-Preferred Drug	Deductible, then 25% Copay
Retail Pharmacy: 31-60 day supply	
Generic Drug	$20 Copay; Deductible waived
Preferred Drug	Deductible, then $80 Copay
Non-Preferred Drug	Deductible, then $140 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid; Deductible waived)
Preventive Maintenance Drug (Generic Drugs Only)	$0 Copay (100% paid; Deductible waived)
Retail Pharmacy: 61-90 day supply	
Generic Drug	$30 Copay; Deductible waived
Preferred Drug	Deductible, then $120 Copay
Non-Preferred Drug	Deductible, then $210 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid; Deductible waived)
Preventive Maintenance Drug (Generic Drugs Only)	$0 Copay (100% paid; Deductible waived)

BENEFIT DESCRIPTION	BENEFIT
Mail Order Pharmacy: 90-day supply	
Generic Drug	$25 Copay; Deductible waived
Preferred Drug	Deductible, then $100 Copay
Non-Preferred Drug	Deductible, then $175 Copay
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	$0 Copay (100% paid; Deductible waived)
Preventive Maintenance Drug (Generic Drugs Only)	$0 Copay (100% paid; Deductible waived)

NOTE: Certain Prescription Drug classes are subject to Step Therapy. (See the Prescription Drug Card Program section for further details regarding Step Therapy.)

Dispense as Written
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Advanced Control Specialty Formulary
Advanced Control Specialty Formulary (ACSF) is a moderately aggressive approach and presents specialty trend management. The formulary utilizes formulary exclusions, new-to-market (NTM) drug management and tiering strategies to help ensure clinically appropriate utilization and cost-effectiveness of specialty therapies.

Specialty Pharmacy Program
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician may be obtained directly from the specialty pharmacy program or dispensed at any participating retail pharmacy authorized to dispense specialty products. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician's office, infusion center or other clinical setting, or the Covered Person's home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

ELIGIBILITY FOR PARTICIPATION

Employee Eligibility
A Full-Time Employee of the Employer who regularly works 30 or more Hours of Service per week will be eligible to enroll for coverage under this Plan once he/she completes a waiting period of 30 days from the first day he or she reports for employment with the Employer. Participation in the Plan will begin as of the first day of the month following completion of the waiting period provided all required election and enrollment forms are properly submitted to the Plan Administrator.

You are not eligible to participate in the Plan if you are a part-time, temporary, leased or Seasonal Employee, an independent contractor or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency), or a person covered by a collective bargaining agreement that does not provide for participation in this Plan.

Full-Time Employees will be given credit towards satisfaction of the waiting period if the Employee had not completed the initial waiting period under the group's prior plan on the day that it ended. Any period of time that the Employee satisfied will be applied to the waiting period under this Plan. The Employee will then be eligible to enroll for coverage under this Plan once he/she completes the remainder of the 30 day waiting period. Participation in the Plan will begin as of the first day of the month following completion of the waiting period provided all required election and enrollment forms are properly submitted to the Plan Administrator.

Dependent Eligibility
Your Dependents are eligible for participation in this Plan provided he/she is:

(1) Your Spouse.

(2) Your Child until the end of the month in which he/she attains age 26.

(3) Your Child age 26 or older, who is unable to be self-supporting by reason of mental or physical handicap and is incapacitated, provided the Child suffered such incapacity prior to the end of the month in which he/she attained age 26. Your Child must be primarily dependent upon you for support. The Plan Sponsor may require subsequent proof of your Child's disability and dependency, including a Physician's statement certifying your Child's physical or mental incapacity.

(4) A Child for whom you are required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Plan Administrator at no cost.

The below terms have the following meanings:

"Spouse" means any person who is lawfully married to you under any state law. Specifically excluded from this definition is a spouse by reason of common law marriage, whether or not permitted in your state. The Plan Administrator may require documentation proving a legal marital relationship.

"Child" means your natural born son, daughter, stepson, stepdaughter, legally adopted Child (or a Child placed with you in anticipation of adoption), or a Child for whom you are the Legal Guardian. Coverage for a Child for whom you are the Legal Guardian will remain in effect until such Child no longer meets the age requirements of an eligible Dependent under the terms of the Plan, regardless of whether or not such Child has attained age 18 (or any other applicable age of emancipation of minors).

"Child placed with you in anticipation of adoption" means a Child that you intend to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the Child in anticipation of adoption of the Child. The Child must be available for adoption and the legal process must have commenced.

"Legal Guardian" means 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 an individual that is placed with such person by judgment, decree, or other order of any court of competent jurisdiction.

The Plan Administrator, in its sole discretion, shall have the right to require documentation necessary to establish an individual's status as an eligible Dependent.

When You and Your Dependents are Covered Employees
When both you and your Spouse are covered Employees, each of you must choose coverage as either an Employee or as a Dependent. You may not be covered under this Plan as both an Employee and a Dependent. Eligible Dependent Children of 2 covered Employees may not be enrolled as Dependents of both Employees, whether the Employees are married or unmarried.

Court Ordered Coverage for a Child
Federal law requires the Plan, under certain circumstances, to provide coverage for your Children. The details of these requirements are summarized below.

The Plan Administrator shall enroll for immediate coverage under this Plan any Child, who is the subject of a "qualified medical child support order" ("QMCSO"). If you are ordered to provide such coverage for a Child and you are not enrolled in the Plan at the time the Plan Administrator receives a QMCSO, the Plan Administrator shall also enroll you for immediate coverage under this Plan. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Plan Administrator determines that the order is a QMCSO. Any required contribution for coverage pursuant to this section will be deducted from your pay in accordance with the Employer's payroll schedule and policies.

A QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates you to support or provide health care coverage to your Child and includes certain information concerning such coverage. The Plan Administrator will determine whether any child support order it receives constitutes a QMCSO. Except for QMCSO's, no Child is eligible for Plan coverage, even if you are required to provide coverage for that Child under the terms of a separation agreement or court order, unless the Child is an eligible Child under this Plan. Procedures for determining a QMCSO may be obtained, free of charge, by contacting the Plan Administrator.

Timely Enrollment
Once you are eligible to participate in the Plan, you must enroll for coverage by completing all election and enrollment forms and submitting them to the Plan Administrator within 31 days after satisfaction of the eligibility requirements. If you are required to contribute towards the cost of coverage you must complete and submit a payroll deduction authorization for the Plan Administrator to deduct the required contribution from your pay. In addition, as part of the enrollment requirements, you will be required to provide your social security number, as well as the social security numbers of your Dependents. The Plan Administrator may request this information at any time for continued eligibility under the Plan. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Plan.

If you decline enrollment for you and/or your Dependents, you must provide a written statement to the Plan Administrator indicating that the reason you are declining enrollment is due to other health coverage. If you lose such other health coverage, it may constitute a Special Enrollment Event (described below) that gives you and/or your Dependents a right to enroll in the Plan mid-year due to such loss of coverage. However, if you failed to submit such written statement when initially eligible, you will lose your right to this special mid-year enrollment opportunity.

If you fail to complete and submit the appropriate election and enrollment forms within the 31-day period described above, you will not be eligible to enroll in the Plan until the next open enrollment period or unless you experience a Special Enrollment Event or a Status Change Event.

Open Enrollment Period
You and your Dependents may enroll for coverage during the Plan's open enrollment period, designated by the Plan Sponsor and communicated to you prior to such open enrollment period. During this time, you will be permitted to make changes to any existing benefit elections. Benefit elections made during the open enrollment period will be effective as of July 1 and will remain in effect until the next open enrollment period unless you or your Dependent experiences a Special Enrollment Event or Status Change Event.

Late Enrollment
If you did not enroll during your original 31-day eligibility period, you may do so by making written application to the Plan Administrator during the annual open enrollment period (refer to annual open enrollment period section above). In these circumstances, you and/or your eligible Dependents will be considered Late Enrollees.

Special Enrollment Event
A special enrollment event occurs when you or your Dependents suffer a loss of other health care coverage, when you become eligible for a state premium assistance subsidy or acquire a new Dependent as a result of marriage, birth, adoption, or placement for adoption. In these circumstances, you and/or your eligible Dependents will be considered Special Enrollees.

Each special enrollment event is more fully described below:

(1) **Loss of Other Coverage (other than under Medicaid or SCHIP).** If you declined enrollment for yourself or your Dependents (including your Spouse) because you or your Dependents had other health coverage (including coverage under a group health plan sponsored by a governmental or educational institution, a medical care program of the Indian Health Service or of a tribal organization), you may enroll for coverage for yourself and/or your Dependents under this Plan if the other health coverage is lost as a result of one of the following provided, however, you submitted a written statement to the Plan Administrator when you and/or your Dependents were initially eligible stating that other health coverage was the reason for declining enrollment under this Plan:

(a) The other health coverage was under COBRA and the maximum continuation period available under COBRA has been exhausted;

(b) Loss of eligibility under the other health coverage for reasons other than non-payment of the required contribution or premium, making a fraudulent claim or intentional misrepresentation of a material fact in connection with the other plan; or

(c) Employer contributions cease for the other health coverage.

If you are already enrolled in a benefit option available under the Plan and your Dependent lost his or her other health coverage, you may enroll in a different benefit option available under the Plan due to the special enrollment event of your Dependent.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 31 days after the date the other health coverage was lost. Coverage under the Plan will become effective on the date you submit the appropriate election and enrollment forms to the Plan Administrator.

(2) **Loss of Coverage under Medicaid or SCHIP or Eligibility for a State Premium Assistance Subsidy.** If you or your Dependents did not enroll in the Plan when initially eligible because you and/or your Dependents were covered under Medicaid or a state sponsored Children's Health Insurance Program (SCHIP) and your coverage terminates because you or your Dependents are no longer eligible for Medicaid or SCHIP or you or your Dependents become eligible for a state premium assistance subsidy under Medicaid or SCHIP, you may enroll for coverage under this Plan for yourself and your Dependents after Medicaid or SCHIP coverage terminates or after you or your Dependents' eligibility for a state assistance subsidy under Medicaid or SCHIP is determined.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 60 days after coverage under Medicaid or SCHIP terminates or within 60 days after eligibility for a state premium assistance subsidy under Medicaid or SCHIP is determined. Coverage under the Plan will become effective on the date you submit the appropriate election and enrollment forms to the Plan Administrator.

(3) **Acquisition of a New Dependent.** If you acquire a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll for coverage under this Plan for yourself and your Dependents. You must submit the appropriate election and enrollment forms to the Plan Administrator within 31 days after the date you acquire such Dependent.

(a) Coverage becomes effective for a Dependent Child who is born after the date your coverage becomes effective as of such Child's date of birth and will continue for the first 31 days after birth. If you wish to continue coverage beyond this 31-day period, you must complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 31 days after the Child's birth. Failure to enroll in the Plan within the 31-day period described above will result in no coverage under the Plan beyond the first 31 days after the Child's birth.

(b) Coverage for a newly acquired Dependent due to marriage will be effective on the date of marriage provided you complete and submit the required election and enrollment forms (including a payroll deduction

authorization, if applicable) within 31 days after your date of marriage. Failure to enroll in the Plan within the 31-day period described above will result in no coverage under the Plan.

(c) Coverage for a newly acquired Dependent due to adoption (or placement with you in anticipation of adoption) will be effective as of the date of adoption (or placement in anticipation of adoption) provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 31 days after adoption or placement in anticipation of adoption, as applicable. Failure to enroll in the Plan within the 31-day period described above will result in no coverage under the Plan.

Status Change Event

Generally, your election under the Plan will remain in effect for the entire Plan Year unless you experience a Special Enrollment Event (described above) or a Status Change Event (as permitted by the Employer's Section 125 Plan). If a Status Change Event occurs, you may make a new election under the Plan provided your new election is consistent with the Status Change Event.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 31 days after the Status Change Event. Coverage under the Plan will become effective on the date you submit the appropriate election and enrollment forms to the Plan Administrator.

TERMINATION OF COVERAGE

Termination of Employee Coverage
Coverage under the Plan will terminate on the earliest of the following dates:

(1) The date the Plan terminates, in whole or in part.

(2) If you fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid.

(3) The date you report to active military service unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained below.

(4) The end of the month in which you cease to be eligible for coverage under the Plan.

(5) The end of the month in which you terminate employment or cease to be included in an eligible class of Employees.

(6) The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud.

(7) The date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact.

Termination of Dependent Coverage
Coverage under the Plan will terminate on the earliest of the following dates:

(1) The date the Plan terminates, in whole or in part.

(2) The date the Plan discontinues coverage for Dependents.

(3) The date your Dependent becomes covered as an Employee under the Plan.

(4) The date coverage terminates for the Employee.

(5) If you and/or your Dependents fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid.

(6) The date the Dependent Spouse reports to active military service.

(7) The end of the month in which a Dependent ceases to be a Dependent as defined by the Plan.

(8) The date your Dependent (or any person seeking coverage on behalf of your Dependent) performs an act, practice or omission that constitutes fraud.

(9) The date your Dependent (or any person seeking coverage on behalf of your Dependent) makes an intentional misrepresentation of a material fact.

Retroactive Termination of Coverage
Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice or omission that constitutes fraud with respect to the Plan or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required Employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

Continuation of Coverage under the Family and Medical Leave Act (FMLA)
The Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA), as amended, and as promulgated in regulations issued by the Department of Labor.

During any leave taken under the FMLA, you may maintain coverage under the Plan on the same conditions as coverage would have been provided if you had been continuously employed during the leave period. Failure to make required payments within 30 days of the due date established by your Employer will result in the termination of coverage for you and/or your eligible Dependents.

If you fail to return to work after the FMLA leave, the Employer may have the right to recover its contributions toward the cost of coverage during the FMLA leave.

If coverage under the Plan terminates during the FMLA leave, coverage will be reinstated for you and your covered Dependents if you return to work at the end of the FMLA leave.

Continuation of Coverage under State Family and Medical Leave Laws
To the extent this Plan is required to comply with a state family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such state family and medical leave law, as well as under FMLA.

Continuation of Coverage under USERRA
You may elect to continue Plan coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) if you are absent from work due to military service in the Uniformed Services (as defined under USERRA). You may elect to continue coverage for yourself and any of your Dependents that were covered under the Plan at the time of your leave. Your eligible Dependents do not have an independent right to elect coverage under USERRA; therefore, unless you elect to continue coverage on their behalf, your eligible Dependents will not be permitted to continue coverage under USERRA separately.

To elect coverage under USERRA, you must submit your election to continue coverage under USERRA, on a form prescribed by the Plan Administrator to the Plan Administrator within 60 days after the date of your leave. Coverage under the Plan will become effective as of the date of your leave and will continue for the lesser of (a) 24 months (beginning on the date your absence begins); or (b) the period of time beginning on the date your absence begins and ending on the day after the date you return to employment with the Employer or fail to apply for or return to employment with the Employer within the time limit applicable under USERRA.

If your leave is 31 days or more, you will be required to pay up to 102% of the full contribution under the Plan. If your leave is 30 days or less, you will not be required to pay more than the amount (if any) you would have paid had you remained an active Employee of the Employer. Your Employer will notify you of the procedures for making payments under this Plan.

Continuation coverage provided under USERRA counts towards the maximum coverage period under COBRA continuation coverage.

An Employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No waiting period will apply to an Employee returning from USERRA leave (within the applicable time period) unless the waiting period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.

ELIGIBLE MEDICAL EXPENSES

Eligible expenses shall be the charges actually made for services provided to the Covered Person and will be considered eligible only if the expenses are:

(1) Routine care or preventive services provided such services are ordered and performed by a Physician and not otherwise excluded under the Plan; or

(2) Due to Illness or Injury provided such services are ordered and performed by a Physician, Medically Necessary and not otherwise excluded under the Plan.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted. All eligible expenses Incurred at a Participating Provider will be reimbursed to the provider.

(1) **Acupuncture:** Acupuncture treatment that is Medically Necessary, appropriate and is provided within the scope of the Acupuncturist's license; and you are directed to the Acupuncturist for treatment by a licensed Physician.

(2) **Allergy Services:** Allergy testing, serum, and injections. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(3) **Ambulance Service:** Professional ambulance service to transport the Covered Person:

(a) To the nearest Hospital equipped to treat the specific Illness or Injury in an emergency situation; or

(b) To another Hospital in the area when the first Hospital did not have services required and/or facilities to treat the Covered Person; or

(c) To and from a Hospital during a period of Hospital confinement to another facility for special services which are not available at the first Hospital; or

(d) From the Hospital to the patient’s home or to a Skilled Nursing Facility, Rehabilitation Facility, or any other type of convalescent facility nearest to the patient’s home when there is documentation the patient required ambulance transportation.

Professional ambulance charges for convenience are not covered.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(4) **Ambulatory Surgical Center:** Services and supplies provided by an Ambulatory Surgical Center.

(5) **Anesthetics:** Anesthetics and their professional administration.

(6) **Blood and Blood Derivatives:** Blood, blood plasma or blood components not donated or replaced and the administration of blood and blood products including blood extracts or derivatives.

(7) **Cardiac Rehabilitation:** Cardiac rehabilitation services which are rendered: (a) under the supervision of a Physician; and (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery or any other medical condition if medically appropriate; and (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a medical care facility.

Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(8) **Chemotherapy:** Services and supplies related to chemotherapy. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(9) **Chiropractic Care/Spinal Manipulation:** Skeletal adjustments, manipulation, or other treatment in connection with the correction by manual or mechanical means of structural imbalance or subluxation in the human body, including x-rays. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(10) **Circumcision:** Services and supplies related to circumcision. Circumcision performed while Hospital confined following birth will be considered as a newborn expense.

(11) **Cleft Palate and Cleft Lip:** Services and supplies related to cleft palate and cleft lip. Cleft palate is defined as a birth deformity in which the palate (the roof of the mouth) fails to close, and cleft lip is defined as a birth deformity in which the lip fails to close. Eligible expenses include the following when provided by a Physician, or other professional provider:

(a) Oral and facial Surgery, surgical management and follow-up care by plastic surgeons and oral surgeons.

(b) Habilitative speech therapy.

(c) Otolaryngology treatment.

(d) Audiological assessments and treatment.

(e) Orthodontic Treatment.

(f) Prosthodontic treatment.

(g) Prosthetic treatment such as obturators, speech appliances and feeding appliances.

(12) **Cochlear Implants:** Services and supplies related to cochlear implants when Medically Necessary for bilateral severe to profound sensorineural deafness, and the related maintenance and adjustments. Benefits include post-cochlear implant aural therapy under the recommendation of a Physician. Replacement of a cochlear implant and its external components may be a Covered Expense if the existing device malfunctions and cannot be repaired; replacement is due to a change in the Covered Person's condition that makes the present device non-functional; or the replacement or upgrade is not for Cosmetic purposes.

(13) **Cognitive Therapy:** Restorative or rehabilitative cognitive therapy under the recommendation of a Physician. Cognitive therapy is defined as therapy which embraces mental activities associated with thinking, learning and memory. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(14) **Contraceptives:** Contraceptive procedures and medications other than those considered preventive services, including, but not limited to: orals, patches, injections, diaphragms, intrauterine devices (IUD), implants and any related office visit. Some contraceptives may be available under the Prescription Drug Card Program. The Plan does not cover contraceptive supplies or devices available without a Physician’s prescription or contraceptives provided over-the-counter (unless the expense qualifies as a preventive service).

(15) **Cosmetic Procedures/Reconstructive Surgery:** Cosmetic procedures or Reconstructive Surgery will be considered eligible only under the following circumstances:

(a) For the correction of a Congenital Anomaly for a Dependent Child.

(b) Any other Medically Necessary Surgery related to an Illness or Injury.

(c) Charges for reconstructive breast Surgery following a mastectomy will be eligible as follows:

(i) Reconstruction of the breast on which the mastectomy has been performed;

(ii) Surgery and reconstruction of the other breast to produce symmetrical appearance; and

(iii) Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the Covered Person.

(16) **Dental Care:** Dental services and x-rays rendered by Dentist or dental surgeon for:

(a) Excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth and related biopsy of bone, tooth, or related tissues when such conditions require pathological examinations.

(b) Emergency repair due to Injury to sound natural teeth, including the emergency replacement of sound natural teeth. It does not include biting or chewing Injuries, unless the biting or chewing Injury is a result of an act of domestic violence or a medical condition (including both physical and mental health conditions).

(c) Surgery needed to correct Accidental Injuries to the jaws, cheeks, lips, tongue, floor, and roof of the mouth.

(d) Excision of benign bony growths of the jaw and hard palate.

(e) External incision and drainage of cellulitis.

(f) Incision of sensory sinuses, salivary glands, or ducts.

(g) Excision of partially or completely impacted teeth.

(h) Surgical preparation of soft tissues and excision of bone or bone tissue performed with or without extraction or excision of erupted, partially erupted or completely un-erupted teeth.

(i) Frenectomy (the cutting of the tissue in the midline of the tongue).

(j) Surgical procedures related to repositioning of teeth, tooth transplantation or re-implantation.

(k) Reduction of fractures and dislocation of the jaw.

(l) Frenectomy (the cutting of the tissue in the midline of the tongue).

General anesthesia and associated services from a hospital, free-standing facility, or health care treatment facility in conjunction with dental care provided by a health care practitioner when any of the following are met:

(a) A Dependent Child 7 years of age or younger;

(b) A Covered Person is developmentally disabled;

(c) A successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition; or

(d) A Covered Person has sustained extensive facial or dental trauma.

(17) **Developmental Delay:** Testing and Medically Necessary treatment of developmental delay, including therapy. Any developmental delays that meet the definition of a Mental Disorder or Substance Use Disorder are paid under the separate Mental Disorder and Substance Use disorder benefits.

(18) **Diabetic Education:** The following diabetic education and self-management programs: diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with diabetes.

(19) **Diabetic Supplies:** All Physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes that are not covered under the Prescription Drug Card Program. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(20) **Diagnostic Testing, X-ray, and Laboratory Services:** Diagnostic testing, x-ray and laboratory services, and services of a professional radiologist or pathologist. Dental x-rays are not eligible expenses, except as specified under Dental Care. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(21) **Dialysis:** Treatment of a kidney disorder by dialysis as an Inpatient in a Hospital or other facility or for expenses in an outpatient facility or in the Covered Person's home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces Inpatient or outpatient

dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in the Covered Person's home as shown under the Durable Medical Equipment benefit.

(22) **Durable Medical Equipment:** The rental of oxygen, wheelchairs, walkers, special Hospital beds, iron lungs and other Durable Medical Equipment subject to the following:

(a) The equipment must be prescribed by a Physician and Medically Necessary; and

(b) The equipment will be provided on a rental basis; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item (oxygen equipment is not limited to the purchase price); and

(c) Benefits will be limited to standard models as determined by the Plan; and

(d) The Plan will pay benefits for only one of the following unless Medically Necessary due to growth of the Covered Person or if changes to the Covered Person's medical condition requires a different product, as determined by the Plan: a manual wheelchair, motorized wheelchair, or motorized scooter; and

(e) If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible subject to prior approval by the Plan. In all cases, repairs, or replacement due to abuse or misuse, as determined by the Plan, are not covered; and

(f) Expenses for the rental or purchase of any type of air conditioner, air purifier or any other device or appliance will not be considered eligible.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(23) **Emergency Services/Emergency Room:** When you experience an Emergency Medical Condition, coverage for Emergency Services will continue until your condition is Stabilized and:

(a) Your attending Physician determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another provider if you need more care; and

(b) You are in a condition to be able to receive from the Non-Participating Provider delivering services the notice and consent criteria with respect to the services; and

(c) Your Non-Participating Provider delivering the services meets the notice and consent criteria with respect to the services.

If you go to an emergency room for what is not an Emergency Medical Condition, the Plan may not cover your expenses. See the Medical Schedule of Benefits and the General Exclusions and Limitations for specific Plan details. If your Physician decides you need to stay in the Hospital (emergency admission) or receive follow-up care, these are not Emergency Services. Different benefits and requirements apply.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(24) **Gender Reassignment Services:** Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a Physician. This coverage is provided according to the terms and conditions of the Plan that apply to all other covered medical conditions, including Medical Necessity requirements, Medical Management, Prescription Drug programs, and exclusions for Cosmetic services (except as allowed per guidelines). Additional guidelines or requirements may need to be satisfied before benefits are paid under the Plan. Coverage includes, but is not limited to, Medically Necessary services related to gender transition such as gender reassignment (sex change) Surgery, breast removal, gonadectomy, breast implants, hormone therapy, and psychotherapy.

Services that are excluded on the basis that they are Cosmetic include, but are not limited to: abdominoplasty; blepharoplasty; body contouring (liposuction of waist); brow lift; calf implants; cheek/malar implants; chin/nose implants; collagen injections; construction of a clitoral hood; drugs for hair loss or growth; face lifting; facial bone reduction; facial feminization and masculinization Surgery; feminization of torso; forehead lift; jaw reduction (jaw contouring); hair removal (e.g., electrolysis, laser hair removal; exception: a limited number of electrolysis or laser hair removal sessions are considered Medically Necessary for skin graft preparation for genital Surgery); hair transplantation; lip enhancement; lip reduction; liposuction; masculinization of torso; mastopexy; neck tightening; nipple reconstruction; nose implants; pectoral implants; pitch-raising Surgery; removal of redundant skin; rhinoplasty; skin resurfacing (dermabrasion/chemical peel); tracheal shave (reduction thyroid chondroplasty); voice modification Surgery (laryngoplasty, cricothyroid approximation or shortening of the vocal cords); and voice therapy/voice lessons.

(25) **Genetic Testing:** Diagnostic testing of Genetic Information and counseling when Medically Necessary. Genetic testing is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(26) **Hearing Aids:** Hearing aids (including the fitting thereof) and related supplies. For purposes of this Plan, cochlear implants are not considered a hearing aid and will be paid under the cochlear benefit. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(27) **Home Health Care:** Services provided by a Home Health Care Agency to a Covered Person in the home. The following are considered eligible home health care services:

(a) Home nursing care;

(b) Services of a home health aide or licensed practical nurse (L.P.N.), under the supervision of a registered nurse (R. N.);

(c) Visits provided by a medical social worker (MSW);

(d) Physical, occupational, speech, or respiratory/pulmonary therapy if provided by the Home Health Care Agency;

(e) Medical supplies, drugs and medications prescribed by a Physician;

(f) Laboratory services; and

(g) Nutritional counseling by a licensed dietician.

For the purpose of determining the benefits for home health care available to a Covered Person, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and each 2 hours of home health aide services shall be considered as one home health care visit.

In no event will the services of a Close Relative, transportation services, housekeeping services and meals, etc., be considered an eligible expense.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(28) **Hospice Care:** Hospice care on either an Inpatient or outpatient basis for a terminally ill person rendered under a Hospice treatment plan. The Hospice treatment plan must certify that the person is terminally ill with a life expectancy of 18 months or less.

Covered services include:

(a) Room and board charges by the Hospice.

(b) Other Medically Necessary services and supplies.

(c) Nursing care by or under the supervision of a registered nurse (R.N.) for up to 8 hours per day.

(d) Home health care services furnished in the patient's home by a Home Health Care Agency for the following:

(i) health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.); and

(ii) physical and speech therapy.

(e) Counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family.

(f) Nutritional counseling by a licensed dietician.

(g) Respite care.

(h) Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family after the patient's death. For the purposes of bereavement counseling, the term "Patient's Immediate Family" means the patient's spouse, parents of a Dependent Child and/or Dependent Children who are covered under the Plan.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(29) **Hospital Services or Long-Term Acute Care Facility/Hospital:**

(a) Inpatient

Room and board, including all regular daily services in a Hospital or Long-Term Acute Care Facility/Hospital. Care provided in an Intensive Care Unit (including cardiac care (CCU) and burn units).

Miscellaneous services and supplies, including any additional Medically Necessary nursing services furnished while being treated on an Inpatient basis.

(b) Outpatient

Services and supplies furnished while being treated on an outpatient basis.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(30) **Infertility:** Diagnosis and testing of infertility (the inability to conceive) and the correction of an underlying medical condition. All other treatment, drugs, or procedures for the promotion of conception will not be considered eligible (e.g., invitro fertilization, GIFT, artificial insemination, etc.).

(31) **Infusion Therapy:** Services, supplies, and equipment necessary for infusion therapy provided:

(a) By a free-standing facility;

(b) By an outpatient department of a Hospital;

(c) By a Physician in his/her office; or

(d) In your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient infusion therapy services and supplies are Covered Expenses:

(a) The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;

(b) Professional services;

(c) Total parenteral nutrition (TPN);

(d) Chemotherapy;

(e) Drug therapy (includes antibiotic and antivirals);

(f) Pain management (narcotics); and

(g) Hydration therapy (includes fluids, electrolytes, and other additives).

Infusion therapy provided by a Home Health Care Agency will not be subject to the Home Health Care maximum benefit.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(32) **Lenses:** Initial pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye or for aphakic patients. Soft lenses or sclera shells intended for use as corneal bandages.

(33) **Maternity:** Expenses Incurred by all Covered Persons for:

(a) Pregnancy.

(b) Preventive prenatal and breastfeeding support as identified under the preventive services section below.

(c) Services provided by a Birthing Center.

(d) Amniocentesis testing when Medically Necessary.

(e) Up to 2 ultrasounds per pregnancy (more than 2 only when it is determined to be Medically Necessary).

(f) When not prohibited by state or local laws, elective induced abortions when the pregnancy is the result of documented rape or incest or when carrying the fetus to full term would seriously endanger the life of the mother.

If complications arise after the performance of any abortion for any Covered Person, any expenses Incurred to treat those complications will be eligible, whether the abortion was eligible or not.

Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to precertify the maternity admission unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

If the mother is discharged earlier, the Plan will pay for one home visit after delivery by a health care provider.

If a newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified or a penalty may be applied.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(34) **Medical and Surgical Supplies:** Casts, splints, trusses, braces, crutches, ostomy supplies, medical orthotics, prescribed compression garments, dressings and other Medically Necessary supplies ordered by a Physician.

(35) **Mental Disorders:** Care, supplies and treatment of a Mental Disorder including, but not limited to treatment for autism, ADD and ADHD and family counseling. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(36) **MinuteClinic:** Walk-in clinic health services provided at MinuteClinic for:

(a) Scheduled and unscheduled visits for minor Illnesses and Injuries;

(b) Routine vaccinations and immunizations administered with the scope of the clinic's license; and

(c) Screening and monitoring services.

Expenses for health examinations needed to go to school, camp, or sporting events, or to join in a sport or other recreational activity will not be covered under the MinuteClinic benefit but may be payable under other provisions of the Plan.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(37) **Morbid Obesity:** Surgical treatment for Morbid Obesity will only be covered if all the following conditions are met:

(a) The Covered Person has either (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, or musculoskeletal dysfunction.

(b) The Covered Person has at least a 24-month history of Morbid Obesity as documented in such person's medical records.

(c) The Covered Person does not have an underlying diagnosed medical condition that would cause Morbid Obesity (e.g., an endocrine disorder) that can be corrected by means other than surgical treatment.

(d) The Covered Person has completed full growth (18 years old or supporting documentation of complete bone growth).

(e) The Covered Person has failed to achieve and maintain significant weight loss and such person has participated in a Physician-supervised nutrition and exercise program for at least 6 months (occurring within the 24-month period prior to the proposed surgical treatment) and such participation is documented in his or her medical records.

(f) The Covered Person must be evaluated by a licensed professional counselor, psychologist, or psychiatrist within 12 months prior to the proposed surgical treatment. The evaluation should document the following:

(i) that there is no significant psychological problem that would limit the ability of the Covered Person to understand the procedure and comply with any medical and/or surgical recommendations;

(ii) any psychological co-morbidities that may be contributing to the Covered Person's inability to lose weight or a diagnosed eating disorder; and

(iii) the Covered Person's willingness to comply with the preoperative and postoperative treatment plans.

The Plan does not cover Experimental and/or Investigational treatment of Morbid Obesity, including but not limited to:

(a) Loop gastric bypass;

(b) Gastroplasty, more commonly known as "stomach stapling" (not to be confused with vertical band gastroplasty); and

(c) Mini gastric bypass.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(38) **Nutritional Counseling:** Services related to nutritional counseling for a covered medical condition. Nutritional counseling is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

(39) **Nutritional Supplements:** Physician-prescribed nutritional supplements or other enteral supplementation necessary to sustain life for Covered Persons who are or will become malnourished or suffer from disorders, which left untreated will cause chronic disability or intellectual disability. Covered Expenses include rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation, and special dietary treatment when prescribed by a Physician for Covered Persons with inherited metabolic diseases, such as phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.

Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(40) **Occupational Therapy:** Rehabilitative occupational therapy rendered by a qualified Physician or a licensed occupational therapist under the recommendation of a Physician. Expenses for Maintenance Therapy or therapy primarily for recreational or social interaction will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(41) **Off-Label Drug Use:** Services and supplies related to Off-Label Drug Use (the use of a drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

(a) The named drug is not specifically excluded under the General Exclusions and Limitations section of the Plan; and

(b) The named drug has been approved by the FDA; and

(c) The Off-Label Drug Use is appropriate and generally accepted by the medical community for the condition being treated; and

(d) If the drug is used for the treatment of cancer, The American Hospital Formulary Service Drug Information or NCCN Drugs and Biologics Compendium recognize it as an appropriate treatment for that form of cancer.

(42) **Physical Therapy:** Physical therapy rendered by a qualified Physician or a licensed physical therapist under the recommendation of a Physician. This includes Medically Necessary aquatic therapy (hydrotherapy or pool therapy) for musculoskeletal conditions when provided by a physical therapist or other recognized, licensed provider. Eligible expenses include the professional charges for physical therapy modalities administered in a pool, which require direct one-on-one patient contact. Charges for aquatic exercise programs or separate charges for use of a pool are not covered. Maintenance Therapy will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(43) **Physician's Services:** Services of a Physician for medical care or Surgery.

(a) Services performed in a Physician's office on the same day for the same or related diagnosis. Services include, but are not limited to: examinations, supplies, injections, x-ray, and laboratory tests (including the reading or processing of the tests), cast application and minor Surgery. If more than one Physician is seen in the same clinic on the same day, only one Copay will apply.

(b) For multiple or bilateral surgeries performed during the same operative session which are not incidental or not part of some other procedure and which add significant time or complexity (all as determined by the Plan) to the complete procedure, the charge considered will be: (i) 100% for the primary procedure; (ii) 50% for the secondary procedure, including any bilateral procedure; and (iii) 50% for each additional covered procedure. This applies to all Surgical Procedures, except as determined by the Plan.

(c) For surgical assistance by an Assistant Surgeon, the charge will be 25% of the corresponding Surgery.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(44) **Podiatry:** Treatment for the following foot conditions: (a) bunions when an open cutting operation is performed; (b) non-routine treatment of corns or calluses; (c) toenails when at least part of the nail root is removed or treatment of ingrown toenails; (d) any Medically Necessary Surgical Procedure required for a foot condition. Orthopedic shoes when an integral part of a leg brace will also be covered.

(45) **Pre-Admission Testing:** Outpatient pre-admission testing performed prior to a scheduled Inpatient hospitalization or Surgery.

(46) **Prescription Drugs:** Prescription Drugs, injectables or supplies used for the treatment of a covered Illness or Injury, which are dispensed through the Physician's office, infusion center or other clinical setting, the Covered Person's home by a third party, or take-home Prescription Drugs from a Hospital are covered under the major medical benefits of this Plan and separate from the Prescription Drug Card Program benefits. Benefits will be paid the same as "All Other Eligible Expenses" listed in the Medical Schedule of Benefits.

Your Prescription Drug Card Program Administrator may have certain provisions regarding Specialty Drug coverage. In those cases, those drugs will only be payable under the major medical benefits if those drugs fall outside any Specialty Pharmacy Program, as applicable (as noted in the Prescription Drug Card Program section).

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(47) **Preventive Services and Routine Care:** The following preventive services and routine care are paid as shown in the Medical Schedule of Benefits:

(a) Preventive Services

(i) Evidence-Based Preventive Services

Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (the "Task Force") with respect to the individual involved, except that with respect to breast cancer screening, mammography and prevention of breast cancer, the recommendations of the Task Force issued in 2016 will be considered the current recommendations until further guidance is issued by the Task Force or the Health Resources and Services Administration.

(ii) Routine Vaccines

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

(iii) Prevention for Children

With Respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

(iv) Prevention for Women

With respect to women, such additional preventive care, and screenings, not otherwise addressed by the Task Force, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and published on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services). Those guidelines generally include the following:

(A) Well-woman visits. Well-woman preventive care visits annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The inclusion of a well-woman visit is not meant to limit the coverage for any other preventive service described elsewhere in this Plan document that might be administered as part of the well-woman visit.

Coverage for prenatal care is limited to pregnancy-related Physician office visits including the initial and subsequent history and physical exams of the pregnant woman. In the event a provider bills a “maternity global rate”, the portion of the claim that will be considered for prenatal visits and therefore, preventive care, is 40% of the “maternity global rate”. As a result, 60% of the “maternity global rate” will be considered for delivery and postnatal care and the normal cost-sharing provisions would apply. Items not considered preventive (and therefore subject to normal cost-sharing provisions) include Inpatient admissions, high risk specialist units, ultrasounds, amniocentesis, fetal stress tests, delivery including anesthesia and certain pregnancy diagnostic lab tests.

(B) Screening for gestational diabetes.

(C) Human papillomavirus (HPV) testing. High-risk HPV DNA testing in women with normal cytology results. Screening is limited to women age 30 or older and is limited to 1 screening every 3 Calendar Years.

(D) Counseling annually for sexually transmitted infections (including for the human immunodeficiency virus (HIV)) and screening annually for HIV for all sexually active women. Limited to 2 counseling sessions per Calendar Year.

(E) Screening and counseling annually for interpersonal and domestic violence.

(F) Contraceptive methods and counseling, as prescribed by your Physician. All FDA approved contraceptive methods (see Preventive Drugs section below), sterilization procedures and patient education and counseling for women with reproductive capacity. Contraceptive counseling is limited to 2 visits per 12-month period.

For purposes of the above, the sterilization procedures to be considered preventive include any FDA approved sterilization implants and surgical sterilization either abdominally, vaginally, or laparoscopically. Eligible charges for a sterilization procedure and all ancillary services will be covered when sterilization is the primary purpose of the services provided and/or if it is performed as a standalone procedure and billed as such. However, complications arising following a sterilization procedure are not covered as preventive services. Covered Expenses do not include charges for a sterilization procedure to the extent the procedure was not billed separately by the provider or because it was not the primary purpose of the procedure. To the extent sterilization is part of another procedure and/or is not a separate line on the bill, the sterilization procedure is not a Covered Expense.

(G) Breastfeeding support, supplies, and counseling in conjunction with each birth, including the following:

(1) Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postnatal period (60 days from baby’s date of birth). Lactation consultation is limited to 6 cumulative visits per 12-month period.

(2) Breastfeeding equipment will be covered, subject to the following:

(i) Rental of a Hospital grade electric pump while the baby is Hospital confined; and

(ii) Purchase of a standard (non-Hospital grade) electric breast pump or manual breast pump if requested during pregnancy or during the duration of breastfeeding, provided the Covered Person has not received either a standard electric breast pump or a manual breast pump within the last 3 Calendar Years and provided the Covered Person remains continuously enrolled in the Plan.

(3) For women using a breast pump from a prior pregnancy, one new set of breast pump supplies will be covered at 100% with each subsequent pregnancy for initiation or continuation of breastfeeding.

For a detailed listing of women's preventive services, please visit the U.S. Department of Health and Human Services website at: https://www.hrsa.gov/womens-guidelines. For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any preventive service required to be covered under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services), the above shall be deemed to be amended to cover such preventive services to the extent required by such guidelines.

(v) Preventive Drugs means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

For a detailed listing of preventive services, please visit the U.S. Department of Health and Human Services website at: https://www.healthcare.gov/what-are-my-preventive-care-benefits. For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any preventive service required to be covered by the U.S. Department of Health and Human Services (HHS) the above shall be deemed to be amended to cover such preventive service to the extent required by the HHS.

(b) Routine Care

Routine care including, but not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or immunizations (including flu vaccines), well child care, pap smears, mammograms, colon exams and PSA testing. If a diagnosis is indicated after a routine exam, the exam will still be payable under the routine care benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other Illness.

The above routine care items are covered in addition to and to the extent they are not otherwise included for coverage under the Preventive Services section of the Plan.

(48) **Prosthetic Devices:** Artificial limbs, eyes, or other prosthetic devices when necessary due to an Illness or Injury. This benefit includes any necessary repairs to restore the prosthesis to a serviceable condition. If such prosthesis cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repairs, or replacement due to abuse or misuse, as determined by the Plan, are not covered.

(49) **Qualified Clinical Trial Expenses:** Expenses that are, except as excluded below, healthcare items and services for the treatment of cancer or any other life threatening condition for a qualifying individual enrolled in a Qualified Clinical Trial that are otherwise consistent with the terms of the Plan and would be covered if the Covered Person did not participate in the Qualified Clinical Trial.

For purposes of this section, a "life threatening condition" means any condition or disease from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and a "qualifying individual" means any Covered Person who is eligible to participate in a Qualified Clinical Trial according to the trial protocol for treatment of cancer or any other life threatening condition that makes his or her participation in the program appropriate, as determined based on either (i) a conclusion of a referring health care professional or (ii) medical and scientific information provided by the Covered Person.

Notwithstanding the above, Qualified Clinical Trial expenses do not include any of the following:

(a) Costs associated with managing the research associated with the Qualified Clinical Trial; or

(b) Costs that would not be covered for non-Experimental and/or Investigational treatments; or

(c) Any item or service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(50) **Radiation Therapy:** Radium and radioactive isotope therapy treatment. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(51) **Reconstructive Surgery:** See Cosmetic Procedures/Reconstructive Surgery.

(52) **Rehabilitation Facility:** Inpatient care in a Rehabilitation Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Skilled Nursing Facility confinement; and (c) is not for Custodial Care.

See the Skilled Nursing Facility benefit for services and supplies provided for confinements in a Skilled Nursing Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(53) **Respiratory/Pulmonary Therapy:** Respiratory/pulmonary therapy under the recommendation of a Physician. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(54) **Retail Clinics:** Services and supplies provided by a Retail Clinic. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(55) **Routine Newborn Care:** Routine newborn care including Hospital nursery expenses and routine pediatric care while confined following birth will be considered as part of the newborn's expense.

If the newborn is ill, suffers an Injury or requires care other than routine care, benefits will be provided on the same basis as any other eligible expense.

(56) **Second Surgical Opinion:** Voluntary second surgical opinions for elective, non-emergency Surgery when recommended for a Covered Person.

Benefits for the second opinion will be payable only if the opinion is given by a specialist who: (a) is certified in the field related to the proposed Surgery; and (b) is not affiliated in any way with the Physician recommending the Surgery.

If the second opinion conflicts with the first opinion, the Covered Person may obtain a third opinion, although this is not required.

(57) **Skilled Nursing Facility:** Skilled nursing care in a Skilled Nursing Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Rehabilitation Facility confinement; and (c) is not for Custodial Care.

See the Rehabilitation Facility benefit for services and supplies provided for confinements in a Rehabilitation Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(58) **Sleep Disorders:** Sleep disorder treatment and sleep studies that are Medically Necessary.

(59) **Speech/Hearing Therapy:** Restorative or rehabilitative speech or hearing therapy rendered by a qualified Physician or a licensed speech or hearing therapist under the recommendation of a Physician, necessary because of loss or impairment due to an Illness, Injury or Surgery or therapy to correct a Congenital Anomaly. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(60) **Sterilization:** Elective sterilization procedures (this does not include reversal of sterilization). Elective sterilization procedures are covered in addition to and to the extent they are not otherwise included for coverage under the preventive services section of the Plan.

(61) **Substance Use Disorders:** Care, supplies, and treatment of a Substance Use Disorder, including smoking and tobacco cessation and family counseling. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(62) **Teladoc Network Providers:** Teladoc provides 24/7/365 access to a national network of U.S. board-certified Physicians who can resolve many of your medical issues. Teladoc services involve the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact.

For any questions with respect to Teladoc, please contact the Plan Administrator. Coverage under this benefit does not include consults from your regular Physician; it only includes coverage for consults to the extent the Physician who is consulted participates in the Teladoc program. To learn more about Teladoc, see the Teladoc contact information under General Plan Information section of the Plan.

Teladoc benefits include:

- 24/7/365 access to a Physician online or by phone
- Fast treatment
- Talk to a Teladoc Physician from anywhere at home, work, or while traveling
- Save money by avoiding expensive urgent care or emergency room visits

Call Teladoc:

- When you need care now
- If you're considering the emergency room or urgent care center for non-emergency issues
- On vacation, on a business trip, or away from home
- For short-term prescription refills

Teladoc providers treat conditions such as:

- Cold and flu
- Bronchitis
- Respiratory infection
- Sinus problems
- Allergies
- Urinary tract infection
- Pediatric care
- Poison ivy
- Pink eye
- Ear infections

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(63) **Telemedicine:** Services related to the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact by a covered provider. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(64) **Temporomandibular Joint Dysfunction (TMJ):** Surgical and non-surgical treatment of any joint problem including any Temporomandibular Joint Dysfunction (TMJ) disorder, craniomaxillary disorder, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull.

The following are Covered Expenses:

(1) A single examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation, as necessary;

(2) Diagnostic x-rays;

(3) Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of service;

(4) Diagnostic therapeutic masticatory muscle and temporomandibular joint injections;

(5) Appliance therapy utilizing an appliance that does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the maximum allowable fee for use of a single appliance, regardless of the number of appliances used in treatment. The benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair, and replacement of the appliance; and

(6) Surgical Procedures.

Covered Expenses do not include charges for:

(1) Occlusal analysis; or

(2) Any irreversible procedure, including but not limited to: orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures and full dentures.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(65) **Transplants (other than those received through the Aetna IOE Program):** Services and supplies in connection with Medically Necessary non-Experimental and/or non-Investigational transplant procedures.

(a) If both the donor and the recipient are covered under this Plan, eligible expenses Incurred by each person will be treated separately for each person.

(b) If the recipient is covered under this Plan and the donor is not covered, eligible expenses Incurred by the donor will be considered eligible if not covered by the donor's plan.

(c) If the donor is covered under this Plan and the recipient is not covered, eligible expenses Incurred by the donor will not be covered.

(d) The Usual and Customary fee of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology, and pathology fees for the removal of the organ and a Hospital's charge for storage or transportation of the organ.

See the Aetna Institute of Excellence (IOE) Program section of the Plan with respect to coverage for transplants received through the Aetna IOE Program.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Exclusions:

(a) Non-human and artificial organ transplants.

(b) The purchase price of bone marrow, any organ, tissue, or any similar items which are sold rather than donated.

(c) Transplants which are not medically recognized and are Experimental and/or Investigational in nature.

(d) Lodging expenses, including meals.

(e) Expenses related to the Covered Person’s travel.

(66) **Urgent Care Facility:** Services and supplies provided by an Urgent Care Facility. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

AETNA INSTITUTE OF EXCELLENCE (IOE) PROGRAM

The Institute of Excellence (IOE) is a facility that contracted with Aetna to furnish particular services and supplies to you in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

Transplant Expenses
Once it has been determined that you or one of your eligible Dependents may require an organ transplant, you, or your Physician must call the Medical Management Program Administrator to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements. Organ means solid organ; stem cell; bone marrow and tissue.

Benefits may vary if an IOE facility or a non-IOE facility is used. In addition, some expenses listed below may only be payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered at the Participating Provider level only if performed in a facility that has been designated as an IOE facility. Any treatment or service related to transplants that are provided by a facility that is not specified as an IOE network facility (even if the facility is considered a network facility for other types of services), will be payable as shown in the Medical Schedule of Benefits. Please read each section below carefully.

Covered Transplant Expenses
Covered transplant expenses include the following:

(1) Charges for activating the donor search process with national registries.

(2) Compatibility testing of prospective organ donors that are immediate family members. For purposes of this section an “immediate” family member is defined as a first-degree biological relative. These are your biological parent, sibling, or child.

(3) Inpatient and outpatient expenses directly related to a transplant.

(4) Charges made by a Physician or a transplant team.

(5) Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.

(6) Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant services are typically Incurred during the 4 phases of transplant care described below. Expenses Incurred for one transplant during these 4 phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date the patient is discharged from the Hospital or outpatient facility for the admission or visits related to the transplant, whichever is later.

The 4 phases of one transplant occurrence and a summary of covered transplant expense during each phase are as follows:

(1) Pre-transplant evaluation/screening. Pre-transplant evaluation screening includes all transplant-related professional and technical components required for assessment, evaluation, and acceptance into a transplant facility’s transplant program.

(2) Pre-transplant candidacy screening. Pre-transplant candidacy screening includes Human Leukocyte Antigen (HLA) typing/compatibility testing of prospective organ donors that are immediate family members.

(3) Transplant event. A transplant event includes Inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more Surgical Procedures or medical therapies for a transplant; Prescription Drugs provided during your Inpatient stay or outpatient visits, including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your Inpatient stay or outpatient visits; cadaveric and live donor procurement.

(4) Follow-up care. Follow-up care includes all covered transplant expenses; home health care services; home infusion services and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

One Transplant Occurrence
The following are considered one transplant occurrence:

(1) Heart.

(2) Lung.

(3) Heart/Lung.

(4) Simultaneous Pancreas Kidney (SPK).

(5) Pancreas.

(6) Kidney.

(7) Liver.

(8) Intestine.

(9) Bone marrow/stem cell transplant.

(10) Multiple organs replaced during one transplant Surgery.

(11) Tandem transplants (stem cell).

(12) Sequential transplants.

(13) Re-transplant of same organ type within 180 days of first transplant.

(14) Any other single organ transplant, unless otherwise excluded under the Plan.

More Than One Transplant Occurrence
The following are considered more than one transplant occurrence:

(1) Autologous blood/bone marrow transplant followed by allogeneic blood/bone marrow transplant (when not part of a tandem transplant).

(2) Allogeneic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant).

(3) Re-transplant after 180 days of the first transplant.

(4) Pancreas transplant following a kidney transplant.

(5) A transplant necessitated by an additional organ failure during the original transplant Surgery/process.

(6) More than one transplant when not performed as part of a planned tandem or sequential transplant (i.e., a liver transplant with subsequent heart transplant).

Limitations
Transplant coverage does not include charges for the following:

(1) Outpatient drugs, including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.

(2) Services and supplies furnished to a donor when recipient is not a Covered Person.

(3) Home infusion therapy after the transplant occurrence.

(4) Harvesting or storage of organs without the expectation of immediate transplant for an existing Illness.

(5) Harvesting and/or storage of bone marrow, tissue, or stem cells without the expectation of transplantation within 12 months for an existing Illness.

(6) Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.

Travel and Lodging Expenses
Travel and lodging expenses will be covered under the Plan subject to the conditions described below.

(1) Distance requirement. The IOE facility must be more than 100 miles away from the patient's residence.

(2) Travel allowances. Travel is reimbursed between the patient's home and the facility for round trip (air, train, or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking, and toll cost will be reimbursed per IRS guidelines.

(3) Lodging allowances. Reimbursement of expenses Incurred by the patient and any companion for hotel lodging away from home is reimbursed at a rate of $50 per night per person, to a maximum of $100 per night.

(4) Overall maximum. Travel and lodging reimbursements are limited to $10,000 for any one transplant or procedure type, including tandem transplants. This is a combined maximum for the patient, companion, and donor.

(5) Companions. One companion is permitted per adult and 2 parents or guardians are permitted per Child.

ALTERNATE BENEFITS

In addition to the benefits specified, the Plan may elect to offer benefits for services furnished by any provider pursuant to a Plan-approved alternate treatment plan, in which case those charges Incurred for services provided to a Covered Person under an alternate treatment plan to its end, will be more cost effective than those charges to be Incurred for services to be provided under the current treatment plan to its end.

The Plan shall provide such alternate benefits at its sole discretion and only when and for so long as it determines that alternate treatment plan is Medically Necessary and cost effective. If the Plan elects to provide alternate treatment plan benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for such Covered Person in any other instance or for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.

GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Plan for expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations, or other terms of the Plan.

(1) **Administrative Services:** Expenses for completion of claim forms and shipping and handling will not be considered eligible.

(2) **Adoption:** Expenses related to adoption will not be considered eligible.

(3) **After Termination Date:** Expenses which are Incurred after the termination date of your coverage under the Plan will not be considered eligible.

(4) **Alternative Medicine:** Expenses for services or supplies related to alternative medicine will not be considered eligible, including but not limited to acupressure, aromatherapy, ayurveda, faith healing, guided mental imagery, herbal supplements and medicine, holistic medicine, macrobiotics, ozone therapy, reflexotherapy, relaxation response, shiatsu, and yoga.

(5) **Biofeedback:** Expenses related to biofeedback will not be considered eligible.

(6) **Cardiac Rehabilitation:** Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

(7) **Chelation Therapy:** Expenses for chelation therapy will not be considered eligible, unless due to heavy metal poisoning.

(8) **Close Relative:** Expenses for services, care or supplies provided by a person who normally resides in the Covered Person's home or by a Close Relative will not be considered eligible.

(9) **Communication Devices and Systems:** Expenses related to communication devices and systems, telephones, televisions and computer systems and related equipment will not be considered eligible, except after surgical removal of the larynx or a diagnosis of permanent lack of larynx function.

(10) **Complications:** Expenses for care, services or treatment required as a result of complications from a treatment or procedure not covered under the Plan will not be considered eligible. This exclusion does not apply to complications from abortions as specified under Eligible Medical Expenses.

(11) **Convenience Items:** Expenses for personal hygiene and convenience items, including but not limited to bath/shower chairs, transfer equipment or supplies, or bed side commodes will not be considered eligible.

(12) **Cosmetic Procedures:** Expenses for Cosmetic and reconstructive procedures will not be considered eligible, except as specified under Eligible Medical Expenses.

(13) **Counseling:** Expenses for religious, marital, or relationship counseling will not be considered eligible, except as specified under Eligible Medical Expenses.

(14) **Custodial Care:** Expenses for Custodial Care will not be considered eligible, except as specified under the Home Health Care and Hospice Care benefits.

(15) **Dental Care:** Expenses Incurred in connection with dental care, treatment, x-rays, implants, general anesthesia, or Hospital expenses will not be considered eligible, except as specified under Eligible Medical Expenses.

(16) **Environmental Control or Enhancement:** Expenses for services that are primarily and customarily used for environmental control or enhancement and certain medical devices will not be considered eligible, including but not limited to:

(a) Common household items including water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment;

(b) Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps, or modifications or additions to living/working quarters or transportation vehicles;

(c) Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas, or saunas;

(d) Medical equipment including blood pressure monitoring devices, unless prescribed by a Physician for preventive care and ambulatory blood pressure monitoring is not available to confirm diagnosis of hypertension and PUVA lights and stethoscopes; or

(e) Communication system, telephone, television or computer systems and related equipment or similar items or equipment.

(17) **Exams:** Expenses related to routine exams for the purpose of employment, school, sports or camp examinations will not be considered eligible. This exclusion does not apply to preventive services as described under the Eligible Medical Expenses section of the Plan.

(18) **Exercise Programs:** Expenses for exercise programs for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.

(19) **Experimental and/or Investigational:** Expenses for treatment, procedures, devices, drugs, or medicines which are determined to be Experimental and/or Investigational will not be considered eligible, except for Off-Label Drug Use or when such expenses are considered Qualified Clinical Trial Expenses.

(20) **Foot Care:** Expenses for routine foot care, treatment of weak, unstable, or flat feet, or shock wave therapy will not be considered eligible, unless for metabolic or peripheral vascular disease.

(21) **Foot Orthotics:** Expenses for foot only orthotics, orthopedic shoes (except those that are an integral part of a leg brace), arch supports or for the exam, prescription or fitting thereof will not be considered eligible, unless for diabetes or hammer toe.

(22) **Governmental Agency:** Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).

(23) **Growth Hormones:** Expenses related to growth hormones will not be considered eligible except as specified under the Prescription Drug Card Program section of the Plan.

(24) **Hair Loss:** Expenses for hair loss, hair transplants, wigs or any drug that promises hair growth, whether or not prescribed by a Physician, will not be considered eligible. This exclusion does not apply to the Medically Necessary treatment of alopecia areata.

(25) **Hearing Exams:** Expenses for routine hearing examinations will not be considered eligible. This exclusion does not apply to any expenses otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(26) **Holistic Clinic:** Expenses for services rendered in a premenstrual syndrome clinic or holistic medicine clinic will not be considered eligible.

(27) **Homeopathic Treatment:** Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.

(28) **Hospital Observation:** Expenses for Hospital Inpatient services when you are in observation status will not be considered eligible.

(29) **Hypnotherapy:** Expenses for hypnotherapy will not be considered eligible.

(30) **Illegal Occupation/Felony:** Expenses for or in connection with an Injury or Illness arising out of an illegal occupation or commission of a felony will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or due to an act of domestic violence.

(31) **Immunizations:** Expenses for immunizations required for foreign travel will not be considered eligible. This exclusion does not apply to any expenses otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(32) **Infertility:** Expenses for confinement, treatment or services related to infertility (the inability to conceive) or the promotion of conception will not be considered eligible, except diagnosis and testing of infertility and the correction of an underlying medical condition as specified under Eligible Medical Expenses.

Nothing in this section is intended to exclude coverage for any infertility counseling or treatment required to be covered (if any) as a preventive service under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines).

(33) **Maintenance Therapy:** Expenses for Maintenance Therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.

(34) **Massage Therapy:** Expenses for massage therapy or Rolfing will not be considered eligible.

(35) **Medically Necessary:** Expenses which are determined not to be Medically Necessary will not be considered eligible.

(36) **Missed Appointments:** Expenses for missed appointments will not be considered eligible.

(37) **No Legal Obligation:** Expenses for services provided for which the Covered Person has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires this Employer's Plan to be primary.

(38) **Non-Covered Procedures:** Expenses for services related to a non-covered Surgery or procedure will not be considered eligible regardless of when the Surgery or procedure was performed.

(39) **Not Performed Under the Direction of a Physician:** Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

(40) **Not Recommended by a Physician:** Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.

(41) **Nutritional Supplements:** Expenses for nutritional supplements or other enteral supplementation will not be considered eligible, except as specified under Eligible Medical Expenses. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(42) **Obesity:** Expenses for surgical and non-surgical care and treatment of obesity including weight loss, whether or not it is in any case a part of a treatment plan for another Illness, will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

Additionally, expenses for non-surgical treatment of Morbid Obesity will not be considered eligible.

(43) **Occupational Therapy:** Expenses for occupational therapy primarily for recreational or social interaction will not be considered eligible.

(44) **Operated by the Government:** Expenses for treatment at a facility owned or operated by the government will not be considered eligible unless the Covered Person is legally obligated to pay. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.

(45) **Oral or Dental Splints and Appliances:** Expenses for oral or dental splints and appliances will not be considered eligible unless custom made for the treatment of documented sleep apnea.

(46) **Outside the United States (U.S.):** Expenses for services or supplies if the Covered Person leaves the U.S. or the U.S. Territories for the express purpose of receiving medical treatment will not be considered eligible.

(47) **Over-the-Counter (OTC) Medication:** Expenses for any over-the-counter medication will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(48) **Plan Maximums:** Expenses for charges in excess of Plan maximums will not be considered eligible.

(49) **Pre-Surgical Testing:** Expenses for pre-surgical/procedural testing duplicated during a Hospital confinement will not be considered eligible.

(50) **Prior to Effective Date:** Expenses which are Incurred prior to the effective date of your coverage under the Plan will not be considered eligible.

(51) **Private Duty Nursing:** Expenses for private duty nursing will not be considered eligible, except those nursing services which are considered eligible under the Home Health Care and Hospice Care benefits.

(52) **Radioactive Contamination:** Expenses Incurred as the result of radioactive contamination or the hazardous properties of nuclear material will not be considered eligible.

(53) **Recreational and Educational Therapy:** Expenses for recreational and educational services; learning disabilities; behavior modification services; vocational testing or training; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aerobic and strength conditioning will not be considered eligible. Diabetic education is considered eligible as specified under Eligible Medical Expenses. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.

(54) **Refractive Errors:** Expenses for radial keratotomy, Lasik Surgery, or any Surgical Procedure to correct refractive errors of the eye will not be considered eligible.

(55) **Removal of Excess Skin:** Expenses for Surgical Procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss Surgery will not be considered eligible.

(56) **Required by Law:** In any case where an individual is required by law to maintain insurance coverage (or to maintain any other security or reserve amount in lieu of insurance coverage), expenses of a Covered Person that would be paid by such insurance coverage are not eligible expenses, regardless of whether the individual is in fact covered under such coverage. For purposes of any required automobile, motorcycle or other vehicle coverage, otherwise eligible expenses below the minimum required coverage or the actual coverage elected, whichever is higher, will be excluded from coverage under this Plan.

(57) **Riot/Revolt:** Expenses resulting from a Covered Person’s participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

(58) **Services Not Permitted Under Applicable State or Local Laws:** Some state or local laws restrict the scope of health care services that a provider may render. In such cases, the Plan will not cover such health care services.

(59) **Sexual Dysfunction/Impotence:** Expenses for services, supplies or drugs related to sexual dysfunction/ impotence not related to organic disease will not be considered eligible, except as specified under the Prescription Drug Card Program. Expenses for sex therapy will not be considered eligible.

(60) **Sleep Therapy:** Expenses for treatment, services and supplies for sleep therapy will not be considered eligible.

(61) **Stand-by Physician:** Expenses for technical medical assistance or stand-by Physician services will not be considered eligible.

(62) **Sterilization:** Expenses for the reversal of elective sterilization will not be considered eligible.

(63) **Surrogate:** Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan and for any Covered Person other than the Employee and Spouse will not be considered eligible, including but not limited to pre-pregnancy, conception, prenatal, childbirth and postnatal expenses. This exclusion does not apply to preventive services for any Covered Person as described under the Eligible Medical Expenses section of the Plan.

(64) **Therapies and Treatments:** Expenses for the following therapies and treatments will not be considered eligible:

(a) Immunotherapy for recurrent abortions;

(b) Chemonucleolysis;

(c) Light treatments for Seasonal Affective Disorder (S.A.D);

(d) Immunotherapy for food allergy;

(e) Prolotherapy; or

(f) Sensory integration therapy.

(65) **Travel:** Expenses for travel will not be considered eligible, except as specified under Eligible Medical Expenses.

(66) **Usual and Customary Charge:** Expenses in excess of the Usual and Customary Charge will not be considered eligible.

(67) **Vision Care:** Expenses for vision care, including routine eye exams, professional services for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices will not be considered eligible. However, benefits will be provided for the necessary initial placement of a pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye. This exclusion does not apply to aphakic patient and soft lenses or sclera shells intended for use as corneal bandages and as otherwise covered as a preventive service under the Eligible Medical Expense section of the Plan.

(68) **Vision Therapy:** Expenses for vision therapy/orthoptic therapy will not be considered eligible.

(69) **War:** Expenses for the treatment of Illness or Injury resulting from actively participating in a war or any act of war or terrorism, whether declared or undeclared, civil war, hostilities, or invasion, or while in the armed forces of any country or international organization will not be considered eligible.

(70) **Weekend Admissions:** Expenses for care and treatment billed by a Hospital for non-Emergency Medical Condition admissions on a Friday, Saturday or Sunday will not be considered eligible, unless Surgery is scheduled within 24 hours.

(71) **Workers' Compensation:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Workers' Compensation Law or occupational disease law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Workers' Compensation or similar law and have reached the maximum reimbursement paid under Workers' Compensation or similar law will not be eligible for payment under this Plan.

PRESCRIPTION DRUG CARD PROGRAM

Eligible expenses include Prescription Drugs and medicines prescribed by a Physician or authorized prescriber and dispensed by a licensed pharmacist, which are deemed necessary for treatment of an Illness or Injury including but not limited to: insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician; diabetic supplies; smoking/tobacco deterrents; sexual dysfunction/impotence medication; growth hormones; and contraceptives (regardless of intended use). See the Prescription Drug Schedule of Benefits for any cost-sharing provisions, if applicable.

When your prescription is filled at a retail pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

When using the mail order program, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

Expenses for certain medications that are not covered under the Prescription Drug Card Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under the medical benefits section of the Plan subject to any applicable major medical Deductibles and Coinsurance as well as any coverage limitations and exclusions applicable to the major medical component of the Plan. Please refer to the Eligible Medical Expenses and the General Limitations and Exclusions section of the Plan.

NOTE: Coverage, limitations and exclusions for Prescription Drugs will be determined through the Prescription Drug Card Program elected by the Plan Sponsor and will not be subject to any limitations and exclusions under the major medical component of the Plan (except for certain medications that are not covered under the Prescription Drug Card Program). For a complete listing of Prescription Drugs available under the Prescription Drug Card Program, as well as any exclusions or limitations that may apply, please contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

Dispense as Written
The Plan requires pharmacies dispense Generic Drugs when available unless the Physician specifically prescribes a Preferred or Non-Preferred Drug and marks the script "Dispense as Written" (DAW). Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent when the Physician allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Advanced Control Specialty Formulary
Advanced Control Specialty Formulary (ACSF) is a moderately aggressive approach and presents specialty trend management. The formulary utilizes formulary exclusions, new-to-market (NTM) drug management and tiering strategies to help ensure clinically appropriate utilization and cost-effectiveness of specialty therapies.

Specialty Pharmacy Program
Self-administered Specialty Drugs that do not require administration under the direct supervision of a Physician may be obtained directly from the specialty pharmacy program or dispensed at any participating retail pharmacy authorized to dispense specialty products. For additional information, please contact the Prescription Drug Card Program Administrator.

Specialty Drugs that must be administered in a Physician’s office, infusion center or other clinical setting, or the Covered Person’s home by a third party, will be considered under the Medical Benefits section of the Plan. Those drugs that can be self-administered and do not require the direct supervision of a Physician are only eligible under the Prescription Drug Program.

Step Therapy

What is Step Therapy?
Certain Prescription Drug classes are subject to Step Therapy. Step Therapy is a type of prior authorization. In most cases, you must first try a less expensive drug on the formulary (also called a drug list) that has been proven effective for most people with your condition before you can move up a "step" to a more expensive drug. This might mean trying a similar, more affordable Brand Name Drug. The more affordable drugs in the first phase are known as "Step 1" Prescription Drugs. Please note the formulary may change at any time. You will receive notice when necessary.

However, if you have already tried the more affordable drug and it didn't work or if your Physician believes it is Medically Necessary for you to be on a more expensive drug, he or she can contact the Plan Administrator to request an exception. If your Physician's request is approved, the Plan will cover the more expensive drug. The more expensive drugs are known as "Step 2" Prescription Drugs.

Step Therapy is a program especially for people who take Prescription Drugs regularly for ongoing conditions like arthritis and high blood pressure.

In Step Therapy, drugs are grouped in categories based on cost:

- Front-line drugs - the first step - are Generic Drugs proven to be safe, effective, and affordable. These drugs should be tried first because they can provide the same health benefit as more expensive drugs, at a lower cost.

- Back-up drugs - Step 2 and Step 3 drugs - are Brand Name Drugs. There are lower-cost brand drugs (Step 2) and higher-cost brand drugs (Step 3). Back-up drugs typically cost more than front-line drugs.

How does Step Therapy work?
The next time the Physician writes a prescription, ask the Physician if a Generic Drug listed by the Plan as a front-line drug is appropriate. It makes good sense to ask for these drugs first because, for most everyone, they work as well as Brand Name Drugs - and they almost always cost less.

If the Covered Person already tried a front-line drug, or his or her Physician decides one of these drugs isn't appropriate, then the Covered Person's Physician can prescribe a back-up drug. The Covered Person should ask his or her Physician if one of the lower-cost Brand Name Drugs (Step 2 drugs) listed by the Plan is appropriate. Remember, the Covered Person can always get a higher-cost Brand Name Drug at a higher Copay if the front-line or Step 2 back-up drugs are not appropriate.

If on October 1, 2023, the Covered Person is currently using a medication that requires Step Therapy he or she may continue using that medication. If the Covered Person is trying to fill a medication for the first time in 6 months, he or she may be required to use the first-line therapy before the Step Therapy medication can be filled. Please contact the Prescription Drug Card Program Administrator for more information on the Step Therapy program.

Failure to use the Step Therapy program may result in the Covered Person being responsible for the entire cost of the drug.

Brand Name Drug: Means a trade name medication.

Generic Drug: A Prescription Drug which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Non-Preferred Drug: Any Brand Name Drugs that do not appear on the list of Preferred Drugs.

Preferred Drug: A list of Brand Name Drugs that has been developed by a Pharmacy and Therapeutics Committee comprised of Physicians, Pharmacists, and other health care professionals. The list of Brand Name Drugs is subject to periodic review and modification based on a variety of factors such as, but not limited to, Generic Drug availability, Food and Drug Administration (FDA) changes, and clinical information. The Prescription Drug Card Program Administrator will have a list of Preferred Drugs available.

Prescription Drug: Any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, "Caution: federal law prohibits dispensing without prescription"; (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a list of Preventive Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

Preventive Maintenance Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as preventive maintenance services used to treat the prevention of conditions relating to:

(1) Hypertension.

(2) Heart failure.

(3) Heart disease.

(4) Liver disease and/or bleeding disorder.

(5) Diabetes.

(6) Asthma.

(7) Conditions resulting from osteoporosis and/or osteopenia.

(8) Stroke.

(9) Depression.

(10) Various pediatric conditions, such as vitamins and fluoride deficiency, and maternal and fetal problems during pregnancy.

For a list of Preventive Maintenance Drugs, contact the Prescription Drug Card Program Administrator identified in the General Plan Information section of this Plan.

Specialty Drug means those Prescription Drugs, medicines, agents, substances, and other therapeutic products that include one or more of the following particular characteristics:

(1) Address complex, chronic diseases with many associated co-morbidities (e.g., cancer, rheumatoid arthritis, hemophilia, multiple sclerosis);

(2) Require a greater amount of pharmaceutical oversight and clinical monitoring for side effect management and to limit waste;

(3) Limited pharmaceutical supply chain distribution as determined by the applicable drug's manufacturer; and/or

(4) Relative expense.

COBRA CONTINUATION COVERAGE

The right to COBRA Continuation Coverage was created by a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and/or your eligible Dependents when your coverage under the Plan ends because of a life event known as a "qualifying event".

Qualified Beneficiary
In general, you, your Spouse and any Dependent Child covered under the Plan on the day before a qualifying event that causes you to lose coverage under the Plan is considered a "qualified beneficiary".

In addition, any Dependent Child who is born to or placed for adoption with you during a period of COBRA continuation coverage is considered a "qualified beneficiary".

Each qualified beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

Qualifying Event
If you are a covered Employee, you, your Spouse and/or Dependent Child will become a qualified beneficiary if you lose your coverage under the Plan because of either one of the following qualifying events:

(1) Your hours of employment are reduced; or

(2) Your employment ends for any reason other than your gross misconduct.

You, your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 18 months provided you elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage.

You, your Spouse and Dependent Child have an independent right to elect COBRA Continuation Coverage. You and/or your Spouse may elect coverage on behalf of either one of you and parents may elect coverage on behalf of their Dependent Child.

If you are the Spouse and/or Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events:

(1) Your spouse/parent-Employee dies;

(2) Your spouse/parent-Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(3) You/your parents become divorced or legally separated.

Your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 36 months provided such Spouse and/or Dependent Child provide notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date they are given notice of their rights to elect COBRA Continuation Coverage and their obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If you are a Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose coverage under the Plan because you cease to be eligible for coverage under the Plan as a Dependent Child. You may elect to continue coverage under the Plan for up to a maximum period of 36 months provided you provide notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of; (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage and your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

Extension of 18-Month Continuation Coverage Period
If you, your Spouse or Dependent Child is determined to be disabled by the Social Security Act (SSA); you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for this extension in coverage, notification must be given to your Employer on a date that is both within 60 days after the later of (a) the date of the SSA determination; (b) the date coverage under the Plan would end due to the qualifying event; or (c) the date you are given notice of your obligation to provide such notice and before the end of the initial 18-month period of coverage. If you are later determined not disabled by SSA, you must notify your Employer within 30 days following the later of (a) the date of the SSA determination; or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and any Dependent Child in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. To qualify for this extension in coverage, notification must be given to your Employer within 60 days after the later of (a) the date coverage under the Plan would end due to the qualifying event or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

Notice Requirement
The notice must be postmarked (if mailed) or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage is lost and if you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan or if you are eligible for an extension of COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

For qualifying events such as divorce or legal separation of the Employee and Spouse or a Dependent Child's loss of eligibility under the Plan, the notice must contain the following information:

(1) Name and address of the covered Employee or former Employee;

(2) Name and address of your Spouse, former Spouse, and any Dependent Children;

(3) Description of the qualifying event; and

(4) Date of the qualifying event.

In addition to the information above, if you, your Spouse, or any Dependent Child is determined by SSA to be disabled within 60 days after your COBRA continuation coverage begins, the notice must also contain the following information:

(1) Name of person deemed disabled;

(2) Date of disability determination; and

(3) Copy of SSA determination letter.

If you cannot provide a copy of the SSA's determination by the deadline, complete and provide the notice as instructed and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage or extension of such coverage will be available until the copy of the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified in the request, the notice may be rejected.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

Notice must be sent to the COBRA Administrator at:

Flores Associates COBRA
1218 S Church Street
Charlotte, NC 28203
(704) 335-8211

Termination of COBRA Continuation Coverage
COBRA continuation coverage automatically ends 18, 29 or 36 months (whichever is applicable) after the date of the qualifying event; however, coverage may end before the end of the maximum period on the earliest of the following events:

(1) The date the Plan Sponsor ceases to provide any group health plan coverage;

(2) The date on which the qualified beneficiary fails to pay the required contribution;

(3) The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise) or entitled to either Medicare Part A or Part B (whichever comes first); or

(4) The first day of the month that begins more than 30 days after the date of the SSA's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage
Once COBRA continuation coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated. The amount you are required to pay for COBRA continuation coverage is 102% of the actual cost of coverage you elect unless you qualify for the 11-month period of extended coverage due to disability (as specified above). In the event of disability, you may be required to pay up to 150% of the actual cost of coverage you elect for the 11-month extension period.

Additional Information
Additional information about the Plan and COBRA continuation coverage is available from the Plan Administrator, who is identified on the General Plan Information page of this Plan.

Current Addresses
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members.

CLAIM PROCEDURES

You will receive an Employee identification card which will contain important information, including claim filing directions and contact information.

At the time you receive treatment, show the Employee identification card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by submitting the required information to:

Meritain Health, Inc.
P.O. Box 853921
Richardson, TX 75085-3921
(800) 925-2272

Most claims under the Plan will be “post service claims.” A “post service claim” is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

(1) The date of service;

(2) The name, address, telephone number and tax identification number of the provider of the services or supplies;

(3) The place where the services were rendered;

(4) The diagnosis and procedure codes;

(5) The amount of charges (including Network repricing information);

(6) The name of the Plan;

(7) The name of the covered Employee; and

(8) The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan or if a certain procedure or treatment is a Covered Expense before the treatment is rendered, is not a “claim” since an actual written claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Timely Filing
All claims must be filed with the Third Party Administrator within 12 months following the date services were Incurred. Claims filed after this time period will be denied.

Procedures for all Claims
The Plan's claim procedures are intended to reflect the Department of Labor's claims procedures regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant (i.e., you and your covered Dependents) must follow the procedures outlined in this section. There are 4 different types of claims: (1) Urgent Care Claims; (2) Concurrent Care Claims; (3) Pre-Service Claims; and (4) Post-Service Claims. The procedures for each type of claim are more fully described below:

(1) **Urgent Care Claims.** If your claim is considered an urgent care claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless you fail to provide sufficient information to determine whether or to what extent, benefits are covered or payable under the Plan. If you fail to provide sufficient information for the Plan to decide your claim, the Plan Administrator will notify you as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A claim for benefits is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. In determining if the initial claim for benefits should be treated as an urgent care claim, the Plan will defer to a determination, if any, by an attending provider that the claim should be treated as an urgent care claim, if that determination is timely provided to the Plan.

(2) **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Plan Administrator will notify you of the adverse determination at a time sufficiently in advance of the reduction or termination to allow you, the claimant, to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies and the Plan Administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

(3) **Pre-Service Claims.** For a pre-service claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time to notify you of the Plan's benefit determination for up to 15 days provided that the Plan Administrator notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Plan Administrator expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(4) **Post-Service Claims.** For a post-service claim, the Plan Administrator will notify you of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days provided that the Plan Administrator notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you have already received (or any other claim for health benefits that is not a pre-service claim or an urgent care claim).

Manner and Content of Notice of Initial Adverse Determination
If the Plan Administrator denies a claim, it must provide to you in writing or by electronic communication:

(1) An explanation of the specific reasons for the denial;

(2) A reference to the Plan provision or insurance contract provision upon which the denial is based;

(3) A description of any additional information or material that you must provide in order to perfect the claim;

(4) An explanation of why the additional material or information is necessary;

(5) Notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;

(6) A statement describing your right to request an external review (or, if applicable, to request a second level appeal) or, if applicable, to bring an action for judicial review;

(7) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon your request and without charge); and

(8) If the adverse determination is based on the Plan's Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances or (b) a statement that the same will be provided upon your request and without charge.

Any notice of adverse determination also will include the following information:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable);

(2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and

(5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

For an adverse determination concerning an urgent care claim, the information described in this Section may be provided to you orally within the permitted time frame provided that a written or electronic notification in accordance with this section is furnished to you no later than 3 days after the oral notification.

Internal Review of Initial Adverse Benefit Determination
If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the procedures described below.

You have 180 days after you receive notice of an initial adverse determination within which to request a review of the adverse determination. For a request for a second level appeal, you have 60 days after you receive notice of an adverse determination at the first level of appeal to request a second level appeal of the adverse determination.

If you request a review of an adverse determination within the applicable time period, the review will meet the following requirements:

(1) The Plan will provide a review that does not afford deference to the adverse determination that is being appealed and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse determination that is the subject of the appeal and who is not a subordinate of the individual who made that adverse determination.

(2) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor a subordinate of any such individual.

(3) The Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Plan in connection with the Plan's review of an adverse determination, without regard to whether the advice is relied upon in making the adverse determination on review.

(4) For a requested review of an adverse determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and you by telephone, facsimile, or other available similarly expeditious method.

(5) The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information, and records relating to the claim and to submit issues and comments relating to the claim in writing to the Plan. The reviewer will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(6) You will be provided, free of charge, any new or additional evidence or rationale considered, relied upon, or generated by the Plan in connection with the claim. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of its determination on review to give you a reasonable opportunity to respond prior to such determination.

(7) The Plan will ensure that all claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

(8) The Plan will provide you with continued coverage pending the outcome of an internal appeal.

All requests for review of initial adverse benefit determinations (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P.O. Box 660908
Dallas, TX 75266-0908

Deadline for Internal Review of Initial Adverse Benefit Determinations

(1) Urgent Care Claims. The Plan provides for 2 levels of appeal for urgent care claims. For each level of appeal, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 36 hours after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

(2) Pre-Service Claims. The Plan provides for 2 levels of appeal for a pre-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

(3) Post-Service Claims. The Plan provides for 2 levels of appeal for a post-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

Manner and Content of Notice of Decision on Internal Review of Initial Adverse Benefit Determinations
Upon completion of its review of an initial adverse determination (or a first-level appeal adverse determination), the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an adverse determination, the notice will include:

(1) A description of the Plan's decision;

(2) The specific reasons for the decision;

(3) The relevant Plan provisions or insurance contract provisions on which its decision is based;

(4) A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records and other information in the Plan's files which is relevant to your claim for benefits;

(5) A statement describing your right to request an external review (or, if applicable, to request a second level appeal),or, if applicable, to bring an action for judicial review;

(6) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol, or other similar criterion will be provided without charge to you upon request;

(7) If the adverse determination on review is based on a Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances or (b) a statement that such an explanation will be provided without charge upon request.

Any notice of adverse determination will include the following information:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable);

(2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and

(5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Calculation of Time Periods
For purposes of the time periods described in the Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review of an adverse benefit determination) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

Adverse Determination
For purposes of the Plan's claim procedures, an "adverse determination" is a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit resulting 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 and/or Investigational or not Medically Necessary or appropriate. Adverse determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

Plan's Failure to Follow Procedures
If the Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Plan internal claim procedures and you will be entitled to pursue any available remedy (including any available external review process) under state or federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

However, the Plan will not be treated as failing to follow its claim procedures and you will not be deemed to have exhausted the Plan's administrative remedies merely because of a failure by the Plan that would be considered (based on applicable regulations) a "*de minimis* violation" that does not cause and is not likely to cause prejudice or harm to you as long as the Plan can demonstrate that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you. You may request a written explanation of any violation by the Plan of these procedures. If you request such an explanation, the Plan will provide it within 10 days and, if applicable, the explanation will include a specific description of the Plan's reasons for asserting that the violation does not cause the Plan's internal claim procedures to be exhausted. If a court or external review rejects your request for an immediate review (based on a claim that you should be deemed to have exhausted the Plan's internal claim procedures), because the court or external reviewer determines that the "*de minimis* violation" exception applies, the Plan will provide to you a notice of your right to resubmit your internal appeal with a reasonable time (no longer than 10 days) after the court or external reviewer makes such a determination. Any applicable time limit for you to re-file your claim will begin to run when you receive that notice from the Plan.

External Review of Adverse Benefit Determinations
If you have exhausted the Plan's internal appeal process (or if you are eligible to request an external review for any other reason under the above procedures), you may request an external review of the Plan's final adverse determination for certain health benefit claims.

The Plan will provide for an external review process in accordance with applicable state law (if any). If no external review process exists under applicable state law or if the state law external review process does not meet certain minimum standards of the NAIC Uniform Health Carrier External Review Model Act (or the temporary "NAIC-similar" standards described in Department of Labor Technical Release 2011-02), the Plan will provide for an external review process that meets federal law requirements. Governmental plans that are not eligible to participate in a qualifying state process must elect to participate in a federal process administered by HHS or in the federal external review process that applies to ERISA-governed, self-funded Plans. If the Plan elects to participate in the federal external review process that applies to an ERISA self-funded plan, the external review procedures described below will apply.

Note that the federal external review process (including the expedited external review process described later in these procedures) is <u>not</u> available for review of all internal adverse determinations. Specifically, federal external review is not available for review of an internal adverse determination that is based on a determination that a claimant fails to meet the eligibility requirements under the terms of the Plan. Also, the federal external review process is available only for:

(1) An adverse determination that involves medical judgment (including, but not limited to determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the Plan's determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and

(2) A rescission of coverage; and

(3) An adverse determination for Surprise Bills (medical and air ambulance bills), including determination of whether an adverse determination is subject to Surprise Bill provisions.

For any adverse determination for which external review is available, the federal external review requirements are as follows:

(1) You have 4 months following the date you receive notice of the Plan's final internal adverse determination within which to request an external review. The request for an external review must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P.O. Box 660908
Dallas, TX 75266-0908

(2) Within 5 business days following the date the Plan receives your external review request the Plan will complete a preliminary review. The Plan will notify you in writing within one business day after it completes the preliminary review whether the claim is eligible for the external review process:

(a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the U.S. Department of Health and Human Services Health Insurance Assistance Team (HIAT).

(b) If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

(3) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) (as soon as administratively feasible) to make a determination on the request for external review. Within 5 business days following assignment of the IRO, the Plan will forward to the IRO all information and materials relevant to the final internal adverse determination.

(4) The assigned IRO will notify you in writing (within a reasonable period of time) of the request's eligibility and acceptance for external review. The notice will include a statement regarding your right to submit any additional information, within 10 business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information received by the IRO will be forwarded on and shared with the Plan. The Plan, based upon any new information received, may reconsider its final internal adverse determination. Reconsideration by the Plan will not delay the external review process. If the Plan does not reconsider its final internal adverse benefits determination, the IRO will continue to proceed with the external review process.

(5) Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to you and the Plan. The IRO's notice is required to contain the following:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;

(f) A statement that judicial review may be available to you; and

(g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Expedited External Review
You may request an expedited external review if you have received:

(1) An initial internal adverse determination if the adverse determination involves a medical condition for which the time frame for completion of an expedited internal appeal under the Plan's internal claim procedures would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(2) A final internal adverse determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or if the final internal adverse determination concerns an admission, availability of care, continued stay or health care item or service for which you received Emergency Services but have not been discharged from a facility.

The following requirements apply to an expedited external review:

(1) Immediately following the date the Plan receives the external review request the Plan will complete a preliminary review. The Plan will notify you in writing immediately after completion of the preliminary review whether the request is eligible for the external review process.

(a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will include contact information for the Employee Benefits Security Administration.

(b) If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

(2) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) to make a determination on the request for external review. The Plan will promptly forward to the IRO, by any available expeditious method (e.g., telephone, facsimile, etc.), all information and materials relevant to the final internal adverse determination.

(3) The IRO must provide notice to the claimant and the Plan (either in writing or orally) as expeditiously as the claimant's medical condition or circumstance require and no later than 72 hours after it receives the expedited external review request from the Plan. If notice is not provided in writing, the IRO must provide written notice to you and the Plan as confirmation of the decision within 48 hours after the date of the notice. The IRO's notice is required to contain the following information:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;

(f) A statement that judicial review may be available to you; and

(g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Effect of External Review Determination
A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable state or federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

State Insurance Laws
Nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable state law.

Statute of Limitations for Plan Claims
Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

Appointment of Authorized Representative
A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Third Party Administrator. However, in connection with a claim involving urgent care or services rendered by a Participating Provider, the Plan will permit a health care professional with knowledge of the Covered Person’s medical condition to act as the Covered Person’s authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

Physical Examinations
The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition for coverage.

COORDINATION OF BENEFITS

Benefits Subject to This Provision
This provision applies to all benefits provided under any section of this Plan.

Excess Insurance
If at the time of Injury, Illness, disease, or disability there is available or potentially available, any coverage (including, but not limited to, coverage resulting from a judgment at law or settlements), the benefits under the Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

(1) Any primary payer besides the Plan;

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(3) Any policy of insurance from any insurance company or guarantor of a third-party;

(4) Workers' Compensation or other liability insurance company; or

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Vehicle Limitation
When medical payments are available (or, under applicable law should be available) under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title, or classification. If medical payments would have been available under a vehicle insurance policy if minimum legally required levels of coverage had been in effect, but the minimum level of coverage was not in effect, the Plan shall pay excess benefits only, determined as if the minimum legally required level of coverage had been in effect at the applicable time.

Allowable Expenses
"Allowable expenses" shall mean any Medically Necessary item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered in the amount that would be payable in accordance with the terms of the Plan shall be deemed to be the benefit.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as allowable expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

Other Plan
"Other Plan" means any of the following plans, other than this Plan, providing benefits or services for medical or dental care or treatment:

(1) Group, blanket, or franchise insurance coverage;

(2) Any group Hospital service prepayment, group medical or dental service prepayment, group practice or other group prepayment coverage;

(3) Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, school insurance or employee benefit organization plans;

(4) Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;

(5) Coverage under any Health Maintenance Organization (HMO); or

(6) Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of Injuries arising out of a motor vehicle accident and any other medical and liability benefits received under any automobile policy.

Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled “Order of Benefit Determination” will pay as if there were no other plan involved. When this Plan is secondary, this Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. When there is a conflict in the order of benefit determination, this Plan will never pay more than 50% of allowable expenses.

Order of Benefit Determination
For the purposes of the section entitled “Application to Benefit Determinations,” the rules establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim:

(1) A plan without a coordinating provision will always be the primary plan.

(2) The plan covering the person directly rather than as an employee's dependent is primary and the other plans are secondary.

(3) Active/laid-off employees or retirees: The plan which covers a person as an active employee (or as that employee’s dependent) determines its benefits before the plan which covers a person as a laid-off or retired employee (or as that employee’s dependent). If the plan which covers that person has not adopted this rule and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

(4) Dependent Children of parents not separated or divorced or unmarried parents living together: The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent 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.

(5) Dependent Children of separated or divorced parents or unmarried parents not living together: When parents are separated or divorced or unmarried and not living together, neither the male/female nor the birthday rules apply. Instead:

(a) The plan of the parent with custody pays first;

(b) The plan of the spouse of the parent with custody (the step-parent) pays next;

(c) The plan of the parent without custody pays next; and

(d) The plan of the spouse of the non-custodial parent pays last.

Notwithstanding the above provisions, if there is a court decree that would otherwise establish financial responsibility for the Child’s health care expenses, the benefits of the plan that covers the Child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent child.

(6) If a person whose coverage is provided under a right of continuation pursuant to state or federal law (e.g., COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information
For the purpose of determining the applicability of and implementing the terms of this coordination of benefits provision or any provision of similar purpose of any other plan, this Plan may, without notice to any person, release to, or obtain

from any insurance company or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan is deemed to consent to the release and receipt of such information and agrees to furnish to the Plan such information as may be necessary to implement this provision.

Facility of Payment
Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of Recovery
Whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this Plan.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations, or exclusions or should otherwise not have been paid by the Plan. This Plan may also inadvertently pay benefits that are later found to be greater than the maximum allowable charge. In this case, this Plan may recover the amount of the overpayment from the person or entity to which it was paid, primary payers or from the party on whose behalf the charge(s) were paid. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment.

A Covered Person, provider, another benefit plan, insurer or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have discretion in deciding whether to obtain payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for any other Injury or Illness) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for any other Injury or Illness) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, most recent edition of the ICD or CPT standards, Medicare guidelines, HCPCS standards or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, a Covered Person and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns ("Plan Participants") shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s) or damages arising from another party's act or omission for which the Plan has not already been reimbursed.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

(1) In error;

(2) Pursuant to a misstatement contained in a proof of loss or a fraudulent act;

(3) Pursuant to a misstatement made to obtain coverage under this Plan within 2 years after the date such coverage commences;

(4) With respect to an ineligible person;

(5) In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Subrogation, Third Party Recovery and Reimbursement provisions; or

(6) Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Covered Person if such payment is made with respect to the Covered Person.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

Medicaid Coverage
You or your Dependent's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of you or your Dependent. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of such person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

Coordination of Benefits with Medicaid
In all cases, benefits available through a state or federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

Coordination of Benefits with Medicare
When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare.

When you, your Spouse or Dependents (as applicable) are eligible for or entitled to Medicare and covered by the Plan, the Plan at all times will be operated in accordance with any applicable Medicare secondary payer and non-discrimination rules. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end stage renal disease, rules concerning active employees age 65 or over and rules concerning working disabled individuals (as discussed below).

In accordance with federal law, the following rules apply in determining whether Medicare or Plan coverage is primary health care coverage:

(1) The Working Aged Rule: Medicare benefits are secondary to benefits payable under the Plan for individuals entitled to Medicare due to being age 65 or over and who have Plan coverage as a result of his or her current employment status (or the current employment status of a Spouse). When you or your Spouse become eligible for Medicare due to the attainment of age 65, you or your Spouse may still be eligible for benefits provided under the Plan based on your current employment status.

If, as a result, you have or your Spouse has primary coverage under the Plan, the Plan will pay the portion of your Incurred expenses that are normally covered by the Plan. All or part of the remaining amount, if any, may be paid by Medicare if the expenses are covered expenses under Medicare and the portion of the expenses covered by Medicare exceeds the portion covered by the Plan. If the expenses are not covered by the Plan but are Medicare-covered expenses, then Medicare will process its payment of the expenses as if you do not have Plan coverage.

(2) The Working Disabled Rule: Medicare benefits are secondary to benefits payable under the Plan for covered individuals under age 65 entitled to Medicare on the basis of disability (other than end-stage renal disease) and who are covered under the Plan as a result of current employment status with an employer. That is, if you or your Dependents are covered by the Plan based on your current employment status, Medicare benefits are secondary for you or your covered Dependents entitled to Medicare on the basis of disability (other than end-stage renal disease). In this case the Plan is primary.

(3) End-Stage Renal Disease Rule: Medicare benefits are secondary to benefits payable under the Plan for covered individuals eligible for or entitled to Medicare benefits on the basis of end-stage renal disease ("ESRD"), for a period not to exceed 30 months generally beginning the first day of the month of eligibility or entitlement to Medicare due to ESRD. (Special rules apply if you were entitled to Medicare based on age or disability prior to becoming eligible for Medicare due to ESRD.) Because an ESRD patient can have up to a 3-month wait to obtain Medicare coverage, the Plan's primary payment responsibility may vary up to 3 months. If the basis of your entitlement to Medicare changes from ESRD to age or disability, the Plan's primary payment responsibility may terminate on the month before the month in which the change is effective and the rules set forth above, if applicable, will apply. Your Employer can provide you with more detailed information on how this rule works.

Medicare and COBRA
For most COBRA beneficiaries (e.g., the working aged or disabled Medicare beneficiaries), Medicare rules state that Medicare will be primary to COBRA continuation coverage and this would apply to this Plan’s Continuation of Benefits (COBRA) coverage. For an ESRD-related Medicare beneficiary, COBRA continuation coverage (if elected) is generally primary to Medicare during the 30-month coordination period.

Coordination of Benefits with TRICARE
The Plan at all times will be operated in accordance with any applicable TRICARE secondary payer and non-discrimination rules issued by the Department of Defense.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Payment Condition

(1) The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of you and/or your Dependents, plan beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other insurance or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

(2) The Covered Person, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

(3) In the event a Covered Person settles, recovers, or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

(4) If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

Subrogation

(1) As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation, or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person fails to so pursue such rights or action.

(2) If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

(3) The Plan may, at its discretion, in its own name or in the name of the Covered Person, commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

(4) The Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Persons and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims if the Covered Person fails to file a claim or pursue damages against:

(a) The responsible party, its insurer, or any other source on behalf of that party;

(b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(c) Any policy of insurance from any insurance company or guarantor of a third party;

(d) Workers' Compensation or other liability insurance company; or

(e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

(1) The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

(2) No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

(3) The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

(4) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

(5) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, disease, or disability.

Covered Person is a Trustee Over Plan Assets

(1) Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Covered Person understands that he/she is required to:

(a) Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

(b) Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

(c) In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment, or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

(d) Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

(2) To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

(3) No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance
If at the time of Injury, Illness, disease or disability, there is available or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under the Plan's "Coordination of Benefits" section.

The Plan's benefits shall be excess to any of the following:

(1) The responsible party, its insurer, or any other source on behalf of that party;

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(3) Any policy of insurance from any insurance company or guarantor of a third party;

(4) Workers' Compensation or other liability insurance company; or

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Separation of Funds
Benefits paid by the Plan, funds recovered by the Covered Person and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person or filing of bankruptcy by the Covered Person, will not affect the Plan's equitable lien, the funds over which the Plan has a lien or the Plan's right to subrogation and reimbursement.

Wrongful Death
In the event that the Covered Person dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

Obligations
(1) It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Plan:

(a) To cooperate with the Plan or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and cooperating in trial to preserve the Plan's rights;

(b) To provide the Plan with pertinent information regarding the Illness, disease, disability, or Injury, including Accident reports, settlement information and any other requested additional information;

(c) To take such action and execute such documents as the Plan may require facilitating enforcement of its subrogation and reimbursement rights;

(d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;

(e) To promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received;

(f) To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;

(g) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or coverage;

(h) To instruct his/her attorney to ensure that the Plan or its authorized representative is included as a payee on any settlement draft;

(i) In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and

(j) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

(2) If the Covered Person and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

(3) The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Persons' cooperation or adherence to these terms.

Offset
If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status
(1) In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

(2) If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation
The Plan Sponsor retains sole, full, and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation and reimbursement rights.

Severability
In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan's right to subrogation and reimbursement may be subject to applicable state subrogation laws.

DEFINITIONS

In this section you will find the definitions for the capitalized words found throughout this Plan. There may be additional words or terms that have a meaning that pertains to a specific section and those definitions will be found in that section provided, however, that any such capitalized word shall have such meaning when used in any other section. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan. Please refer to the appropriate sections of this Plan for that information.

Accident means a non-occupational sudden and unforeseen event, definite as to time and place or a deliberate act resulting in unforeseen consequences.

Ambulatory Surgical Center means a free-standing surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures; (3) has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located; and (5) does not provide for overnight accommodations.

Assistant Surgeon means a Physician who actively assists the Physician in charge of a case in performing a Surgical Procedure. Depending on the type of Surgery to be performed, an operating surgeon may have one Assistant Surgeon, or 2 Assistant Surgeons if Medically Necessary. The technical aspects of the Surgery involved dictate the need for an Assistant Surgeon.

Birthing Center means a place licensed as such by an agency of the state. If the state does not have any licensing requirements, it must meet all of the following tests: (1) is primarily engaged in providing birthing services for low risk pregnancies; (2) is operated under the supervision of a Physician; (3) has at least one registered nurse (R.N.) certified as a nurse midwife in attendance at all times; (4) has a written agreement with a licensed ambulance for that service to provide immediate transportation of the Covered Person to a Hospital as defined herein if an emergency arises; and (5) has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

Calendar Year means January 1 – December 31.

Close Relative means a Covered Person's spouse, parent (including step-parents), sibling, child, grandparent, or in-law.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time.

Coinsurance has the same meaning as set forth in the section of this Plan entitled "General Overview of the Plan".

Congenital Anomaly means a physical developmental defect that is present at birth.

Copay has the same meaning as set forth in the section of this Plan entitled "General Overview of the Plan".

Cosmetic means any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease.

Covered Expense means:

(1) An item or service listed in the Plan as an eligible medical expense for which the Plan provides coverage.

(2) For Prescription Drug expenses, any Prescription Drugs, or medicines eligible for coverage under the Prescription Drug Card Program.

Covered Person means, individually, a covered Employee and each of his or her Dependents who are covered under the Plan.

Custodial Care means care, or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Dentist means an individual who is duly licensed to practice dentistry or to perform oral surgery in the state where the service is performed and is operating within the scope of such license. A Physician will be considered a Dentist when performing any covered dental services allowed within such license.

Dependent is a Covered Person, other than the Employee**,** who is covered by the Plan pursuant to the terms and conditions set forth in the "Eligibility for Participation" section of the Plan.

Durable Medical Equipment means equipment that:

(1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of an Illness or Injury; and

(4) Is appropriate for use in the home.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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 individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) Serious impairment to bodily functions; or

(3) Serious dysfunction of any bodily organ or part.

Emergency Services means treatment given in a Hospital’s emergency room for an Emergency Medical Condition. This includes evaluation of, and treatment to Stabilize an Emergency Medical Condition.

Employee is defined in the "Eligibility for Participation" section of the Plan.

Employer means the McDuffie County Board of Commissioners, or any successor thereto.

Experimental and/or Investigational means services, supplies, care, and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Plan Administrator as set forth below.

The Plan Administrator must make an independent evaluation of the Experimental or non-Experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. In addition to the above, the Plan Administrator will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental and/or Investigational:

(1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental and/or Investigational; or

(2) If the drug, device, medical treatment or procedure or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed, and approved by the treating facility's Institutional Review

Board or other body serving a similar function or if federal law requires such review or approval, then it is deemed to be Experimental and/or Investigational; or

(3) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials or is the subject of the research, Experimental, study, Investigational or other arm of on-going Phase III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational; or

(4) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the FDA for general use.

Expenses for drugs, devices, services, medical treatments, or procedures related to an Experimental and/or Investigational treatment (related services) and complications from an Experimental and/or Investigational treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental and/or Investigational treatment.

Final determination of Experimental and/or Investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment, or procedure is covered under the Plan will be made by and in the sole discretion of the Plan Administrator.

FMLA means the Family and Medical Leave Act of 1993, as may be amended from time to time.

Full-Time Employee is defined in the "Eligibility for Participation" section of the Plan.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from the individual or a family member. This 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. Genetic Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility) and (2) establishing contribution or premium accounts for coverage under the Plan.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended from time to time.

Home Health Care Agency means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions, it: (1) is duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; (2) qualifies as a Home Health Care Agency under Medicare; (3) meets the standards of the area-wide healthcare planning agency; (4) provides skilled nursing services and other services on a visiting basis in the patient's home; (5) is responsible for administering a home health care program; and (6) supervises the delivery of a home health care program where the services are prescribed and approved in writing by the patient's attending Physician.

Hospice means an agency that provides counseling and incidental medical services and may provide room and board to terminally ill individuals and which meets all of the following requirements: (1) has obtained any required state or governmental Certificate of Need approval; (2) provides 24-hour-a-day, 7 days-a-week service; (3) is under the direct supervision of a duly qualified Physician; (4) has a nurse coordinator who is a registered nurse (R.N.) with 4 years of full-time clinical experience, at least 2 of which involved caring for terminally ill patients; (5) has a social-service coordinator who is licensed in the jurisdiction in which it is located; (6) is an agency that has as its primary purpose the provision of hospice services; (7) has a full-time administrator; (8) maintains written records of services provided to the patient; (9) the employees are bonded and it provides malpractice and malplacement insurance; (10) is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; (11) provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist or a certified respiratory therapist; and (12) provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

Hospital means a facility which: (1) is licensed as a Hospital where licensing is required; (2) is open at all times; (3) is operated mainly to diagnose and treat Illnesses or Injuries on an Inpatient basis; (4) has a staff of one or more Physicians on call at all times; (5) has 24-hour-a-day nursing services by registered nurses (R.N.'s); and (6) has organized facilities for major Surgery.

However, an institution specializing in the care and treatment of Mental Disorders or Substance Use Disorders which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, a Skilled Nursing Facility, a convalescent home, or a similar institution.

Hour(s) of Service mean each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer (or a related Employer) and each hour for which an Employee is paid, or entitled to payment by the Employer (or a related Employer) for a period of time during which no duties are performed due to vacation, holiday, Illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence, but excluding Hours of Service to the extent that the compensation for those services constitutes income from sources outside the United States or performed as (1) a bona fide volunteer (as defined in Treas. Reg. Section 54.4980H-1(a)(7)) or (2) part of a federal or state work study program. For purposes of this definition, a related Employer is any entity that must be treated as part of the same “applicable large employer” as the Employer for purposes of Code Section 4980H, as determined at the time that the applicable Hour of Service is performed or credited.

For Employees paid on an hourly basis, an Employer must calculate actual Hours of Service from records of hours worked and hours for which payment is made or due (the “actual method”). For Employees paid on a non-hourly basis, the Employer must calculate Hours of Service based on the actual method or, provided doing so does not substantially understate the Employee’s hours, using an equivalency method where the Employee is credited with either: (1) 8 Hours of Service for each day for which the Employee would be required to be credited with one Hour of Service; or (2) 40 Hours of Service for each week for which the Employee would be required to be credited with at least one Hour of Service.

Illness means a non-occupational bodily disorder, disease, physical sickness, pregnancy (including childbirth and miscarriage), Mental Disorder or Substance Use Disorder.

Incurred means the date the service is rendered, or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Injury means physical damage to the body, caused by an external force and which is due directly and independently of all other causes, to an Accident.

Inpatient means any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for room and board is made by the Hospital.

Intensive Care Unit means 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: (1) facilities for special nursing care not available in regular rooms and wards of the Hospital; (2) special lifesaving equipment which is immediately available at all times; (3) at least 2 beds for the accommodation of the critically ill; and (4) at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 31-day eligibility period. A Special Enrollee is not considered a Late Enrollee.

Legal Guardian is defined in the "Eligibility for Participation" section of the Plan.

Lifetime Maximum means the maximum benefit payable during an individual's lifetime while covered under this Plan. Benefits are available only when an individual is eligible for coverage under this Plan. The Plan may provide for a Lifetime Maximum benefit for specific types of medical treatment. Any Lifetime Maximum will be shown in the applicable Schedule of Benefits.

Long-Term Acute Care Facility/Hospital (LTACH) means a facility that provides specialized acute care for medically complex patients who are critically ill; have multi-system complications and/or failures and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour-a-day, 7 days a week basis. The severity of the LTACH patient’s condition requires a Hospital stay that provides: (1) interactive Physician direction with daily on-site assessment; (2) significant ancillary services as dictated by complex, acute medical needs - such as full service and laboratory, radiology, respiratory care services, etc.; (3) a patient-centered outcome-focused, interdisciplinary approach requiring a Physician-directed professional team that includes intensive case management to move the patient efficiently through the continuum of care; (4) clinically competent care providers with advanced assessment and intervention skills; and (5) education for the patient and family to manage their present and future healthcare needs.

Maintenance Therapy means medical and non-medical health-related services that do not seek to cure or that are provided during periods when the medical condition of the patient is not changing or does not require continued administration by medical personnel.

Medically Necessary/Medical Necessity means treatment is generally accepted by medical professionals in the United States as proven, effective, and appropriate for the condition based on recognized standards of the health care specialty involved.

(1) "Proven" means the care is not considered Experimental and/or Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA) for general use.

(2) “Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, Injury, Illness, or a clinical condition.

(3) "Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Plan.

All criteria must be satisfied. When a Physician recommends or approves certain care it does not mean that care is Medically Necessary.

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

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

Morbid Obesity is defined as (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, or musculoskeletal dysfunction.

Non-Participating Provider means a health care practitioner or health care facility that has not contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Orthodontic Treatment means the corrective movement of teeth to treat a handicapping malocclusion of the mouth.

Out-of-Pocket Maximum has the same meaning as set forth in the section of this Plan entitled “General Overview of the Plan”.

Participating Provider means a health care practitioner or health care facility that has contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Physician means a legally licensed Physician who is acting within the scope of their license and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Nurse Practitioner, Physician’s Assistant, Speech Therapist, Speech Pathologist and Licensed Midwife (if covered by the Plan). An employee of a Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan.

Plan means the McDuffie County Board of Commissioners Employee Benefit Plan.

Plan Administrator means the administrator of the Plan.

Plan Sponsor means McDuffie County Board of Commissioners or any successor thereto.

Plan Year means the period from July 1 - June 30 each year.

Prescription Drug is defined in the "Prescription Drug Card Program" section of the Plan.

Preventive Maintenance Drug is defined in the "Prescription Drug Card Program" section of the Plan.

Primary Care Physician (PCP) means a licensed Physician practicing in one of the following fields: (1) family practice; (2) general practice; (3) internal medicine; (4) obstetrics and gynecology; or (5) pediatrics.

Qualified Clinical Trial means a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening condition and is described in (1), (2) or (3) below:

(1) The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

   (a) The National Institutes of Health;

   (b) The Centers for Disease Control and Prevention;

   (c) The Agency for Health Care Research and Quality;

   (d) The Centers for Medicare & Medicaid Services;

   (e) A cooperative group or center of one of the entities described in (a) through (d) above;

   (f) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants; or

(g) The Department of Veteran Affairs; the Department of Defense or the Department of Energy, if (i) the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Reconstructive Surgery means Surgery that is incidental to an Injury, Illness or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such Surgery as Cosmetic when a physical impairment exists, and the Surgery restores or improves function. Additionally, the fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Illness or Congenital Anomaly does not classify Surgery to relieve such consequences or behavior as Reconstructive Surgery.

Rehabilitation Facility means a facility must meet all of the following requirements: (1) must be for the treatment of acute Injury or Illness; (2) is licensed as an acute Rehabilitation Facility; (3) the care is under the direct supervision of a Physician; (4) services are Medically Necessary; (5) services are specific to an active written treatment plan; (6) the patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care; (7) nursing services are available 24 hours a day; and (8) the confinement is not for Custodial Care or maintenance care.

Residential Treatment Facility means a facility that provides 24-hour treatment for Mental Disorders or Substance Use Disorders on an Inpatient basis. It must provide at least the following: room and board; medical services; nursing and dietary services; patient diagnosis, assessment, and treatment; individual, family and group counseling; and educational and support services. A Residential Treatment Facility is recognized if it is accredited for its stated purpose by the Joint Commission and carries out its stated purpose in compliance with all relevant state and local laws.

Retail Clinic means a health care treatment facility, located in a retail store, that is often staffed by nurse practitioners and physician assistants who provide minor medical services on a “walk-in” basis (no appointments required).

Seasonal Employee means an Employee who is hired into a position that recurs annually at about the same time each year for which the customary annual employment is 6 months or less.

Security Standards mean the final rule implementing HIPAA’s Security Standards for the Protection of Electronic PHI, as amended.

Semi-Private Room means a Hospital room shared by 2 or more patients.

Skilled Nursing Facility is a facility that meets all of the following requirements:

(1) It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Illness. 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) Its 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, developmentally disabled, Custodial, or educational 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 Enrollee is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 31-day eligibility period and who later enrolls in the Plan due to a Special Enrollment Event.

Specialist means a licensed Physician that provides services to a Covered Person within the range of their specialty (e.g., cardiologist, neurologist, etc.).

Specialty Drug is defined in the "Prescription Drug Card Program" section of the Plan.

Spouse is defined in the "Eligibility for Participation" section of the Plan.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment for the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or with respect to an Emergency Medical Condition of a pregnant woman who is having contractions (1) there is adequate time to effect a safe transfer to another Hospital before delivery; and (2) transfer will not pose a threat to the health or safety of the woman or her unborn child to deliver (including the placenta).

Substance Use Disorder means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

Surgery or **Surgical Procedure** means any of the following:

(1) The incision, excision, debridement or cauterization of any organ or part of the body and the suturing of a wound;

(2) The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;

(3) The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;

(4) The induction of artificial pneumothorax and the injection of sclerosing solutions;

(5) Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;

(6) Obstetrical delivery and dilation and curettage; or

(7) Biopsy.

Surprise Bill/Surprise Billing happens when people unknowingly get care from providers that are outside of their health Plan's Network and can happen for both emergency and non-emergency care.

Third Party Administrator means Meritain Health, Inc., P.O. Box 853921, Richardson, TX 75085-3921.

Urgent Care Facility means a facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as may be amended from time to time.

Usual and Customary Charge (U&C) means, with respect to Non-Participating Providers, charges made for medical or dental services or supplies essential to the care of the individual that will be subject to a Usual and Customary

determination. Subject to the rest of this definition, the Usual and Customary Charge means the lesser of the charge by other providers in the same geographic area or billed charges for the same or comparable service or supply. From time to time, the Plan may enter into an agreement with a Non-Participating Provider (directly or indirectly through a third party) which sets the rate the Plan will pay for a service or supply. In these cases the Usual and Customary Charge will be the rate established in such agreement with the Non-Participating Provider.

The Plan may reduce the Usual and Customary Charge by applying reimbursement policies administered by the Plan's Third Party Administrator. These reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

(1) The duration and complexity of a service;

(2) Whether multiple procedures are billed at the same time, but no additional overhead is required;

(3) Whether an Assistant Surgeon is involved and necessary for the service;

(4) If follow up care is included;

(5) Whether there are any other characteristics that may modify or make a particular service unique; and

(6) When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

The reimbursement policies utilized are based on review of the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which are otherwise consistent with Physician or dental specialty society recommendations; and the views of Physicians and Dentists practicing in the relevant clinical areas.

The Usual and Customary Charge for covered services will be based on the median contract rate when a Covered Person had no control over the services performed by a Non-Participating Provider who is under agreement with a Network facility or when the Covered Person seeks Emergency Services for an Emergency Medical Condition from a Non-Participating Provider.

PLAN ADMINISTRATION

Delegation of Responsibility
The Plan Sponsor is a named fiduciary of the Plan with full discretionary authority for the control and management of the operation and administration of the Plan. The Plan Sponsor may delegate fiduciary and other responsibilities to any individual or entity. Any person to whom any responsibility is delegated may serve in more than one fiduciary capacity with respect to the Plan and may be a participant in the Plan.

Authority to Make Decisions
The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to you and/or your Dependent's rights and to decide questions of Plan interpretation and those of fact and law relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that you and/or your Dependent (as applicable) are entitled to them.

The duties of the Plan Administrator include the following:

(1) To administer the Plan in accordance with its terms;

(2) To determine all questions of eligibility, status, and coverage under the Plan;

(3) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;

(4) To make factual findings;

(5) To decide disputes which may arise relative to a Covered Person's rights;

(6) To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials; or, alternatively, to appoint a qualified administrator to carry out these functions on the Plan Administrator's behalf;

(7) To keep and maintain the Plan documents and all other records pertaining to the Plan;

(8) To appoint and supervise a Third Party Administrator to pay claims;

(9) To perform all necessary reporting as required by federal or state law;

(10) To establish and communicate procedures to determine whether a child support order or decree is a QMCSO;

(11) To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and

(12) To perform each and every function necessary for or related to the Plan's administration.

Amendment or Termination of Plan
The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

MISCELLANEOUS INFORMATION

Assignment of Benefits
No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements, or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an alternate recipient, in the manner described in the Plan's QMCSO procedures.

Clerical Error
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to you and/or your Dependents have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity with Applicable Laws
This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions, or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of Plan. It is intended that the Plan will conform to the requirements of any applicable federal or state law.

Cost of the Plan
The Plan Sponsor is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan, including, but not limited to, payment of Plan expenses from Trust. If applicable, a biometric evaluation to determine health risk factors associated with a wellness program will be paid from the Trust. The amount of contribution (if any) for your coverage or coverage for your Dependents will be determined from time to time by the Plan Sponsor, in its sole discretion.

Interpretation of this Document
The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Plan are used for convenience of reference only. You and your Dependents are advised not to rely on any provision because of the heading.

The use of the words, “you” and “your” throughout this Plan applies to eligible or covered Employees and, where appropriate in context, their covered Dependents.

Minimum Essential Coverage
Refer to the Employer’s Summary of Benefits and Coverage (SBC) for determination as to whether the Plan provides “minimum essential coverage” within the meaning of Code Section 5000A(f) and any accompanying regulations or guidance and whether it provides “minimum value” within the meaning of Code Section 36B(c)(2)(C)(ii) and any accompanying regulations or guidance (e.g., the Plan provides at least 60% actuarial value).

No Contract of Employment
This Plan and any amendments constitute the terms and provisions of coverage under this Plan. The Plan shall not be deemed to constitute a contract of any type between the Employer and any person or to be consideration for or an inducement or condition of the employment of any Employee. Nothing in this Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

Release of Information
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release, or obtain any information necessary to determine the acceptability of any applicant or person covered for benefits under this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the applicable privacy standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Workers' Compensation
This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any Workers' Compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that you received or are eligible to receive Workers' Compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement you receive from Workers' Compensation. The Plan will exercise its right to recover against you. The Plan reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

(1) The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

(2) No final determination is made that the Injury or Illness was sustained in the course of or resulted from your employment;

(3) The amount of Workers' Compensation benefits due specifically to health care expense is not agreed upon or defined by you or the Workers' Compensation carrier; or

(4) The health care expense is specifically excluded from the Workers' Compensation settlement or compromise.

You are required to notify the Plan Administrator immediately when you file a claim for coverage under Workers' Compensation if a claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so or to reimburse the Plan for any expenses it has paid for which coverage is available through Workers' Compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

HIPAA PRIVACY PRACTICES

The following is a description of certain rules that apply to the Plan Sponsor regarding uses and disclosures of your health information.

Disclosure of Summary Health Information to the Plan Sponsor
In accordance with HIPAA's standards for privacy of individually identifiable health information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

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

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

"Summary health information" is information, which may include individually identifiable health information, that summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but that excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by 5-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes
Except as described under "Disclosure of Summary Health Information to the Plan Sponsor" above or under "Disclosure of Certain Enrollment Information to the Plan Sponsor" below or under the terms of an applicable individual authorization, the Plan may disclose PHI to the Plan Sponsor and may permit the disclosure of PHI by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the PHI to administer the Plan. The Plan Sponsor by formally adopting this Plan document certifies that it agrees to:

(1) Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;

(2) Ensure that any agents, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

(5) Make available PHI in accordance with section 164.524 of the privacy standards;

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards;

(7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards;

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services ("HHS"), for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards;

(9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards, is established as follows:

(a) The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. The Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.

(b) In the event any of the individuals described in (a) above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan administration" functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

(1) The Plan documents have been amended to incorporate the above provisions; and

(2) The Plan Sponsor agrees to comply with such provisions.

Disclosure of Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the privacy standards, the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered under the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage; Disclosures of Genetic Information
Except as otherwise provided below, the Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

The Plan will not use or disclose Genetic Information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include Genetic Information.

"Underwriting purposes" is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); and (3) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, "underwriting purposes" does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

In accordance with HIPAA's standards for security (the "Security Standards"), to enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

(1) Implement and maintain administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

(2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.

(3) Ensure that any agent, including any business associate or subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI.

(4) Report to the Plan any security incident of which it becomes aware.

(5) The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

GENERAL PLAN INFORMATION

Name of Plan:	McDuffie County Board of Commissioners Employee Benefit Plan
Plan Sponsor: **(Named Fiduciary)**	McDuffie County Board of Commissioners 210 Railroad Street Thomson, GA 30824 (706) 595-2101
Plan Administrator:	McDuffie County Board of Commissioners 210 Railroad Street Thomson, GA 30824 (706) 595-2101
Plan Sponsor EIN:	58-6002987
Plan Year:	July 1 - June 30
Meritain Health, Inc. Group Number:	20334
Plan Type:	Welfare benefit plan providing medical and Prescription Drug benefits.
Plan Funding	All benefits are paid out of the McDuffie County Board of Commissioners Health Benefit Trust, which is funded from the Employer's general assets.
Contributions:	The cost of coverage under the Plan is funded in part from McDuffie County Board of Commissioners Health Benefit Trust and in part by Employee contributions.
Third Party Administrator:	Meritain Health, Inc. P.O. Box 853921 Richardson, TX 75085-3921 (800) 925-2272
COBRA Administrator:	Flores Associates COBRA 1218 S Church Street Charlotte, NC 28203 (704) 335-8211
Medical Management Program Administrator:	Meritain Health Medical Management 7400 West Campus Road, F-510 New Albany, OH 43054-8725 (800) 242-1199
Teladoc Program Administrator:	Teladoc, Inc. 1945 Lakepointe Drive Lewisville, TX 75057 (800) 835-2362 www.teladoc.com
Prescription Drug Card Program Administrator:	Scrip World, LLC/CVS Caremark (866) 475-7589 www.caremark.com

Agent for Service of Legal Process:	McDuffie County Board of Commissioners 210 Railroad Street Thomson, GA 30824 (706) 595-2101
Trust	The Health Benefit Trust is managed and held by: UMB Bank, N.A. 1010 Grand Boulevard Kansas City, MO 64103

The Plan is a legal entity. Legal notice may be filed with and legal process served upon, the Plan Administrator.

MERITAIN HEALTH, INC.
ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement (this "**Agreement**"), effective as of **July 01, 2023** (the "**Effective Date**"), is by and between **Meritain Health, Inc**., (including any of its affiliates performing Services hereunder) having its principal office at **300 Corporate Parkway, Amherst, New York 14226** ("**Meritain**") and **McDuffie County Board of Commissioners** having its principal office at **210 Railroad Street, Thomson, GA 30824** ("**Client**"). This Agreement applies to services to be provided by Meritain to Client in connection with Client's self-funded employee welfare benefit plan(s) formally known as: **McDuffie County Board of Commissioners Employee Benefit Plan** (the "**Plan**"). In consideration of the mutual covenants and promises stated herein, and other good and valuable consideration, the receipt and sufficiency of which are acknowledged by each party, the parties agree as follows:

1. **DEFINITIONS.**

The following words and phrases have the meanings set forth below:

a. **Applicable Law** means any laws, codes, legislative acts and regulations, including but not limited to the Employee Retirement Income Security Act, as amended ("**ERISA**") and the Health Insurance Portability and Accountability Act, as amended ("**HIPAA**"), (collectively the "**Applicable Laws**") to the extent applicable to a party's performance under this Agreement (and in the case of Client, applicable to the Plan).

b. **Claim** means a request by any person or entity for payment or reimbursement for Covered Services.

c. **Claims Payment Account** means an account established, owned and funded by Client for payment or reimbursement of Covered Services, which account constitutes an asset of Client and not the Plan.

d. **Covered Services** means the medical care, treatments, services or supplies described in the Plan Document as eligible for payment or reimbursement under the terms of the Plan. Covered Services may include at Client's request, but are not limited to, utilization review services (including pre-admission certification, second surgical opinion, concurrent review and discharge planning) and case management services (including those related to transplants, premature births, spinal cord injuries, multiple trauma, chemotherapy claims, medical appropriateness, end stage cancer patients, AIDS and large claims over $50,000 in the aggregate per year).

e. **Participant** means any person who is eligible, properly enrolled and entitled to benefits under the terms of the Plan.

f. **Plan Document(s)** means the instrument(s), including the Summary Plan Description, if applicable, that set forth and govern the duties of Client, as the designated Plan Administrator, as well as the eligibility and benefit provisions that provide for the payment or reimbursement of Covered Services.

g. **Provider** means a preferred provider network, physician, dentist, pharmacy, hospital, laboratory or other medical practitioner, or medical care facility, or a vendor of supplies or services, who or which is authorized to receive payment or reimbursement for Covered Services under the terms of the Plan.

h. **Summary Plan Description ("SPD")** means the written materials that describe the terms and conditions under which the Plan operates, including without limitation coverage limits and procedures of the Plan (as described in Section 102 of ERISA if applicable).

2. **SERVICES.**

a. Scope of Services. Meritain shall provide only those services expressly described in the attached schedules (the "**Services**"), which are incorporated herein. Meritain's obligations apply only to Claims

incurred on or after the Effective Date and prior to the date this Agreement terminates or expires in accordance with its terms (the "**Termination Date**"). In its performance of the Services, Meritain shall be entitled to rely, without investigation or inquiry, upon any written or oral information or communication of Client, its agents or its third-party medical management vendor or third-party pharmacy benefits manager, if any.

b. Subcontractors. Any of the Services may, at Meritain's discretion, be performed directly by it or wholly or in part through an affiliate of Meritain, or by another entity with which Meritain has an arrangement.

c. Suspension of Services. If Client fails to pay Fees (as hereinafter defined) when due or fund its Claims Payment Account as required under Section 7.c. of this Agreement, in addition to any other remedies under this Agreement, at law or in equity, Meritain shall have the right to suspend Services including without limitation the processing of Claims until the Fees have been paid or the Claims Payment Account has been funded in accordance with Section 7.c. of this Agreement.

d. Exclusivity. Meritain shall be the sole and exclusive provider to Client of each of the Services with respect to the Plan.

3. **TERM; TERMINATION.**

a. Term; Renewal. The initial term of this Agreement begins as of the Effective Date and continues through and including **June 30, 2024** (the "**Initial Term**"), unless sooner terminated as provided in this Section. Unless a party provides the other with at least forty-five (45) days notice of non-renewal prior to the end of the Initial Term or any renewal term (a "**Renewal Term**"), (and the Initial Term and any Renewal Terms, collectively, the "**Term**") this Agreement will automatically renew in each instance for successive twelve (12) month Renewal Terms.

b. Renewal Fees. Meritain may increase the Administrative Rates (as defined and set forth in the Fee Schedule) for each Renewal Term subject to Client's agreement as to such Administrative Rates. If the parties fail to agree upon new Administrative Rates, the existing Administrative Rates for the immediately prior Initial or Renewal Term, plus a percentage amount equal to the change in the Consumer Price Index for all Urban Areas for the previous twelve (12) months, shall apply for each such Renewal Term, and the parties agree that notwithstanding anything to the contrary herein, this Agreement shall be deemed amended to reflect such increase without further action by either party.

c. Termination. This Agreement may be terminated:

i. by Meritain: (A) upon five (5) business days written notice to Client for Client's failure to pay any Fees when due if not paid in full within such notice period; (B) subject to the following subsection 3.c.i.C, upon five (5) business days written notice to Client for Client's failure to fund the Claims Payment Account as required under Section 7.c. of this Agreement if not funded in full within such notice period; (C) immediately upon written notice to Client for Client's failure to fund the Claims Payment Account as required under Section 7.c. of this Agreement two (2) or more times within any three (3) month period; or (D) immediately upon notice to Client for Client's failure to promptly sign and deliver stop loss insurance applications and disclosures, or any information or data necessary for Meritain to perform the Services;

ii. by either party upon thirty (30) days written notice to the other party for the other party's material breach of this Agreement, if such breach is not cured during such thirty (30) day period;

iii. by either party upon thirty (30) days written notice after the other party: (A) becomes insolvent; (B) is, or states in writing that it is, unable to pay its debts as they become due; (C) makes an assignment for the benefit of its creditors; (D) files or has filed against it any proceeding in United States Bankruptcy Court; (E) is subject to a levy, seizure or sale of a substantial part of its property

or assets on behalf of creditors; or (F) is subject to the appointment of a receiver for at least thirty (30) days.

d. Early Termination. If Client terminates this Agreement prior to the expiration of the Initial Term or any Renewal Term, other than as permitted under Section 3.c. of this Agreement (an "**Early Termination**"), Client acknowledges that such Early Termination will cause damages to Meritain, and agrees to compensate Meritain for such damages as provided in this Section.

i. Client further acknowledges that the actual damages likely to result from an Early Termination are difficult to estimate as of the Effective Date and may be difficult for Meritain to prove. Accordingly, Client agrees that it shall pay, within thirty (30) days of any notice of termination on or before the effective date of such Early Termination, whichever occurs first, an amount as calculated below under Section 3.d.iii of this Agreement (the "**Early Termination Fee**").

ii. The parties intend that Client's payment of the Early Termination Fee is to be a reasonable measure of the anticipated probable harm to Meritain arising as a result of any Early Termination, would serve to compensate Meritain for any such Early Termination, and, although the actual damages incurred by Meritain as a result of such Early Termination (including actual, direct, indirect, consequential, special, and other damages) might exceed or be less than the Early Termination Fee, they do not intend for it to serve as punishment or penalty for any such Early Termination.

iii. The Early Termination Fee will be calculated in accordance with the chart set forth below:

Duration of Initial Term or Renewal Term (the "In-Force Term") at Date of Termination	**Number of Months of the In-Force Term Fulfilled**	**Early Termination Fee**
3 Years	0-23 Months	9% of the current total Administrative Rates multiplied by the number of covered employees at the time of termination, multiplied by the number of months of the In-Force Term that has been fulfilled.
	24-35 Months	5% of the current total Administrative Rates multiplied by the number of covered employees at the time of termination multiplied by the number of months of the In-Force Term that has been fulfilled.
2 Years	0-23 Months	5% of the current total Administrative Rates multiplied by the number of covered employees at the time of termination multiplied by the number of months of the In-Force Term that has been fulfilled.
1 Year	0-11 Months	100% of the current total Administrative Rates multiplied by the number of covered employees at the time of termination multiplied by the number of months remaining in the In-Force Term.

e. Effect of Termination.

i. Run-Out. Upon termination of this Agreement, for any reason other than termination by Meritain under Section 3.c. of this Agreement and subject to Client's payment of the Fees for run-out services set forth under the Fee Schedule, Meritain will continue to process Claims that were incurred prior to, but not processed as of, the Termination Date, which are received by Meritain not more than six (6) months following the Termination Date (the "**Run-Out Period**"). The terms and conditions of this Agreement including without limitation Client's obligation to fund the Claims Payment Account, will survive the termination of this Agreement and remain in effect with respect, and to the extent applicable, to such Claims during the Run-Out Period. Meritain will have no obligation with respect to Claims received after the expiration of the Run-Out Period. For the avoidance of doubt, Meritain

may terminate or suspend its obligations under this Section pursuant to Section 2.c. or Section 3.c. of this Agreement.

ii. Subrogation. Unless Client directs Meritain, within sixty (60) days of the Termination Date, to send it all cases in the Meritain subrogation process, Meritain will continue subrogation and recovery efforts on all such cases and will remit to Client all proceeds it receives, less applicable fees under the Fee Schedule and Disclosures Exhibit. If Client requests to receive subrogation cases from Meritain, it will: (A) be deemed to have released Meritain and its subrogation vendor from and against any and all suits, claims, losses, fees and expenses related to the subrogation cases; and (B) reimburse Meritain for all out-of-pocket expenses.

iii. Records. Upon termination of this Agreement, following payment to Meritain of all Fees due Meritain will release to Client or to a successor administrator, in Meritain's standard format, claims data and records in accordance with Meritain's then-standard policies and procedures within a reasonable time period following the Termination Date. Any other records requests by Client will be subject to Meritain's agreement to such request and Client's payment of any costs or other charges associated with such request.

4. **STANDARD OF CARE.**

Meritain will discharge its obligations under this Agreement with that level of reasonable care which a similarly situated services provider would exercise under similar circumstances. In connection with fiduciary powers and duties under this Agreement set forth in the Administrative Services Schedule, if any, Meritain shall observe the standard of care and diligence required of a fiduciary under ERISA Section 404(a)(1)(B).

5. **FIDUCIARY DUTY.**

Client is the "plan sponsor," "plan administrator" and "named fiduciary" with respect to the Plan, as such terms are interpreted under Applicable Law. Client, as Plan Administrator, retains complete authority and responsibility for the Plan, its operation, and the benefits provided thereunder. Meritain is empowered to act on behalf of Client in connection with the Plan only to the extent expressly stated in this Agreement, and that unless otherwise expressly set forth in the Administrative Services Schedule, and if so to the limited extent so set forth in the Administrative Services Schedule: (i) the Services will not include the power to exercise discretionary authority over Plan operations or Plan assets (if any), and (ii) Meritain will not for any purpose be deemed to be the "Plan Administrator" of the Plan or a "fiduciary" with respect to the Plan. Meritain's non-fiduciary services under this Agreement are intended to and will consist only of those "ministerial functions" described in 29 C.F.R. 2509.75-8, D-2 and will be performed within the framework of policies and interpretations established by Client. Client has the sole and complete authority to determine eligibility of persons to participate in the Plan, and has selected and is solely responsible for the Plan's benefit and coverage design.

6. **FEES.**

a. Client shall pay Meritain all fees, costs, and other charges as set forth in the Fee Schedule, and any other fees, costs, or charges that may be set forth in this Agreement including any Schedule or Exhibit (collectively, the "**Fees**") on the first (1st) day of the month or on such other date agreed to in writing by the parties in accordance with Meritain's then-standard policies. Meritain will provide appropriate documentation regarding the Fees due and owed prior to the due date for that month's Services based on eligible employees at the time the invoice is generated. If Client elects electronic funds transfer withdrawal from Meritain for the payment of Fees, Client authorizes Meritain to withdraw the Fees from its bank account on the due date. Adjustments to eligibility will be accounted for in the next invoice processing period. If the Fees are not received by Meritain within ten (10) days of due date, then in addition to any other remedies under this Agreement, at law or in equity, Meritain may charge a one and one-half percent (1.5%) late charge per month calculated from the first day of the month on all unpaid amounts.

b. If Client is in default of paying any Fees under this Agreement, Meritain shall have the right to set-off such amounts against any monies due Client, including without limitation subrogation recoveries.

7. CLIENT'S RESPONSIBILITIES.

Client shall:

a. maintain and furnish to Meritain current, accurate Plan eligibility and coverage information, and submit to Meritain written notice of any changes with respect to the status of any of the Participants within fifteen (15) days after Client becomes aware of any such change. Such information shall be provided in a format reasonably acceptable to Meritain and shall include the following with respect to each Participant: name and address, social security number, date of birth, type of coverage, sex, relationship to employee, changes in coverage, date coverage begins or ends, and any other information necessary to determine eligibility and coverage levels under the Plan. When dependents reach the maximum age specified in the Plan Document, such dependent will no longer be a Participant, and Client hereby directs Meritain to automatically terminate such dependents from eligibility under the Plan without notice or further instruction from Client. Upon termination of dependent under this Section, Meritain will provide notice of such termination to Client;

b. resolve all ambiguities and disputes relating to eligibility of Participants; and adjudicate all appeals of denials of Claims;

c. with respect to the Claims Payment Account:

   i. establish the Claims Payment Account and execute and deliver to Meritain and to a mutually agreed-upon depository any and all documents necessary to empower Meritain to act as a signatory on such account, if requested;

   ii. deposit into the Claims Payment Account, within two (2) business days (or as otherwise agreed to in writing by the parties, but no more than four (4) business days) of receipt of a funding request, all monies required for the satisfaction of Claims;

   iii. upon Meritain's request, fund claims within one (1) business day if necessary in Meritain's sole discretion for reasons including without limitation, meeting stop loss funding obligations and meeting prompt pay deadlines; and

   iv. agree that Meritain will not be responsible for any consequences resulting from Client's untimely funding of Claims, and that failure to fund Claims in a timely manner may result in claim denials by its stop loss carrier, lost discounts from Providers, and/or interest and penalties, all of which may require Client to fund any such additional sums.

d. provide Meritain with copies of any and all revisions or changes to the Plan at least thirty (30) days prior to the effective date of the changes;

e. maintain and operate the Plan in accordance with all Applicable Laws;

f. as required under Applicable Law: (i) provide and timely distribute to Participants all notices, information, materials and documents, (ii) maintain all recordkeeping, and file all forms relative to the Plan, and (iii) timely prepare or cause to be prepared, and timely execute, any documents, forms or contracts with respect to the Plan;

g. timely pay: (i) any and all taxes, licenses and fees levied, if any, by any local, state or federal authority in connection with the Plan, and (ii) any payments, underpayments, fines, penalties, interest, surcharges, assessments, or other fees or charges assessed or levied by any governmental or regulatory entity on

or in connection with the Plan ("Regulatory Fees"); Client shall be solely liable for any Regulatory Fees and shall indemnify Meritain if any are assessed against Meritain; and

h. perform those other obligations as set forth in this Agreement including without limitation any Schedule.

8. **CONFIDENTIALITY.**

a. Confidential Information. Each party acknowledges that it may gain access to business proprietary data, rates, provider discounts, procedures, materials, lists, systems and information of the other party ("**Confidential Information**") under this Agreement. Confidential Information does not include Protected Health Information as defined by HIPAA. Neither party may use Confidential Information of the other for its own purpose, nor disclose such Confidential Information to any third party other than a party's representative who has a need to know such information in relation to the administration of the Plan, and provided that such representatives are informed of the confidentiality provisions of this Agreement and agree to abide by them. Notwithstanding the foregoing, Client shall not disclose preferred Provider network ("**PPN**") discount information to any third party, including without limitation Client's representatives, without Meritain's prior written consent, which may be withheld in Meritain's sole discretion, and until each recipient has executed a confidentiality agreement reasonably satisfactory to Meritain.

b. Plan Participant Information. Each party will maintain the confidentiality of Participant-identifiable information in accordance with Applicable Law and the terms of the HIPAA business associate agreement attached hereto as the Health Insurance Portability and Accountability Act (HIPAA) Schedule and incorporated herein.

c. Upon Termination. Upon termination of this Agreement a party, upon the request of the other, will return or destroy all copies of all of the other's Confidential Information in its possession or control except to the extent such Confidential Information must be retained pursuant to Applicable Law or in Meritain's case cannot be disaggregated from Meritain's databases. Meritain may retain copies of any such Confidential Information it deems necessary for the defense of litigation concerning the Services, for use in the processing of run-out Claims and for regulatory purposes.

d. Injunctive Relief. The parties each acknowledge that compliance with this Section is necessary to protect the business and goodwill of each party and its affiliates and that any actual or potential breach will cause irreparable harm to the non-breaching party or its affiliates for which money damages may not be adequate. Each party therefore agrees that if a party or its representatives breach or attempt to breach this Section the non-breaching party may request for temporary, preliminary and permanent equitable relief, without bond, to restrain such breach. The prevailing party shall be entitled to recover from the other party the attorneys' fees and costs it expends in any action related to such breach or attempted breach.

9. **RECORDS; AUDIT RIGHTS.**

a. Meritain shall maintain records of Claims made and benefits paid in such form and format as is convenient for Meritain for at least seven (7) years, or longer if required by Applicable Laws.

b. Subject to the provisions of this Section and the remainder of this Agreement, Client may audit Meritain's records in connection with the administration of the Plan no more frequently than once every twelve (12) months, provided that any such audit be commenced within one (1) year following the period being audited.

c. Meritain shall provide Client with reasonable access to such records. Meritain shall only provide access to information that is: (i) in its possession; (ii) reasonably necessary to administer the Plan; and (iii) not restricted from disclosure under Applicable Law or any agreement between Meritain and a third party.

d. Client shall give Meritain at least four (4) weeks prior written notice, which must include: (i) a statement explaining its need to perform the audit; (ii) a description of the type(s) of information within the scope of the audit, including dates, a complete and accurate listing of the transactions to be pulled for the audit, and identification of the potential auditor; and (iii) a representation that the information to be disclosed by Meritain is reasonably necessary for the administration of the Plan.

e. Audits shall occur at a reasonable time and place, in a manner that does not unreasonably interfere with Meritain's ability to conduct its normal business, and at Client's sole expense. Client shall reimburse Meritain its costs for an audit which, with Meritain's approval: (i) cannot be completed within five (5) business days, or (ii) otherwise imposes exceptional administrative demands. Meritain reserves the right to review and approve the sample size, the objectives of the audit and the sampling methodology proposed by the auditors.

f. Subject to Meritain's approval, which may be withheld in its reasonable discretion, Client may designate a third party to conduct an audit or receive information hereunder, further subject to Client and such third party's written agreement, in a form acceptable to Meritain, that: (i) no portion of the audit is based upon a contingency fee arrangement; (ii) each shall only use the minimally necessary amount of audit information solely for purposes of administering the Plan and that each shall protect and maintain such information as confidential and shall not disclose the information to any other person or entity other than Meritain; and (iii) each shall provide Meritain with copies of all reports and summaries compiled as a result of the audit, including any draft report. Upon Meritain's request, the auditors shall meet with Meritain to discuss any finding contained in a draft report. Meritain may, in its discretion, include a supplementary statement in any final audit report.

g. Client will utilize individuals to conduct audits on its behalf that are qualified by appropriate training and experience for such work, and will perform its review in accordance with Applicable Law. Client and such individuals will not make or retain any record of Provider negotiated rates included in the audited transactions, or payment identifying information concerning treatment of drug or alcohol abuse, mental/nervous or HIV/AIDS or genetic markers, in connection with any audit.

10. **OVERPAYMENTS.**

a. Meritain shall reprocess any identified errors in Plan benefit payments (other than errors Meritain reasonably determines to be de minimis), and, subject to Applicable Law, seek to recover any resulting overpayment by attempting to contact the party receiving the overpayment twice via letter, phone, or email. Client may direct Meritain not to seek recovery of overpayments from Participants, and if so then Meritain shall have no further responsibility with respect to those overpayments. Meritain is not responsible for pursuing overpayment recovery through litigation.

b. If Meritain elects to use a third-party recovery vendor, collection agency, or attorney to pursue the recovery, the overpayment recoveries will be credited to Client less the Fees for non-subrogation recovery services as set forth under the Fee Schedule and Disclosures Exhibit. Client shall cooperate with Meritain in recovering all overpayments of Plan benefits.

11. **INDEMNIFICATION.**

a. Each party shall indemnify, defend, and hold harmless the other party and its affiliates, and their officers, directors, employees and agents from and against any and all claims, suits, actions, liabilities, losses, fines, penalties, damages and expenses of any kind (including, but not limited to, actual attorneys' fees) which the indemnified party may incur by reason of a third-party claim arising out of the other party's: (i) gross negligence or willful misconduct; or (ii) breach of its fiduciary duties, if any, with respect to the Plan.

b. Client shall indemnify, defend and hold harmless Meritain and its affiliates, and their officers, directors, employees and agents from and against any and all claims, suits, actions, liabilities, losses, fines,

penalties, damages and expenses of any kind (including, but not limited to, actual attorneys' fees) which Meritain may incur by reason of a third-party claim arising out of:

i. Client's failure to fund Claims as required under this Agreement;

ii. Client's failure to maintain and operate the Plan in accordance with Applicable Law;

iii. the adjudication, denial, or partial payment of a Claim by Client or its stop loss carrier, third-party medical management vendor or third-party pharmacy benefits manager, if any;

iv. any action taken by Meritain at the direction of Client;

v. Meritain's inability to comply with PPN or State prompt pay requirements due to circumstances beyond its control including without limitation additional information needed to process a Claim, incomplete eligibility or coverage information, or untimely Claim repricing from the vendor.

c. Meritain shall indemnify, defend and hold harmless Client and its affiliates, and their officers, directors, employees and agents from and against any and all claims, suits, actions, liabilities, losses, fines, penalties, damages and expenses of any kind (including, but not limited to, actual attorneys' fees) which Client may incur by reason of a third-party claim arising out of Meritain's fraud, embezzlement or other willful financial misconduct.

d. The party seeking indemnification under this Section (the "**Indemnified Party**") shall promptly notify the other (the "**Indemnifying Party**") in writing of its claim for indemnification. Such written notice shall set forth in reasonable detail the third-party claim for which indemnification is sought (the "**Third-Party Claim**") and the basis for indemnification. Failure to so notify the Indemnifying Party shall relieve the Indemnifying Party of its obligations hereunder only to the extent such failure adversely prejudiced the Indemnifying Party.

e. The Indemnifying Party shall be entitled to control and appoint lead counsel with respect to the Third-Party Claim at its own expense. If the Indemnifying Party assumes control of the defense of any Third-Party Claim in accordance with this Section the Indemnifying Party may settle the Third-Party Claim without the Indemnified Party's consent if the settlement: (i) does not require any admission against interest by the Indemnified Party; (ii) provides that any monetary damages shall be paid in full by the Indemnifying Party; and (iii) includes a release of the Indemnified Party from all liability alleged in the Third-Party Claim. Each Party shall cooperate, and cause its respective Indemnitees to cooperate, in the defense or prosecution of any Third-Party Claim.

f. This Section shall survive any expiration or termination of this Agreement with respect to any matter concerning which a claim has been asserted by notice to the other party during the Term or within one (1) year after the Termination Date.

12. **DEFENSE OF CLAIM LITIGATION.**

In the event of a legal, administrative or other action arising out of the administration, processing or determination of a Claim, the party designated in this Agreement as the fiduciary which rendered the decision in the appeal last exercised by the Participant which is being appealed to the court ("**appropriate named fiduciary**") shall undertake the defense of such action at its expense and settle such action when in its reasonable judgment it appears expedient to do so. If the other party is also named as a party to such action, the appropriate named fiduciary will defend the other party if the action relates solely and directly to actions or failure to act by the appropriate named fiduciary and there is no conflict of interest between the parties. Client shall pay the amount of Plan benefits included in any judgment or settlement in such action. The non-fiduciary party shall not be liable for any other part of such judgment or settlement, including but not limited to legal expenses and punitive damages, except to the extent, if any, provided under Section 11 of this Agreement.

13. **LIMITATION OF LIABILITY; NO WARRANTIES.**

a. **IN NO EVENT SHALL MERITAIN HAVE ANY LIABILITY OR OBLIGATION TO CLIENT IN EXCESS OF THE ADMINISTRATIVE FEES ACTUALLY PAID BY CLIENT TO MERITAIN FOR THE TWELVE (12) MONTHS PRIOR TO THE ACT OR OMISSION GIVING RISE TO ANY SUCH LIABILITY OR OBLIGATION.**

b. **IN NO EVENT SHALL EITHER PARTY BE LIABLE UNDER THIS AGREEMENT FOR ANY SPECIAL, CONSEQUENTIAL, PUNITIVE, OR INCIDENTAL DAMAGES, OR FOR LOST PROFITS, LOSS OF USE, LOSS OF REPUTATION OR GOODWILL, COST OF PROCUREMENT OF SUBSTITUTE SERVICES OR ANY SIMILAR CLAIM OR DEMAND, AND EACH PARTY EXPRESSLY WAIVES ITS RIGHT TO MAKE ANY CLAIMS TO THE CONTRARY.**

c. Client expressly agrees and acknowledges that: (i) Meritain does not render medical services or treatments to Participants; (ii) Meritain is not responsible for the health care that is delivered by Providers, or for a Provider's refusal to provide health care; (iii) Providers are solely responsible for the health care they deliver to Participants; (iv) Providers are not the agents or employees of Meritain and Meritain shall not be liable for the actions or lack thereof by Providers including without limitation under any theories of vicarious liability, agency, ostensible authority, respondeat superior or imputed liability; and (v) the indemnification obligations under Section 11 of this Agreement do not apply to any portion of any loss, liability, damage, expense, settlement, cost or obligation caused by the acts or omissions of Providers with respect to Participants.

d. **TO THE FULLEST EXTENT PERMITTED BY APPLICABLE LAW, MERITAIN EXCLUDES ALL WARRANTIES RELATED TO THIS AGREEMENT AND THE SERVICES, WHETHER IMPOSED BY STATUTE OR BY OPERATION OF LAW OR OTHHERWISE, THAT ARE NOT EXPRESSLY STATED HEREIN, INCLUDING THE IMPLIED WARRANTIES, WARRANTIES OF MERCHANTABILITY, AND FITNESS FOR A PARTICULAR PURPOSE.**

14. **DISPUTE RESOLUTION.**

If there is a dispute between the parties related to this Agreement, the parties shall first attempt to resolve such dispute by having the parties' Chief Executive Officers (or their designees) meet in person within thirty (30) days of written notice of dispute issued by either party. If the dispute is not resolved after reasonable efforts by the Chief Executive Officers within such thirty (30) day period, either party may then proceed to arbitration under this Section. All disputes, controversies or claims arising out of or relating to the operation or interpretation of this Agreement shall be settled by arbitration before one arbitrator, administered by JAMS in accordance with its standard procedures for arbitration between domestic commercial parties. The arbitrator shall be jointly selected by Client and Meritain and shall be a former federal judge. Any award rendered by the arbitrator shall be final and binding upon the parties and judgment upon any such award may be entered in any court having jurisdiction thereof. Arbitration shall take place in Buffalo, New York. The expenses of the arbitrator shall be borne equally by the parties. Each party shall pay its own fees and costs relating to any arbitral proceedings, including experts' and attorneys' fees. The arbitrator shall render its determination in a manner consistent with the terms of this Agreement.

15. **MISCELLANEOUS.**

a. No Insurance; Claims Payment. This Agreement shall not be deemed a contract of insurance under Applicable Law. Meritain does not insure, guarantee or underwrite the liability of Client under the Plan. Notwithstanding anything to the contrary herein, Client, and not Meritain, shall remain solely liable for the payment of Claims and all other expenses incidental to the Plan. Without limiting the foregoing, if the Centers for Medicare and Medicaid Services ("CMS") determines that the Plan has underpaid a claim under Medicare secondary payor laws, Plan assets will be used to correct such underpayment, and Meritain will not be required to make such payment with its funds, regardless of when CMS requires such payment.

b. Use of Trade Names. Meritain may make lawful references to Client and use of its logo in its marketing activities and in informing health care providers as to the organizations and plans for which Services are to be provided.

c. Force Majeure. With the exception of Client's obligations under Sections 6.a. and 7.c. of this Agreement, neither party shall be deemed to have breached this Agreement, or be liable for any failure or delay in its performance under this Agreement, if prevented from doing so by a cause(s) beyond its reasonable control, including without limitation acts of God; acts of terrorism; natural disasters; pandemics and epidemics; wars; riots; labor disputes or shortages; and governmental laws, ordinances, rules, regulations, or the opinions rendered by any court, whether valid or invalid.

d. Subsequent Documents. Each party shall timely execute or provide any further documents reasonably necessary to effect any term of this Agreement.

e. Assignment. Client may not assign this Agreement, in whole or in part, without the prior written consent of Meritain, which consent shall not be unreasonably withheld. Any attempted assignment in violation of this Section shall be void and of no effect.

f. Miscellaneous. The parties have entered into this Agreement as independent contractors and not as agents of one another, and neither shall have any authority to act as the representative of the other, or to bind the other to any third party, except as specifically set forth herein. This Agreement shall be construed and enforced in accordance with the laws of the State of New York without reference to its conflicts of laws principles, to the extent such laws are not preempted by ERISA. The federal courts located in Erie County, New York shall have sole and exclusive jurisdiction of any dispute related hereto or arising hereunder. **EACH PARTY EXPRESSLY WAIVES ANY RIGHT TO A JURY TRIAL IN ANY LEGAL PROCEEDING ARISING UNDER OR IN CONNECTION WITH THIS AGREEMENT.** No delay or failure of either party in exercising any right hereunder shall be deemed to constitute a waiver of that right. There are no intended third-party beneficiaries of this Agreement (including without limitation Participants). The headings in this Agreement are for reference only and shall not affect the interpretation or construction of this Agreement. This Agreement (including without limitation incorporated attachments, schedules and exhibits) constitutes the complete and exclusive contract between the parties and supersedes any and all prior or contemporaneous oral or written communications or proposals not expressly included herein. Unless expressly provided for otherwise, if there is any conflict between the terms of this Agreement and any schedule, the terms of this Agreement will control. If any provision of this Agreement is held to be invalid, illegal or unenforceable for any reason or in any respect, such invalidity, illegality or unenforceability shall in no event affect, prejudice or disturb the validity of the remainder of this Agreement, which shall be in full force and effect, enforceable in accordance with its terms. No modification or amendment of this Agreement shall be valid unless in a writing signed by each party. This Agreement may be executed in two (2) or more counterparts, each and all of which shall be deemed an original and all of which, together, shall constitute one and the same instrument. A party's electronic signature on this Agreement shall be binding and of the same force and effect as an original signature. By executing this Agreement, Client acknowledges and agrees that it has reviewed all terms of and conditions incorporated into this Agreement and intends to be legally bound by the same.

g. Notices. Any notice or other communication permitted or required to be given under this Agreement shall be in writing and shall be: (i) delivered in person, (ii) mailed, by certified mail, return receipt requested, postage prepaid, or (iii) sent by recognized overnight courier,

If to Meritain:

Meritain Health, Inc. 300 Corporate Parkway Amherst, New York 14226 Attn: Regional President	and	Meritain Health, Inc. 300 Corporate Parkway Amherst, New York 14226 Attn: Corporate Counsel

If to Client:

McDuffie County Board of Commissioners
210 Railroad Street,
Thomson, GA 30824

Attention: **David Crawley, County Manager**

h. Survival. Notwithstanding anything herein to the contrary, the following sections shall survive the expiration or termination of this Agreement: Section 3.d. in accordance with its terms, Section 3.e. in accordance with its terms, Section 8, Section 9.a. in accordance with its terms, Section 11, Section 12 and those terms that by their nature are intended to survive by their nature or in accordance with their express terms.

In **Witness Whereof**, the parties have executed this Agreement on the dates set forth below.

MERITAIN HEALTH, INC.	**MCDUFFIE COUNTY BOARD OF COMMISSIONERS**
	
Name: Tricia Menendez	Name:
Title: Regional President	Title:
Date: August 09, 2023	Date:

ADMINISTRATIVE SERVICES SCHEDULE

Subject to the terms and conditions of this Agreement including without limitation this Administrative Services Schedule, the terms and conditions of the Services are set forth below.

1. **MEDICAL CLAIMS ADMINISTRATION.**

   a. Meritain shall:

      i. receive, on behalf of Client, Claims data and documentation from Participants and Providers, process Claims incurred during the Term that contain all information necessary for Meritain to process such Claims, using Meritain's then-current claim determination procedures in a manner consistent with the Plan and this Agreement, and prepare and send explanation of benefits forms to Participants as required by and consistent with Applicable Law;

      ii. process, issue and distribute payments from the Claims Payment Account to Participants, Providers or others as applicable. Meritain shall not be obligated to disburse more than the amount made available by Client for disbursement from the Claims Payment Account, nor, under any circumstance, be responsible to use its own assets to satisfy any Claim;

      iii. make employee identification cards available to Participants and provide Participants with a toll-free telephone number for servicing;

      iv. provide out-of-network discount program and cost management services, and reasonable assistance to Client in pursuing rights of recovery arising from subrogation services and non-subrogation recovery services.

      v. process No Surprises Act Claims in accordance with Section 8 below;

2. **CLAIM FIDUCIARY.**

Client and Meritain agree that with respect to Section 503 of ERISA, Client will be the "appropriate named fiduciary" of the Plan for the purpose of reviewing denied Claims under the Plan. Meritain shall refer to Client, for its exclusive and final resolution: (a) any questions concerning the meaning of any part of the Plan Documents and Summary Plan Description; (b) the validity of any questionable or disputed Claims; and (c) any appeals of any denial of a Claim, pursuant to Applicable Law.

3. **NETWORK ACCESS.**

Provide access to Client's selected preferred Provider network (the "**PPN**"), as identified under the Fee Schedule. Client acknowledges and agrees that: (a) Meritain makes no representations regarding the value or cost effectiveness of the PPN; (b) the PPN, and not Meritain, is responsible for provider credentialing, Provider contracting, recruiting and retention, network composition, licensing, accreditation, maintaining adequate staffing, practice and professional standards and all other activities pertinent to the responsibilities of PPNs; (c) Meritain does not own, direct or control the PPN and makes no guarantee and disclaims any obligation to make any specific Providers or any particular number of Providers available for use by Participants or that any level of discounts or savings will be afforded to or realized by Client, the Plan or Participants. Access to the PPN and PPN discounts is at all times contingent on Client's compliance with the terms of the PPN and Provider contracts, including without limitation timely funding of Claims in accordance with the Provider's contracted rates. Notwithstanding anything to the contrary in this Agreement, Client agrees to comply with the terms of the PPN and the Provider contracts.

Meritain, through its affiliate Aetna, has value-based contracting ("**VBC**") arrangements with contracted Providers within the PPN ("**Network Providers**"). These arrangements reward providers based on indicators of value, such as, effective population health management, efficiency and quality care. Contracted rates with Network Providers

may be based on fee-for-service rates, case rates, per diems, performance-based contract arrangements, risk-adjustment mechanisms, quality incentives, pay-for-performance and other incentive and adjustment mechanisms. These mechanisms may include payments to physicians, physician groups, health systems, and other Provider organizations, including but not limited to organizations that may refer to themselves as accountable care organizations and patient-centered medical homes, in the form of periodic payments and incentive arrangements based on performance. Meritain will process any incentive payments or other payments or adjustments attributable to the Plan in accordance with the terms of each VBC arrangement or adjustment mechanism. Each customer's results will vary. It is possible that incentives paid to a particular Network Provider or health system may be required even if Client's own population did not experience the same financial or qualitative improvements. It is also possible that incentives will not be paid to a Network Provider even if Client's own population did experience financial and quality improvements. Upon request, Meritain will provide additional information regarding our VBC arrangements.

4. **REPORTING.**

a. Meritain will provide direct access to Client's Claims data and eligibility data and standard Claims and statistical reporting.

b. Prepare a monthly written account report, which shall include but not limited to: (i) the funding provided by Client; (ii) the name of each Participant or Provider that submitted a Claim to Meritain; (iii) the value of each Claim submitted; (iv) the amount paid for each of the Claims satisfied; and (v) the total amount of all of the Claims satisfied.

c. Prepare Meritain's standard claim and statistical reports as reasonably requested.

d. If applicable and requested by Client, to the extent maintained by Meritain timely provide Client with the information ERISA requires to enable Client to file the Plan's Annual Report (IRS Form 5500), and provide the Internal Revenue Service an annual report of tax reportable Claim payments made to Providers.

5. **STOP LOSS.**

a. Upon request by Client, Meritain shall:

i. use commercially reasonable efforts to procure stop loss insurance proposals (specific and aggregate) from selected stop loss carriers for Client's consideration, which stop loss insurance (the "**Policy**") shall be an asset of Client and not of the Plan;

ii. remit premiums for the Policy on behalf of Client, subject to Client's timely remittance of funds for such premiums to Meritain; and

iii. prepare and file stop loss claims with Client's carrier, provided that in no event shall Meritain have any obligation to file a stop loss claim or otherwise pursue or investigate any potential claim prior to the receipt of any actual Claim for which reimbursement would be sought from the carrier.

b. Client shall: (i) provide Meritain a copy of the insurance binder or Policy promptly upon request; (ii) promptly notify Meritain if any information provided to the stop loss Insurance carrier on behalf of Client is incomplete or inaccurate; and (iii) timely forward to Meritain all funds required to satisfy Client's Policy premiums on or before the first (1st) day of each month.

c. Client agrees and acknowledges that:

i. Meritain shall not be liable for any acts or omissions in connection with the placement or administration of stop loss insurance including the Policy;

ii. quotations and the terms of the Policy, including but not limited to the premiums, specific and aggregate retention levels, and limitations of coverage for certain Participants issued by the carrier are subject to the carrier's final review and such quotations and terms may change based on the carrier's underwriting guidelines after coverage is placed; and

iii. Meritain shall not be liable for Client's failure to provide full, complete and timely information to secure stop loss insurance coverage, or for changes made by the insurer arising out of final underwriting.

iv. Meritain does not insure or otherwise provide any guarantees with respect to the adequacy of the Policy, nor does Meritain make any representations regarding a carrier's obligation to reimburse Client for any Claims or other Plan costs under the Policy, including state-imposed surcharges, taxes, or assessments. Client agrees and acknowledges that its obligation to pay Claims pursuant to its Plan Documents, this Agreement, and as required under Applicable Law, is not dependent or contingent on any acts or omissions of its stop loss carrier regarding the Policy, including without limitation any potential or expected reimbursement or any denial of same.

6. **OTHER SERVICES.**

a. Plan Documents. If requested by Client, assist in the setting of Plan contribution levels and provide drafts of the Plan Document (including the SPD) in accordance with Client's instructions for review and approval by Client and its counsel. Client remains at all times responsible for the Plan's compliance with Applicable Law, including without limitation the timely distribution of Plan Documents (including SPDs).

b. SBC Services. If requested by Client, Meritain shall prepare draft Summaries of Benefits and Coverage ("**SBC**"), provided that Client remains responsible to ensure the Plan's compliance with Applicable Law, including without limitation the compliance and timely distribution of such documents.

c. State Reporting and Remittance. Meritain shall file, on Client's behalf, State Reports, and shall remit Client's payments of State Assessments, under Applicable State Law, to the extent that Meritain's then-current policies and procedures support a particular State Report or State Assessment. For the purposes of this Section 6.c.: (i) "**State Reports**" means those reports required to be filed under Applicable State Law with respect to a Plan's eligible Participants or Claims activity other than any required by any State department of revenue; (ii) "**State Assessments**" means assessments or surcharges related to a Plan's Participants or Claims activity levied directly on Client or the Plan other than any required by any State department of revenue; and (iii) "**Applicable State Law**" means the Applicable Laws of any State. Client acknowledges and agrees that: (i) neither Meritain nor its affiliates process or adjudicate claims covered under any pharmacy benefits plan, and any such claims will not be included within the scope of Meritain's obligations under this clause; and (ii) Meritain's obligations under this clause are at all times contingent upon Client's timely provision of all information and funding required for State Reports and State Assessments.

7. **ADDITIONAL SERVICES.**

Additional Services, if any, are as described in the accompanying Schedule(s) for such Services.

8. **NO SURPRISES ACT (NSA) SERVICES.**

a. For the purposes of this Section, the following terms shall have the meaning set forth below:

i. **No Surprises Act (NSA) Services** means those Services set forth in Section 8.b. below.

ii. **Eligible Claim** means a Claim for health care services from a Provider which is: (i) considered out-of-network for the applicable Client Plan; and (ii) identified by Meritain as qualifying as a surprise bill as described in the NSA; and (iii) which is not a Contracted Rate Claim (as defined below).

iii. **Contracted Rate Claim** means a Claim for health care services from a Provider which is: (i) considered out-of-network for the applicable Client Plan; and (ii) identified by Meritain as qualifying as a surprise bill as described in the NSA; and (iii) for which there is a rate that the Provider is obligated by contract, as a result of negotiations or through a network as identified on Members' identification card, to accept as payment in full.

iv. **No Surprises Act** means the "No Surprises Act," as part of the Consolidated Appropriations Act of 2021 (HR 133, Public law 116-260) and related rules, regulations, and guidelines.

v. **Qualifying Payment Amount or QPA** means the median contract rate for a service based on the applicable Contract Rate(s) of Meritain and/or its affiliate(s) in a particular market and/or other relevant factors, calculated pursuant to Applicable Law.

b. No Surprises Act (NSA) Services. Meritain agrees to provide the NSA Services according to the terms and conditions of this Section b., subject to the corresponding Fees set forth in the Fee Schedule of the Agreement.

i. Identification of Eligible Claims. Meritain shall review Claims and identify Eligible Claims.

ii. Calculation of the QPA. Upon receipt of Eligible Claims, Meritain will calculate the QPA.

iii. Dispute Resolution and Arbitration. If a Provider disputes the initial payment amount or whether its claim qualifies as an Eligible Claim, Meritain will handle the dispute resolution (in accordance with the NSA, if applicable, and any arbitration pursuant to the NSA. Client will reimburse Meritain for the associated administrative fees (filing fees and the certified IDR entity fee) paid by Meritain in conjunction with IDR for Eligible Claims. During the open negotiation period and arbitration, in each case pursuant to the NSA, Client authorizes Meritain to negotiate an amount up to ten percent (10%) greater than the initial payment amount made to the Provider.

c. NSA Disputes and Government Audits. If Client is audited by the Department of Labor pursuant to the NSA (an "**NSA Audit**"), Meritain agrees to provide Client with the logic used to calculate the initial payment amount for the applicable Eligible Claim within ten (10) business days of Client's request. Client agrees to utilize the logic and any other information provided by Meritain solely for the purpose of the NSA Audit and for no other reason.

d. Fees. Client shall pay Meritain the applicable fees set forth in the Fee Schedule of the Agreement for providing the NSA Services with respect to Eligible Claims and with respect to Contracted Rate Claims.

e. Government Audits. Client agrees to handle and resolve NSA Audits in an expeditious manner. Client acknowledges that except as expressly set forth in this Supplement, Meritain has no responsibility to resolve NSA Audits.

f. Confidentiality. For the avoidance of doubt, the parties acknowledge and agree that the QPA, logic used to calculate the QPA methodology, logic used to identify Eligible Claims and other information related to the QPA Services set forth in this Schedule are Confidential Information of Meritain subject to the provisions set forth in the Agreement related to Confidential Information.

MEDICAL MANAGEMENT SERVICES SCHEDULE

Subject to the terms and conditions of this Agreement including without limitation this Medical Management Services Schedule, the terms and conditions of medical management Services are set forth below.

1. **UTILIZATION MANAGEMENT.**

   a. Inpatient: Upon request of a Participant or Provider, Meritain will review actual or scheduled admissions and, using clinical criteria, determine medical necessity, conduct concurrent reviews and document discharge planning, based upon the information provided. If Meritain provides case management Services under this Agreement then cases triggered by case management flags will be closely monitored and placed into case management as necessary.

   b. Outpatient: Upon request of a Participant or Provider, Meritain will review certain outpatient services when prior authorization of the outpatient service is mandated by the Plan, and using clinical criteria, determine medical necessity, based upon the information provided.

   c. Inpatient and Outpatient: Meritain will: (i) adjudicate requests for pre-certification of medical necessity required under the Plan ("**Pre-Service Claims**"); (ii) adjudicate appeals of denied Pre-Service Claims submitted by Participants and/or Providers (to the extent that Client has made appropriate provision in any applicable Plan Documents identifying Meritain's role with respect to Pre-Service Claims and appeals, and informed Meritain of the same), and direct any other Pre-Service Claim appeals to Client for its adjudication and response in a reasonable manner and/or as mutually agreed; and (iii) respond to Client, Provider and Participant requests for predetermination for medical necessity that do not constitute Pre-Service Claims as well as to related requests for reconsideration.

2. **CASE MANAGEMENT.**

Case Management is a collaborative process to assess, plan, implement, coordinate, monitor and evaluate the options and services required to meet a Participant's health needs. Licensed health care professionals provide the case management services using telephonic and other communication methods to promote high quality and cost-effective outcomes. Case Management includes review and management, when appropriate, of cases identified through the services, as well as the management of cases referred from external sources such as the member, provider, claims payer, stop loss carrier, etc.

3. **EXTERNAL REVIEW ORGANIZATION ("ERO") SERVICES.**

Upon Client's request in each instance and subject to Client's payment of Meritain's then-current fee for ERO services, Meritain shall arrange for review of appeals of denials of Claims by an ERO in accordance with the Plan Document and Applicable Law.

PHARMACY BENEFIT MANAGEMENT SERVICES SCHEDULE

Subject to the terms and conditions of this Agreement including without limitation this Pharmacy Benefit Management Services Schedule (this "**PBM Schedule**"), the pharmacy benefit management services (the "**PBM Services**") with respect to Client's PBM Plan (as hereinafter defined) are described below.

1. **DEFINITIONS.**

For the purposes of this PBM Schedule, the following phrases shall have the meaning set forth below:

a. **AWP** means the average wholesale price of a Covered Drug as identified by Medi-Span (or other drug pricing source mutually agreed upon by Meritain and PBM Vendor). The applicable AWP for prescriptions: (i) filled in any retail Network Pharmacy will be the AWP on the date the drug was dispensed for the 11-digit National Drug Code ("**NDC**") for the package size from which the drug was actually dispensed as such 11-digit NDC is reported by the Network Pharmacy, and (ii) filled in any mail service Network Pharmacy will be the AWP on the date the drug was dispensed for the 11-digit NDC for the package size from which the drug was actually dispensed. The standard package size applicable to a mail service Network Pharmacy means one hundred (100) units (i.e., pills, tablets, capsules, etc.); unless a smaller package size is available from the manufacturer, or the actual package size dispensed for liquids and topical treatments. If Medi-Span does not provide an AWP for a particular 11-digit NDC (and Meritain and PBM Vendor have not agreed upon another drug pricing source for such NDC), the applicable AWP for such prescriptions will be the lowest cost AWP per unit for such Covered Drug as reported by Medi-Span.

b. **Brand Name Drug** means a Covered Drug that is not a Generic Drug.

c. **Covered Drug** means any prescription drugs, devices, over-the-counter drugs, supplies and Specialty Products that are prescribed by a Prescribing Provider and that are covered under the PBM Plan including all services usually and customarily rendered by a pharmacy in the normal course of business such as including dispensing, counseling and product consultation.

d. **Generic Drug** means a prescription drug, whether identified by its chemical, proprietary, or non-proprietary name that is: (i) therapeutically equivalent and interchangeable with Brand Name Drugs having an identical amount of the same active ingredient(s) and approved by the FDA; or (ii) classified and reported as a generic drug by the PBM vendor or Medi-Span.

e. **Formulary** means the list of Covered Drugs developed and maintained by Meritain and its PBM Vendor, as amended from time to time, and adopted by Client for its PBM Plan.

f. **Maximum Allowable Cost** or **MAC** means the unit price established by the PBM Vendor for a drug with more than two sources included on the MAC drug list applicable to Client, which list may be amended from time to time by the PBM Vendor in maintaining its generic pricing program.

g. **Mail Service Pharmacy** means any licensed mail service pharmacy that has entered into an agreement with the PBM Vendor to supply or dispense Covered Drugs.

h. **Network Pharmacy** means any Retail Pharmacy, Mail Service Pharmacy or Specialty Pharmacy.

i. **PBM Claim** means a request by any person, PBM Participant, or Network Pharmacy for payment or reimbursement for Covered Drugs.

j. **PBM Participant** means any person who is eligible, properly enrolled and entitled to benefits under the terms of the PBM Plan.

k. **PBM Plan** means that benefit plan or benefit plan component under the Plan that provides coverage for prescription drugs and/or other drugs and items prescribed by a Prescribing Provider, including Specialty Products, and which will include significant cost-sharing benefits and minimal cost sharing by individual PBM Participants (i.e. copayments, deductibles, and/or co-insurances consistent with traditional industry standards), all as more specifically described in such PBM Plans.

l. **PBM Documents** means the documents that specify the Covered Drugs, items that are expressly excluded from coverage under the PBM Plan, the amount which a PBM Participant is required to pay for a prescription in accordance with the PBM Plan (which may be a deductible, coinsurance or copayment, or other reimbursement rates), and any other information and terms necessary for the implementation and management of the PBM Plan.

m. **PBM Vendor** means the organization that Meritain has arranged to provide claims processing and adjudication and other services for the PBM Plan.

n. **PBM Vendor Specialty Pharmacy** means a licensed pharmacy owned and operated by the PBM Vendor that supplies and dispenses Specialty Products.

o. **Prescribing Provider** means any physician, dentist, hospital, or other medical practitioner, or medical care facility or vendor of supplies or services, who or which is authorized to prescribe medications or drugs.

p. **Retail Pharmacy** means any licensed retail pharmacy that has entered into an agreement with the PBM Vendor to participate in the retail network established by the PBM Vendor to supply or dispense prescription drugs.

q. **Specialty Pharmacy** means any licensed pharmacy that has entered into an agreement with the PBM Vendor to supply or dispense Specialty Products.

r. **Specialty Products** means those Covered Drugs, medicines, agents, substances and other therapeutic products that are designated by the PBM Vendor as Specialty Products due to their particular characteristics, including one or more of the following: (i) they address complex, chronic diseases with many associated co-morbidities (e.g., cancer, rheumatoid arthritis, hemophilia, multiple sclerosis), (ii) they require a greater amount of pharmaceutical oversight and clinical monitoring for side effect management and to limit waste, (iii) they have limited pharmaceutical supply chain distribution as determined by the drug's manufacturer and/or (iv) their relative expense.

s. **U&C** means a pharmacy's usual and customary selling price for a Covered Drug.

2. **TERMINATION.**

Either party may terminate this PBM Schedule and the PBM Services upon at least forty-five (45) days written notice to the other party prior to the end of the Initial Term or any Renewal Term, such termination to be effective only upon the end of such Initial Term or Renewal Term. The termination or expiration of this PBM Schedule or the PBM Services hereunder by itself as permitted under this Section shall in no event constitute or result in the termination or expiration of this Agreement.

3. **PBM PROGRAM.**

a. PBM Documents. Meritain shall provide Client with the required PBM Documents for completion by Client. The terms of the PBM Documents, and any amendments or changes thereto, must be mutually agreed upon by the parties, and Client shall sign and return to Meritain such mutually agreed upon PBM Documents within such reasonable time that is required by Meritain. If Client does not timely sign and return the PBM Documents, such PBM Documents will be deemed accepted by Client and Meritain will

proceed to implement the PBM Plan in accordance with the information provided by Client in the PBM Documents.

b. Formulary. Client acknowledges and agrees that it shall participate in the Formulary as offered by Meritain, provided however, such Formulary is subject to change at PBM Vendor's sole discretion due to various factors, including without limitation market conditions, clinical information or cost. If Client desires to participate in the Formulary differently than as provided by Meritain, Client shall identify the nature and extent of such changes or deviations in the PBM Documents provided by Meritain, and such deviations and/or changes must be agreed upon by both parties in writing.

c. Cost Share. Client acknowledges and agrees that the terms and rates of this PBM Schedule and Meritain's obligation to perform hereunder are contingent upon Client's PBM Plan providing significant cost sharing consistent with industry standards ("**Traditional Cost-Sharing**"). If Client's PBM Plan does not have Traditional Cost-Sharing or is later modified such that it does not have Traditional Cost-Sharing for one-hundred percent patient responsibility plans or cash card plans, then notwithstanding anything to the contrary herein, Meritain shall have the right in its sole discretion and upon notice to Client to adjust the rates of this PBM Schedule retroactive to the point in time when Client instituted the one-hundred percent patient responsibility or cash card benefit plan.

d. Reporting. Meritain shall provide standard PBM Claims, eligibility, and management reporting to Client.

e. Call Center. Meritain shall make available to Client through the PBM Vendor, a toll-free telephone number to assist Client and its PBM Participants with eligibility and benefits verification, location of Network Pharmacies and other related PBM Participant matters.

4. PRIOR AUTHORIZATION PROGRAM.

Meritain shall arrange for prior authorization services through the PBM Vendor ("**PA Program**"), and drugs subject to the PA Program ("**PA Drugs**") are determined by the PBM Vendor. Under the PA Program, prior authorization from the PBM Vendor is required for any PA Drugs prior to being covered as a Covered Drug under the PBM Plan. Client acknowledges that the PA Program is based solely on objective criteria and the limited amount of patient information made available in the process of considering a request for prior authorization, and that determining whether to authorize coverage of a PA Drug under the PA Program is based on industry standard guidelines selected by the PBM Vendor. The PBM Vendor may rely entirely upon information about the PBM Participant and the diagnosis of the PBM Participant's condition provided to it from sources deemed reliable, including but not limited to the Prescribing Provider and the dispensing pharmacist. Notwithstanding the foregoing, none of Meritain or any of its affiliates, nor PBM Vendor, will undertake, and none of the foregoing are required, to make diagnoses, or to substitute its judgment for the professional judgment and responsibility of the Prescribing Provider.

5. CLAIMS PROCESSING.

Meritain shall arrange for claims processing and adjudication of PBM Claims by the PBM Vendor, including on-line claims processing for Covered Drugs dispensed by Network Pharmacies. Meritain does not process PBM Claims under the PBM Plan. The on-line claims processing services for Covered Drugs dispensed by Network Pharmacies shall include the following functions: (a) verification and application of eligibility, formulary inclusion, utilization history and the Plan's prescription drug program design; (b) drug utilization review; (c) calculation of benefits in accordance with the PBM Documents; and (d) the provision of ministerial adjudication of PBM Claims.

6. APPEALS.

a. Client is the "plan sponsor," "plan administrator" and "named fiduciary" with respect to the PBM Plan, as such terms are interpreted under Applicable Law. Client, as Plan Administrator, retains complete authority and responsibility for the PBM Plan, its operation, and the benefits provided thereunder. Meritain is empowered to act on behalf of Client in connection with the PBM Plan only to the extent expressly stated

in this PBM Schedule, and except as provided in this Section: (i) the PBM Services will not include the power to exercise discretionary authority over Plan operations or Plan assets (if any), and (ii) Meritain will not for any purpose be deemed to be the "Plan Administrator" of the Plan or a "fiduciary" with respect to the Plan. Meritain's services under this PBM Schedule are intended to and will consist only of those "ministerial functions" described in 29 C.F.R. 2509.75-8, D-2 and will be performed within the framework of policies and interpretations established by Client. Client has the sole and complete authority to determine eligibility of persons to participate in the PBM Plan, and has selected and is solely responsible for the PBM Plan's benefit and coverage design.

b. Client and Meritain agree that with respect to Section 503 of ERISA, Meritain, except as set forth under Section 6.d. of this PBM Schedule, will be the "appropriate named fiduciary" of the PBM Plan for the purpose of reviewing appeals of denials of prior authorization requests and appeals of denials of PBM Claims under the PBM Plan ("**Appeals**"). Client understands that the performance of fiduciary duties under ERISA necessarily involves the exercise of discretion on Meritain's part in the determination and evaluation of facts and evidence presented in support of any Appeals. Therefore, and to the extent not already implied as a matter of law, Client hereby delegates to Meritain discretionary authority to determine entitlement to benefits under the applicable Plan Documents for Appeals received, including discretionary authority to determine and evaluate facts and evidence, and discretionary authority to construe the terms of the PBM Plan. It is also agreed that, as between Client and Meritain, Meritain's decision on any Appeals is final and that Meritain has no other fiduciary responsibility.

c. Meritain shall receive, on behalf of Client, Appeals, and review Appeals received during the Term using its Appeal review procedures in a manner consistent with the Plan and Applicable Law.

d. If Meritain receives any Appeals involving or arising out of cost-share provisions or any other matter not expressly within the scope of Meritain's obligations under this Section it will refer such to Client for its exclusive and final resolution.

e. If the denial is upheld in the final level of appeal under the Plan Document, the Appeal will be reviewed to determine if the appeal is eligible for External Review Organization ("**ERO**") review, and if eligible, then the PBM Participant will be informed of his or her right to appeal to an ERO.

7. NETWORK PHARMACY ACCESS.

a. Network Access. Meritain shall arrange for access to Network Pharmacies through the PBM Vendor for Client and its PBM Participants for Covered Drugs. Meritain shall provide Client and its Participants with web-based access to the list of Network Pharmacies. Network Pharmacies are authorized to charge, and PBM Participants must pay, all applicable cost-share prior to dispensing the Covered Drug. Notwithstanding the foregoing, Retail Pharmacies and Mail Service Pharmacies for each Generic Drug dispensed are authorized to charge and collect from PBM Participants the lessor of: (i) the applicable cost-share, (ii) U&C, (iii) the MAC price, or (iv) the discount rate. Client acknowledges that the PBM Vendor, and not Meritain, is responsible for pharmacy credentialing, contracting, recruiting, licensing, accreditation, maintaining adequate staffing, practice and professional standards and all other activities pertinent to the responsibilities accorded to the pharmacy network.

b. Specialty Product Network Access. Client may select in the PBM Document the PBM Vendor's network that it desires to participate in and have access to for Specialty Products as set forth below:

   i. Open Network. Under the Open Network Specialty Products option, Specialty Products may be filled through either a Specialty Pharmacy or a Retail Pharmacy. Specialty Products are not available from a Mail Service Pharmacy, and any Specialty Product prescription submitted to a Mail Service Pharmacy will be rejected with a "NDC not covered" message, and the prescription will automatically transfer to a Specialty Pharmacy. Client authorizes Meritain to permit the PBM Vendor and the Specialty Pharmacy to communicate with PBM Participants and Prescribing Providers regarding the transition from a Mail Service Pharmacy (or other pharmacy) to the selected Specialty

Pharmacy, and to advise PBM Participants filling Specialty Products in pharmacies of the option to fill prescriptions through the selected Specialty Pharmacy. A current list of Specialty Products offered under this provision may be obtained from Meritain upon request.

ii. Exclusive Network. Under the Exclusive Network Specialty Products option, Specialty Products may only be filled through a Specialty Pharmacy and are not available through either Retail Pharmacies or Mail Service Pharmacies, unless Client elects in the PBM Documents the option to allow for a one-time only fill of a Specialty Product at a Retail Pharmacy. Specialty Product prescriptions submitted to a Retail Pharmacy or Mail Service Pharmacy, except for the first time fill exception if elected, will be rejected with a "NDC not covered" message, and the prescription will be transferred to a Specialty Pharmacy. A current list of Specialty Products offered under this provision may be obtained from Meritain upon request.

c. Meritain does not direct or exercise any control over the professional judgment exercised by any pharmacist in dispensing prescriptions or otherwise providing pharmaceutical related services at any Participating Pharmacy, the Mail Service Pharmacy or the Specialty Pharmacy. All pharmacies are independent contractors of PBM Vendor and Client acknowledges and agrees that neither Meritain nor the PBM Vendor shall have any liability to Client, the PBM Plan, any PBM Participant, or any other person or entity for any act or omission of any such pharmacy or its agents or employees.

8. CLINICAL/TREND PROGRAMS.

Meritain shall make available to Client certain clinical/trend programs as offered by the PBM Vendor, provided however such additional clinical/trend programs may be subject to an additional fee, and may be amended, changed, or deleted at the PBM Vendor's discretion. Client's selection of these services and implementation thereof must be documented via the PBM Documents or other written request from Client.

9. DRUG UTILIZATION REVIEW ("DUR").

Meritain shall arrange for the provision of a standard concurrent DUR analysis of each prescription submitted by a pharmacy on-line in order to assist the dispensing pharmacist and the Prescribing Provider to identify potential drug interactions, incorrect prescriptions or dosages, and certain other circumstances that may be indicative of inappropriate prescription drug usage. DUR shall not substitute for the professional judgment of the Prescribing Provider, the dispensing pharmacist, or any other Provider providing services to PBM Participants.

a. Utilization management and safety.

i. Point of Sale Safety Review. Real-time safety alerts to pharmacies at the time a prescription is filled. (Alerts of interactions, allergies, therapeutic duplications, etc.).

ii. Standard Fraud, Waste, and Abuse Program. Pharmacy claims and target drugs, including but not limited to controlled substances are monitored to identify instances of fraud, waste and abuse.

iii. Retrospective Review. Pharmacist review of any retail or mail order drug claims or prescriptions within 72 hours to identify potential safety concerns or issues.

b. Medical Appropriateness.

i. Dose Optimization. Point-of-sale identification of opportunities where a high strength, single dose can be used in place of multiple daily dose quantities.

ii. Quantity Limits. Control maintenance over drugs with potential adverse effects of overdose, misuse or PBM Participant safety concerns without eliminating coverage.

iii. Dispense as Written ("**DAW**") 1 & 2. If elected by Client in the PBM Documents, DAW 1: outreach to physicians to determine if a Generic Drug may be substituted for a Brand Name Drug. If elected

by Client in the PBM Documents, DAW 2: outreach to PBM Participants to determine if a Generic Drug may be substituted for a Brand Name Drug, and if so, encourage and educate such designated PBM Participant on the use and benefits of the Generic Drug equivalent.

10. **RATES AND FEES.**

Client shall fund all PBM Claims, including applicable dispensing fees, pursuant to the Claims payment section of this Agreement. Client shall also pay the applicable fees, if any, for the clinical/trend programs elected by Client pursuant to this Agreement. The discounts set forth in the PBM Schedule represent an aggregate estimate that may be realized by Client, as measured annually, on a component basis for all participating groups that are contracted with Meritain to provide pharmacy benefit management services.

11. **RATES FOR BRAND, GENERIC, AND COMPOUND DRUGS DISPENSED AT A RETAIL PHARMACY OR A MAIL SERVICE PHARMACY.**

Table A.

Rates, Credits, and Discounts	Retail Pharmacy Discounts	Mail Service Pharmacy	90 Day at Retail Pharmacy
Average Annual Brand Discount	AWP – 19.75%	AWP – 25.00%	AWP – 22.50%
Average Annual Generic Drug Discount	AWP – 85.75%	AWP – 88.00%	AWP – 85.75%
Dispensing Fee/Rx	$0.45	$0.00 (subject to change for changes in postal rates)	$0.00

Compound Prescriptions: Lesser of U&C or combined AWP plus applicable service fee.

a. In no event shall the rates set forth above in Table A be applied to Specialty Products, regardless of the pharmacy from which they are dispensed. The rates for Specialty Products are set forth below in Table B or Table C, as applicable, for Specialty Products.

b. For each eligible generic prescription-drug claim, ingredient cost will be calculated at the lesser of the applicable U&C (retail only), MAC, or AWP discount price in determining the discount achieved.

c. The generic drug discount will apply to all MAC and non-MAC generics, including single source generics.

d. The retail reimbursement rates do not apply to non-retail providers such as long-term care facilities, home infusion pharmacies, and Indian Health/Tribal/Urban providers.

e. The proposed pricing as set forth above assumes the method of determining AWP based on the pricing files published by Medi-Span on or after September 27, 2009.

f. Limited distribution specialty/biotech drugs, over-the-counter products, supplies, administration of vaccines, compounds, subrogation claims and in-house or 340B pharmacy claims are excluded from the discounts set forth in this PBM Schedule.

g. 90Day at Retail Pharmacy Network. The discounts and/or rebates for the 90-day at Retail Pharmacy as set forth in this PBM Schedule only apply if Client, elects in writing, the PBM Vendor's 84-90 day at Retail Pharmacy network option and if an 84-90 days' supply of Brand Name Drugs and Generic Drugs is filled at the PBM Vendor's certain network of 90-day Retail Pharmacies as designated by the PBM Vendor (a "90-Day Retail Pharmacy").

12. **SPECIALTY PRODUCT REIMBURSEMENT RATES.**

a. Option 1- Retail Pharmacies & Specialty Pharmacy – Open Network:

Table B.

Pharmacy Location	Ingredient Cost	Dispensing Fee
Specialty Pharmacy	AWP – 20.00%	$0.00
Retail Pharmacy Specialty Products	AWP – 19.75%	$0.45

b. Option 2- Specialty Pharmacy- Exclusive Network:

Table C.

Exclusive Network	Ingredient Cost	Dispensing Fee
Specialty Medication	AWP – 20.50%	$0.00

13. **ADDITIONAL FEES & CHARGES.**

Table D.

	Fee
Participant and Pharmacy Submitted Paper Claims Processing	$1.50 per claim
Pharmacy Audit Recoveries	20% of audit recoveries
Prescription Drug Claim Audit Recoveries	20% of audit recoveries
Custom Ad-Hoc Reporting/Programming	billed at Meritain's then-current rate for such services
If Client Maintains and/or Operates an In-House Pharmacy	$2.00 per paid Covered Drug

14. **REBATES.**

a. Rebates to Client:

	Retail Pharmacy Discounts	Mail Service Pharmacy	90 Day at Retail Pharmacy
Rebate per covered and paid Brand Drug dispensed at a Retail Pharmacy or Mail Service Pharmacy	$200.00	$600.00	$515.00

	PBM Vendor Specialty Pharmacy	Non-PBM Specialty Pharmacy or Retail Pharmacy	Mail Service Pharmacy

Rebate per covered and paid Specialty Products dispensed at a: • **PBM Vendor Specialty Pharmacy;** • **Retail Pharmacy;** • **Mail Service Pharmacy;** • **Specialty Pharmacy that is not a PBM Vendor Specialty Pharmacy ("Non-PBM Specialty Pharmacy")**	$1,700.00	$200.00	$600.00

b. The rebates as set forth above will be paid to Client within 45 days of Meritain's receipt of rebates from PBM Vendor for the PBM Plan.

c. The rebate for Brand name Drugs provided at a Retail Pharmacy will apply to Brand Name Drugs and Specialty Products for the treatment of the human immunodeficiency virus (HIV).

d. The following PBM Claims and/or Covered Drugs do not qualify for rebates and are excluded from the Rebate Guarantee:

- Over the Counter Drugs
- Limited Distribution (LDD) Drugs
- 340B Claims
- Compound Drugs
- Paper or PBM Participant Submitted PBM Claims
- Coordination of Benefits (COB) or Secondary Payor
- Vaccines and Vaccine Administration
- Biosimilar Drugs
- Brand Name Drugs and Specialty Products not on the Formulary
- Brand Name Drugs and Specialty Products provided or paid under consumer card or discount card programs

TELEMEDICINE SERVICES SCHEDULE

Subject to the terms and conditions of this Agreement including without limitation this Telemedicine Services Schedule (this "**Telemedicine Schedule**"), the Telemedicine Services provided by Meritain, through Meritain's supplier or vendor of Telemedicine (the "**Telemedicine Vendor**"), are described below.

1. **TERMS AND CONDITIONS.**

   a. Meritain shall:

      i. provide Participants with access to telephonic or video-conference consultations where available, with a certain network of providers (including without limitation Providers and other medical, health and wellness practitioners) available from the Telemedicine Vendor, as elected by Client in writing and set forth in the Plan Document ("**Telemedicine**"). Prescriptions for medications may be available through Telemedicine only where permitted by law and incident to the establishment of physician-patient relationship and a diagnostic consultation; and

      ii. provide Client with monthly Telemedicine utilization reports;

      iii. have no obligation to offer Telemedicine in States that prohibit Telemedicine or prohibit physicians from performing such services; and

      iv. have the option, by providing written notice to Client to: (A) unilaterally amend or modify this the Telemedicine Schedule in a similar manner that Meritain's agreement with its supplier of Telemedicine ("**Telemedicine Vendor**") is modified or amended; and (B) immediately suspend access to Telemedicine or terminate this Telemedicine Schedule in the event Meritain's Telemedicine Vendor is suspended or terminated. Upon Client's receipt of notice of modification or amendment, Client, if it does not desire to accept such modified or amended terms, either party may at its option, by providing written notice to the other, terminate this Telemedicine Schedule.

   b. Client agrees:

      i. that Telemedicine will only be offered as a Covered Service under a Plan as described in the Plan Document and will not be offered to employees as a standalone or voluntary benefit not included under a Plan; and

      ii. the Telemedicine Services shall commence upon the implementation date as agreed upon in writing by Meritain. At least thirty (30) days before the implementation date Client shall provide Meritain all necessary information required in accordance with Meritain's then-current policies. Failure to do so may result in a delay in the commencement of Telemedicine.

HEALTHCARE BLUEBOOK SERVICES SCHEDULE

Subject to the terms and conditions of this Agreement including without limitation this Healthcare Bluebook Services Schedule (this "**HCBB Schedule**"), the services for Healthcare Bluebook™ provided by Meritain through Meritain's vendor, the Healthcare Bluebook ("**HCBB**") are described below (the "**HCBB Services**").

1. **HCBB SERVICES.**

   a. Meritain shall provide Participants access to a web-based portal to identify Providers by cost and quality with color coding (the "**Price and Quality Portal**"), and shall make available to Participants a toll-free telephone number to access HCBB's customer service support staff, Monday through Friday from 8:00 a.m. to 5:00 p.m. Central Time excluding holidays, for servicing.

   b. Reporting. Meritain shall make available HCBB's standard reporting as follows: (A) monthly reporting of Participant utilization of the Price and Quality Portal; and (B) if applicable, reporting with respect to any incentives paid to applicable Participants.

2. **CLIENT RESPONSIBILITIES.**

   a. Client shall:

      i. prior to the commencement of the HCBB services, promptly provide Meritain any necessary information and/or complete any documentation, as requested by Meritain, for Meritain to implement the HCBB Services. Client's failure to timely do so may result in a delay in the commencement of the HCBB Services;

      ii. provide to Participants all necessary information for Participants to access the Price and Quality Portal, including without limitation the web-based link or address;

3. **INCENTIVE PROGRAMS.**

   a. Incentive Programs: Certain incentive programs are available from HCBB, and may be elected by Client. Client agrees that Client has elected, and Meritain shall provide to Client, the following incentive program:

      i. All Green. If Participants utilize a Provider that is assigned as "green" for certain medical procedure categories designated by HCBB, such Participants will automatically receive an incentive payment in accordance with the cash value assigned by HCBB for such procedure. Meritain will provide Client a list of those certain procedure categories that qualify for an incentive and the cash value of each such procedure.

   b. Incentive Payments. Unless otherwise mutually agreed in writing upon between Meritain and Client, incentives issued through Meritain or HCBB shall be paid out as cash to Participants. Client agrees to those certain cash values assigned by HCBB as communicated to Client by Meritain, and that such values are not subject to modification or customization by Client. With respect to incentives issued through Meritain, Meritain shall issue or pay any applicable the cash incentives to the applicable Participants within seventy-five (75) days of adjudication of the Claim of the Covered Benefit that qualifies for such incentive. Upon Client's receipt of a request for payment, Client shall pay for any and all cash incentives issued or paid by Meritain or HCBB to Participants under Client's elected incentive program in accordance with the payment terms for Claims funding and payments as set forth in this Agreement.

   c. Taxation. Client acknowledges that there may be a taxable event as a result of any incentive payment under Applicable Law and that Client shall be responsible for such taxable events. In the event incentive payments are issued through Meritain or HCBB and the incentive payment is $600.00 or more during a calendar year, Meritain will issue and file the Internal Revenue Service Form 1099 for such incentive.

4. **DISCLAIMERS.**

   a. **MERITAIN DOES NOT REPRESENT, WARRANT, OR GUARANTEE THE INFORMATION PROVIDED BY HCBB OR THAT ANY SAVINGS, REDUCTION IN COST, OR IMPROVED OUTCOME OR QUALITY WILL BE ACHIEVED FOR CLIENT OR PARTICIPANTS. ANY AND ALL SERVICES PROVIDED BY HCBB ARE BASED ON HCBB'S CURRENT POLICIES, PROCEDURES, AND AVAILABLE SERVICES.**

   b. This HCBB Schedule and the HCBB Services are at all times subject to Meritain's agreement with HCBB. If Meritain's agreement with HCBB is modified or amended in a manner that affects this HCBB Schedule, Meritain shall have the option by providing written notice to Client, to unilaterally amend or modify this HCBB Schedule in a similar or same manner. Upon Client's receipt of notice of such modification or amendment, if Client does not desire to accept such modified or amended terms, either party may at its option, by providing written notice to the other, terminate this HCBB Schedule.

FEE SCHEDULE

1. **FEES FOR ADMINISTRATIVE SERVICES.**

Unless otherwise stated, the monthly fees and charges for the administrative Services (the "**Administrative Fees**") are calculated by multiplying the listed rates in the table below (the "**Administrative Rates**") by the applicable number of employees enrolled in the Plan each month.

Administrative Services	**Per Employee Per Month July 01, 2023 – June 30, 2024**
• **Aetna Choice® POS II Network Access** • **ATLAS Reporting Package** • **Case Management** • **Data File Feed** • **ID Card Production** • **Medical Plan Administration*** • **Pharmacy Benefits Manager ("PBM") Coordination Fee** • **Reinsurance Administration** • **State Reporting and Remittance** • **Summary of Benefits and Coverage ("SBC") Production** • **Utilization Management**	$5.30

Administrative Services	**Fee July 01, 2023 – June 30, 2024**	**Frequency of Occurrence**
Healthcare Bluebook - All Green Rewards	$2.20	Per Employee Per Month
Telemedicine◊☼	$1.55	Per Employee Per Month
Deerwalk Coordination	$0.60	Per Employee Per Month

***Pharmacy Benefit Credit**: This Administrative Fee which includes medical plan administration (the "**Medical Administration Fee**") is contingent on Client's election of the PBM Services provided by Meritain as set forth in the PBM Schedule. In consideration of Client electing the PBM Services provided by Meritain, Client receives a monthly reduction of $26.00 PEPM on the Medical Administration Fee (the "**PBM Credit**"). The Medical Administration Fee specifically listed and set forth above includes and accounts for such PBM Credit. In the event Client terminates the PBM Schedule or the PBM Services as permitted under the PBM Schedule, Client, as of the effective date of such termination, will no longer receive the PBM Credit, and Meritain, without notice to Client, will automatically increase and adjust the Medical Administration Fee set forth above by the PBM Credit, to be paid by Client. Such monthly increase will be reflected on Client's invoice. Further, Client may be subject to additional fee(s) charged by Meritain for pharmacy coordination and out-of-pocket accumulator integration with Client's new pharmacy benefit manager.

Selected PPN: Aetna Choice® POS II

◊This pricing for Telemedicine may increase anytime during the Term due to a price increase by the Telemedicine Vendor. If such fee increase occurs, Meritain will notify Client in writing of the pricing increase. If Client does not desire to accept such new proposed fees, Client shall have the ability to terminate the Telemedicine Services upon written notice to Meritain.

☼The consult fee or Claim for Telemedicine Services ("**Telemedicine Claim**") is not included in this PEPM fee for Telemedicine. Client, through the Claims Payment Account or directly to the Telemedicine Vendor, or Participant, as applicable, is responsible to pay the Telemedicine Claim. If Client has a Qualified High Deductible Health Plan ("**QHDHP**"), Participant(s) under the QHDHP that receive Telemedicine Services are responsible to pay any applicable Telemedicine Claim until such Participant's deductible is satisfied.

2. **ADDITIONAL FEES:**

a. Out-of-Network Discount Program Fees: Fees to be paid to out-of-network discount programs will be billed by Meritain on a contingent fee basis, based on the program's percentage fee of savings resulting from the discount program.

b. Other Fees and Services: Client agrees to pay vendors' fees for certain additional services including, but not limited to (i) fees for independent case review, (ii) contingency fees for subrogation services, (iii) contingency fees for non-subrogation recovery services; and (iv) contingency fees and other fees for cost management vendors, claim auditors, bill negotiators and discount programs.

c. With respect to Section 2.a. and 2.b. of this Fee Schedule, the Disclosures Exhibit sets forth a description of contingency fees, other administrative fees or similar compensation which Meritain may receive in connection with these vendor services.

d. No Surprises Act (NSA) Services: Client will pay Meritain a fee equal to 28% of the difference between a Provider's billed charges for Covered Services and the Qualified Payment Amount (QPA) repriced and paid by Meritain. If the final amount paid by the Plan after open negotiations or arbitration pursuant to the NSA is greater than the QPA, such fee will be adjusted to represent the difference between Provider's billed charges for Covered Services and the final amount paid by the Plan. Client understands and acknowledges that Meritain makes no guarantee that any level of savings will be afforded to or realized by Client or Participants pursuant to the NSA Services. If a material change is initiated by judicial, legislative or regulatory action which materially affects the cost of NSA Services administration Meritain may adjust Fees for the NSA Services subject to Client agreement.

e. Run-Out Fees:

i. one-hundred percent (100%) of three (3) months of the then-current Administrative Rates based upon enrollment at the time of termination due on or before the Termination Date, plus;

ii. fifty percent (50%) of three (3) months of the then-current Administrative Rates based upon enrollment at the time of termination due by the end of the second month after the Termination Date.

iii. Meritain will also bill Client any applicable PPN access, integration or run-out fees charged by the PPN, if any, for Claims processed during the Run-Out Period.

iv. Client shall be responsible to pay the applicable fees charged by Meritain, if any, for any cost management programs provided by Meritain during the Run-Out Period.

f. Additional Fees and Services:

i. Printing Fees: billed at cost;

ii. AdHoc Reporting and/or Custom I.T. Services: billed at Meritain's then-current rate for such Services;

iii. Records Expense: billed at cost for obtaining records to investigate Claims;

iv. Translation Services of the Plan Document or Summary of Benefits and Coverage ("**SBC**"): If requested by Client, Pricing varies based on document, word count, and target language. Quoted pricing requires approval by Client prior to the commencement of any requested translation services.

3. **REMITTANCE SERVICES.**

Upon written request and if agreed to by Meritain, Meritain may collect certain fees and premiums from Client for remittance to a third party with whom Client has a direct relationship, e.g. a broker commission. In these instances, Meritain will pass-through all fees and will not collect or retain an administrative or service fee. Meritain has no relationship with any such third parties, and assumes no risk or liability with respect to such third parties' services or Client's payment of such fees. Those amounts known to Meritain as of the Effective Date are set forth below, and are subject to change predicated upon Client's agreement with such third-parties.

	July 01, 2023 – June 30, 2024	**Frequency of Occurrence**
Broker Fee(s)	$20.25	Per Employee Per Month

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) SCHEDULE

This Health Insurance Portability and Accountability Act (HIPAA) Schedule to the Administrative Services Agreement between Meritain and Client (the "**HIPAA Agreement**") is incorporated by reference therein and is hereinafter referred to as this "**BA Agreement**". Client represents that it has the authority to agree to the terms and conditions of this BA Agreement for and on behalf of Covered Entity for which Business Associate provides plan administration services ("**Covered Entity**") under current and future agreements between the parties ("**Services Agreement**"). For purposes of this BA Agreement, "**Business Associate**" includes Meritain and those subsidiaries and affiliates of Meritain that create, receive, transmit or otherwise maintain Protected Health Information, as defined below, in connection with this BA Agreement.

In conformity with the regulations at 45 C.F.R. Parts 160-164 (the "**Privacy and Security Rules**") Business Associate will under the following conditions and provisions have access to, maintain, transmit, create and/or receive certain Protected Health Information:

1. **DEFINITIONS.**

Capitalized terms used and not otherwise defined in this Agreement shall have the meanings assigned to such terms by HIPAA. The following terms shall have the meaning set forth below:

a. **Individual** shall have the same meaning as the term "individual" in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502 (g).

b. **Protected Health Information** shall have the same meaning as the term "Protected Health Information", as defined by 45 C.F.R. § 160.103, limited to the information created, maintained, transmitted or received by Business Associate from or on behalf of Covered Entity.

c. **Standard Transactions** means the electronic health care transactions for which HIPAA standards have been established, as set forth in 45 C.F.R., Parts 160-162**.**

2. **OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE.**

a. Business Associate agrees to not use or disclose Protected Health Information other than for purposes of performing its obligations under the Services Agreement, or permitted or required by this BA Agreement or as Required By Law.

b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this BA Agreement.

c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this BA Agreement.

d. Business Associate agrees to report to Covered Entity any use or disclosure of Protected Health Information not provided for by this BA Agreement, of which it becomes aware, including a Breach of Unsecured Protected Health Information.

e. Business Associate agrees to report to Covered Entity any Security Incident without unreasonable delay, and in no event later than thirty (30) calendar days after becoming aware that such Security Incident affects Covered Entity's Information.

f. Business Associate agrees to report to Covered Entity any Breach of Unsecured Protected Health Information without unreasonable delay and in no case later than thirty (30) calendar days after becoming aware that such Breach affects Covered Entity's Protected Health Information. Such notice shall include the identification of each Individual whose Unsecured Protected Health Information has been, or is

reasonably believed by Business Associate, to have been, accessed, acquired, or disclosed in connection with such Breach. In addition, Business Associate shall provide any additional information reasonably requested by Covered Entity for purposes of investigating the Breach. Business Associate's notification of a Breach under this Section shall comply in all respects with each applicable provision of Section 13400 of Subtitle D (Privacy) of ARRA, 45 C.F.R. 164.410, and related guidance issued by the Secretary from time to time.

g. Business Associate shall require that any subcontractors that create, receive, maintain, or transmit Protected Health Information on behalf of Business Associate agree in writing to the restrictions and conditions that are no less protective than those that apply through this BA Agreement to Business Associate with respect to such information, in accordance with 45 C.F.R. § 164.502(e) (1) (ii) and 164.308(b) (2), if applicable.

h. Business Associate shall provide access directly to an Individual, at the request of Covered Entity or an Individual and in a prompt and reasonable manner, including in the electronic form or format requested by the Individual, to Protected Health Information in a Designated Record Set, subject to and consistent with the timing and other provisions of 45 C.F.R. § 164.524.

i. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set at the request of Covered Entity or an Individual subject to and consistent with the timing and other provisions of 45 C.F.R. § 164.526, and in the time and manner designated by Covered Entity.

j. Business Associate agrees to make (i) internal practices, books, and records, including policies and procedures, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity, and (ii) policies, procedures, and documentation relating to the safeguarding of Electronic Protected Health Information available to the Secretary, in a time and manner designated by the Secretary, for purposes of the Secretary determining Covered Entity's or Business Associate's compliance with the Privacy and Security Rules.

k. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information with 45 C.F.R. § 164.528.

l. Business Associate agrees to provide to an Individual, at the request of Covered Entity or an Individual, an accounting of disclosures of Protected Health Information subject to and consistent with the timing and other provisions of 45 C.F.R. § 164.528.

m. With respect to Electronic Protected Health Information, Business Associate shall implement and comply with the administrative safeguards set forth at 45 C.F.R. § 164.308, the physical safeguards set forth at 45 C.F.R. § 164.310, the technical safeguards set forth at 45 C.F.R. § 164.312, and the policies and procedures set forth at 45 C.F.R. § 164.316 to reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Covered Entity. Business Associate acknowledges that, (i) the foregoing safeguards, policies and procedures requirements shall apply to Business Associate in the same manner that such requirements apply to Covered Entity, and (ii) Business Associate shall be subject to HIPAA enforcement provisions, as amended from time to time, for failure to comply with the Security Rule safeguards, policies and procedures requirements and any guidance issued by the Secretary from time to time with respect to such requirements.

n. If Business Associate conducts any Standard Transactions on behalf of Covered Entity, Business Associate shall comply with, and require any Subcontractor to comply with, the applicable requirements of 45 C.F.R. Parts 160-162.

o. Business Associate acknowledges that it shall be subject to the HIPAA enforcement provisions, as amended from time to time, for (i) impermissible uses and disclosures, (ii) failure to provide breach

notification to Covered Entity, (iii) failure to provide access to a copy of Electronic Protected Health Information to either Covered Entity or the Individual, or the Individual's designee, (iv) failure to disclose Protected Health Information where required by the Secretary to investigate or determine Covered Entity's compliance with HIPAA, and (v) failure to provide the accounting of disclosures required in this BA Agreement.

p. To the extent Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s).

3. **PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE.**

a. General Use and Disclosure. Except as otherwise provided in this BA Agreement, Business Associate may use or disclose Protected Health Information to perform its obligations under this Agreement, provided that such use or disclosure would not violate the Privacy and Security Rules if done by Covered Entity.

b. Specific Use and Disclosure Provisions.

i. Except as otherwise provided in this BA Agreement, Business Associate may use Protected Health Information for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

ii. Except as otherwise provided in this BA Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached in accordance with the Breach and Security Incident notifications requirements of this BA Agreement.

iii. Business Associate shall not directly or indirectly receive remuneration in exchange for any Protected Health Information of an Individual without Covered Entity's prior written approval and notice from Covered Entity that it has obtained from the Individual, in accordance with 45 C.F.R. § 164.508, a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by Business Associate.

iv. Except as otherwise provided in this BA Agreement, Business Associate may use Protected Health Information to provide data aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

v. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j).

vi. The provisions of this BA Agreement notwithstanding, Business Associate is permitted to de-identify Protected Health Information, provided that it does so in accordance with HIPAA de-identification rules. De-identified information does not constitute Protected Health Information, and may be used and disclosed by Business Associate for its own purposes, including, without limitation, for purposes of developing comparative databases, performing statistical analysis and research, and improving the quality of Business Associate's products and services.

vii. Plan Sponsor may identify, in writing, certain Plan Sponsor employees or third parties who Covered Entity has authorized to receive Protected Health Information from Business Associate in connection with plan administration. Subject to more restrictive state and federal law, Business

Associate will disclose Protected Health Information to Plan Sponsor designated employees or third parties. In the case of Plan Sponsor designated employees, the Plan Sponsor must represent and warrant compliance with 45 C.F.R. § 164.504(f). In the case of a third party, Business Associate may require specific written authorization from Plan Sponsor in each instance and execution by the third party of a non-disclosure agreement reasonably acceptable to Business Associate.

4. **OBLIGATIONS OF COVERED ENTITY.**

a. Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions.

i. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices agreed to in accordance with 45 C.F.R. § 164.520(b)(2), to the extent that such limitation(s) may affect Business Associate's use or disclosure of Protected Health Information.

ii. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes affect Business Associate's uses or disclosures of Protected Health Information.

iii. Covered Entity agrees that it will not impose special limits or restrictions on the uses and disclosures of its Protected Health Information that may impact in any manner the use and disclosure of Protected Health Information by Business Associate under the Services Agreement and this BA Agreement, including, but not limited to, restrictions on the use and/or disclosure of Protected Health Information as provided for in 45 C.F.R. § 164.522(a), unless such restrictions are required by 45 C.F.R. § 164.522(a). The foregoing notwithstanding, Business Associate agrees to accommodate reasonable requests for alternative means of communications pursuant to 45 C.F.R. § 164.522(b).

b. Permissible Requests by Covered Entity. Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy and Security Rules if done by Covered Entity except that Business Associate may use Protected Health Information in its possession (i) for Business Associate's proper management and administrative services, or (ii) to provide Data Aggregation services to the Covered Entity as permitted by 45 C.F.R. § 164.504(e) (2) (i) (B).

5. **TERM AND TERMINATION.**

a. Term. The provisions of this BA Agreement shall take effect on the Effective Date and shall terminate upon expiration or termination of the Services Agreement, except as otherwise provided herein.

b. Termination for Cause. Without limiting the termination rights of the parties pursuant to the Services Agreement and upon either party's knowledge of a material breach by the other party, the non-breaching party shall either:

i. Provide an opportunity for the breaching party to cure the breach or end the violation, or terminate the Services Agreement, if the breaching party does not cure the breach or end the violation within the time specified by the non-breaching party; or

ii. Immediately terminate the Services Agreement, if cure of such breach is not possible.

c. Effect of Termination. The parties mutually agree that it is essential for Protected Health Information to be maintained after the expiration of the Services Agreement for regulatory and other business reasons. Notwithstanding the expiration of the Services Agreement, Business Associate shall extend the protections of this BA Agreement to such Protected Health Information, and limit further use or disclosure of the Protected Health Information to those purposes that make the return or destruction of the Protected Health Information infeasible.

6. **MISCELLANEOUS.**

a. Regulatory References. A reference in this BA Agreement to a section in the Privacy and Security Rules means the section as in effect or as amended, and for which compliance is required.

b. Amendment. The Parties agree to take such action to amend this BA Agreement from time to time as is necessary for Covered Entity and Business Associate to comply with the requirements of HIPAA.

c. Survival. The respective rights and obligations of Business Associate under Section 5.c. of this BA Agreement shall survive the termination of this BA Agreement.

d. Interpretation. Any ambiguity in this BA Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy and Security Rules. In the event of any inconsistency between this BA Agreement and the Services Agreement, including any other appendices, Schedules and attachments, the terms and conditions of this BA Agreement shall control.

DISCLOSURES EXHIBIT

DISCLOSURE NOTICE REGARDING INSURANCE COMMISSIONS AND OTHER COMPENSATION

U.S. Department of Labor rules permit the receipt of insurance commissions and other compensation by service providers such as Meritain (and its affiliates) if proper disclosure is given and an appropriate independent Plan fiduciary acknowledges in writing receipt of the information and approves the transaction. The commissions and other compensation to be paid to Meritain are set forth in this Agreement. By signing this Agreement and renewal documents or amendments, Client certifies that it is an independent fiduciary of the Plan and that it acknowledges in writing receipt of the following information and approves the transactions (including the receipt of commissions and other compensation by Meritain and its affiliates) as described below.

1. STATEMENT OF AFFILIATION.

Prodigy Health Group, Inc. is a diversified health care services holding company whose subsidiaries include American Health Holding, Inc., Scrip World, LLC, Precision Benefit Services, Inc., Meritain Health, Inc. and PERFORMAX, Inc. (referred to herein collectively as "**affiliates**" or individually as an "**affiliate**"). Each affiliate is free to recommend to a client, products and services offered by other companies, which may include another affiliate; however, no affiliate is required to recommend an affiliate and no affiliate is limited or restricted in recommending the products and/or services of any vendor. Affiliates may be entitled to reasonable compensation (including commissions and fees) from other companies, including affiliates, and such compensation is earned in the ordinary course of business in arms' length transactions. In addition, certain inter-company agreements exist amongst the affiliates to provide for the exchange of certain goods and services and leases of real property at market-based rates of compensation.

2. DESCRIPTION OF CHARGES, FEES, DISCOUNTS, PENALTIES AND ADJUSTMENTS APPLICABLE TO ANY CONTRACTS WITH MERITAIN.

Meritain may receive compensation from insurance carriers ("**Carriers**") and managing general underwriters ("**MGUs**") in the form of fixed or contingent commissions and administrative fees. In some instances, the broker is entitled to a portion of the fixed or contingent commissions and administrative fees paid to Meritain. In those instances, Meritain will remit those amounts to the broker.

The parties acknowledge and agree that stop loss insurance policies are issued for one year terms, and therefore, Meritain is unable to disclose future commissions as of execution of this Agreement. Meritain will disclose future commissions (if any) at such time the policy is renewed or reissued.

Fixed Sales Commissions on Gross Insurance Premiums Payable to Meritain Per Year (if applicable):

Carrier	Commission type	Commission %
Benecon Veris- Everest/Benecon	Meritain Stop Loss Commission	0.00 %
Benecon Veris- Everest/Benecon	Broker Stop Loss Commission	0.00 %

Carrier	Commission type	Commission %
Aetna IOE	Meritain Transplant Commission	0%
Aetna IOE	Broker Transplant Commission	0%

Contingent Commissions

Contingent commissions may depend on a combination of factors such as growth, profitability, volume, retention and increased services that Meritain provides under agreements with certain Carriers and MGUs. There is no guarantee that Meritain will receive any contingent commissions. Also, in cases where Meritain agrees to provide administrative services that would otherwise be provided by a Carrier or MGU, some Carriers and MGUs pay administrative fees for these services. Below are descriptions of such commissions and fees that Meritain may receive:

None.

Other Fees

From time to time, Meritain may engage third party vendors to perform or provide services in connection with this Agreement. In some cases Meritain will pay the vendor as a subcontractor out of fees it has collected pursuant to this Agreement.

Subrogation Recovery Fee: When Meritain provides or arranges for subrogation services, Client agrees to pay Meritain a contingency fee of 25% of the gross savings resulting from such services.

Non-Subrogation Recovery Services Fee: When Meritain provides or arranges for non-subrogation recovery services, Client agrees to pay Meritain a contingency fee of up to 25% of the gross recovery, which shall include vendor fee, resulting from such services.

In the event Meritain engages an out-of-network discount program, claim auditor or bill review services, independent case reviewer, cost management vendor, bill negotiator, discount program or other contingency fee vendor to provide services on behalf of the Plan, Meritain shall be entitled to retain a contingency fee up to 28% of the net savings resulting from the engagement, and such contingency fee of the net savings does not include any additional third-party vendor fee that may be assessed for such services.

In cases where Meritain, itself or through an affiliate, provides direct negotiation services to reduce claim amounts to increase savings on behalf of the Plan, Meritain shall be entitled to retain a contingency fee up to 35% of the savings resulting from such services.

Meritain, through its affiliate Aetna, has a variety of different VBC arrangements with many Network Providers. These arrangements compensate Network Providers to improve indicators of value such as, effective population health management, efficiency and quality care. Aetna's VBC models include: Pay-for-Performance (P4P), Bundled Payments, Patient Centered Medical Homes (PCMH), and Accountable Care Organizations (ACOs). Aetna will continue to evolve its VBC arrangements over time. Aetna employs a broad spectrum of different reimbursement and other incentive and adjustment arrangements with Network Providers to advance the goals of improving the quality of patient care and health outcomes, while controlling costs. Client's financial responsibility under each VBC arrangement is determined based on provider performance or other adjustment mechanisms, using an allocation method appropriate for each particular program. These methods may include: percentage of allowed claims dollars, percentage of plan participant member months, or specific savings for bundles payment cases.

Meritain will process any payments in accordance with the terms of each VBC arrangement or adjustment mechanism. In each of the VBC models, all self-funded customers reimburse Meritain for any payment attributable to their plan. Each customer's results will vary. It is possible that payments paid to a particular Network Provider or health system may be required even if Client's own population did not experience that same financial or qualitative improvements. It is also possible that payments will not be paid to a Network Provider even if Client's own population did experience financial and quality improvements.

The disclosures set forth in this Disclosures Exhibit represent Meritain's best reasonable estimate of the total amount of all direct and indirect compensation Meritain may receive in connection with this Agreement. The actual amount may vary during the course of this Agreement based upon changes in the number of participants, utilization and other factors external to this Agreement. With respect to all direct and indirect compensation Meritain actually receives as a result of this Agreement, Meritain will disclose such amounts to Client annually, upon request, to the extent required to assist Client in filing its Form 5500.

In regards to the PBM Services set forth in the PBM Schedule of this Agreement, Meritain through its affiliate, receives compensation based on a mark-up, known as a differential, between the charges billed by the PBM Vendor and the charges billed to Client as set forth in the PBM Schedule. The actual amount of differential-based

compensation that Meritain's affiliate may receive cannot be predicted, as it depends on various future factors such as the level of actual utilization and other factors external to the PBM Schedule. An estimate of the amount of differential-based compensation is possible by taking into account the range of percentage differentials between the charges billed to Meritain's affiliate by the PBM Vendor and the charges billed to Client. While Meritain and its affiliate anticipate that the differential will remain the same during the effective period of the PBM Schedule, there may be instances where the negotiated rates between Meritain's affiliate and the PBM Vendor are adjusted, and such adjustment can have the effect of increasing or decreasing the differential amount retained. If such adjustment occurs, Meritain through its affiliate shall have the right to retain the adjusted differential amount even if greater than the previously earned differential amount as further compensation for its services. The disclosures set forth in this Disclosures Exhibit together with any other disclosures provided in this Agreement, represent Meritain's full disclosure by which to reasonably estimate the total amount of all direct and indirect compensation Meritain's affiliate may receive in connection with the PBM Services.

Rebates: Meritain may receive and is entitled to retain rebates from the PBM Vendor based on certain prescription drugs covered under the PBM Plan that are filled for Participants. Client acknowledges that the PBM Vendor on its own account contracts or negotiates with pharmaceutical manufacturers to obtain rebates on certain prescription drugs, and Meritain may receive manufacturer rebates from the PBM Vendor directly attributable to the utilization of certain Covered Drugs by Participants under the PBM Plan. The actual amount of rebates vary by manufacturer and cannot be predicted as it depends on several factors, including but not limited to, the pharmaceutical manufacturer's offering of rebates, the type of prescription drug, the volume of utilization of certain prescription drugs, benefit designs, formulary, and/or the PBM Vendor's agreements with pharmaceutical manufacturers. Meritain has agreed to offer Client rebate amounts as specifically set forth under Section 14 of the PBM Schedule in connection with Covered Drugs obtained by Participants under the PBM Plan. If rebate amounts received by Meritain in connection with Covered Drugs under the PBM Plan exceed the rebate amounts offered to Client as specifically set forth in the PBM Schedule, Meritain shall have the right to retain the difference for such rebate amounts as further compensation for its services.

MERITAIN HEALTH
An Aetna Company

Claim Processing Authorization Agreement

McDuffie County Board of Commissioners ("Plan Sponsor"), as Plan Administrator for the McDuffie County Board of Commissioners Employee Benefit Plan ("Plan"), hereby directs and authorizes Meritain Health, Inc. ("Meritain") to begin processing claims for the plan year beginning as of 7/1/2023 in accordance with the direction contained herein, based on the most current version of the plan benefit grid, which, for the avoidance of doubt, is attached to this agreement (the "Current Version"), until the Plan Document is finalized. Meritain agrees to process claims under the Plan in accordance with the direction contained herein as soon as reasonably practicable following Meritain's receipt of all necessary information, except that Meritain shall process claims in accordance with the Plan Document upon the formal adoption of the Plan Document by the Plan Sponsor. Any changes to benefits under the Plan Document which are not contained in the Current Version will apply to claims not processed by Meritain prior to the commencement of claims processing under the finalized Plan Document.

Plan Sponsor acknowledges and agrees that: (A) Meritain is not responsible for any claims, losses, damages or expenses incurred by Plan Sponsor or the Plan arising out of or in connection with the direction contained herein, including without limitation underpayments, overpayments or adjustments to claims based on changes to plan benefits from those contained in the Current Version including any changes subject to stop loss policy parameters which are not contained in the Current Version and which are requested by Plan Sponsor to be made to the Plan Document subsequent to the Current Version; and (B) it shall indemnify, defend and hold Meritain harmless from any claims, losses, damages or expenses incurred by Meritain arising out of or in connection with Meritain's processing of claims in accordance with the direction contained herein.

McDuffie County Board of Commissioners	Meritain Health, Inc.
_____	_____
Authorized Signature	Authorized Signature
_____	_____
Date	Date
_____	_____
Name	Name
_____	_____
Title	Title

STAFF REPORT

BOARD OF COMMISSIONER MEETING: October 4, 2023

DATE: September 29, 2023
TO: McDuffie County Board of Commissioners
FROM: Carrie Edwards
ISSUE: Consideration to approve CivicClerk Select Agenda and Meeting Management Solution software.

BACKGROUND: CivicPlus's Agenda and Meeting Management solutions, Select and Essential (formerly CivicClerk and Municode Meetings, respectively), are the only agenda and meeting management solutions that integrate with Municode's Online Code Hosting Platform. The integration between Select/Essential and Municode's Online Code Hosting Platform allows users to push newly adopted legislation directly to the Municode Online Code Hosting Platform's landing page. Municode Online Code Hosting Platform's subscription feature, eNotify, proactively notifies staff and residents via email when Select/Essential has pushed new or updated legislation to the Municode Online Code Hosting Platform landing page.

FACTS AND FINDINGS:

1. The purpose of the software is to integrate our current website, through CivicPlus Agenda and Meeting Management, to provide seamless transactions for both our community and the county.
2. The software proactively transitions all ordinances and community needed information through one sole source in the management solution platform.

Total Investment - Initial Term	USD 7,437.00
Annual Recurring Services - Year 2	USD 5,035.80

Initial Term & Renewal Date	12 Months
Initial Term Invoice Schedule	100% Invoiced upon Signature Date

Renewal Procedure	Automatic 1 year renewal term, unless 60 days notice provided prior to renewal date

STAFF RECOMMENDATION: Staff recommends the approval of the request.

ATTACHMENTS:

1. Agenda and Meeting Management Select Sole Source Letter
2. Agenda and Meeting Management Select Statement of Work
3. Agenda and Meeting Management Select Proposal

CIVICPLUS

To Whom It May Concern,

CivicPlus's Agenda and Meeting Management solutions, Select and Essential (formerly CivicClerk and Municode Meetings, respectively), are the only agenda and meeting management solutions that integrate with Municode's Online Code Hosting Platform. The integration between Select/Essential and Municode's Online Code Hosting Platform allows users to push newly adopted legislation directly to the Municode Online Code Hosting Platform's landing page. Municode Online Code Hosting Platform's subscription feature, eNotify, proactively notifies staff and residents via email when Select/Essential has pushed new or updated legislation to the Municode Online Code Hosting Platform landing page.

When coupled with OrdBank (a feature of Municode's Online Code Hosting Platform), the integration between Select/Essential and the Municode Online Code Hosting Platform also enables the creation of Enhanced History Notes. Upon supplementation of legislation pushed from Select/Essential to Municode Codification, the Enhanced History Notes for amended sections are hyperlinked directly to the Select/Essential instance for the specific meeting in which that piece of legislation was adopted. This link gives staff and residents instant access to the agenda, minutes, audio, video and vote tallies (if applicable) related to the legislation that amended the specific section of the municipal code. The only platforms capable of creating Enhanced History Notes inside the Municode Online Code Hosting Platform are Select/Essential. Both of which are CivicPlus solutions.

In addition, only Civicplus Websites (Engage Open, Engage Central) integrate with Municode's Online Code Hosting Platform, providing for a two way search between CivicPlus Websites and Municode's Online Code Hosting Platform. This search feature is unique to CivicPlus.

Finally, CivicPlus is the only provider capable of integrating the search function between CivicPlus Websites and Civicplus' agenda and meeting management solutions, Essential and Select. (Engage Open integrates with Essential. Engage Central integrates with Select.) This search integration enables staff and residents who are performing a search on their CivicPlus websites to simultaneously search Essential or Select as appropriate.

No other companies or individuals in the United States have the right to sell these integrated products. Please let me know if you have any questions or would like any further documentation.

Regards,

Eric Grant

VP/GM, CivicPlus

civicplus.com | 302 South 4th Street, Suite 500 | Manhattan, KS 66502 | 888-228-2233

CIVICPLUS

agenda and meeting management

SELECT

Premium Implementation

Powering and Empowering Government

CivicPlus Company Overview

CivicPlus History

CivicPlus began in 1998 when our founder, Ward Morgan, decided to focus on helping local governments work better and engage their residents through their web environment. Over the years, CivicPlus has continued to implement new technologies and merge with industry forerunners to maintain the highest standards of excellence and efficiency for our customers.

Our portfolio includes solutions for website design and hosting, parks and recreation management, emergency and mass communications, agenda and meeting management, 311 and citizen relationship management, process automation and digital services, codification, licensing and permits, web governance and ADA remediation, social media archiving, and FOIA management.

EXPERIENCE

20+ Years

12,000+ Customers

900+ Employees

RECOGNITION

Inc. 5000 11-time Honoree

GovTech 2022 Top 100 Company

Stevie® Awards Recognized with multiple, global awards for sales and customer service excellence

Our commitment to deliver the right solutions in design and development, end-user satisfaction, and secure hosting has been instrumental in making us a leader in government web technology. We are proud to have earned the trust of our over 12,000 customers and their 100,000+ administrative users. In addition, over 340 million residents engage with our solutions daily.

Primary Office

302 S. 4th Street Suite 500
Manhattan, KS 66502
Toll Free: 888.228.2233 | Fax: 785.587.8951
civicplus.com

Powering & Empowering Government

We empower municipal leaders to transform interactions between residents and government into consistently positive experiences that elevate resident satisfaction, increase revenue, and streamline operations.

Local government leaders tell us that one of their most pressing needs is to improve how residents access and experience municipal services; however, they struggle with budget cutbacks and technology constraints. CivicPlus enables civic leaders to solve these problems, making consistently positive interactions between residents and government possible.

What sets us apart is our Civic Experience Platform. CivicPlus is the only government technology company exclusively committed to powering and empowering local governments to efficiently operate, serve, and govern using our innovative and integrated technology solutions built and supported by former municipal leaders and award-winning support teams. With it, municipalities increase revenue and operate more efficiently while fostering trust among residents.

Features & Functionality

Agenda & Meeting Management Select System

CivicPlus' Agenda & Meeting Management Select software is the fastest, most intuitive way to streamline the entire agenda management process — from creating agenda items to managing live meetings. It provides time-saving automation while allowing clerks to balance these conveniences with manual controls and overrides. Internal collaboration with Select is easy with customized workflows, version tracking, and built-in communication tools.

Our innovators designed it to offer configuration flexibility so that the system can be scaled from the most simple agenda process to the most complex. Built-in integrations and a suite of APIs make working with other internal applications easy. Agenda & Meeting Management Select's user-defined roadmap ensures that the product will continue to grow and adapt as transparency requirements and compliance expectations change.

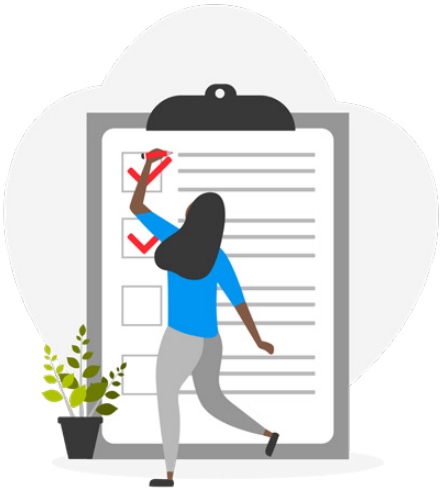
Fully Integrated, Cloud-Based Software Suite

- User-friendly, modern interface
- Unlimited users
- Unlimited storage
- Highly configurable to your agenda and meeting management processes
- Adaptable permission settings
- Confidential attachments
- Field-level versioning
- Integrated code of ordinances
- Built-in integrations with Dropbox, Microsoft's One Drive, Google Drive, Laserfiche, Zoom, and API availability (additional fees may apply)
- Single sign-on through the CivicPlus Platform
- Secure Cloud-Based Hosting
- Automatic Updates
- Customer-Defined Roadmap
- Enhanced Analytics for Data Visibility

Part of the Integrated CivicPlus Platform

Our powerful CivicPlus Platform is the foundation on which all our CivicPlus solutions are built, allowing them to work seamlessly and securely, leveraging existing data, and reducing information silos so your administrative staff can collaborate efficiently. Administrators can take advantage of authentication using our identity provider integrations to provide a single sign-on experience for internal users. The entire system is cloud-based, eliminating the need for internal application management. Agenda & Meeting Management Select is hosted in Microsoft's Azure cloud service, providing a stable multi-user environment while ensuring high availability and uptime. CivicPlus is also the only technology provider that offers an integration between our agenda & meetings software and an online code of ordinances—with Municode Codification.

Agenda Management



FLEXIBLE, CUSTOMIZED TEMPLATES

Standardized templates throughout the system provide consistency and clarity to agendas, packets, staff reports, and minutes.

EFFICIENTLY MANAGE AGENDA PACKETS OF ANY SIZE

The software compiles your items and all the legislation, memorandums, or supporting documentation into a bookmarked PDF packet quickly and easily, no matter the size of the packet. Create multiple packet versions instantly to include or exclude specific attachments for your different internal and external users. Last-minute changes to the agenda or packet can be made and published with minimal effort.

Administrators choose what they publish to the public, internal users, and elected or appointed officials and when the information goes out. Automated email notifications can be enabled so all users, both internal and external, know when the meeting documents are published.

CONVENIENT, ANYTIME AGENDA MODIFICATIONS

Changes to the agenda can be made at any time by administrators without affecting global configurations or settings. Drag-and-drop reordering allows you to move items and automatically renumbers everything on the agenda. One-touch copy and move functions enable you to duplicate or move agenda items from meeting to meeting, eliminating the need for duplicate data entry.

CREATE AGENDA ITEMS IN SECONDS

An easy-to-use item entry allows staff members to enter agenda items, upload attachments, and send through the workflow with a few clicks. Configurable field types and our embedded text editor ensure that you are capturing all the information needed for Select to generate staff reports. Automated PDF file conversion and built-in integrations with Microsoft's OneDrive and Google Drive simplify the inclusion of supporting documentation and attachments.

AUTOMATE YOUR APPROVALS PROCESS

The workflow engine streamlines the routing of your agenda items, automates notifications, and gives full transparency to collaborators as it passes through the approval process. As contributors change items, the system tracks revisions, keeping them visible within the item fields and on the item timeline. In-app messaging and task assignments keep everyone in the loop and agenda prep moving forward.

CUSTOM TAGS TO GROUP LIKE AGENDA ITEMS

Administrators can set up tags that can be used by staff when creating their agenda items for improved searching and reporting. Associate like content with pre-defined tags relevant to your community.

Meeting Management

AUTOMATED MINUTES SETUP

A fully-integrated minutes module will automatically migrate all your agenda content. No manual pre-meeting minutes setup or agenda import is required. Move from the meeting agenda to the minutes module with a single click.

KEEP UP WITH THE MEETING ACTION

Meetings move fast. Agenda & Meeting Management Select's cloud-based platform allows you to move quickly through your agenda items, recording official actions and discussion, without having to wait for the system to catch up. The clean, intuitive interface gives single-screen access to all your meeting controls. (additional fees apply)

SPEAKER MANAGER

Speakers can be added to the discussion at any time during the live meeting, while the built-in speaker timer helps keep meetings running efficiently.

EASY, INTUITIVE MINUTES-TAKING

While in your live meeting, use the Minutes module to capture critical meeting actions from a single screen with a clean and intuitive user interface. Take roll and manage attendance, record motions and votes, enter speaker information, and record comments or discussion to be brought into your minutes document.

If using CivicPlus Media's integrated video streaming and video-on-demand service, you can also create bookmarks for the accompanying video during the live meeting. Additional fees apply

Additional fees apply.

Board Portal

FLEXIBLE ACCESS

Your officials can choose how to access meeting content—helping them work better, faster. Efficiently deliver packets of any size by paper, email, Dropbox, OneDrive, Google Drive, or post to the Board Portal. It is optimized for all devices, including desktops, laptops, and tablets. No separate application required.

A PERSONAL MEETING REPOSITORY

Give officials a personal, secure location to review and take notes on all meeting content, including agendas, supporting documents, minutes, and media.

FIND WHAT YOU NEED- FASTER

Agenda & Meeting Management Select automatically indexes published meeting content with Board Portal search functionality, so it is easy for officials to find information quickly. Our full-text search tool empowers officials to locate past items, attachments, minutes, and agendas by searching a keyword, date range, and more. An item summary view allows officials to see the motions, votes, and any comment or discussion on the item that was recorded in the meeting minutes in an intuitive display, preventing a manual search through full minutes documents.

Public Resident Portal

CONTENT ACCESSIBILITY

It's not enough to be transparent by publishing your agendas and other meeting documents online. Your meeting content must be accessible to all members of the public.

Closed captioning is also available with our CivicPlus Media service for live streaming and on-demand video. Additional fees apply for CivicPlus Media and closed captioning.

CONTENT TRANSPARENCY

Build public trust with access to fully searchable meeting content, including legislative decisions and public meeting videos. Meet municipal transparency requirements while keeping residents engaged and informed.

Public Resident Portal

- Resident portal to embed on any webpage gives access to all meeting content on a single page
- PDF downloads of Agenda, Packet, Minutes, Notices, and Other pertinent meeting documents
- HTML agenda view hyperlinks attachments within the meeting agenda for direct access to specific documents
- Full-text search and filtering options
- Email notifications
- Social sharing
- Side-by-side agenda and video display with optional CivicPlus Media live streaming and on-demand video service (additional fees apply)
- Optional Motions and Vote minutes display updates the HTML agenda view to allow residents to quickly see the final disposition of agenda items without having to read full minutes documents
- Mobile-responsive
- Custom branding
- Integrated live or on-demand video with bookmarks to easily jump to desired content (additional fees apply)
- Optional public commenting forum
- Easily jump to past, current, upcoming events with an embedded calendar and continuous scrolls

The Civic Experience Platform

Developed specifically to enable municipalities to deliver consistently positive interactions across every department and every service, the Civic Experience Platform includes technology innovations that deliver frictionless, one-stop, and personalized resident interactions. Local governments that leverage our Civic Experience Platform also benefit from:

- Single Sign-On (SSO) to all of your CivicPlus products supporting two-factor authentication and PCI Level password compatibility
- A single dashboard and toolbar for administrative access to your CivicPlus software stack
- Access to a continually growing and fully documented set of APIs to better connect your administration's processes and applications
- A centralized data store with robust data automation and integration capabilities

CIVICPLUS PORTAL

CivicPlus Portal empowers residents to be more engaged and informed about progress in your community. Portal streamlines the resident user experience as they interact with the CivicPlus products leveraged by you – driving revenue, trust, and satisfaction.

With a single username and password, they can watch a public meeting recording, submit a public works request, pay a utility bill, or register for an upcoming event. The result is more engaged and informed voters and fewer phone calls, walk-ins, or emails to your department asking how to find documents or submit records requests.

INTEGRATION HUB

Integration Hub is a tool that can help you unify your disparate cloud-based solutions and your CivicPlus solutions, assemble powerful workflows, and setup complex automations—without the need for a developer. With Integration Hub's easy-to-use drag-and-drop interface, non-technical users can build integrations for syncing content and data between CivicPlus solutions or with third parties (for an additional fee) saving your staff's valuable time. The possibilities are endless with Integration Hub, but here are a few examples of integrations you can create with Select today:

- Automatically add agenda or minute files to the Document Center to be displayed on a CivicEngage® Central website after they are published in Select
- Set-up a workflow to post in the CivicEngage Central News Flash once you've published your Select meeting documents

Shorten your pre-meeting to-do list and send your meeting information instantly with a custom integration using the Integration Hub.

Integrated Code of Ordinances & Web

As the only local government software provider with an integrated codification, agenda and meeting management, and municipal website solution offering, our suite allows for digital transformation of the entire legislative process - from the start of the agenda process to the final online publishing of the newly adopted legislation.

If you are a customer of CivicPlus' codification services, the cutting-edge integration between your meetings & agenda management and code of ordinances reduces the manual steps associated between your agenda management and codification processes. As an example, you can send ordinances directly to the CivicPlus for codification by our team of legal editors. When pushed from Agenda & Meeting Management Select, this uncodified legislation will be visible on the landing page of our Online Code Hosting platform nearly instantaneously. You can also take this to the next level by integrating our Municipal Website solutions with our Online Code Hosting system, allowing for one-stop search, capabilities. With this integration, the public can instantly access your code, meetings, packets, and agendas in one simple search straight from your municipal website.

EXAMPLES OF MEANINGFUL CIVIC EXPERIENCE INTEGRATIONS

The following are examples of integrations between the CivicPlus Agenda & Meeting Management Select with other CivicPlus solutions and tools. If you have yet to experience all that CivicPlus can provide, please reach out for additional information and a quote.

CivicEngage Municipal Websites	• Set-up a workflow to post in CivicEngage's News Flash once you've published your meeting documents. • Automatically add agenda or minute files to CivicEngage's Document Center to be displayed on your website after they are published in Select. • Meeting information and dates are automatically integrated to the CivicEngage Calendar. • Meeting files are automatically included in the website's search results.
Codification	• Send adopted ordinances to the Codification Legal Team in one click. • Send ordinances straight to your online code portal as "Adopted and Not Yet Codified". • Instantly link your online code to the meeting content produced within Select.
CivicPlus Media	• Share high-definition, on-demand video or live video feeds of your meetings directly from Select and CivicPlus Media, seamlessly integrated with your meeting agendas and equipped with clear bookmarking and navigation.
Integration Hub	• Third-party integrations examples include integrations with Zoom, Webex, and GoToMeetings, and with Laserfische, Google Drive, Dropbox, and other APIs.

Implementation

Project Timeline

~~Twelve to Fourteen Weeks~~

While every implementation is unique, the following timeline can provide you with information about the different implementation stages and what you can expect at each stage.

PHASE 1: INITIATE	• Project Kickoff communication including timeline, deliverables, and an implementation questionnaire to capture details for your configuration
PHASE 2: ANALYZE	• Template Review meeting to review and discuss needs for Proposed Agenda Template • Obtain internal approvals on Proposed Agenda Template and send in final approval
PHASE 3: OPTIMIZE	• Virtual consulting session(s) to review current processes and documents and discuss desired goals, best practices, and configuration options • Premium system configuration is completed and handed off for review, testing, and feedback • Configuration adjustments made per submitted feedback
PHASE 5: EDUCATE	• Live, virtual training sessions are conducted within configured site
PHASE 6: LAUNCH	• System Launch

Premium Implementation Plan

Implementation & Support Experience Designed for You

Agenda & Meeting Management Select has the experience and expertise to help administrations of any size transform the entire meeting management process. We know implementation can't be a one size fits all solution and offer flexible packages designed to meet your desired outcomes.

Our Premium Implementation Package is the perfect fit for automating manual or inefficient agenda and meeting processes. It is designed for organizations with less than 50 internal users and a desire for a guided implementation experience. A dedicated and knowledgeable Implementation consultant will manage your project from end-to-end—consulting and collaborating with your team, configuring the system to automate your process, and delivering live virtual training to your user groups. Key project staff will have online access to the timeline and all expected checkpoints and deliverables for a fully transparent implementation.

Beyond implementation, your users will feel empowered by our in-application support tools, a full online help center, as well as phone, email, and live chat support with members of the dedicated, award-winning Technical Support team.

CONSULTING

Up to 2 Hours of Virtual Consultation

During this consulting session, your implementation consultant will be reviewing your submitted project questionnaire with your key project staff. The implementation consultant will review your custom template designs and discuss the configurations that will be made to ensure your workflows match your current agenda and meeting processes.

DESIGN

We will design up to 5 custom templates to ensure consistency in system-generated meeting documents: Agendas, Item/Staff Report, Minutes, Agenda Script.

CONFIGURATION

Our team will configure your system with Premium customization options to map existing processes to our Agenda & Meeting Management Select system. Additional custom configurations can be made by administrative users at any time using Help Center resources.

TRAINING

Up to 4 hours of Virtual Training

Your implementation consultant will guide user groups through live, virtual training sessions using your custom configured Agenda & Meeting Management Select solution. We recommend no more than 20 users per session. Individual sessions are either 30 or 60 minutes in duration.

Continuing Services

Technical Support & Services

With technology, unlimited support is crucial. Our live technical support engineers based in North America are ready to answer your staff members' questions and ensure their confidence.

AWARD-WINNING

CivicPlus has been honored with one Gold Stevie® Award, two Silver Stevie® Awards, and four Bronze Stevie® Awards in the categories of Front-Line Customer Service Team of the Year – Technology Industries, Customer Service Training or Coaching Program of the Year – Technology Industries, Customer Service Department of the Year – Computer Software – Up to 1000 Employees, and Most Valuable Response by a Customer Service Team (COVID-19). The Stevie Awards are the world's top honors for customer service, contact center, business development, and sales professionals.

CIVICPLUS HELP CENTER

CivicPlus customers have 24/7 access to our online Help Center where users can review articles, user guides, FAQs, and can get tips on best practices. Our Help Center is continually monitored and updated by our dedicated Knowledge Management Team to ensure we are providing the information and resources you need to optimize your solution. In addition, the Help Center provides our release notes to keep your staff informed of upcoming enhancements and maintenance.

CONTINUING PARTNERSHIP

We won't disappear after your website is launched. You'll be assigned a dedicated customer success manager. They will partner with you by providing information on best practices and how to utilize the tools of your new system to most effectively engage your residents.

Support at a Glance

- Technical support engineers available 8 a.m. – 6 p.m. (CST) Monday – Friday (excluding holidays)
- Accessible via phone and email
- 4-hour response during normal hours
- 24/7 emergency technical support for named points of contact
- Dedicated customer success manager
- Online self-service help with the CivicPlus Help Center (civicplus.help)

Maintenance

- Regular review of site logs, error messages, servers, router activity, and the internet in general
- Full backups performed daily
- Regularly scheduled upgrades including fixes and other enhancements
- Operating system patches
- Testing and development

2021 Support Metrics

- Total Tickets – 103,759
- Average Chat Response – 3:48 Minutes
- Average Phone Response – 7:57 Minutes
- Customer Satisfaction Score – 95.7%
- Solved in One Touch – 71.2%

Hosting & Security

Redundant power sources and internet access ensures consistent and stable connections. We invest over 1.0M annually to ensure we adapt to the ever-changing security landscape while providing maximum availability. CivicPlus' extensive, industry-leading process and procedures for protecting and hosting your site is unparalleled.

CLOUD-HOSTING WITH AZURE

The infrastructure is fully hosted within the Azure Cloud environment using their Infrastructure as a Service (IaaS) model. Using a mix of Azure Virtual Machines and Storage Accounts, all processing and data storage in done within this environment. All users need is a web browser to access and utilize the application. Your system is monitored 24/7/365 with a 99.9% guaranteed up-time (excluding maintenance). Additional details regarding our hosting and security services can be provided upon request.

DISASTER RECOVERY

Agenda & Meeting Management Select utilizes Azure's Site Recovery Services and Geographically Redundant Storage Accounts (GRS) to provide disaster recovery between Azure regions. All data is written to a GRS account which creates copies of that data in data centers across multiple Azure regions, so access to the data is always available. Site Recovery Services allows us to quickly spin up and failover to clones of our Azure Virtual Machines.

Disclaimer

Proposal as Non-Binding Document

A successful project begins with a contract that meets the needs of both parties. This proposal is intended as a non-binding document, and the contents hereof may be superseded by an agreement for services. Its purpose is to provide information on a proposed project we believe will meet your needs based on the information available. If awarded the project, CivicPlus reserves the right to negotiate the contractual terms, obligations, covenants, and insurance requirements before a final agreement is reached. We look forward to developing a mutually beneficial contract with you.

Enhancement Options

CivicPlus Media: Live Streaming & On-Demand Video

Increase resident engagement and participation by sharing high-definition live video feeds of your meetings directly from Agenda & Meeting Management Select and CivicPlus Media. Stream up to 3 concurrent live proceedings and seamlessly integrate all video content directly into your meeting agendas. Videos feature clear bookmarking and navigation so viewers can quickly find discussions of interest. Viewers can watch videos from any device with no software or application downloads necessary. Integrated closed captioning services are available at an additional cost.

Live Meeting Manager

CivicClerk's fully integrated Live Meeting Manager will automatically migrate all your agenda content. No manual pre-meeting minutes setup or agenda import is required. One-click control allows you to update your in-chamber display screens, set your video bookmarks, and queue items in the Board Portal for your elected and appointed officials.

- Automatic Video Bookmarking – Automatically timestamp agenda items to their corresponding discussion in the meeting video so those watching the recording can quickly access topics of interest.
- Display Pages – Keep meeting participants informed and engaged by displaying the current item, speaker, or vote results automatically to the constituents attending the meeting.
- Flexible Voting – Minutes takers can record motions and votes instantly in Live Meeting Manager or initiate electronic voting when desired. Apply motions and votes to individual agenda items or multiple agenda items as a group.

Boards & Committees Module

The Boards and Committees module tracks vacancies, applications, and appointments. Interactive dashboards give you quick access to actionable information. Easily manage rosters and generate communications using customized templates. Store system-generated communications and other necessary documentation at the board or individual member level. Track training and other internal requirements. Additional fees apply.

Historical File Import

As part of your implementation project, we will import up to 7,500 PDF, MP4, or MP3 documents to your new system. The process includes indexing your imported agendas for keyword searching and retrieval. You and your citizens will still have access to this historical information with increased functionality. Historic meeting documents imported into CivicPlus Agenda & Meeting Management Select by your implementation consultant will be optimized for character recognition to improve complete text search, and accessibility for screen reading assistive devices.

CivicPlus
302 South 4th St. Suite 500
Manhattan, KS 66502
US

Statement of Work

Quote #: Q-47749-1
Date: 8/29/2023 3:11 PM
Expires On: 11/30/2023

Client:
MCDUFFIE COUNTY, GEORGIA

Bill To:
MCDUFFIE COUNTY, GEORGIA

SALESPERSON	Phone	EMAIL	DELIVERY METHOD	PAYMENT METHOD
Darren Cornejo		darren.cornejo@civicplus.com		Net 30

QTY	PRODUCT NAME	DESCRIPTION	PRODUCT TYPE
1.00	CivicClerk Annual Fee	CivicClerk Annual Fee - Agenda and Minutes Management	Renewable
1.00	CivicClerk Year 1 Annual Fee Discount	Year 1 Annual Fee Discount	Renewable
1.00	Agenda & Meeting Management Select Premium Implementation Package	Premium Implementation Package – Up to 3 Boards	
1.00	CivicClerk Premium Configuration	CivicClerk Premium Configuration	One-time
1.00	CivicClerk Custom Template Design	CivicClerk Custom Template Set - includes 2 Agenda templates, 1 Item Report template, 1 Minutes template, 1 Agenda Script template	One-time
2.00	CivicClerk Consulting (1h, virtual)	1 hour Virtual Consulting	One-time
1.00	CivicClerk Virtual Training (Half Day Block)	Training (Virtual) - half day, up to 4 hours	One-time

~~List Price - Year 1 Total~~	~~USD 8,636.00~~
Total Investment - Initial Term	USD 7,437.00
Annual Recurring Services - Year 2	USD 5,035.80

Initial Term & Renewal Date	12 Months
Initial Term Invoice Schedule	100% Invoiced upon Signature Date

Renewal Procedure	Automatic 1 year renewal term, unless 60 days notice provided prior to renewal date

Renewal Invoice Schedule	Annually on date of signing
Annual Uplift	5% starting in Year 2

This Statement of Work ("SOW") shall be subject to the terms and conditions of the CivicPlus Master Services Agreement and the applicable Solution and Services terms and conditions located at https://www.civicplus.help/hc/en-us/p/legal-stuff (collectively, the "Binding Terms"), By signing this SOW, Client expressly agrees to the terms and conditions of the Binding Terms throughout the term of this SOW.

Acceptance

The undersigned has read and agrees to the following Binding Terms, which are incorporated into this SOW, and have caused this SOW to be executed as of the date signed by the Customer which will be the Effective Date:

Authorized Client Signature	CivicPlus
By:	By:
_____	_____
Name:	Name:
_____	_____
Title:	Title:
_____	_____
Date:	Date:
_____	_____

Organization Legal Name:

_____
Billing Contact:

_____
Title:

_____
Billing Phone Number:

_____
Billing Email:

_____
Billing Address:

_____

_____
Mailing Address: (If different from above)

_____

_____
PO Number: (Info needed on Invoice (PO or Job#) if required)

_____

STAFF REPORT

BOARD OF COMMISSIONER MEETING: October 4, 2023

DATE: September 29, 2023
TO: McDuffie County Board of Commissioners
FROM: Carrie Edwards
SUBJECT: Animal Services Camera Quote with Driven Security and Accord

BACKGROUND: Animal Services web-based and cloud purchase through Driven Security Verkada cameras and switch and wiring installation through Accord.

FACTS AND FINDINGS:

- The Animal Shelter is need of cameras for the protection of McDuffie county property and the well-being of the animals housed within the shelter.
- The Verkada Cameras will allow for web and cloud-based access in order to have the capacity to monitor while not on site.

Driven Security	$ 8,652.40
Accord Installation	$ 6,115.00
Total:	$14,767.40

Annual	$955.20 Annual

STAFF RECOMMENDATION: Staff recommends the approval of the request.

Driven Security
10645 N Tatum Blvd, Ste 200-410
Phoenix, AZ 85028 US
256-434-8086
customerservice@drivenlocks.com
https://www.drivenlocks.com

Sales Quote

ADDRESS

Driven Security
10645 N Tatum Blvd
Ste 200-410
Phoenix AZ 85028 USA

SHIP TO

Robert Spurlin
210 Railroad Street
Thomson GA 30824 USA

Sales Quote # 7204
Sales Rep Mason Million
Expiration Date 10/06/2023

Quote Date	09/22/2023	**Approved Date**	09/22/2023	**Order Date**	

SHIP VIA

UPS-GROUND

Disclaimer: Reflects pricing before any applicable state and local taxes

ITEM # DESCRIPTION	QTY	PRICE	TOTAL
CM42-768-HW Verkada CM42 Indoor Mini Dome Camera, 5MP, Fixed Lens, 768GB of Storage, Max 90 Days of Retention	5	$1199.20	$5996.00
CD42-768E-HW Verkada CD42-E Outdoor Dome Camera, 5MP, Fixed Lens, 768GB of Storage, Maximum 90 Days of Retention	1	$1599.20	$1599.20
LIC-1Y Verkada 1-Year Camera License	6	$159.20	$955.20

Accepted By

Accepted Date

SUBTOTAL	$8550.40
SHIPPING	$102.00
TAX	$0.00
TOTAL	$8652.40

Please give us a review here of how we are doing!
https://www.trustpilot.com/evaluate/drivenlocks.com

1 ACCORD
TECHNOLOGIES

We have prepared a quote for you

Animal Shelter Camera

Quote # CO-002506 Version 2

Prepared for:

Thomson-McDuffie Government

Prepared by:

Carlos Ochoa

1 ACCORD
TECHNOLOGIES

Tuesday, September 26, 2023

Thomson-McDuffie Government
Robert Spurlin
210 Railroad Street
IT Department
Thomson, GA 30824
robert.spurlin@thomson-mcduffie.gov

Dear Robert,

Federal Tax ID: 83-1698736
E-Rate SPIN: 143051019
E-Verify ID: 1338537

1 Accord Technologies is a technology solutions provider that was formed in August 2018. Our core principles and vision guide our decisions every day. Our founding members desired to create a company focused on client and employee success. We believe that creating a healthy work culture for our team will continue to drive innovation. Our hope is that our clients will see the difference in our delivery and personal touch. We are a high-spirited company without the big corporate restraints. Our focus is on problem solving to enable the best technology outcomes across every aspect of your business or institution. 1 Accord Technologies partners with some of the most advanced technology companies in the industry, and we seek to understand your needs and goals to deliver a total integrated solution. Our mission is to seek to understand before seeking to be understood.

1 Accord Technologies is headquartered in Middle Georgia with the capacity to deliver our services across the Southeast. We are capable of projects at any scale and specialize in K-12 network environments. Our experienced team of sales associates and engineers have a thorough understanding of the needs in the K-12 arena, so we are well versed in delivering technology solutions across a single campus or district-wide. We pride ourselves in maintaining great working relationships with our manufacturers and distributors which helps us deliver timely and cost-efficient results for our customers. Our primary core strength is customer service. We enjoy helping people, and we look forward to helping you.

Our services include:

Innovation | Integrity | Teamwork
IT Consulting | Network Design & Implementation | Cybersecurity | Managed Services | Intercoms Paging & Alerts
Classroom Audio | School Safety | Server Virtualization | Desktop Virtualization | Hosted-VoIP | Security Cameras
Lesson Capture | Interactive Panels | Fiber & Data Cabling

Carlos Ochoa
Account Executive
1 Accord Technologies

1 ACCORD TECHNOLOGIES

Statement of Work

Scope of Work: Thompson McDuffie Government Animal Shelter Camera

1. Introduction:
This document outlines the scope of work for the installation of security cameras for Thompson McDuffie Government's Animal Shelter.

2. Pre-Installation:
   a. Site Survey: Conduct a thorough assessment of the installation site to determine the optimal positioning for The Animal Shelter
   b. Equipment Procurement: Ensure that all necessary equipment.

3. Installation:
   a. Cameras: 1 Accord Technologies will install Verkada Cameras , Provided by district, for coverage in the following rooms.

      1. Lobby
      2. Office
      3. Cat Room
      4. Puppy Room
      5. Large Dog Room
      6. Exterior Building

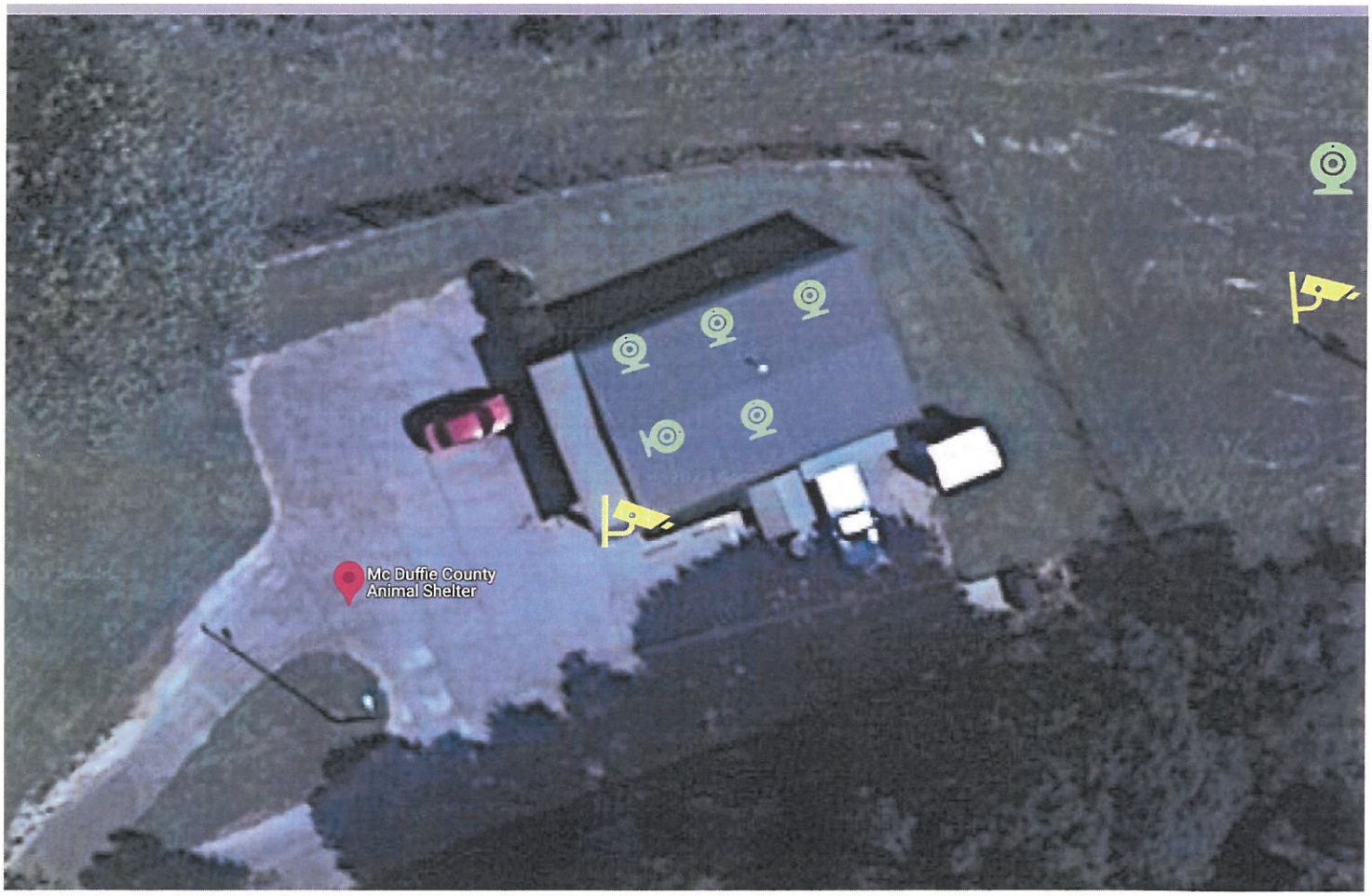
   b. Running Category 6 Cable:
      i. 1AT will provide and Install Category 6 Cable for Security Cameras
      ii. Run the Category 6 cable along the designated pathway, ensuring it is properly secured and concealed where necessary.
      iii. Terminate and test the Category 6 cable connections at both ends to ensure proper connectivity.

   c. Switch Installation:
      i. 1AT will provide and install a 24port Power Over Ethernet Switch.

4. Configuration
   a. 1AT will be responsible for configuration and integration of all network hardware.

5. Project Completion:
   a. Clean up the installation area, removing any debris and ensuring the work area is left in a clean and orderly condition.
   b. Obtain sign-off from the client, confirming their satisfaction with the installed system and completion of the project.

Statement of Work



1 ACCORD TECHNOLOGIES

Equipment

Description		Price	Qty	Ext. Price
	POE Switch			
FS-424E-FPOE	**Layer 2/3 FortiGate switch controller compatible PoE+ switch with 24 x GE RJ45 ports, 4 x 10 GE SFP+, with automatic Max 421W POE output limit**	$1,871.00	1	$1,871.00
			Subtotal:	**$1,871.00**

Cabling

Description		Price	Qty	Ext. Price
CAB-MAT	**Cabling Material - QTY: 6 CAT6 plenum rated Drops**	$1,189.73	1	$1,189.73
LABOR	**Labor - Cable Drops, PoE Switch and. Camera Installation**	$3,054.27	1	$3,054.27
			Subtotal:	**$4,244.00**

Animal Shelter Camera

Prepared by:

1 Accord Technologies
Carlos Ochoa
478-451-7060
Fax (678) 433-9169
carlos.ochoa@1accord.com

Prepared for:

Thomson-McDuffie Government
210 Railroad Street
IT Department
Thomson, GA 30824
Robert Spurlin
(706) 466-9251
robert.spurlin@thomson-mcduffie.gov

Quote Information:

Quote #: CO-002506
Version: 2
Delivery Date: 09/26/2023
Expiration Date: 10/31/2023

Quote Summary

Description	Amount
Equipment	$1,871.00
Cabling	$4,244.00
Total:	$6,115.00

Taxes, shipping, handling and other fees may apply. We reserve the right to cancel orders arising from pricing or other errors.

1 Accord Technologies

Signature: Carlos O

Name: Carlos Ochoa

Title: Account Executive

Date: 09/26/2023

Thomson-McDuffie Government

Signature: _____

Name: Robert Spurlin

Title: Technology Director

Date: _____

EXECUTIVE SUMMARY

ACO/E&R/NOD REPORT FOR SEPTEMBER 2023

OBJECTIVE:

To get approval of digest changes from the governing body of the County.

CONSIDERATIONS:

Approval of $13.75 Changes to the PROPERTY TAX DIGEST
Approval of $ 0.00 Changes to the MOBILE HOME DIGEST

FISCAL:

This will INCREASE/DECREASE the amount of revenue that is due to the County for the M&O.

The INCREASE to the Property Tax Digest are from property tax appeals being settled.

There are no changes to the Mobile Home Digest.

Prepared By:
Stacey W. Thomas
McDuffie County Tax Commissioner

Reviewed By:
David Crawley
County Manager

Data Date	Owner	BILL_TYPE	BILL_NO	BILL_YEAR	PROPERTY KEY	STATE	COUNTY	SCHOOL	THOMSON	Bellemede Lighting	Northview Lighting	CedarCreek Lighting	Deerfield Lighting	EliasStation Lighting	Fire fee	OakGrove Lighting	Total Est Tax
9/29/2023	THOMPSON GAS & OIL CO INC	R	12810	2023	12810	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
9/23/2023	THOMPSON GAS & OIL CO INC	R	12810	2023	12810	$ -	$ 25.30	$ 52.86	$ 22.32	$ -	$ -	$ -	$ -	$ -	$ 200.00	$ -	$ 300.48
Change to 2023 PROPERTY DIGEST (No Mobile Homes)						**$ -**	**$ (25.30)**	**$ (52.86)**	**$ (22.32)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ (200.00)**	**$ -**	**$ (300.48)**
9/1/2023	WATSON-BROWN FOUNDATION INC	R	14147	2022	11234	$ -	$ 62.47	$ 141.74	$ 55.12	$ -	$ -	$ -	$ -	$ -	$ 3.12	$ -	$ 262.45
9/29/2023	WATSON-BROWN FOUNDATION INC	R	14147	2022	11234	$ -	$ 46.85	$ 106.30	$ 41.34	$ -	$ -	$ -	$ -	$ -	$ 3.12	$ -	$ 197.61
Change to 2022 PROPERTY DIGEST (No Mobile Homes)						**$ -**	**$ 15.62**	**$ 35.44**	**$ 13.78**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 64.84**
9/1/2023	WATSON-BROWN FOUNDATION INC	R	13984	2021	11163	$ -	$ 93.71	$ 224.28	$ 82.68	$ -	$ -	$ -	$ -	$ -	$ 2.84	$ -	$ 403.51
9/29/2023	WATSON-BROWN FOUNDATION INC	R	13984	2021	11163	$ -	$ 70.28	$ 168.21	$ 62.01	$ -	$ -	$ -	$ -	$ -	$ 2.84	$ -	$ 303.34
Change to 2021 PROPERTY DIGEST (No Mobile Homes)						**$ -**	**$ 23.43**	**$ 56.07**	**$ 20.67**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 100.17**
GRAND TOTAL							$ 13.75	$ 38.65	$ 12.13								$ (35.30)