Human Resources
Benefits

Summary Plan Description

SAS Institute Inc. Dental Plan

Full-Time and Part-Time Employees of SAS
and Eligible Affiliated Employers

Effective January 1, 2016

INTRODUCTION

This document is the Summary Plan Description ("SPD") for the SAS Institute Inc. Dental Plan ("Plan"). This document highlights the main provisions of the Plan as of January 1, 2016. Full details of the Plan are contained in the Plan document, which is available from SAS Institute Inc., the Plan Sponsor.

The Plan is sponsored by SAS Institute Inc. ("SAS"). The coverage in this document applies only to such eligible Full-Time and Part-Time Employees and their covered Dependents as described herein. For purposes of this Plan, the term "Calendar Year" is the same time frame as the Plan's "Plan Year."

SAS has had and continues to have the right at any time, and from time to time, to modify, alter or amend the Plan, in whole or in part, effective as of a specified date, without the approval, consent or acceptance of any Participant or any other person, organization or entity. SAS' right to make such amendments to the Plan or any document related to the Plan shall permit SAS to change, at any time, and from time to time, the benefits offered to eligible Participants, including, without limitation (i) all dental benefits and (ii) the right to change Participant contributions to the cost of any Benefits.

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I. IMPORTANT INFORMATION

A. GENERAL INFORMATION

Type of Plan: The Plan is an employee welfare benefit plan providing group Dental Benefits. This Plan is a "self-funded" plan, and the benefits of this Plan are paid solely from the general assets of SAS and are not guaranteed through a policy of insurance.

Type of Plan Administration: The Plan provides payment of and provides reimbursement for certain dental expenses. The general administration of the Plan is provided by SAS through its Benefits Department. Claims for benefits are administered by the Claims Administrator, as defined below.

Plan Name: SAS Institute Inc. Dental Plan, which is a component plan of the SAS Institute Inc. Welfare Benefits Plan.

Plan Number: 501

Plan Sponsor Tax Identification Number: 56 -1133017

Plan Administrator Tax Identification Number: 56 -1133017

Effective Date: The original effective date of the Plan is January 1, 2014.

Plan Year: January 1 through December 31

Plan Sponsor:
SAS Institute Inc.
SAS Campus Drive
Cary, NC 27513
(919) 677-8000

Plan Administrator: SAS
Institute Inc.
SAS Campus Drive
Cary, NC 27513
(919) 677-8000

Agent for Service of Legal Process: SAS
Institute Inc.
SAS Campus Drive
Cary, NC 27513
(919) 677-8000
Attn: Office of General Counsel

Claims Administrator: The Claims Administrator provides claims administration for the Plan and does not insure or otherwise guarantee benefits.

The Claims Administrator for Dental benefits is:
Ameritas
PO Box 82520
Lincoln, NE 68501-2520

COBRA Administrator:

COBRA Direct
P.O. Box 70
Sanford, NC 27331
919-352-3019 (phone)
919-774-3782 (fax)

Eligible Subsidiaries and/or Affiliates Who Have Adopted the Plan: IDeaS, VSTI, SAS Federal

B. FUNDING THE PLAN AND PAYMENT OF BENEFITS

The Employer and eligible Employees share the cost of the coverage for themselves and their covered dependents. The cost of coverage is determined by the Employer based on the claims paid under the Plan and the related administrative costs.

C. CIRCUMSTANCES RESULTING IN LOSS OR REDUCTION OF BENEFITS

There are circumstances which may result in ineligibility or in denial, loss, suspension, offset, reduction or recovery of benefits that a Covered Person might reasonably expect the Plan to provide. These circumstances include, but are not limited to:

- Subrogation, reimbursement and third party recovery rights of the Plan.
- Coordination of benefits when a Covered Person is enrolled in more than one plan and this Plan is not the primary plan.
- Reductions due to charges that exceed Usual and Customary allowances. Reductions or denials due to services that are not generally accepted as appropriate, and/or which are not Medically Necessary, and/or which are considered as overutilization.
- Treatment, services and supplies that are excluded from coverage by the Plan, whether or not Medically Necessary.
- Fraud or intentional misrepresentation of a material fact against the Plan.
- Non-compliance with the Plan's certification requirements.
- Non-compliance with the Plan's claims filing deadline.

These provisions are described in greater detail throughout this document.

D. OBTAINING COVERAGE INFORMATION

A Covered Person may obtain information at no cost on whether, and under what circumstances, existing and/or new drugs, tests, devices, procedures and other services are covered, as well as obtain specific benefit information, by contacting SAS Benefits Department who may direct the Covered Person to the Claims Administrator.

E. EXAMINATION

The Claims Administrator shall have the right and opportunity to have a Covered Person examined whose injury or Illness is the basis of a claim hereunder when, and as often as it may reasonably require, during pendency of a claim hereunder, and also the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law.

F. WRITTEN NOTICE

Any written notice required under the Plan shall be deemed received by a Covered Person if sent by regular mail, postage prepaid, to the last address of such covered Employee on the records of the Employer, or if provided pursuant to the electronic delivery requirements of ERISA.

G. CLERICAL ERROR/DELAY

Clerical error made on the records of the Employer and delays in making entries on such records shall not invalidate coverage or cause coverage to be in force or to continue in force. The Effective Dates of coverage shall be determined solely in accordance with the provisions of the Plan regardless of whether any contributions with respect to Covered Persons 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. Errors cannot provide a benefit to which a Covered Person is not otherwise entitled.

H. ACCEPTANCE/COOPERATION

Accepting benefits under the Plan means that the Covered Person has accepted its terms and is obligated to cooperate with the Plan Sponsor in doing what the Plan Sponsor may ask to help protect the Plan's rights and carry out its provisions.

The Plan Administrator or its designee has discretionary authority to determine eligibility for and the amount of benefits under this Plan.

Failure to enforce a provision does not waive other provisions or the enforcement of that provision in other instances. Enforceability of any single provision shall not affect enforceability

of other provisions.

I. NOT A CONTRACT OF EMPLOYMENT

Nothing contained in this Plan shall be construed as:

- A contract of employment between an Employer and any Employee.
- A right of any Employee to be continued in the employment of an Employer.
- Consideration or inducement for employment with an Employer.
- A condition of employment between an Employer and any Employee.
- A limitation of the right of an Employer to discharge any Employee, with or without cause, at any time.

All Employees shall be subject to discharge to the same extent as if the Plan had never been adopted.

J. HIPAA PRIVACY

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. This Plan will use and disclose information that is protected by HIPAA ("protected health information") in a manner consistent with HIPAA's provisions, authorizations you may provide to us, and as permitted or required by law. By law, the Plan is required to obligate its business associates to also observe applicable HIPAA requirements. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of SAS. The Plan may disclose protected health information to the Employer in certain limited circumstances.

Under HIPAA, Covered Persons have certain rights with respect to their protected health information, including the right to request access to or a copy of their information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. Covered Persons also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if they believe their rights under HIPAA have been violated.

The Plan's use and disclosure of protected health information is described by a privacy notice (the "Privacy Notice") that also contains a more detailed description of your rights under HIPAA. For a copy of the Privacy Notice, please contact Michelle Jones, Manager, Benefits (the "Privacy Official").

II. ELIGIBILITY AND ENROLLMENT

A. EMPLOYEE ELIGIBILITY REQUIREMENTS

Newly hired Full-Time Employees and Part-Time Employees who work at least 20 hours per week have the option to elect or decline coverage for themselves and their eligible dependents. If coverage is desired, an employee must complete and submit a Benefits Enrollment/Change form in the manner specified by the SAS Benefits Department within sixty (60) days of employment as described in the section of this SPD entitled "Enrollment Requirements for Employees and Dependents" and pursuant to the procedures set by the SAS Benefits Department. Participation in the Plan begins on the date of full-time or part-time employment.

Non-resident aliens, contract or leased employees, students, seasonal, substitute, temporary or temporary agency employees are not eligible to participate in this Plan. In addition, any person who is reclassified into an eligible class, either by action of the Plan Administrator or by a governmental or judicial authority, will not be eligible to participate in the Plan for the period of time the person was excluded from the Plan because of his classification. Upon the date of reclassification, the reclassified person will be eligible to participate in the Plan immediately.

B. DEPENDENT ELIGIBILITY REQUIREMENTS

A covered Employee may enroll his/her eligible Dependents in the Plan. If an Employee and his/her Spouse/Domestic Partner are both employed by the Employer then the Employee may elect coverage under the Plan EITHER as an individual Employee or as a Dependent under the Spouse's/Domestic Partner's coverage, but not both. Also, if both parents are employed by the Employer, Children will be covered as Dependents of one parent only. If a Dependent is a nonresident alien, he is not eligible to participate in the Plan.

If a covered Employee wants to enroll his Domestic Partner or his Domestic Partner's Child, he will be required to sign an Affidavit of Domestic Partnership. If the covered Employee terminates coverage for his Domestic Partner or his Domestic Partner's Child by filing a Termination of Domestic Partnership Statement with the Plan Administrator, via the SAS Benefits Department, he may not enroll another Domestic Partner in the Plan until at least one year has elapsed from the date of the filing of the Termination of Domestic Partnership Statement. All other Plan provisions for adding or dropping Dependents apply to Domestic Partners, unless noted otherwise in this document.

An Employee must be covered under this Plan in order to cover any eligible Dependents under this Plan.

The Plan Sponsor retains the right to request whatever documentation is necessary to confirm that an individual qualifies as a Dependent. If an Employee is asked to certify the status of persons for which he is claiming Dependent status and it is discovered that false information has been provided, benefits will be terminated for the dependent, and the Employee will be asked to

reimburse the Plan for overpaid benefits. It is a federal crime, under HIPAA, to provide false information in order to obtain benefits from a health plan.

C. ENROLLMENT REQUIREMENTS FOR EMPLOYEES AND DEPENDENTS

Full-Time Employees and Part-Time Employees working at least 20 hours per week may elect coverage and pay the required contribution once satisfying the eligibility requirements as provided under "Employee Eligibility Requirements."

Coverage for the Employee and the Employee's Dependent(s) does not become effective until the Employee completes the Benefits Enrollment/Change form provided by the Plan Administrator and delivers such form to the Plan Administrator, via the SAS Benefits Department. If an Employee fails to submit an Enrollment/Change form within 60 days from full-time or part-time employment, he will automatically be enrolled in the Plan with Employee Only Coverage.

If the Employee does not request enrollment for his Dependent(s) within 60 consecutive days of becoming eligible to enroll in the Plan, then the Employee may not enroll the Dependent(s) until the Plan's next open enrollment period, or, if earlier, the date of a Qualifying Change in Status event.

Dependents are eligible for enrollment in the Dental Plan only if the employee is also enrolled. Dependents enrolled after the effective date of this Plan and in accordance with the terms of this Plan will become covered on the later of:

- The same date as the Employee.
- The date the Dependent is acquired (for birth or adoption).
- The date of the Qualifying Change in Status.
- The date that the Enrollment/Change form and supporting documentation is received by the Benefits Department.

Refer to the Summary Plan Description for the Premium Conversion and Flexible Spending Account Plan for additional information regarding the ability to change elections for coverage during the middle of the Calendar Year.

D. COST OF COVERAGE

The covered Employee shares the cost of coverage in two ways:

1. The covered Employee pays a portion of the monthly cost of coverage for himself and for his Dependents that are enrolled in the Plan, which is referred to as premiums (the Employer subsidizes the rest); and

2. The Covered Person pays a portion of the cost of certain health care services he receives, including but not limited to: Deductibles, plan maximum amounts, out-of-pocket expenses, penalties for non-compliance, and non-covered expenses.

The monthly cost of coverage (premium) is communicated when the Employee first enrolls and during each annual Open Enrollment period. The current premiums can also be found on the Benefits Department Web site located on the SWW.

All eligible premiums are automatically deducted on a pre-tax basis from the Employee's wages pursuant to the Premium Conversion Plan sponsored by SAS. The Premium Conversion Plan, also known as a "cafeteria plan," is described in the Summary Plan Description for the SAS Institute Inc. Premium Conversion and Flexible Spending Account Plan. Premiums for a Domestic Partner or the Children of a Domestic Partner who are enrolled in the Plan must be deducted on an after-tax basis unless the Domestic Partner or the Children qualify as the Employee's dependents under federal tax law.

By law, cafeteria plans are subject to certain restrictions. The coverage that an Employee elects during the initial enrollment period or annual open enrollment period will remain in effect until the next Open Enrollment period, unless the Employee experiences a qualifying Special Enrollment Event, Change in Status, Change in Coverage or Change in Cost, each of which is described in the Premium Conversion and Flexible Spending Account Plan Summary Plan Description.

More details regarding the payment of premiums on a pre-tax basis may be found in the Premium Conversion and Flexible Spending Account Plan Summary Plan Description. This Summary Plan Description is available on the SAS Benefits Department SWW website or by contacting the SAS Benefits Department.

Certain exceptions to the cost sharing provisions of this section may apply if an Employee is on a leave of absence (e.g. Family Medical Leave, Uniformed Services Employment and Reemployment Rights Act Leave, disability leave, etc.). Please refer to those provisions of this SPD for more detailed information regarding payment of premiums during a leave of absence.

E. ENROLLMENT REQUIREMENTS FOR NEWBORN OR ADOPTIVE CHILDREN

A newborn Child of a Participant may be covered under the Plan from the date of birth or if coverage for the Child is requested no later than 60 days after the date of birth and any required premium contributions are made. An adoptive Child of Participant is covered under the Plan from (i) the date the Child is placed with the Participant pending final adoption if coverage for the Child is requested no later than 60 days after the date of adoptive placement and any required premium contributions are made OR (ii) if the Child is placed with Participant pending final adoption within 60 days of the Child's date of birth, from the date of birth, if coverage for the Child is requested no later than 60 days after the date of birth and any required premium contributions are made. If coverage for the Child is <u>not</u> requested within the applicable 60-day

period, the Child may only be enrolled during the annual Open Enrollment period or as provided in "**Mid-Year Benefit Election Changes**," described in the Premium Conversion and Flexible Spending Account Plan Summary Plan Description.

If an Eligible Employee does not have medical coverage under the Plan at the time coverage for the Child is requested, the Eligible Employee and Child may only be enrolled as provided in "**Mid-Year Benefit Election Changes**," set forth in the Premium Conversion and Flexible Spending Account Plan Summary Plan Description.

F. FAMILY AND MEDICAL LEAVE ACT (FMLA) OF 1993

This section is intended as a summary of the FMLA, not as a complete interpretation of the law. Rights under the FMLA are described in greater detail in other SAS policies and procedures.

If a Participant takes FMLA Leave, the Employer must provide the same health coverage during the FMLA Leave with the same level of contribution required of the Participant during active employment and in the manner directed by the Plan Administrator, which may or may not be on a pre-tax basis. If a Participant takes paid FMLA Leave, he will continue to participate in the Plan. If a Participant takes unpaid FMLA Leave, and the Participant is required to pay for the cost of coverage under the Plan, he or she may elect to either continue or discontinue his or her participation in the Plan. The Participant must notify the Plan Administrator, via the SAS Benefits Department, of his desire to make such change. If a Participant fails to make the payments on a timely basis, the Employer, after giving written notice, can end the coverage during the leave if payment is more than 30 days late.

If a Participant chooses not to retain coverage during unpaid FMLA Leave, the former Participant's coverage under the Plan, subject to any changes that affect the workforce as a whole, must be restored upon his or her return to service with the Employer before the expiration of the FMLA Leave period whether his or her coverage was voluntarily revoked or cancelled due to non-payment of premiums. The Participant must be treated as though no service or coverage interruption had occurred.

If a Participant on FMLA Leave notifies the Employer during the leave that he will not be returning to work, the Participant's coverage under the Plan shall terminate on the last day of the month following the Participant's termination effective date.

G. UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA) OF 1994

The Plan complies with USERRA. If any provision of this Plan is found to be in conflict with USERRA, the conflicting provision shall be reformed, to the full extent practicable, to conform to the requirements of USERRA and any provision which is still in conflict will be void and of

no further force or effect. All other benefits and exclusions of the Plan will remain effective to the extent that there is no conflict with USERRA.

- **USERRA LEAVE OF ABSENCE OF 12 MONTHS OR LESS**:
  If a Participant is called to a USERRA Leave and the duration of the USERRA Leave is 12 months or less, then the Participant and his covered Dependents may continue to be covered under the Plan during such USERRA Leave by paying the portion of the premium for the coverage that the Participant would have paid if he/she had continued in the same position and had not taken the USERRA Leave.

- **USERRA LEAVE OF ABSENCE OF GREATER THAN 12 MONTHS**:
  If a Participant is called to a USERRA Leave and the duration of the USERRA Leave is greater than 12 months, then the Participant and his covered Dependents may continue to be covered under the Plan during such USERRA Leave up to the maximum period of coverage described below by paying the premium as directed by the SAS Benefits Department which shall not exceed the COBRA premium determined under the COBRA section of the Plan for such coverage. The maximum duration of continued coverage available for a USERRA Leave that exceeds 12 months shall be the lesser of: the 24-month period beginning on the date on which the covered Employee's absence for the USERRA Leave commenced; or the day after the date on which the Participant on the USERRA Leave fails to apply for or return to a position of employment with the Employer, as determined under USERRA.

H. QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Coverage shall be provided to the Child of a covered Employee or his or her covered Spouse if the Child is the subject of a QMCSO in accordance with applicable law, or is the subject of a National Medical Support Notice (NMSN) that is deemed to operate as a QMCSO.

The term "Alternate Recipient" means any Child of a covered Employee or his or her covered Spouse who is recognized under a QMCSO as having a right to enrollment under a group health plan.

A QMCSO is a court order that usually results from a divorce that provides for child support or health care coverage for the Child of a covered Employee or eligible Spouse. The court order creates or recognizes the existence of the alternate recipient's right to, or assigns to the alternate recipient the right to, receive benefits for which the covered Employee or Spouse is eligible under the Plan. The QMCSO must specify:

- The name and last known mailing address of the covered Employee or Spouse required to pay for the coverage and the name and mailing address of each alternate recipient.
- A reasonable description of the type of coverage to be provided by the Plan or the manner in which such coverage is to be determined.
- Each Plan to which the order applies.
- The period for which coverage must be provided.

The court order may not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan.

When a Plan Administrator receives a medical child support order (including an NMSN), the following steps must be taken by the Plan Administrator:

- Notify both the covered Employee or Spouse and each alternate recipient of receipt of the order.
- Furnish an explanation of the Plan's procedures for determining whether the court order is a QMCSO.
- Determine if it is qualified.
- Notify the covered Employee or Spouse and each alternate recipient of the determination and, if the order is determined to be qualified, provide the alternate recipient with a full explanation of the benefits as described within this SPD.

The Plan Administrator is responsible for deciding whether the court order satisfies the conditions of a QMCSO.

I. OTHER COVERAGE

- **DISABILITY**: If a Participant becomes Totally Disabled, coverage under the Plan may be continued at the option of the Plan Sponsor for up to one (1) year after the Participant qualifies for long-term disability insurance while the Participant is on a Leave of Absence due to a disability, subject to the payment of any required contributions, provided the Participant otherwise complies with the Employer's Leave of Absence policies and procedures. The determination of whether or not the absence qualifies as a long-term disability will be made by the Employer's authorized third-party administrator. Thereafter, coverage may be continued under COBRA. See "**Continuation of Benefits (COBRA)"** for coverage continuation options.

- **LEAVE OF ABSENCE OTHER THAN FMLA LEAVE OR USERRA LEAVE**: A Participant who takes a Leave of Absence other than (i) FMLA Leave, (ii) USERRA Leave or (iii) a Leave of Absence on account of being Totally Disabled, will continue to be covered under the Plan through the end of the month following 30 working days while on such leave, subject to the payment of any required contributions, provided the Participant otherwise complies with the Employer's Leave of Absence policies and procedures. If the Leave of Absence is unpaid, the Participant may revoke his or her election to participate in the Plan if the Leave of Absence qualifies as a Change in Status under the SAS Institute Inc. Premium Conversion and Flexible Spending Account Plan. In order to continue to participate in the Plan during an unpaid Leave of Absence, the Participant must pay the required contributions in the manner directed by the Plan Administrator.

- **LAPSE IN COVERAGE**: If a former Participant requests re-enrollment when there has been a lapse in coverage, the person may only be enrolled during the annual open enrollment or as provided in "Mid-Year Benefit Election Changes," set forth in the Premium Conversion

and Flexible Spending Account Plan (except in the case when COBRA has been elected and continued with no lapse in coverage).

- **REHIRED EMPLOYEES**: If a former Participant is rehired by the Employer within 30 days during the same Plan Year and again becomes eligible to participate in the Plan, the former Participant may re-enroll for the remaining portion of the Plan Year but must elect the same benefit elections existing immediately prior to his termination. If the former Participant should return to service with the Employer after 30 days, but during the same Plan Year, the former Participant may re-enroll with new benefit elections for the remaining portion of the Plan Year.

- **TRANSFERRED EMPLOYEES**: If an Eligible Employee transfers with no break in service from one wholly owned subsidiary that participates in the Plan to another, the eligible Employee will be treated as if the transfer never occurred as far as coverage under the Plan is concerned (including, but not limited to, the waiting period, pre-existing condition exclusion period, applicable Deductibles, out-of-pocket maximum, etc.).

III. TERMINATION OF COVERAGE

A. EMPLOYEES

A Participant's coverage under this Plan will terminate on the earliest of the following dates:

- The date of termination of this Plan.
- The last day of the month in which the Participant's employment terminates.
- The last day of the month in which the Participant ceases to meet the Plan's eligibility requirements for Employees.
- The date benefits under the Plan are terminated for the class of which the Participant is a member by modification of the Plan.
- If employed by an affiliate or a subsidiary of SAS that participates in the Plan, the date such entity terminates participation in the Plan.
- The date an Employee becomes a full-time member of the armed forces, except as required by USERRA.
- The date on which a Participant commits a fraud against the Plan or makes an intentional misrepresentation to the Plan.

See "**Continuation of Benefits (COBRA)**" for coverage continuation options.

B. DEPENDENTS

A Dependent's coverage under this Plan shall terminate on the earliest of the following dates:

- The date of termination of this Plan.
- The date of termination of all coverage under the Plan with respect to Dependents.

- The last day of the month in which coverage terminates for the Participant who has enrolled the Dependent for any reason. In the case of a Participant who is a Covered Employee who dies, coverage for such Participant's Dependents will continue for up to one year (12 Calendar Year months) following the Participant's death, subject to the other terms and conditions of the Plan, including payment of the required premiums and Dependent eligibility requirements.
- The date the Dependent becomes covered under the Plan as an Employee.
- The date the Dependent becomes a full-time member of the armed forces, except as required by USERRA.

- The last day of the period for which the required contribution has been paid if the required contribution for the next period is not paid when due.
- The date on which the person ceases to meet the Plan's eligibility requirements for Dependents.
- The date on which the Employee who has enrolled the Dependent fails to provide any lawfully required information concerning the Dependent.
- The date the Domestic Partner or a Child of a Domestic Partner ceases to qualify as a Dependent because the Domestic Partner's relationship with the Participant has terminated (for this purpose, the Domestic Partnership relationship is terminated if the covered individual no longer meets the definition of "Domestic Partner" or by filing a Termination of Domestic Partnership Statement with the SAS Benefits Department).
- The date on which a Dependent commits a fraud against the Plan or makes an intentional misrepresentation to the Plan.

See "**Continuation of Benefits (COBRA)**" for coverage continuation options.

IV. SCHEDULE OF DENTAL BENEFITS

MAXIMUM BENEFIT PER CALENDAR YEAR* **$2,000**
***The Maximum Benefit applies to all services except Orthodontic and Temporomandibular Joint Dysfunction Treatment.

LIFETIME MAXIMUM BENEFIT FOR ORTHODONTIC TREATMENT **$2,500**

LIFETIME MAXIMUM FOR TEMPOROMANDIBULAR JOINT DYSFUNCTION **$1,800**

DEDUCTIBLE PER CALENDAR YEAR ..... **None**

COINSURANCE BENEFIT PERCENTAGE (payable by the Plan):
Preventive and Diagnostic Services **100%**
Basic and Restorative Services **100%**
Major Services **60%**
Orthodontic Treatment **50%**
Temporomandibular Joint Dysfunction **50%**

V. DENTAL BENEFIT PROVISIONS

Dental coverage under this Plan is limited to the necessary, Usual and Customary (U&C) allowances as determined by the Claims Administrator, subject to the application of Maximum Benefit, Deductible, and Coinsurance Benefit Percentage provisions as stated in the "Schedule of Dental Benefits." All covered expenses will count toward the covered person's individual dental calendar year maximum benefit that is shown on the Schedule of Benefits, as applicable.

For covered persons who were terminated from the Plan and are later reinstated after a lapse in coverage (for example, a covered person ends employment and later is re-hired and re-enrolls in this Plan), the lifetime maximum benefits will not start over. The lifetime maximum benefit will continue to accumulate from the level satisfied at the time of the covered person's termination.

A. COVERED DENTAL EXPENSES

The Plan will consider payment of the following covered expenses Incurred by a covered person, subject to any deductibles, Plan participation amounts, maximums or limits shown on the Schedule of Benefits, and to all other provisions as stated in this SPD. Benefits are based on the Usual and Customary allowance, fee schedule or Negotiated Rate. Any procedure that is not

specifically listed as covered is excluded.

PREVENTIVE AND DIAGNOSTIC SERVICES:

- Routine oral examination, limited to **2** examinations per Calendar Year. Comprehensive or periodontal evaluation contributes to this frequency.
- Comprehensive or periodontal evaluation, limited to **1** examination per provider.
- Prophylaxis treatment (scaling and polishing of teeth), limited to **2** treatments per Calendar Year.
- One (**1**) additional routine exam, and one (**1**) additional cleaning or periodontal maintenance per Calendar Year for diabetics, heart disease management patients and pregnant women.
- Topical application of fluoride or fluoride varnish.
- Topical application of a sealant on each permanent posterior tooth up to age 19, limited to 1 per tooth in a 3 year period.
- Office visit during office hours other than for routine oral examination, limited to **2** visits per Calendar Year.
- Oral hygiene instruction.
- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater).
- Accession of tissue, gross and microscopic examination and preparation of written report, limited to 1 per twelve month period and 1 per biopsy/excision.
- Laboratory accession of transepithelial cytologic sample, microscopic examination.
- Dental X-rays including:
    - Full mouth series, limited to **1** series during any period of 36 consecutive months;
    - Panoramic view, limited to **1** during any period of 36 consecutive months; and
    - Bitewing X-ray series, limited to **2** series per Calendar Year.

BASIC AND RESTORATIVE SERVICES:

- Periapical and Extraoral X-rays.
- Other X-rays as needed for diagnosis (except X-rays taken in connection with orthodontic treatment or TMD treatment).
- Problem focused evaluation, limited to **1** examination per Calendar Year.
- Periodontal Maintenance treatment (scaling and polishing of teeth), up to **4** treatments per Calendar Year when periodontal disease is evident. Prophylaxis treatment contributes to this frequency.
- Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures allowed once per Calendar Year.
- Pulp vitality tests.
- Special consultation by a specialist for case presentation when diagnostic procedures have been performed by a general Dentist.
- Space Maintainers, fixed and removable, including removal of fixed space maintainer, limited to space maintenance for unerupted teeth, following extraction of primary teeth.

Allowances include all adjustments within 6 months of the placement date.

- Amalgam and Resin-based Composite Restorations, limited to 1 of any of these procedures per tooth per 6 months.
- Core Buildup, including any pins.
- Stainless Steel Crowns, prefabricated and resin-based, limited to 1 of any of these procedures per 12 months.
- Sedative filling.
- Emergency or palliative visits for relief of pain.
- Extractions.
- Oral surgery, including surgical removal of impacted teeth.
- Biopsy of oral tissue.
- Inhibiting appliances to correct harmful habits like bruxism or thumb sucking, such as occlusal guards (night guards). Benefits are not available for devices placed for athletic purposes.
- Endodontics including root canal therapy and retreatment, pulp caps, and apicoectomy/periradicular surgeries.
- Periodontal scaling and root planning per quadrant (limited to 4 quadrants per Calendar Year).
- Periodontal therapy including: Gingivectomy or gingivoplasty, Gingival Flap, Osseous Surgery and Tissue Grafts. Each quadrant is limited to one of each therapy type per 3 years.
- Guided tissue regeneration and distal or proximal wedge procedures.
- Provisional splinting
- Localized delivery of antimicrobial agents, each quadrant is limited to 2 of these per 2 years.
- Full Mouth Debridement, limited to 1 procedure in a 5 year period.
- Local anesthetics and antibiotic drugs injected by the attending Dentist.
- Nitrous oxide for Dependent Children under the age of 12.
- Nitrous oxide for members age 12 and over will be considered when a physician's statement of health is submitted certifying a medical condition is present in the patient that would not allow safe dental treatment without the administration of nitrous oxide.
- Anesthesia, Non-Intravenous Conscious Sedation and IV Sedation in conjunction with surgical procedures.
- For treatment outside of surgical procedures, anesthesia benefits are considered by the plan when the patient is permanently disabled and a physician's statement of health certifies the patient has a medical condition that prevents him or her from receiving dental treatment or receiving that treatment safely without anesthesia. In order for this benefit to be considered, the patient must be established as permanently disabled and a statement of health must be submitted to the dental administrator.
- Alveolar and gingival reconstruction.
- Repair of dentures.

MAJOR SERVICES:

- Inlays, onlays, crowns and gold fillings.
- Repair or re-cementing of crowns, inlays, bridgework.
- Relining of dentures.
- Labial veneers.

- All charges and services related to tooth implants are covered when installed in lieu of bridgework.
- Initial installation of partial or full removable dentures or fixed bridgework (including the accompanying inlays and crowns to form abutments) to replace one or more natural teeth extracted while the coverage is in effect under the Dental benefits portion of this Plan (unless the tooth also replaces a tooth that is extracted while covered, and such tooth was not an abutment for a denture or fixed bridgework installed during the preceding 5 years).
- Replacement of existing partial or full removable dentures or fixed bridgework, or the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth, but only if:
    - The replacement or addition of teeth required to replace one or more natural teeth extracted while the coverage is in effect under this Plan or any predecessor plan and after the existing denture or bridgework was installed; or
    - The existing denture or bridgework was installed at least 5 years prior to its replacement and cannot be made serviceable; or
    - The existing denture is an immediate temporary denture, and replacement by a permanent denture is required and takes place within 12 months from the date of installation of the immediate temporary denture.
- Prefabricated and indirectly fabricated post & core procedures.

ORTHODONTIC TREATMENT:

The Plan will provide benefits for orthodontic treatment, subject to any limitations specified in the "**Schedule of Dental Benefits**".

- Oral examinations and diagnosis.
- Initial (and subsequent, if any) installation of orthodontic appliances and adjustment of orthodontic appliances.
- Replacement or repair of retainer.
- Comprehensive full-banded treatment.

Orthodontic programs that are currently being paid by a prior carrier may qualify for coverage under this plan. When submitting claim for benefits under this plan please include total program information and attach benefit statements from the prior carrier showing the amount paid to date for the program. Orthodontic benefits paid under this Plan will be reduced by the amount paid by the previous carrier.

TEMPOROMANDIBULAR JOINT DYSFUNCTION:

The Plan will provide benefits for the diagnosis and treatment of Temporomandibular Joint Dysfunction treatment, subject to any limitations specified in the "**Schedule of Dental Benefits**". If surgery is recommended, a second opinion is required before coverage will be allowed. If the Claims Administrator approves the surgery, benefits will be covered under the SAS Institute Inc. Medical Plan, consistent with the provisions of that plan.

ALTERNATIVE PROCEDURES

If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

The plan administrator may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. The member is strongly encouraged to request pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

B. GENERAL DENTAL PROVISIONS

PRE-TREATMENT ESTIMATE OF BENEFITS:

Usually, before beginning any extensive treatment, the covered person will be advised as to what the dentist intends to do, and this is referred to as the treatment plan. The dentist will submit the treatment plan to the Claims Administrator prior to services being performed. The Claims Administrator will then notify the dentist, in advance, regarding what benefits are payable under this Plan, and how much the covered person will be responsible for paying. Getting a PreTreatment Estimate of Benefits is recommended whenever the dentist's estimated charge is $300 or more. This feature is not mandatory; however dental care can be expensive. Covered persons may want to have an idea how much this Plan will pay before agreeing to have the work done. Note: The Pre-Treatment Estimate is not a guarantee of payment. Benefits are payable if coverage is in effect on the date services are performed (subject to all Plan provisions) and the claim is submitted to the Plan within the timely filing period. If additional procedures are performed, the claim will be reviewed in its entirety.

“SERVICES INCURRED” AND “SERVICES PERFORMED”:

Charges shall be allocated to a particular Calendar Year and to the maximum applicable to such year, in accordance with the date such charge is deemed “Incurred” under this contract. All charges which are “Incurred” with respect to any Treatment Plan shall be deemed “Incurred”:

1. For an appliance, or modification of an appliance: On the date the impression is taken.
2. For a crown, bridge or gold restoration: On the date the tooth is prepared.
3. For root canal therapy: On the date the pulp chamber is opened.
4. For all other services: On the date the service is received.

PAYMENT OF ORTHODONTIC BENEFITS:

Qualified orthodontia expenses that paid up-front lump-sum may be eligible for Health Care Flexible Spending Account reimbursement in full (up to Plan limits) provided the lump sum is paid during the same plan year from which reimbursement is being requested and while the participant was covered under the Plan. Proof of payment is required.
Participants that do not pay up front and opt for monthly payments can be reimbursed by the Health Care Flexible Spending Account as those monthly payments are made (provided the monthly payment is paid during the same plan year from which reimbursement is requested and while the Participant was covered under the Plan.

C. DENTAL EXCLUSIONS

No benefits will be paid under this Plan for:

1. Expenses Incurred prior to the Effective Date of coverage under the Plan, or after coverage is terminated unless Continuation of Benefits applies.

2. Expenses payable under the SAS Medical Plan.

3. Treatment by other than a Dentist, except that scaling or cleaning of teeth may be performed by a licensed dental hygienist if treatment is rendered under a Dentist's supervision and direction.

4. An appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or gold restoration for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered.

5. Surgical removal of implants unless Clinically Eligible for Coverage.

6. Replacement of implants or appliance constructed in association therewith if this Plan covered the original placement within the previous five (5) years.

7. Prosthetic devices (including bridges and crowns) and the fitting thereof which were ordered before, or while, the person was covered under the Dental benefits portion of this Plan, but installed or delivered after termination of his Dental coverage under this Plan.

8. For precision attachments, transplants or replants; endodontic implants, dietary planning for control of dental caries, oral hygiene instruction, training in preventive dental care, or bite registration.

9. Charges Incurred outside the United States if the Covered Person traveled to such a location for the sole purpose of obtaining dental services or supplies.

10. Replacement of a lost or stolen appliances or prosthetic device(s).

11. Cosmetic surgery or dentistry for cosmetic reasons (facings on molar crowns or poetics are always considered cosmetic; treatment for congenital (hereditary) or developmental malformations; cleft palate; maxillary or mandibular (upper and lower jaw) degeneration; enamel hypoplasia (lack of development); fluorosis.

12. Appliances or restorations or procedures for the purpose of splinting, or alter vertical dimensions or restore occlusion.

13. Charges for completing claim forms or missed dental appointments.

14. Charges in excess of the U&C Charge as determined by the Claims Administrator.

15. Charges for which the Covered person is entitled to benefits under any workers' compensation or similar law.

16. Charges that the Covered person is not liable or which would not have been made had no coverage been in force.

17. For services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

The above exclusions and limitations apply notwithstanding any contrary provision in this Summary Plan Description.

If a particular charge is a covered Dental expense and could also be a covered expense under the SAS Medical Plan, such charge will be paid under the appropriate Plan as determined by the Claims Administrator.

VI. COORDINATION OF BENEFITS

Except as noted below, the following Coordination of Benefits provisions apply to Dental benefits.

Coordination of benefits applies when a Covered Person has coverage under this Plan and one or more other Coordinated Plans (as defined below). In such circumstances, one of the plans involved will pay the benefits first. That plan is called the Primary Plan. The other plans involved will pay benefits next. These plans are called Secondary Plans. The rules shown in this provision determine which plan is Primary and which plan is Secondary. Whenever there is more

than one Coordinated Plan, the total amount of benefits paid in a Plan Year under all plans cannot be more than the Allowable Expenses charged for that Plan Year.

In cases where a Covered Person has a High Deductible Health Plan with a Health Savings Account as the Primary Plan, the SAS Dental Plan does not coordinate benefits (cannot be a Secondary Plan).

A. DEFINITIONS

The following definitions will apply **only** to this section:

1. "**This Plan**" means any benefits described in this Summary Plan Description.

2. "**Plan**" means any of these that provide benefits or services for, or because of, health care or treatment:

   - Group insurance and group-type coverage, whether insured or uninsured. This includes group or group-type coverage through HMO's and other prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
   - Coverage through labor-management trusteed plans.
   - Government program coverage for which a person is eligible. This includes Medicare Parts A, B and D; however, Medicaid is excluded.
   - Workers' compensation insurance for an accepted claim. □No-fault motor vehicle laws.

   The term "plan," as defined in this section, shall not be applicable to any coverage held by the Covered Person for hospitalization and/or medical-surgical expenses written as part of or in conjunction with any automobile insurance policy, unless it is a no-fault automobile insurance policy.

3. "**Allowable Expenses**" shall mean any necessary usual, customary and reasonable expenses Incurred while eligible for benefits under This Plan, part or all of which would be covered under any of the plans, but not including any expenses contained in the list of "Exclusions."

B. EFFECTS OF BENEFITS

1. The benefit payable under This Plan shall be integrated with the benefit payable to a person under all other plans. This Plan will pay the amount it would have paid had it been the person's only coverage, up to the total Allowable Expenses, less any amounts paid by other plans that determine benefits first. In the event that the plans that determine benefits first pay as much or more than This Plan would have paid had This Plan been the person's only coverage, This Plan will not pay any benefits.

2. The rules for deciding which plan determines benefits first are:

a. The benefits of a plan that covers the person as an employee, member or subscriber, that is, other than a Dependent, are determined before those of the plan that covers the person as a Dependent.

b. The benefits of a plan that has no rules for coordination with other benefits are determined before This Plan's benefits.

c. Except as stated in paragraph d. below, when This Plan and another plan cover the same child as a Dependent of different persons, called "parents":

   i. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year.
   ii. But if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
   iii. However, if the other plan does not have the rule described in "i", 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.

d. If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

   i. First, the plan of the parent with custody of the child.
   ii. Then, the plan of the Spouse or Domestic Partner of the parent with the custody of the child.
   iii. Finally, the plan of the parent not having custody of the child.

   However, if a court decree states that one of the parents is financially responsible for the health care expenses, the benefits of that plan are determined first.

e. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's Dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

f. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, benefits for such person are determined in this order:

   i. First, the benefits of the plan covering the person as an employee, member or subscriber (or as that person's Dependent).
   ii. Second, the benefits under the continuation coverage.

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 does not apply.

g. If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter time.

h. If none of the above determines which plan is Primary, the Claims Administrator, in the exercise of its discretion, may determine which plan shall be Primary.

C. COORDINATION WITH MEDICARE

If the Covered Person is eligible for Medicare and the employee remains employed by the Employer, the Covered Person will continue to be covered by the Plan and benefits will integrate with those payable from Medicare.

Pursuant to the Medicare secondary payer requirements of federal law, this Plan will pay benefits primary to Medicare for Participants who are Medicare eligible if:

1. Eligibility for Medicare is due to age 65 and the employee has a current employment status with the Employer as defined by federal law and determined by the Plan Administrator, via the SAS Benefits Department;

2. Eligibility for Medicare is due to the disability of the employee or his or her Dependent, and the employee has a current employment status with the Employer as defined by federal law and determined by the Plan Administrator, via the SAS Benefits Department; or

3. Eligibility for Medicare is due to end stage renal disease (ESRD) under the conditions and for the time periods specified under federal law.

When this Plan pays benefits first, without regard to Medicare, and the Covered Person wants Medicare to pay after this Plan, the Participant must enroll for Medicare Parts A and B. If the Covered Person does not enroll for Medicare when he or she is first eligible, the Covered Person must enroll during the special enrollment period which applies to that person when the person stops being eligible under this Plan.

Alternatively, when Medicare pays benefits first, benefits available under Medicare are deducted from the amounts payable under this Plan, whether or not the person has actually enrolled in Medicare. If Medicare pays benefits first, the Participant should enroll for both Medicare Parts A and B when the Covered Person is first eligible. Otherwise, the expenses may not be covered by the Plan or Medicare.

Covered Persons are encouraged to contact their local Social Security Office for information about Medicare as soon as they are eligible. Certain restrictions and timeframes apply regarding the length of time a person has to enroll for Medicare without penalty.

D. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

The Claims Administrator may release or obtain any information if it is deemed necessary to implement this section or if it is deemed necessary for similar sections of other plans. Such information does not require prior notice or consent. Any person who claims benefits under This Plan shall give the Claims Administrator any necessary information required.

E. 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 Claims Administrator reserves the right to decide whether or not to reimburse the organization making the payment and the amount to be paid in order to satisfy the intent of this provision. Any such payment made will fulfill the Plan Sponsor's responsibility to the extent of such payment.

F. RIGHT TO RECOVERY

If the Claims Administrator makes an overpayment because of this or a similar section, the Claims Administrator has the right to recover the excess amount any person to whom payments are made, any other insurance companies, or any other organizations.

VII. SUBROGATION, REIMBURSEMENT, AND THIRD PARTY RECOVERY PROVISIONS

A. REIMBURSEMENT TO THE PLAN

Whenever another party (including a Covered Person's own insurer under an automobile or other policy) is legally responsible or agrees to compensate a Covered Person, by settlement, verdict or otherwise, for an Illness or injury, the Plan will be entitled to reimbursement for any payments it has made hereunder to compensate the Covered Person for such Illness or injury. The Covered Person (or his or her legal representatives, estate or heirs) must promptly reimburse the Plan for any benefits it has paid relating to that Illness or injury, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized and regardless of whether the Covered Person has been made whole and regardless of the application of any rule of law that would limit or preclude reimbursement under state law). If the Plan has not yet paid benefits relating to that Illness or injury, the Plan may reduce or deny future benefits on the basis of the compensation received by the Covered Person.

As a Participant in this Plan, the Covered Person: (1) grants to the Plan a first priority equitable lien against the proceeds of any such settlement, verdict or other amounts received by the Covered Person; (2) grants to the Plan the right to impose a constructive trust on such proceeds;

and (3) assigns to the Plan any benefits the Covered Person may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement.

The Covered Person must cooperate with the Plan and its agents, and must sign and deliver such documents that are relevant to the protection of the Plan's right of reimbursement. The Covered Person must also provide any relevant information, and take such actions to assist the Plan in making a full recovery of the reasonable value of the benefits provided. The Covered Person must not take any action that prejudices the Plan's right of reimbursement.

The Covered Person must notify the Plan if he or she thinks a third-party is responsible for his or her Illness or injury. The Covered Person must also notify the Plan of any lawsuit filed against any third-party that may be responsible and notify the Plan of any settlement, verdict or other amount that he or she receives.

If the proceeds from any settlement, verdict or other amounts awarded are transferred or paid to any other person, including, but not limited to, the Covered Person's legal representative, trust fund or any other person or entity, the Plan hereby will impose a constructive trust on any person or entity holding any such proceeds.

In certain circumstances, the Plan may only advance benefits on behalf of the Covered Person on the condition that he or she agrees, in writing, to reimburse the Plan in full any payments made hereunder out of any recovery obtained by him or her from the other person or his or her insurance company by way of judgment, settlement or otherwise.

The reimbursement required under this provision will not be reduced to reflect any costs or attorneys' fees Incurred in obtaining compensation unless separately agreed to, in writing, by the Plan Administrator, in the exercise of its sole discretion. The Plan's right to reimbursement applies regardless of whether the Covered Person recovers less than initially claimed (or less than the Covered Person's full loss), and even if the legal recovery is designated as not for lost earnings. The Plan's right to receive any payment, reimbursement or recovery discussed above supersedes and has priority over the Covered Person's right to receive any payment, reimbursement or recovery.

B. SUBROGATION

Whenever another party (including a Covered Person's own insurer under an automobile or other policy) is legally responsible or agrees to compensate a Covered Person for his or her Illness or injury and the Plan has paid benefits related to that Illness or injury, the Plan may assume any rights the Covered Person may have against this party.

The Plan is subrogated to all of the rights of the Covered Person against any party liable for the Covered Person's Illness or injury to the extent of the reasonable value of the benefits provided to the Covered Person under the Plan. The Plan may assert this right independently of the Covered Person.

The Covered Person is obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information, assistance and documents that help the Plan obtain its subrogation rights, signing and delivering such documents to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If the Covered Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Covered Person must not prejudice, in any way, the subrogation rights of the Plan.

The costs of legal representation of the Plan in matters related to subrogation will be borne solely by the Plan. The costs of legal representation of the Covered Person must be borne solely by the Covered Person.

The Plan's right to repayment is, and shall be, prior and superior to the right of any other person, entity, including the beneficiary. The Plan's right of subrogation shall take priority over the right of a Covered Person to be fully compensated.

C. RECOVERY OF EXCESS PAYMENTS

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these excess payments from any individual (including a Covered Person), insurance company or other organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered.

If excess payments were made for services rendered to a Covered Person's Dependent(s), the Plan has the right to withhold payment on the Covered Person's future benefits until the overpayment is recovered. In addition, if an overpayment has occurred, the Covered Person grants the Plan a first priority equitable lien in such payment to the extent it can be identified.

If the overpayment is due from another person or organization, the Covered Person agrees to help the Plan or the Company obtain the refund when requested.

Further, whenever payments have been made based on fraudulent information provided by a Covered Person, the Plan will exercise all available legal rights, including its right to rescind coverage retroactively or to withhold payment on future benefits until the overpayment is recovered.

VIII. CONTINUATION OF BENEFITS (COBRA)

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also

become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the COBRA Administrator.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced.
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than his or her gross misconduct.
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).
- You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies.
- The parent-employee's hours of employment are reduced.
- The parent-employee's employment ends for any reason other than his or her gross misconduct.

- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both).
- The parents become divorced.
- The child stops being eligible for coverage under the Plan as a "dependent child".

COBRA COVERAGE AVAILABILITY

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer will notify the COBRA Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the employee and spouse, or a dependent child losing eligibility for coverage as a dependent child), you must notify the COBRA Administrator at the following address within **60** days after the qualifying event occurs.

COBRA Direct
P.O. Box 70
Sanford, NC 27331
919-352-3019 (phone)
919-774-3782 (fax)

The notice should include the name of the Plan, your name, the covered employee's name (if you are covered as a spouse or dependent), your current address and telephone number, a description of the qualifying event, the date of the event, the signature and contact information of the person sending the notice, and documentation to substantiate the qualifying event as requested by the COBRA Administrator, such as a divorce decree or separation agreement.

The notice and required documentation must be postmarked no later than the applicable deadline for giving the notice. If the Benefit Enrollment/Change Form and appropriate documentation are not timely and properly provided, the qualified beneficiary will not be permitted to elect COBRA continuation coverage.

HOW COBRA COVERAGE IS PROVIDED

Once the Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

A qualified beneficiary must elect COBRA within **60** days from the later of the date of the qualifying event or the date notice was sent by the Administrator.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Administrator in a timely fashion, you and your entire family 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 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify the COBRA Administrator in writing using the Benefits Enrollment/Change Form within 60 days of the Social Security Administration's determination of disability. A copy of the Social Security Administration disability determination letter must be mailed to the SAS Benefits Department. In addition to the disability determination letter, your notice must include your name, the covered employee's name (if you are covered as a spouse or dependent), and your current address and telephone number.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Notice must be provided in writing using the Benefits Enrollment/Change Form within **60** days of the later of (1) the date of the second qualifying event; or (2) the date on which the qualified beneficiary would have lost coverage under the Plan due to the second qualifying event if it had occurred before the first qualifying event. In addition, supporting documentation must be provided to substantiate the second qualifying event, such as a divorce decree, separation agreement or death certificate.

PREMIUMS FOR COBRA COVERAGE

Upon election to continue health coverage, a qualified beneficiary must, within 45 days of the date of such election, pay all required contributions to date to the COBRA Administrator. All future contribution payments must be made to the COBRA Administrator and are due the first of each month with a 30-day grace period. If the initial contribution payment is not made within 45 days of the date of the election, COBRA coverage will not take effect. If future contribution payments are not made within the allotted 30-day grace period, COBRA coverage will be terminated retroactively back to the end of the month in which the last full contribution payment was made.

The qualified beneficiary may be required to pay premiums for any period of COBRA coverage equal to 102% of the applicable premium, in accordance with applicable law. However, any qualified beneficiary (including all family members of such individual who are qualified beneficiaries) who is entitled to the disability extension (as specified above) may be required to pay premiums equal to 150% of the applicable premium for the coverage period following the initial 18-month period.

A qualified beneficiary will be notified by the COBRA Administrator of the amount of the required contribution payment and the contribution payment options available.

The cost of COBRA coverage may be subject to future increases during the period it remains in effect.

NOTICE OF OTHER COVERAGE, MEDICARE ENROLLMENT OR CESSATION OF DISABILITY

If, during the period of COBRA coverage, a qualified beneficiary becomes covered under another group health plan, the qualified beneficiary must notify the COBRA Administrator, in writing using the Benefits Enrollment/Change Form, within 30 days after the other coverage becomes effective, or if later, 30 days after exhaustion or satisfaction of any preexisting condition exclusions.

If, during the period of COBRA coverage, a qualified beneficiary becomes entitled to Medicare, the qualified beneficiary must notify the COBRA Administrator, in writing using the Benefits Enrollment/Change Form, within 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).

If, during the period of extended COBRA coverage on account of a disability, the qualified beneficiary is determined by the Social Security Administration not to be disabled, the qualified beneficiary must notify the COBRA Administrator, in writing using the Benefits Enrollment/Change Form within 30 days after the date of the Social Security Administration's determination.

If the Benefits Enrollment/Change Form and any required documentation are NOT timely and properly provided, the qualified beneficiary's COBRA coverage may be terminated retroactively and the qualified beneficiary may be required to repay a portion of the benefits received.

SPECIAL COBRA RIGHTS

Special COBRA rights apply if you lose coverage (or the cost of such coverage increases) because your employment was terminated or your hours have been reduced and you qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. Generally, in this situation, you will be entitled to a second opportunity to elect COBRA coverage for yourself and certain family members, but only within a limited period of 60 days (or less) and only during the six months immediately following your initial loss of coverage. If you think you may qualify for assistance under the Trade Act of 1974, you should contact the COBRA Administrator for additional information.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

IX. HIPAA CREDITABLE COVERAGE CERTIFICATES

When a Covered Person's health coverage ends, he will be issued a Creditable Coverage certificate setting forth the period his health coverage was in effect. The Covered Person can use

this certificate to reduce preexisting condition exclusions that may apply under a later health plan -for example, the plan of a subsequent employer.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Covered Person's period of Plan coverage can reduce the period during which a later plan can exclude coverage for preexisting conditions, provided the individual does not have a break in coverage (not counting any waiting periods) of 63 consecutive days or more. Coverage certificates permit the individual to document his period of coverage under the Plan. The Covered Person will be sent a certificate of his period of coverage under the Plan after his coverage ends. If the Covered Person extends his regular coverage under COBRA, he will be sent another certificate after his COBRA coverage ends. If a Dependent's coverage ends before the covered Employee's does and he notifies the Plan Administrator, via the SAS Benefits Department, a certificate will be issued for the Employee's Dependent.

Creditable Coverage certificates will be sent to the last known address; therefore, it is important that the Covered Person notify the Employer of any address change. Certificates will be issued as promptly as possible.

A Covered Person may request a certificate (or a duplicate certificate) by writing to or calling:

SAS Benefits Department SAS
Institute Inc.
SAS Campus Drive
Cary, NC 27513
919-531-9090

Requests must be received within 24 months of when coverage ended.

X. COMPLIANCE WITH STATE AND FEDERAL MANDATES

To the extent applicable, the Plan will provide coverage and benefits in accordance with the requirements of all applicable laws, including, but not limited to, Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), Newborns' and Mothers' Health Protection Act of 1996, as amended (NMHPA), Women's Health and Cancer Rights Act of 1998 (WHCRA), Family and Medical Leave Act of 1993 (FMLA), Mental Health Parity Act (MHPA), Mental Health Parity Addiction Equity Act (MHPAEA), Health Information Technology for Economic and Clinical Health Act (HITECH), Michelle's Law, Genetic Information Nondiscrimination Act of 2008 (GINA) and the Patient Protection and Affordable Care Act (PPACA).

XI. DEFINITIONS

Refer to the "Definitions" section of the BlueCross BlueShield Member Guide for additional Medical benefits definitions. The additional definitions in the BlueCross BlueShield Member Guide apply only to Medical benefits.

"**Actively at Work**" means the active expenditure of time and energy in the service of the Employer, except that an Employee shall be deemed Actively at Work on each day of a regular paid vacation or on a regular non-working day, provided he was Actively at Work on the last preceding regular working day.

"**Amendment**" means a formal document that changes the provisions of the Plan, duly signed by the authorized person or persons as designated by the Plan Administrator.

"**Beneficiary**" means a Dependent who is covered under this Plan.

"**Board**" shall mean the Board of Directors of SAS.

"**Calendar Year**" means January 1 through December 31 of the same year. For new employees and Dependents, a Calendar Year begins on the person's effective date and runs through December 31 of the same year.

"**Children**" means the employee's natural Children, legally adopted Children (including Children placed for adoption for whom legal adoption proceedings have been started), stepchildren or foster children who are primarily dependent on the Employee for support, alternate recipients under Qualified Medical Child Support Orders, and any other Children who are dependent on the Employee and live with the Employee in a regular parent-child relationship and are related to the Employee by blood or marriage. A grandchild child who resides in the Employee's household is also considered as an eligible Dependent under this Plan if the Employee has guardianship papers for the grandchild or has adopted the grandchild. Children of the Employee's domestic partner who live with the Employee and his Domestic Partner in a regular parent child relationship are considered as an eligible Dependent under this Plan.

"**Claims Administrator**" means Ameritas for Dental benefits.

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

"**Coinsurance Benefit Percentage**" means the portion of eligible expenses payable by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any out-of-pocket expenses in excess of the annual deductible, which are to be paid by the Covered Person.

"**Covered Person**" means any Employee or Dependent covered under this Plan.

"**Creditable Coverage**" means prior continuous health coverage and includes prior coverage under:

a. Another group health plan.
b. Group or individual health insurance coverage issued by a state regulated insurer or an HMO.
   c. COBRA.
d. Medicaid.
e. Medicare.
f. CHIP (Children's Health Insurance Program).
g. The Active Military Health Program.
h. Tricare/CHAMPUS.
i. American Indian Health Care Programs.
j. A State health benefits risk pool.
k. The Federal Employees Health Plan.
l. The Peace Corp Health Program.
m. A public health plan.

"**Dentist**" means a currently licensed Dentist practicing within the scope of the license or any other medical Provider furnishing dental services which the medical Provider is licensed to perform.

"**Dependent**" means with respect to any Full-Time or Part-Time Employee working at least 20 hours per week, any one or more of the following:

a. The Covered Employee's legally married Spouse.

b. The Covered Employee's Domestic Partner of the same or opposite sex.

c. The Covered Employee's Child who has not attained age 26.

d. Any Child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, determined by the Plan Administrator, via the SAS Benefits Department.

"**Disabled Dependent**" means any unmarried child 26 years of age or older who is incapable of self-support due to a physical handicap, developmental disability, mental retardation or mental illness, provided such child (1) becomes so incapable prior to age 26, (2) was covered prior to attainment of such age and (3) is primarily dependent upon the covered employee for support and maintenance as of the date on which coverage would otherwise end. Written certification of the incapacity and continuing dependence from the dependent's treating physician must be provided to the Plan Administrator within 30 days after the date that coverage for the dependent would normally end. Coverage under the Plan may be continued for as long as the incapacity and dependency continue, subject to periodic review by the Plan Administrator or until such coverage would otherwise end under the terms of the Plan (such as when the covered employee's coverage ends, the disabled dependent is deemed permanently disabled and eligible for Medicare or when the covered employee is no longer primarily responsible for the disabled dependents primary support and maintenance). The Plan Administrator reserves the right to have such dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to

determine the existence of such incapacity.

"**Domestic Partner**" means an individual age 18 or older, of the same or opposite sex, who resides in the same residence, shares financial obligations, including basic living expenses, and has been in a sole and exclusive relationship for at least one consecutive year (12 months) with the Employee. The Domestic Partner and the Employee may not be married to anyone and may not be of any blood or marriage relation which would bar marriage under the laws of the state in which they reside.

"**Effective Date**," when applied to a person's coverage under the Plan, means the first day of the person's coverage. The person's Effective Date may or may not be the same as the person's Enrollment Date (as "Enrollment Date" is defined by the Plan).

"**Employee**" means any individual that meets the definition of a Full-Time Employee or Part-Time Employee.

"**Employer**" means SAS Institute Inc. with principal offices headquartered at SAS Campus Drive, Cary, North Carolina 27513, or any other Employer, division, affiliate or wholly owned subsidiary which is authorized by the Board to adopt this Plan, and which, by direction of its governing body adopts this Plan.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended.

"**Experimental or Investigational**" means the use of any medical treatment or procedure, facility, equipment, drug, device, service or supply not yet recognized by the Plan and published records in authoritative medical and scientific literature as acceptable medical practice. These terms will also apply if the medical treatment, procedure, service or supply: required federal or other governmental agency approval and that approval was not granted at the time the services were received; is not covered under Medicare reimbursement laws, regulations, or interpretations; is not commonly and customarily recognized by the majority of the medical profession as appropriate for the condition being treated; or is for research purposes, except as provided by the Claims Administrator, a Qualifying Clinical Trial under this contract.

"**FMLA**" means the Family and Medical Leave Act of 1993, as amended.

"**FMLA Leave**" means a Leave of Absence taken by an Employee in accordance with the Family and Medical Leave Act of 1993, as amended.

"**Full-Time Employee**" means a person who has been classified by the Employer as a full-time salaried Employee and is regularly scheduled to work and Actively at Work at least 35 hours per week. The term "Full-Time Employee" shall exclude any non-resident aliens, contract or leased employees, students, seasonal, substitute, temporary or temporary agency employees.

"**Group Health Plan**" means a plan maintained by an employer to provide medical care, directly through insurance, reimbursement or otherwise, to employees, ex-employees, and their dependents. For purpose of this Plan, Group Health Plan means dental benefits.

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"**Immediate Family**" means a person who is related to a Covered Person, whether the relationship is by blood or exists in law, limited to a Spouse, child, brother or sister. The term "Immediate Family" shall also include a Domestic Partner.

"**Incurred**" means the date a treatment, service or supply is provided to a Covered Person.

"**Leave of Absence**" means any absence authorized by the Employer under its standard personnel practices or under the Family and Medical Leave of Absence Act of 1993, as applied in a uniform and nondiscriminatory manner to all persons similarly situated. Eligible Leaves of Absence include Short-Term and Long-Term Disability, Paternity Leave of Absence, Adoption Leave of Absence, Workers' Compensation Leave of Absence, Personal Leave of Absence, Military Leave and Family and Medical Leave of Absence.

"Lifetime Maximum" means the maximum benefit payable toward covered expenses incurred by an individual during his or her lifetime under the policy. Lifetime maximums are a common feature among orthodontic policies.

"**Maximum Benefit**," as applied to dental benefits under this Plan, means the total amount of dental benefits payable under this Plan on behalf of a Covered Person during any Calendar Year (unless specified otherwise).

"**Medically Necessary**" or "**Medical Necessity**" means the expense Incurred upon the recommendation and approval of a medical Provider for the medical services and supplies generally furnished for cases of comparable nature and severity in the particular geographical area concerned. Any agreement as to fees or charges made between the patient and the medical Provider shall not bind the Plan in determining its liability with respect to necessary expenses. These Incurred expenses must be:

a. Consistent with the symptoms of diagnosis and treatment of the condition, Illness, or injury.
b. Appropriate with regard to standards of good medical practice.
c. Not primarily for the convenience of the patient, the medical Provider or other provider.
d. The most appropriate level of services which can safely be provided to the patient. When applied to an Inpatient, it means that the patient's medical symptoms or conditions require that the services or supplies cannot be safely provided to the patient as an Outpatient.

The fact that a medical Provider might prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary or make the charge an allowable expense under the Plan, even though it is not specifically listed as an exclusion.

"**Medicare**" means the program established by Title I of Public Law 89-98 (79 Statutes 291) as amended entitled "Health Insurance for the Aged Act," and which includes Parts A, B and D and Title XVIII of the Social Security Act (as amended by Public Law 89-97, 79) as amended from time to time.

"**Military Leave**" means a Leave of Absence taken by an Employee for a call to military duty that is protected by the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

"**Minor Emergency Medical Clinic**" means a freestanding facility, which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified medical Provider, a Registered Nurse, and a registered x-ray Technician must be in attendance at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered to be a Minor Emergency Medical Clinic, by whatever actual name it may be called; however, a clinic located on or in conjunction with or in any way made a part of a regular Hospital shall be excluded from the terms of this definition.

"**Multiple Surgical Procedure**" means when more than one surgical procedure is performed during the same period of anesthesia.

"**Orthotic Device**" means an apparatus used to support, align, prevent or correct deformities, or to improve the function of movable parts of the body.

"**Outpatient**" refers to the classification of a Covered Person when that Person received medical care, treatment, services or supplies at a Minor Emergency Medical Clinic, medical Provider's office, or at a Hospital if not registered as an Inpatient bed patient at that Hospital.

"**Part-Time Employee**" means any Employee who has been classified by the Employer as a part-time Employee and is regularly scheduled to work and Actively at Work at least 20 hours and less than 35 hours per week. The term "Part-Time Employee" shall exclude any nonresident aliens, contract or leased employees, students, seasonal, substitute, temporary or temporary agency employees.

"**Participant**" or "**Plan Participant**" means an Employee who is covered under this Plan.

"**Physician**": See definition of "**Provider**".

"**Plan**" means the SAS Institute Inc. Dental Plan, which is a component Plan of the SAS Institute Inc. Welfare Benefits Plan, together with any and all Amendments and supplements hereto.

"**Plan Administrator**" means SAS or such other person or committee (such as the SAS Benefits Department) as may be appointed by SAS to supervise the operation and administration of the Plan.

"**Plan Sponsor**" means SAS Institute Inc.

"**Pregnancy**" means that physical state which results in childbirth, abortion or miscarriage, and any medical treatment or complications arising out of or resulting from such state.

"**Protocol**" means a study plan on which all clinical trials are based. The plan is carefully designed to safeguard the health of the Participants as well as answer specific research questions. A Protocol describes what types of people may participate in the trial; the schedule of tests, procedures, medications, and dosages; and the length of the study. While in a clinical trial, Participants following a Protocol are seen regularly by the research staff to monitor their health and to determine the safety and effectiveness of their treatment.

"**Provider**" means a legally licensed medical or dental doctor or surgeon, chiropractor, osteopath, chiropodist, podiatrist, optometrist, psychologist, physical therapist, nationally certified (Dip. Ac NCCA) or licensed acupuncturist, nationally certified (NCTMB) or licensed massage therapist, certified clinical social worker, and advanced practice registered nurse (nurse midwives are eligible provided they are associated with a birthing center or Hospital) or Physician assistant, to the extent that the same, within the scope of their license, are permitted to perform services provided in this Plan. The term Provider also means a medical facility which is approved by the Plan to render health care services.

"**QMCSO**" means a Qualified Medical Child Support Order in accordance with applicable law.

"**Qualifying Change in Status Event**" means an event so defined in the SPD for the SAS Institute Inc. Premium Conversion and Flexible Spending Account Plan.

"**Reliable Evidence**" means 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, biological product, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, biological product, device, medical treatment or procedure.

"**Spouse**" means the person legally married to the covered Employee. A Spouse does not include an individual from whom the Covered Employee has obtained divorce or who no longer meets the definition of a common-law marriage. Documentation proving a legal marital relationship may be required.

"**Temporomandibular Joint Dysfunction (TMD)**" means jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex muscles, nerves and other tissues related to the temporomandibular joint.

"**Totally Disabled**" as applied to an Employee means (unless specifically provided otherwise) the complete inability of an Employee to substantially perform the important daily duties of the Employee's own occupation, for which the Employee is reasonably suited by education, training or experience. As applied to a Dependent, the term means the Dependent is prevented solely because of a non-occupational injury or non-occupational disease from engaging in all of the normal activities of a person of like age and sex and in good health.
"**Treatment Plan**" means a program of dental care and treatment planned in written outline by a Dentist upon examination of a Covered Person.

"**USERRA**" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

"**Usual and Customary Allowance**" means those charges made for medical services and/or supplies essential to the care of a Covered Person which will be considered Usual and Customary if they are the amount normally charged by the service Provider for similar services and supplies and do not exceed the amount ordinarily charged by most Providers of comparable services and supplies in the geographic area where the services or supplies are received, as set forth by the Claims Administrator per industry-accepted guidelines. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances.

Charges of a participating network Provider will not be subject to Usual and Customary allowance limitations, but to negotiated fees instead.

XII. ERISA RIGHTS

A. RECEIVING INFORMATION ABOUT THE PLAN AND ITS BENEFITS

As a Participant in the SAS Institute Inc. Dental Plan, Covered Persons are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan Participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
- Receive a summary of material reduction in covered services or benefits provided under the Plan within 60 days after the adoption of the changes (unless summaries of changes to the Plan are provided at regular intervals of 90 days).

B. CONTINUING GROUP HEALTH PLAN COVERAGE

A Participant shall be entitled to continue coverage for himself, his Spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event as described in Section XI.

The Participant or his dependents may have to pay for such coverage. Participants should review this Summary Plan Description and the documents governing the Plan for the rules governing COBRA continuation coverage rights.

A Participant shall also be entitled to reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Group Health Plan if he has creditable coverage from another plan. The Participant should be provided a certificate of creditable coverage, free of charge, from his group health plan or health insurance issuer when his coverage is lost, if he becomes entitled to elect COBRA continuation coverage, or when his COBRA continuation coverage ceases, provided that he requests the certificate before losing coverage or up to 24 months after losing coverage.

C. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan Participants and their beneficiaries. No one, including the Employer, or any other person, may fire an Employee or otherwise discriminate against a Participant in any way to prevent him from obtaining a welfare benefit or exercising his rights under ERISA.

D. ENFORCING RIGHTS AS A PARTICIPANT

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

Under ERISA, there are steps a Participant can take to enforce the above rights. For instance, if the Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive the materials within 30 days, he may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Participant up to $110.00 a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a Participant has a claim for benefits which is denied or ignored, in whole or in part, he may file suit in a state or federal court. In addition, if a Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if a Participant is discriminated against for asserting his rights, he may seek assistance from the U.S. Department of Labor, or he may file suit in federal court. The court will decide who should pay court costs and legal fees. If the Participant is successful, the court may order the person he has sued to pay these costs and fees. If the Participant loses, the court may order him to pay these costs and fees, for example, if the court finds his claim is frivolous.

In no event shall a Participant be allowed to file suit in state or federal court until the Participant has exhausted the administrative remedies available under the Plan, including following the procedure for filing claims described below.

E. ASSISTANCE WITH QUESTIONS

If the Participant has any questions about the Plan, he should contact the Plan Administrator. If he has any questions about this statement or about his rights under ERISA, or if he needs assistance in obtaining documents from the Plan Administrator, he should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in his telephone directory, or address requests to Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. A Participant may also obtain certain publications about his rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

XIII. CLAIMS PROVISIONS

A. CLAIM DETERMINATIONS MADE IN ACCORDANCE WITH SUMMARY PLAN DESCRIPTIONS

The Plan's claims procedures shall include administrative safeguards and processes designed to ensure and verify that benefit claims determinations are made in accordance with governing Summary Plan Descriptions and, where appropriate, that the Plan's provisions have been applied consistently with respect to similarly situated claimants.

B. CLAIM DEFINED

A "claim" is any request made by a claimant or a claimant's representative for benefits under the Plan that complies with the Plan's reasonable procedure for filing claims. A request for benefits includes a request for coverage determination, pre-authorization or approval of a Plan benefit, or a utilization review determination in accordance with the terms of the Plan.

Requests for eligibility determinations are not claims for benefits. However, when a claim is denied because the claimant is not eligible for benefits under the terms of the Plan, the claimant has the right to appeal that determination in accordance with the Plan's claims procedures.

C. CLAIM FILING

The Plan Administrator (or Employer) will furnish to the Covered Person, upon request, forms for filing proof of loss. If such forms are not furnished within **15** days after receipt of notice of a

claim, any written form that includes information indicating the occurrence, character, and extent of the loss for which a claim is made may be used to submit a proof of loss. A claim form may be required to be submitted at least once per year for each person who incurs a covered expense.

When to File a Claim

A Covered Person or Provider should file a claim as soon as expenses are incurred for which the Plan provides benefits. A separate claim form must be submitted for each covered individual for whom a claim is made.
There is a maximum of 18 months from the date of service to file a claim. After 18 months, the claim will not be processed.

How to File a Claim

1. Complete all appropriate sections of the claim form.

2. Attach itemized bills to the claim form for covered services. Bills must be complete. Each bill should be itemized and show:

    a. Patient's full name.
    b. Employee's full name and Employee benefit number.
    c. Date and amount charged for each service rendered or items supplied.
    d. Diagnosis of the Illness or injury.
    e. Type of service or supply furnished.
    f. Physician or Provider name.

Where to File a Claim

Dental Claims should be submitted to:

Ameritas
PO Box 82520
Lincoln, NE 68501-2520
Fax: 402-467-7336

D. LIMITATION OF LIABILITY

The Plan Sponsor shall not be obligated to pay any benefits under the Plan for any claim if the proof of loss for such claim was not submitted within the period provided in **"Claim Filing"** above, except in the case of legal incapacity of the Covered Person.

E. URGENT CARE CLAIM RULES

For urgent care claims, the Claims Administrator will notify the claimant of its determination, whether adverse or not, as soon as possible but not later than 72 hours from receipt of the claim

at the initial benefit determination level (and within not later than 72 hours at the appeal level upon review of an adverse benefit determination).

Notice of a benefit grant or denial may be provided orally, provided that a written or electronic notice of benefit grants or denials is sent to the claimant not later than three (3) days after the oral notification.

The term "urgent care claim" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a medical Provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Except as provided in the next sentence, whether a claim is an urgent care claim is to be determined by a person acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a medical Provider with knowledge of the claimant's medical condition determines is an urgent care claim involving urgent care shall be treated as an urgent care claim for purposes of these provisions.

F. CONCURRENT CARE DECISION RULES

For concurrent care decisions, the Claims Administrator will notify the claimant of its decision to terminate or reduce benefits that have already been approved that may disrupt an ongoing course of treatment to be provided over a period of time or a number of treatments at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that decision before the benefit is reduced or terminated.

Any urgent care claim involving ongoing care (requesting to extend a course of treatment beyond the initially prescribed time period or number of treatments) must be decided within 24 hours provided that the claim is made at least 24 hours prior to the expiration of the initially prescribed period.

G. PRE-SERVICE CLAIM RULES

For pre-service claims, generally, the Claims Administrator must notify the claimant of its determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances but not later than 15 days from receipt of the claim at the initial level (or within 30 days at the appeal level). One 15-day extension of time is available with respect to the initial claim decision if the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit necessary information, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Written or electronic notice of benefit grants or denials must be provided in the case of pre-service claims.

A "pre-service" claim is any request for approval of a benefit to which receipt is conditioned by the Plan, in whole or in part, upon advance approval of obtaining medical care (for example, preapproval under utilization review or for a prior authorization).

H. POST-SERVICE CLAIM RULES

For post-service claims, generally, the Claims Administrator will notify the claimant of its adverse determination within a reasonable period of time, but not later than 30 days from receipt of the claim at the initial level (or within 60 days at the appeal level). One 15-day extension of time is available if the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit necessary information, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Written or electronic notice of benefit denials must be provided in the case of post-service claims.

I. INCOMPLETE CLAIMS NOTICE DISCLOSURE REQUIREMENT

The Claims Administrator will determine whether a filed claim is incomplete. A claim is filed in accordance with reasonable filing procedures of the Plan, without regard to whether all information necessary to decide the claim accompanies the filing.

The Claims Administrator must notify the claimant or claimant's representative of failure to follow proper claims filing procedures. With respect to urgent care claims, the Claims Administrator will provide incomplete claims notice within 24 hours of receipt of the claim. With respect to pre-service claims, notice of incomplete claims will be provided within five (5) days. Notification by the Claims Administrator may be oral, unless written notification is requested by the claimant or claimant's authorized representative.

J. MANNER AND CONTENT OF BENEFIT DETERMINATION

The Claims Administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason(s) for the adverse determination;
2. References to the specific Plan provisions upon which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
5. If the Plan utilizes a specific internal rule, guideline, Protocol, or other similar criterion in making the determination, either the specific rule, guideline, Protocol or other similar criterion; or a statement that such a rule, guideline, Protocol or other similar criterion was relied upon and that a copy of such rule, guideline, Protocol or similar criterion will be provided free of charge to the claimant upon request;
6. If the determination is based on a Medical Necessity, Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
7. In the case of a determination concerning an urgent care claim, a description of the expedited review process applicable to such claims.

K. APPEAL OF DENIED CLAIM AND REVIEW PROCEDURE

A claimant will be notified in writing by the Claims Administrator if a claim, or any part of a claim, is denied. If a claimant does not agree with the reason for the denial (including a denial of benefits based on a determination of a claimant's eligibility to participate in the Plan), he may file a written appeal within **180** days after the receipt of the original claim determination. The request should state the basis for the disagreement along with any data, questions, or comments he thinks are appropriate, and should be sent to the office of the Claims Administrator. An appropriate named fiduciary who is neither the person who made the initial determination, nor the subordinate of such person, shall conduct a full and fair review of the determination. The review shall not defer to the initial determination, and it shall take into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was previously submitted or considered in the initial determination. In addition, in deciding an appeal of any 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, or Investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional, who was neither the person who was consulted in connection with the initial benefit determination, nor the subordinate of such person, and who has appropriate training and experience in the field of medicine involved in the medical judgment.

The Claims Administrator will disclose to the claimant the names of any medical professionals consulted as part of the claims process.

In the case of the review of urgent care determination, a request for an expedited appeal of a claim denial may be submitted orally or in writing by the claimant; and all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

The claimant will be notified of the results of the review by the Claims Administrator. On pre-service and post-service claim denials, the Plan requires two levels of mandatory appeals. Both levels of appeals will be completed within 30 days of the date the appeal was received for pre-service claims (15 days per level), and 60 days of the date the claim was received for post-service claims (30 days per level).

L. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

The Claims Administrator shall provide a claimant with written or electronic notification of any adverse benefit determination on review. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. the specific reason(s) for the adverse determination on review;
2. reference to the specific Plan provisions upon which the review is based;
3. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his claim for benefits;
4. a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA;
5. if an internal rule, guideline, Protocol, or other similar criterion was relied upon in making the adverse determination on review, either the specific rule, guideline, Protocol, or other similar criterion; or a statement that such rule, guideline, Protocol, or other similar criterion was relied upon in making the adverse determination on review and that a copy of the rule, guideline, Protocol, or other similar criterion will be provided free of charge to the claimant upon request;
6. if the adverse benefit determination on review is based on a Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
7. the following statement: "Other voluntary alternative dispute resolution methods, such as mediation, may be available. You may seek additional information by contacting your local U.S. Department of Labor office and your State insurance regulatory agency."

M. DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND THE CLAIMS ADMININSTRATOR

In carrying out their responsibilities under the Plan, the Plan Administrator and the Claims Administrator shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was an abuse of discretion (i.e., arbitrary and capricious). Benefits under the Plan will be paid only if the Plan Administrator or the Claims Administrator, as applicable, decides in its discretion that the claimant entitled to them.

N. AUTHORIZED REPRESENTATIVES

A claimant's authorized representative, including a health care Provider, is not precluded from acting on behalf of the claimant in pursuing a benefit claim or appeal. The Claims Administrator shall recognize a health care professional with knowledge of a claimant's medical condition as the claimant's representative in connection with an urgent care claim. The Claims Administrator may establish reasonable procedures for determining whether a person has been authorized to act on behalf of a claimant.

O. PAYMENT OF BENEFITS

All benefits under the Plan are payable to the covered Employee whose illness or injury or whose covered dependent's Illness or injury is the basis of a claim.

In the event of incapacity of a covered Employee and in the absence of written evidence to the Plan of the qualification of a guardian (or person acting under durable power of attorney) for the covered Employee's estate, the Plan may, at its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the Plan Administrator, is or was providing the care and support of such Employee. In the event of death, the personal representative of the estate will act on behalf of the covered Employee.

Benefits for expenses covered under the Plan may be assigned by a covered Employee to the individual or institution rendering the services for which the expenses were incurred. No such assignment will bind the Plan Administrator unless it is in writing and unless it has been received and accepted by the Claims Administrator prior to the payment of the benefit assigned. The Claims Administrator will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received by the Claims Administrator before the proof of loss is submitted. Payment of benefits will be made by the Plan in accordance with any assignment of rights made by or on behalf of a Covered Person if required by a Qualified Medical Child Support Order (QMCSO). The Plan will not take Medicaid eligibility into account and will pay benefits in accordance with any assignment of rights under a state Medicaid law.

P. DISCHARGE OF LIABILITY

Any payment made in accordance with the provisions of this section shall fully discharge the liability of the Plan Administrator to the extent of such payment.

Q. LEGAL ACTIONS

Proper written proof of loss must be filed in accordance with the requirements of the Plan. If timely decisions or other ERISA claims procedures regulations fail to be made or followed, a claimant shall be deemed to have exhausted the administrative remedies available under the Plan and shall be entitled to pursue any available remedies under section 502(a) of the Act to enforce their rights.