Human Resources
Benefits

Summary Plan Description

SAS Institute Inc. Medical Plan

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

PPO Medical Plan and Prescription Coverage
Effective January 1, 2016

INTRODUCTION

This document is the Summary Plan Description ("SPD") for the SAS Institute Inc. Medical 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 medical and prescription drug benefits and (ii) the right to change Participant contributions to the cost of any Benefits.

TABLE OF CONTENTS

I. IMPORTANT INFORMATION

A. GENERAL INFORMATION

Type of Plan: The Plan is an Employee welfare benefit plan providing medical and prescription drug 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 Hospital, surgical, medical, and prescription drug expenses. The general administration of the Plan is provided by SAS through its Benefits Department. Claims for benefits are administered by the Claims Administrators, as defined below. COBRA Administration is provided by the COBRA Administrator, as defined below.

Plan Name: SAS Institute Inc. Medical 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, 1985. The Plan was restated effective January 1, 2011 and amended most recently effective 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

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

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

The Claims Administrator for **Medical benefits** is:

BlueCross and BlueShield of North Carolina
PO Box 35
Durham, NC 27702-0035

The Claims Administrator for **Prescription Drug benefits** is:

PharmAvail
3380 Trickum Road
Building 400, Unit 100
Woodstock, GA 30188

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.
- Possible reductions when private Hospital rooms are used and for certain Multiple Surgical Procedures.

- Reductions due to charges that exceed allowed amounts for medical benefits.
- 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 regarding 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 applicable 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 non-resident 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 Medical 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 is 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 health 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, Copayments, 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. Health care 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 and 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 Re-employment 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 not 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 health 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 under the Plan 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. MEDICAL BENEFITS

The Plan provides for medical coverage under the BlueCross BlueShield Blue Options PPO Plan (the "PPO Plan"). The medical benefits provided under the PPO Plan are administered by BlueCross and Blue Shield of North Carolina (BCBSNC) and are described in the BlueCross BlueShield Member Guide, which is set forth immediately following.

Benefit Booklet
For Employees of
SAS Institute Inc.
for

Blue OPTIONS℠

BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

Blue Options/008539/4ASW/01012016/05252016

BENEFIT BOOKLET

This benefit booklet describes the SAS Institute Inc. Medical Plan (the PLAN). Blue Cross and Blue Shield of North Carolina provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Please read this benefit booklet carefully.

The benefit plan described in this booklet is an EMPLOYEE health benefit plan, subject to the Employee Retirement Income Security Act of 1974 (ERISA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A summary of benefits, conditions, limitations and exclusions is set forth in this benefit booklet for easy reference.

CHANGES TO PLAN/TERMINATION OF PLAN

The Plan may be changed and/or benefits may be reduced or eliminated by execution of an amendment to the Plan by the Plan Sponsor. The Plan Sponsor shall have the right to amend the Plan, at any time and from time to time, to any extent deemed advisable in its discretion, without prior notice to or consent of any Covered Person or of any person entitled to receive payment of benefits under the Plan. Any such amendment shall be set forth in a written instrument which is designated as an amendment to the Plan and executed by the Plan Sponsor.

All changes to the Plan shall become effective as of a date established by the Plan Sponsor, and thereupon all Covered Persons, whether or not they became Covered Persons prior to such amendment, shall be bound thereby. However, no amendment shall be effective with respect to any covered expense incurred prior to the date a change was adopted by the Plan Sponsor, regardless of the effective date of the change.

The Plan shall continue in full force and effect unless and until the Plan Sponsor terminates the Plan. Although the Plan Sponsor has the intention and expectation that the Plan will be maintained indefinitely, the Plan Sponsor is not and shall not be under any obligation or liability whatsoever to continue or maintain the Plan for any given length of time. The Plan Sponsor, in its sole and absolute discretion, may discontinue or terminate the Plan at any time by providing written notice to the covered employees. Such termination will become effective on the date set forth in such written notice.

TABLE OF CONTENTS

GETTING STARTED WITH BLUE OPTIONS

IMPORTANT INFORMATION REGARDING THE PLAN:

In accordance with applicable federal law, the PLAN will not discriminate against any health care provider acting within the scope of their license or certification, or taken any other action to endorse his or her right under applicable federal law. Further, the PLAN shall not impose eligibility rules or variations in premiums based on any specified health status-related factors unless specifically permitted by law.

This benefit booklet provides important information about your benefits and can help you understand how to maximize them. To help you become familiar with some common insurance terms concerning what you may owe after visiting your PROVIDER, see the chart below:

Copayment	The fixed dollar amount you must pay for some COVERED SERVICES at the time you receive them. Copayments are not credited to the deductible; however, they are credited to the OUT-OF-POCKET LIMIT.
Deductible	The dollar amount you must incur for COVERED SERVICES in a BENEFIT PERIOD before benefits are payable under the PLAN. The deductible does not include coinsurance, charges in excess of the ALLOWED AMOUNT, amounts exceeding any maximum, or expenses for noncovered expenses. The PLAN has an embedded deductible which means you have an individual deductible and if DEPENDENTS are covered, you also have a combined family deductible. You must meet your individual deductible before benefits are payable under the PLAN. However, once the family deductible is met, it is met for all covered family members. IN-NETWORK services are credited to your IN-NETWORK deductible and OUT-OF-NETWORK services are credited to your OUT-OF-NETWORK deductible.
Coinsurance	Your share of the costs of a covered health service, after you have met your BENEFIT PERIOD deductible. This is stated as a percentage of the ALLOWED AMOUNT. The coinsurance listed is your share of the cost of a COVERED SERVICE.
OUT-OF-POCKET LIMIT	The OUT-OF-POCKET limit is the dollar amount you pay for COVERED SERVICES in a BENEFIT PERIOD before the PLAN pays 100% for COVERED SERVICES in a BENEFIT PERIOD. The OUT-OF-POCKET LIMIT includes your deductible, coinsurance, and copayments. It does not include charges over the ALLOWED AMOUNT, premiums, and charges for noncovered services. The PLAN has an individual OUT-OF-POCKET LIMIT and if DEPENDENTS are covered, you also have a combined family OUT-OF-POCKET LIMIT. Once the family OUT-OF-POCKET LIMIT is met, it is met for all MEMBERS. Charges for IN-NETWORK services apply to your IN-NETWORK OUT-OF-POCKET LIMIT and charges for OUT-OF-NETWORK services apply to your OUT-OF-NETWORK OUT-OF-POCKET LIMIT.

As you read this benefit booklet, keep in mind that any word you see in small capital letters (SMALL CAPITAL LETTERS) is a defined term and appears in "Glossary" at the end of this benefit booklet.

Using Informational Graphics

Graphic symbols are used throughout this benefit booklet to call your attention to certain information and requirements.

Definitions
This symbol calls attention to definitions of important terms throughout this benefit booklet. Additional terms are in the "Glossary" at the end of this benefit booklet. If you are unsure of the meaning of a term, please check "Glossary."

Cross-Reference
Throughout this benefit booklet, cross-references direct you to read other sections of the benefit booklet when necessary.

Call for PRIOR REVIEW and CERTIFICATION Required

This symbol calls attention to medical/surgical and mental health and substance abuse services which require PRIOR REVIEW and CERTIFICATION in order to avoid a reduced benefit (penalty) or complete denial of benefits.

Limitations and Exclusions

Each subsection in "COVERED SERVICES" describes not only what is covered, but may also list some limitations and exclusions that specifically relate to a particular type of service. Limitations and exclusions that apply to all services are listed in "What Is Not Covered?"

Toll-Free Phone Numbers, Website and Addresses

BCBSNC Website: bcbsnc.com	Find a network PROVIDER by location or specialty, get information about top-performing facilities and information and news about BCBSNC.
Blue Connect Website: **BlueConnectNC.com**	Use our secure website that reflects your specific benefits and information to verify benefits and eligibility, check claims status, download claim and other forms, manage your account, request new ID CARDS, get helpful wellness information and more.
BCBSNC Customer Service: 1-877-275-9787 8 a.m. - 9 p.m. Monday-Friday, except holidays	For questions regarding your benefits, claims inquiries, and new ID CARD requests or to voice a complaint.
PRIOR REVIEW and CERTIFICATION: To request, MEMBERS call: 1-877-275-9787 PROVIDERS call: 1-800-672-7897	Some services require PRIOR REVIEW and CERTIFICATION from BCBSNC before they are considered for coverage. The list of these services may change from time to time. Current information about which services require PRIOR REVIEW can be found online at BlueConnectNC.com.
Magellan Behavioral Health: 1-800-359-2422	For mental health and substance abuse services, BCBSNC delegates the administration of these benefits by contract to BCBSNC, which is not associated with BCBSNC. You must contact BCBSNC directly and request PRIOR REVIEW for inpatient and certain outpatient services, except in EMERGENCIES. In the case of an EMERGENCY, please notify BCBSNC as soon as possible.
Out of North Carolina Care: 1-800-810-BLUE(2583)	For help in obtaining care outside of North Carolina or the U.S., call this number or visit **bcbs.com**.
HealthLine Blue℠: 1-877-477-2424	Talk to a nurse 24/7 to receive timely information and advice on a number of health-related issues. Nurses are available by phone in both English and Spanish.

Toll-Free Phone Numbers, Website and Addresses (*cont.*)

Medical Claims Filing: BCBSNC Claims Department PO Box 35 Durham, NC 27702-0035	Mail completed medical claims to this address.
COBRA Administrator COBRA Direct P.O. Box 70 Sanford, NC 27331 919-352-3019	

SUMMARY OF BENEFITS

This section provides a summary of your Blue Options benefits. A more complete description of your benefits is found in "COVERED SERVICES." General exclusions may also apply - please see "What Is Not Covered?" As you review the "Summary of Benefits" chart, keep in mind:

- Multiple OFFICE VISITS or emergency room visits on the same day may result in multiple copayments
- Coinsurance percentages shown in this section are the part that you pay for COVERED SERVICES
- Amounts applied to deductible and coinsurance are based on the ALLOWED AMOUNT
- Amounts applied to the deductible also count toward any visit or day maximums for those services
- If your benefit level for services includes deductible or coinsurance, your PROVIDER may collect an estimated amount of these at the time you receive services.
- To receive IN-NETWORK benefits, you must receive care from a Blue Options IN-NETWORK PROVIDER. **However, in an EMERGENCY, you may receive care from an IN-NETWORK or OUT-OF-NETWORK PROVIDER. Please see "EMERGENCY CARE" in "COVERED SERVICES" for additional information on EMERGENCY care.**

Please Note: The list of IN-NETWORK PROVIDERS may change from time to time, so please verify that the PROVIDER is still in the PPO network before receiving care. Find a PROVIDER on the BCBSNC website at **bcbsnc.com** or call BCBSNC Customer Service at the number listed on your ID CARD or in "Who to Contact?"

SPECIAL NOTICE IF YOU CHOOSE AN OUT-OF-NETWORK PROVIDER

Your actual expenses for COVERED SERVICES may exceed the stated coinsurance percentage or copayment amount because actual PROVIDER charges may not be used to determine the PLAN'S and MEMBER'S payment obligations. For OUT-OF-NETWORK benefits, you may be required to pay for charges over the ALLOWED AMOUNT, in addition to any copayment or coinsurance amount.

BENEFIT PERIOD - January 1, 2016 through December 31, 2016

Benefit payments are based on where services are received and how services are billed.

Benefits	IN-NETWORK	OUT-OF-NETWORK
LIFETIME MAXIMUM, Deductible, and OUT-OF-POCKET LIMIT		
The following deductibles and maximums apply to the services listed above in the "Summary of Benefits" unless otherwise noted.		
LIFETIME MAXIMUM	Unlimited	Unlimited
Unlimited for all services, except INFERTILITY and orthotic devices for POSITIONAL PLAGIOCEPHALY. If you exceed any LIFETIME MAXIMUM for a specific covered benefit, additional services of that type are not covered. In this case, you may be responsible for the entire amount of the PROVIDER'S billed charge.		
Deductible		
Individual, per BENEFIT PERIOD	$300	$600
Family, per BENEFIT PERIOD	$600	$1,200
Charges for the following do not apply to the BENEFIT PERIOD deductible*:* • inpatient newborn care for well baby.		
OUT-OF-POCKET LIMIT		
Individual, per BENEFIT PERIOD	$1,500	$3,000
Family, per BENEFIT PERIOD	$3,000	$6,000
Charges over ALLOWED AMOUNTS, premiums, and charges for noncovered services do not apply to the OUT-OF-POCKET LIMIT. The OUT-OF-POCKET LIMIT*,* which is the deductible plus any copayments and coinsurance you pay, is the total amount you will pay for COVERED SERVICES.		

Benefits	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE		
Available in an office-based, outpatient, or ambulatory surgical setting, or URGENT CARE center. This benefit is only for services that indicate a primary diagnosis of preventive or wellness. See "PREVENTIVE CARE" in "COVERED SERVICES." Please visit the BCBSNC website at **bcbsnc.com/preventive** for the most up-to-date information on PREVENTIVE CARE covered under federal law.		
Screenings	No Charge	20% after deductible
This includes: gynecological exams, cervical cancer screening, ovarian cancer screening, mammograms (regardless of diagnosis), colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening.		
Other PREVENTIVE CARE as defined by federal law	No Charge	20% after deductible
For a list of PREVENTIVE CARE services that are covered under federal law see the website at **bcbsnc.com/preventive** or call BCBSNC Customer Service at the number in "Who to Contact?" Please note that the following service is also covered at No Charge IN-NETWORK: nutritional counseling visits, regardless of diagnosis (benefits for nutritional counseling visits are also available OUT-OF-NETWORK at No Charge).		
Immunizations	No Charge	No Charge
All immunizations, including travel immunizations and flu shots, will be covered at No Charge regardless of place of service or provider participation status. This should include flu shots administered through a pharmacy, URGENT CARE center or health department.		
Physician/PROVIDER'S Office See Outpatient for OUTPATIENT CLINIC or HOSPITAL-based services. OFFICE VISITS for the evaluation and treatment of obesity are limited to a combined in- and OUT-OF-NETWORK maximum of four visits per BENEFIT PERIOD. Any visits in excess of these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES.		
OFFICE VISIT Services		
PRIMARY CARE PROVIDER	$20 copayment	20% after deductible
SPECIALIST	$30 copayment	20% after deductible
This includes: office SURGERY, x-rays and lab tests.		
CT scans, MRIs, MRAs and PET scans	5% after deductible	20% after deductible

Reminder: The coinsurance figures displayed above refer to a percentage of the ALLOWED AMOUNT.

Benefits	IN-NETWORK	OUT-OF-NETWORK
Therapy Services		
REHABILITATIVE and HABILITATIVE THERAPIES	$30 copayment	20% after deductible
Chiropractic Services	$30 copayment	20% after deductible
Combined in- and OUT-OF-NETWORK BENEFIT PERIOD MAXIMUMS apply to home, office and outpatient settings. 20 visits per BENEFIT PERIOD for physical/occupational therapy. When MEDICALLY NECESSARY and CERTIFICATION is approved, the PLAN will cover up to 40 additional visits. 20 visits per BENEFIT PERIOD for chiropractic services. 30 visits per BENEFIT PERIOD for speech therapy. Any visits in excess of these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES.		
Acupuncture and Massage Therapy	$30 copayment See note below*	
Services must be provided by a licensed Massage Therapist or licensed Acupuncturist. All covered services provided will be considered IN-NETWORK and paid at the IN-NETWORK benefit level. Acupuncture and massage therapy - combined limit of $500 per BENEFIT PERIOD. ***NOTE**: For Massage Therapy and Acupuncture, referral from a medical PROVIDER is required. (Self-referrals or referrals from a Massage Therapist, Chiropractor or Acupuncturist are not eligible).		
Medically monitored cardiac and pulmonary exercise sessions	$30 copayment	20% after deductible
OTHER THERAPIES	No Charge	20% after deductible
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See Outpatient for OTHER THERAPIES provided in an outpatient setting.		
Respiratory Devices	5% after deductible	20% after deductible
Respiratory devices are limited to $1,500 per member per lifetime. If in-network providers are not reasonably available, out-of-network benefits for the fitting of a sleep apnea device will be paid at the in-network benefit level.		
INFERTILITY Services		
Diagnosis and correction of underlying causes of infertility and/or sexual dysfunction		
PRIMARY CARE PROVIDER	$20 copayment	20% after deductible
SPECIALIST	$30 copayment	20% after deductible
Artificial reproductive services, limited to artificial insemination and in vitro fertilization	50% after deductible	50% after deductible
Combined in- and OUT-OF-NETWORK LIFETIME MAXIMUM of $20,000 per MEMBER for INFERTILITY services, including artificial reproductive services provided in all places of service. Any services in excess of this LIFETIME MAXIMUM are not COVERED SERVICES.		
Lenses And Frames	No Charge	
See Vision in "Covered Services" for details. NOTE: This benefit does not apply to the OUT OF POCKET LIMIT.		

Reminder: The coinsurance figures displayed above refer to a percentage of the ALLOWED AMOUNT.

Benefits	IN-NETWORK	OUT-OF-NETWORK
Obesity Treatment/Weight Management		
PRIMARY CARE PROVIDER	$20 copayment	20% after deductible
SPECIALIST	$30 copayment	20% after deductible
Outpatient Physician Services	5% after deductible	20% after deductible
Outpatient HOSPITAL and HOSPITAL-based Services	5% after deductible	20% after deductible
Inpatient Physician Services	5% after deductible	20% after deductible
Inpatient HOSPITAL and HOSPITAL-based Services	5% after deductible	20% after deductible
OFFICE VISITS for the evaluation of obesity are limited to a combined IN- and OUT-OF-NETWORK maximum of four visits per BENEFIT PERIOD. Any visits in excess of these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES.		
URGENT CARE Centers, Emergency Room, and Ambulance		
URGENT CARE Centers	$30 copayment	$30 copayment
Emergency Room Visit	$100 copayment, waived if admitted	$100 copayment, waived if admitted
If admitted to the HOSPITAL from the emergency room, the emergency room copayment does not apply; instead, inpatient HOSPITAL benefits apply to all COVERED SERVICES provided in both the emergency room and during inpatient hospitalization. If held for observation, the emergency room copayment does not apply; instead, outpatient benefits apply to all COVERED SERVICES provided in both the emergency room and during observation. If you are sent to the emergency room from an URGENT CARE center, you may be responsible for both the emergency room copayment and the URGENT CARE copayment.		
Ambulance Services	5% after deductible	20% after deductible
AMBULATORY SURGICAL CENTER		
Ambulatory Surgical Services	5% after deductible	20% after deductible

Reminder: The coinsurance figures displayed above refer to a percentage of the ALLOWED AMOUNT.

Benefits	IN-NETWORK	OUT-OF-NETWORK
Outpatient		
Physician Services	5% after deductible	20% after deductible
HOSPITAL and HOSPITAL-based Services	5% after deductible	20% after deductible
HOSPITAL-based or OUTPATIENT CLINIC Services	5% after deductible	20% after deductible
Therapy Services	5% after deductible	20% after deductible
Includes REHABILITATIVE and HABILITATIVE THERAPIES and OTHER THERAPIES including dialysis; see PROVIDER'S Office for visit maximums.		
Outpatient Diagnostic Services		
Outpatient lab tests and mammography, when performed alone		
Physician Services	5% after deductible	20% after deductible
HOSPITAL and HOSPITAL-based Services	No Charge	20% after deductible
Outpatient lab tests and mammography, when performed with another service		
Physician Services	5% after deductible	20% after deductible
HOSPITAL and HOSPITAL-based Services	5% after deductible	20% after deductible
Outpatient x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests	5% after deductible	20% after deductible
CT scans, MRIs, MRAs, and PET scans	5% after deductible	20% after deductible
Inpatient		
Physician Services	5% after deductible	20% after deductible
HOSPITAL and HOSPITAL-based Services	5% after deductible	20% after deductible
Includes maternity delivery, prenatal and post-delivery care. If you are in a HOSPITAL as an inpatient at the time you begin a new BENEFIT PERIOD, you may have to meet a new deductible for COVERED SERVICES from DOCTORS or OTHER PROFESSIONAL PROVIDERS. See Family Planning in "Covered Services" for more details.		
SKILLED NURSING FACILITY		
	5% after deductible	20% after deductible
Combined in- and OUT-OF-NETWORK maximum of 140 days per BENEFIT PERIOD. Services applied to the deductible count towards this day maximum. CERTIFICATION is required. Any services in excess of these BENEFIT PERIOD MAXIMUMS are not COVERED SERVICES.		

Reminder: The coinsurance figures displayed above refer to a percentage of the ALLOWED AMOUNT.

Benefits	IN-NETWORK	OUT-OF-NETWORK
Other Services		
Orthotic devices for correction of POSITIONAL PLAGIOCEPHALY are limited to one device per MEMBER per lifetime.		
Cranial prosthesis (wigs) Combined in- and OUT-OF-NETWORK maximum of $400 per condition.	No Charge	No Charge
DURABLE MEDICAL EQUIPMENT, HOSPICE services, MEDICAL SUPPLIES, orthotic devices, private duty nursing, PROSTHETIC APPLIANCES, and home health care	5% after deductible	20% after deductible
Smoking cessation - treatment, services and supplies	No Charge	No Charge
On-line consultations and any related on-line services the member makes or receives from a medical provider, practitioner or facility, phone consultations and counseling are not covered services.		
Laser treatment of port wine stain Dx 757.32 Vascular hamartomas. SAS provides a LIFETIME MAXIMUM benefit of $3,000 for treatment of vascular harmatomas located on the face. Standard medical policy applies to all other vascular harmartomas.		
Any services in excess of these BENEFIT PERIOD or LIFETIME MAXIMUMS are not COVERED SERVICES.		
Hearing Services		
Exam $100 maximum per covered person per BENEFIT PERIOD.	No Charge	No Charge
Hearing Aids Hearing aids are limited to one hearing aid per hearing-impaired ear every three years for MEMBERS through age 22. For MEMBERS over age 22, hearing aid replacements will be allowed once every 5 years, up to a $1,500 maximum per hearing aid per ear. This does not include hearing aid batteries.	5% after deductible	20% after deductible

Reminder: The coinsurance figures displayed above refer to a percentage of the ALLOWED AMOUNT.

Benefits	IN-NETWORK	OUT-OF-NETWORK
Mental Health and Substance Abuse Services		
PRIOR REVIEW is required for inpatient and certain outpatient services. Call Magellan Behavioral Health at 1-800-359-2422.		
Mental Health Office Services	$30 copayment	20% after deductible
Mental Health Inpatient Services		
Physician Services	5% after deductible	20% after deductible
HOSPITAL and HOSPITAL-based Services	5% after deductible	20% after deductible
Mental Health Outpatient Services		
Physician Services	5% after deductible	20% after deductible
HOSPITAL and HOSPITAL-based Services	5% after deductible	20% after deductible
Substance Abuse Office Services	$30 copayment	20% after deductible
Substance Abuse Inpatient Services		
Physician Services	5% after deductible	20% after deductible
HOSPITAL and HOSPITAL-based Services	5% after deductible	20% after deductible
Substance Abuse Outpatient Services		
Physician Services	5% after deductible	20% after deductible
HOSPITAL and HOSPITAL-based Services	5% after deductible	20% after deductible
CERTIFICATION Requirements		
Certain services require PRIOR REVIEW and CERTIFICATION by the PLAN in order to receive benefits. See "COVERED SERVICES" and "PRIOR REVIEW (Pre-Service)" in "UTILIZATION Management" for additional information.		

Reminder: The coinsurance figures displayed above refer to a percentage of the ALLOWED AMOUNT.

HOW BLUE OPTIONS WORKS

As a MEMBER of the Blue Options plan, you enjoy quality health care from a network of health care PROVIDERS and easy access to SPECIALISTS. You also have the freedom to choose health care PROVIDERS who do not participate in the PPO network - the main difference will be the cost to you. Although some services do not require CERTIFICATION, MEDICAL NECESSITY guidelines must be met.

Benefits are available for services from an IN- or OUT-OF-NETWORK PROVIDER that is recognized by BCBSNC as eligible. For a list of eligible PROVIDERS, please visit BCBSNC's website at **bcbsnc.com** or call BCBSNC Customer Service at the number listed in "Who to Contact?" Here's a look at how it works:

	IN-NETWORK	OUT-OF-NETWORK
Type of PROVIDER	IN-NETWORK PROVIDERS are health care professionals and facilities that have contracted with BCBSNC, or a PROVIDER participating in the BlueCard® program. ANCILLARY PROVIDERS outside North Carolina are considered IN-NETWORK only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, even if they participate in the BlueCard® program. See "Glossary" for a description of ANCILLARY PROVIDERS and the criteria for determining where services are received. The list of IN-NETWORK PROVIDERS may change from time to time. IN-NETWORK PROVIDERS are listed on BCBSNC's website at **bcbsnc.com**, or call BCBSNC Customer Service at the number listed in "Who to Contact?"	OUT-OF-NETWORK PROVIDERS are not designated as Blue Options PROVIDERS by BCBSNC. Also see "OUT-OF-NETWORK Benefit Exceptions."
ALLOWED AMOUNT vs. Billed Amount	If the billed amount for COVERED SERVICES is greater than the ALLOWED AMOUNT, you are not responsible for the difference. You only pay any applicable copayment, deductible, coinsurance, and noncovered expenses. (See Filing Claims below for additional information.)	You may be responsible for paying any charges over the ALLOWED AMOUNT in addition to any applicable deductible, coinsurance, noncovered expenses and CERTIFICATION penalty amounts, if any except for EMERGENCY SERVICES in the case of an EMERGENCY.
Referrals	BCBSNC does not require you to obtain any referrals.	
After-hours Care	If you need nonemergency services after your PROVIDER'S office has closed, please call your PROVIDER'S office for their recorded instructions.	
Care Outside of North Carolina	Your ID CARD gives you access to participating PROVIDERS outside the state of North Carolina through the BlueCard program, and benefits are provided at the IN-NETWORK benefit level.	If you are in an area that has participating PROVIDERS and you choose a PROVIDER outside the network, you will receive the lower OUT-OF-NETWORK benefit. Care received outside of North Carolina is based on North Carolina policy. Also see "OUT-OF-NETWORK Benefit Exceptions."
PRIOR REVIEW	All IN-NETWORK PROVIDERS in North Carolina and some outside North Carolina are responsible for requesting PRIOR REVIEW when necessary.	Out-OF-NETWORK PROVIDERS are not under contract with BCBSNC and therefore are not obligated to request PRIOR REVIEW.

	IN-NETWORK	OUT-OF-NETWORK
	See "COVERED SERVICES" and "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information about those services which require PRIOR REVIEW and CERTIFICATION.	**Therefore, you are responsible for ensuring that you or your OUT-OF-NETWORK PROVIDER requests PRIOR REVIEW by BCBSNC.** Failure to request PRIOR REVIEW and obtain CERTIFICATION may result in a partial or full denial of benefits. However, PRIOR REVIEW is not required for an EMERGENCY or for an inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a Cesarean section. With respect to covered OUT-OF-NETWORK inpatient admissions (including for mental health or substance abuse services), if PRIOR REVIEW is not requested and CERTIFICATION is not obtained, allowed charges will be reduced by 20%, then deductible and coinsurance will be applied.
Filing Claims	IN-NETWORK PROVIDERS in North Carolina are responsible for filing claims directly with BCBSNC. Claims not received within 18 months from the service date will not be covered.	You may have to pay the OUT-OF-NETWORK PROVIDER in full and submit your own claim to BCBSNC. Mail claims in time to be received within 18 months of the date the service was provided. Claims not received within 18 months from the service date will not be covered.

OUT-OF-NETWORK Benefit Exceptions

In an EMERGENCY, in situations where IN-NETWORK PROVIDERS are not reasonably available as determined by BCBSNC's access to care standards, or in continuity of care situations, OUT-OF-NETWORK benefits will be paid at your IN-NETWORK benefit level. However, you may be responsible for charges billed separately by the PROVIDER which are not eligible for additional reimbursement. If you are billed by the PROVIDER, you will be responsible for paying the bill and filing a claim with BCBSNC.

> For more information, see one of the following sections: "EMERGENCY Care" in "COVERED SERVICES," or "Continuity of Care" in "UTILIZATION MANAGEMENT." For information about BCBSNC's access to care standards, visit BCBSNC's website at **bcbsnc.com** and type "access to care" in the search bar. If you believe an IN-NETWORK PROVIDER is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling BCBSNC before receiving care from an OUT-OF-NETWORK PROVIDER.

Carry Your IDENTIFICATION CARD

Your ID CARD identifies you as a Blue Options MEMBER. Be sure to carry your ID CARD with you at all times and present it each time you seek health care.

> For ID CARD requests, please visit the BCBSNC website at **mybcbsnc.com** or call BCBSNC Customer Service at the number listed in "Who to Contact?"

The Role of a PRIMARY CARE PROVIDER (PCP) or SPECIALIST

THE PLAN does not require that you designate a PCP to manage your health care. However, it is important for you to maintain a relationship with a PCP, who will help you manage your health and make decisions about your health care

needs. If you change PCPs, be sure to have your medical records transferred, especially immunization records, to provide your new PROVIDERS with your medical history. You should participate actively in all decisions related to your health care and discuss all treatment options with your health care PROVIDER regardless of cost or benefit coverage. PCPs are trained to deal with a broad range of health care issues and can help you to determine when you need a SPECIALIST. PROVIDERS from medical specialties such as family practice, internal medicine and pediatrics may participate as PCPs.

Please visit BCBSNC's website at **bcbsnc.com** or call BCBSNC Customer Service to confirm that the PROVIDER is in the network before receiving care.

If your PCP or SPECIALIST leaves the BCBSNC PROVIDER network and they are currently treating you for an ongoing special condition, see "Continuity of Care" in "UTILIZATION MANAGEMENT."

Upon the request of the MEMBER and subject to approval by BCBSNC, a SPECIALIST treating a MEMBER for a serious or chronic disabling or life-threatening condition can act as the MEMBER'S PCP. The selected SPECIALIST would be responsible for providing and coordinating the MEMBER'S primary and specialty care. The selection of a SPECIALIST under these circumstances shall be made under a treatment plan approved by the SPECIALIST and BCBSNC, with notice to the PCP, if applicable. A request may be denied where it is determined that the SPECIALIST cannot appropriately coordinate the MEMBER'S primary and specialty care.

To make this request, or if you would like the professional qualifications of your PCP or IN-NETWORK SPECIALIST, you may call BCBSNC Customer Service at the number listed in "Who to Contact?"

Blue Options covers only those services that are MEDICALLY NECESSARY. Also keep in mind as you read this section:

- **Certain services require PRIOR REVIEW and CERTIFICATION in order for you to avoid a reduced benefit (penalty) or complete denial of benefits. General categories of services are noted below as requiring PRIOR REVIEW. Also see "PRIOR REVIEW/Pre-Service" in "UTILIZATION MANAGEMENT" for information about the review process, and visit BCBSNC's website at BlueConnectNC.com or call BCBSNC Customer Service to ask whether a specific service requires PRIOR REVIEW and CERTIFICATION.**
- Exclusions and limitations apply to your coverage. Service-specific exclusions are stated along with the benefit description in "COVERED SERVICES." Exclusions that apply to many services are listed in "What Is Not Covered?" To understand the exclusions and limitations that apply to each service, read "COVERED SERVICES," "Summary of Benefits" and "What Is Not Covered?"
- You may receive, upon request, information about Blue Options, its services and PROVIDERS, including this benefit booklet with a benefit summary, and a directory of IN-NETWORK PROVIDERS.
- You may also receive, upon request, information about the procedure and medical criteria used by BCBSNC to determine whether a procedure, treatment, facility, equipment, drug or device is MEDICALLY NECESSARY and eligible for coverage, INVESTIGATIONAL or EXPERIMENTAL, or requires PRIOR REVIEW and CERTIFICATION by BCBSNC. BCBSNC medical policies are guides considered by BCBSNC when making coverage determinations. If you need more information about medical policies, visit BCBSNC's website at **bcbsnc.com**, or call BCBSNC Customer Service at the number listed in "Who to Contact?"

Office Services

Care you receive as part of an OFFICE VISIT, electronic visit, or house call is covered, except as otherwise noted in this benefit booklet.

Some PROVIDERS may get ancillary services, such as laboratory services, medical equipment and supplies or SPECIALTY DRUGS, from third parties. In these cases, you may be billed directly by the ANCILLARY PROVIDER. Benefit payments for these services will be based on the type of ANCILLARY PROVIDER, its network status, and how the services are billed. Your OFFICE VISIT copayment may not apply to ancillary services provided by ancillary providers.

A copayment will not apply if you only receive services such as allergy shots or other injections and are not charged for an OFFICE VISIT.

Some DOCTORS or OTHER PROVIDERS may practice in OUTPATIENT CLINICS or provide HOSPITAL-based services in their offices. These services are covered as outpatient services and are listed as HOSPITAL-based or OUTPATIENT CLINIC. See "Summary of Benefits."

> Please check with your PROVIDER before your visit to determine if your PROVIDER will collect deductible and coinsurance, or you can call BCBSNC Customer Service at the number listed in "Who to Contact?" for this information.

Office Services Exclusion

- Certain self-injectable PRESCRIPTION DRUGS that can be self-administered. The list of these drugs may change from time to time. Visit BCBSNC website at **bcbsnc.com** or call BCBSNC Customer Service for a list of these drugs excluded in the office.

PREVENTIVE CARE

The PLAN covers PREVENTIVE CARE services that can help you stay safe and healthy.

Under federal law, you can receive certain covered PREVENTIVE CARE services from an IN-NETWORK PROVIDER in an office-based, outpatient, or ambulatory surgical setting, or URGENT CARE center, at no cost to you. Please note, this benefit is only for services that indicate a primary diagnosis of preventive or wellness and which are identified by recent federal regulations as being eligible. Services, such as diagnostic lab tests, that may be delivered with a PREVENTIVE CARE service are not considered PREVENTIVE CARE. These services and services that do not include a primary diagnosis of preventive or wellness will be subject to your IN-NETWORK benefit level for the location where services are received. In addition, if a particular PREVENTIVE CARE service does not have a federal recommendation or guideline concerning the frequency, method, treatment or setting in which it must be provided, the PLAN may use reasonable medical management procedures to determine any coverage limitations or restrictions that may apply.

Please visit BCBSNC's website at **www.bcbsnc.com/preventive** or call BCBSNC Customer Service at the number in "Who to Contact?" for the most up-to-date information on PREVENTIVE CARE that is covered under federal law, including any limitations that may apply. Certain over-the-counter medications may also be available through the prescription benefit.

PREVENTIVE CARE COVERED SERVICES include:

Routine Physical Examinations and Screenings

Routine physical examinations and related diagnostic services and screenings are covered for MEMBERS as recommended with an A or B rating by the United States Preventive Services Task Force (USPSTF).

Well-Baby and Well-Child Care

These services are covered for each MEMBER including periodic assessments as recommended by the Health Resources and Services Administration (HRSA).

Well-Woman Care

These services are covered for each female MEMBER, including periodic assessments, screenings, counseling, or support services, as recommended by the Health Resources and Services Administration (HRSA).

Contraceptive Methods

Contraceptive methods and procedures are covered for each member with reproductive capacity. Professional fees to insert or remove implants or intrauterine devices, or to administer injectable contraceptives are covered under the Medical Plan. Medications and FDA-approved devices approved for prescription use as contraception for each female member with reproductive capacity are covered in the Prescription Drug Plan.

Contraceptive Methods Exclusions

- Over-the-counter contraceptives
- Male contraceptives

Immunizations

Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) are covered. NOTE: the shingles vaccine is covered in accordance with the Food and Drug Administration (FDA) schedule.

Immunizations Exclusion

- Immunizations required for occupational hazard or international travel, unless specifically covered by the PLAN.

Bone Mass Measurement Services

The PLAN covers one scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23-month period for certain qualified individuals only. Additional follow-up bone mass measurement tests will be covered if MEDICALLY NECESSARY. Please note that bone mass measurement tests will be covered under your diagnostic benefit (not your PREVENTIVE CARE benefit) if the claim for these services indicates a primary diagnosis of something other than preventive or wellness. Your diagnostic benefit will be subject to your benefit level for the location where services are received.

Qualified individuals include MEMBERS who have any one of the following conditions:

- Estrogen-deficient and at clinical risk of osteoporosis or low bone mass
- Radiographic osteopenia anywhere in the skeleton
- Receiving long-term glucocorticoid (steroid) therapy
- Primary hyperparathyroidism
- Being monitored to assess the response or effect of commonly accepted osteoporosis drug therapies
- History of low-trauma fractures
- Other conditions, or receiving medical therapies known to cause osteoporosis or low bone mass.

Colorectal Screening

Colorectal cancer examinations and laboratory tests for cancer are covered for any symptomatic or asymptomatic MEMBER who is at least 50 years of age, or is less than 50 years of age and at high risk for colorectal cancer. Increased/high-risk individuals are those who have a higher potential of developing colon cancer because of a personal or family history of certain intestinal disorders. Some of these procedures are considered SURGERY, such as colonoscopy and sigmoidoscopy, and others are considered lab tests, such as hemoccult screenings. Please note that if lab work is done as a result of a colorectal screening exam, the lab work will be covered under your diagnostic benefit and not be considered PREVENTIVE CARE. It will be subject to your benefit level for the location where services are received.

Gynecological Exam and Cervical Cancer Screening

The cervical cancer screening benefit includes the examination and laboratory tests for early detection and screening of cervical cancer, and a DOCTOR'S interpretation of the lab results. Coverage for cervical cancer screening includes Pap smear screening, liquid-based cytology, and human papillomavirus detection, and shall follow the American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

Newborn Hearing Screening

Coverage is provided for newborn hearing screening ordered by a DOCTOR to determine the presence of permanent hearing loss.

Ovarian Cancer Screening

For female MEMBERS ages 25 and older at risk for ovarian cancer, an annual screening, including a transvaginal ultrasound and a rectovaginal pelvic examination, is covered. A female MEMBER is considered "at risk" if she:

- has a family history with at least one first-degree relative with ovarian cancer, and a second relative, either first-degree or second-degree with breast, ovarian, or nonpolyposis colorectal cancer; or
- tested positive for a hereditary ovarian cancer syndrome.

Prostate Screening

One prostate-specific antigen (PSA) test or an equivalent serological test will be covered per male MEMBER per BENEFIT PERIOD. Additional PSA tests will be covered if recommended by a DOCTOR.

Screening Mammograms

The PLAN provides coverage for one baseline mammogram for any female MEMBER between the ages of 35 and 39. Beginning at age 40, one screening mammogram will be covered per female MEMBER per BENEFIT PERIOD, along with a DOCTOR'S interpretation of the results. More frequent or earlier mammograms will be covered as recommended by a DOCTOR when a female MEMBER is considered at risk for breast cancer.

A female MEMBER is "at risk" if she:

- Has a personal history of breast cancer
- Has a personal history of biopsy-proven benign breast disease
- Has a mother, sister, or daughter who has or has had breast cancer, or
- Has not given birth before the age of 30.

Obesity Treatment/Weight Management

The PLAN provides coverage for OFFICE VISITS for the evaluation and treatment of obesity; see "Summary of Benefits" for visit maximums. Benefits are also provided for surgical treatment of morbid obesity. Morbid obesity surgical services require PRIOR REVIEW and CERTIFICATION or services will not be covered.

The PLAN also provides benefits for nutritional counseling visits to an IN-NETWORK PROVIDER as part of your PREVENTIVE CARE benefits. The nutritional counseling visits may include counseling specific to achieving or maintaining a healthy weight. Nutritional counseling visits are separate from the obesity-related OFFICE VISITS noted above.

Obesity Treatment/Weight Management Exclusions

- Removal of excess skin from the abdomen, arms or thighs
- Any costs associated with membership in a weight management program except as specifically described above
- Any treatment or regimen, medical or surgical for the purpose of reducing or controlling the weight of the member except as specifically described above.

Diagnostic Services

Diagnostic procedures such as laboratory studies, sleep studies, radiology services and other diagnostic testing, which may include electroencephalograms (EEGs), electrocardiograms (ECGs), Doppler scans and pulmonary function tests (PFTs), help your DOCTOR find the cause and extent of your condition in order to plan for your care. Multiple radiology or imaging procedures on the same date of service and/or during the same patient encounter may not be eligible for separate reimbursement.

Certain diagnostic imaging procedures may require PRIOR REVIEW and CERTIFICATION and meet MEDICAL NECESSITY requirements.

Your DOCTOR may refer you to a freestanding laboratory, radiology center, or a sample collection device for these procedures. Separate benefits for interpretation of diagnostic services by the attending DOCTOR are not provided in addition to benefits for that DOCTOR'S medical or surgical services, except as otherwise determined by the PLAN.

Benefits may differ depending on where the service is performed and if the service is received with any other service or associated with a surgical procedure. See "Summary of Benefits."

Diagnostic Services Exclusion

- Lab tests that are not ordered by your DOCTOR or OTHER PROVIDER.

EMERGENCY Care

The PLAN provides benefits for EMERGENCY SERVICES.

An EMERGENCY is the sudden and unexpected onset of a condition of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of an individual, or with respect to a pregnant woman the health of the pregnant woman or her unborn child, in serious jeopardy
- Serious physical impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Death.

Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock and other severe, acute conditions are examples of EMERGENCIES.

What to Do in an EMERGENCY

In an EMERGENCY, you should seek care immediately from an emergency room or other similar facility. If necessary and available, call 911 or use other community EMERGENCY resources to obtain assistance in handling life-threatening EMERGENCIES. If you are unsure if your condition is an EMERGENCY, you can call HealthLine Blue and a HealthLine Blue nurse will provide information and support that may save you an unnecessary trip to the emergency room.

Benefits for services in the emergency room

Situation	Benefit
You go to an IN-NETWORK HOSPITAL emergency room.	Applicable ER copayment and/or coinsurance. PRIOR REVIEW and CERTIFICATION are not required.
You go to an OUT-OF-NETWORK HOSPITAL emergency room.	Benefits paid at the IN-NETWORK copayment or coinsurance level and based on the billed amount. You may be responsible for your OUT-OF-NETWORK deductible if applicable, and for charges billed separately which are not eligible for additional reimbursement. You may be required to pay the entire bill at the time of service and file a claim. PRIOR REVIEW and CERTIFICATION are not required.
You are held for observation.	Outpatient benefits apply to all COVERED SERVICES received in the emergency room and during the observation.
You are admitted to the HOSPITAL from the ER following EMERGENCY SERVICES.	Inpatient HOSPITAL benefits apply for all COVERED SERVICES received in the emergency room and during hospitalization. PRIOR REVIEW and CERTIFICATION are required for inpatient hospitalization and other selected services following EMERGENCY SERVICES (including screening and stabilization) in order to avoid a penalty. You may need to transfer to an IN-NETWORK HOSPITAL once your condition is stabilized in order to continue receiving IN-NETWORK benefits.
You get follow-up care (such as OFFICE VISITS or therapy) after you leave the ER or are discharged.	Use IN-NETWORK PROVIDERS to receive IN-NETWORK benefits. Follow-up care related to the EMERGENCY condition is not considered an EMERGENCY.

URGENT CARE

The PLAN also provides benefits for URGENT CARE services. When you need URGENT CARE, call your PCP, a SPECIALIST or go to an URGENT CARE PROVIDER. If you are not sure if your condition requires URGENT CARE, you can call HealthLine Blue.

Family Planning

Maternity Care

Maternity care benefits, including prenatal care, labor and delivery and post-delivery care, are available to all female MEMBERS. Also visit **www.bcbsnc.com/preventive** for those federally mandated PREVENTIVE CARE services that are available for DEPENDENT CHILDREN. Coverage for breastfeeding counseling and certain breast pumps for pregnant or postpartum MEMBERS are covered under your PREVENTIVE CARE benefit. See **www.bcbsnc.com/preventive** or call BCBSNC Customer Service for additional information and any limitations that may apply. If a MEMBER changes PROVIDERS during pregnancy, terminates coverage during pregnancy, or the pregnancy does not result in delivery, one or more copayments may be charged for prenatal services depending upon how the services are billed by the PROVIDER.

	Mother	Newborn	Payment
Prenatal care	Care related to the pregnancy before birth		A copayment may apply for the OFFICE VISIT to diagnose pregnancy. Deductible and coinsurance apply for the remainder of maternity care benefits.
Labor & delivery services	No PRIOR REVIEW required for inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Mothers choosing a shorter stay are eligible for a home health visit for post-delivery follow-up care if received within 72 hours of discharge.	No PRIOR REVIEW required for inpatient well-baby care for 48 hours after a vaginal delivery or 96 hours after a cesarean section. Benefits include newborn hearing screening ordered by a DOCTOR to determine the presence of permanent hearing loss. (Please see PREVENTIVE CARE in "Summary of Benefits.")	For the first 48/96 hours, only one BENEFIT PERIOD deductible is required for both mother and baby.
Post-delivery services	All care for the mother after the baby's birth that is related to the pregnancy In order to avoid a penalty, PRIOR REVIEW and CERTIFICATION are required for inpatient stays extending beyond 48/96 hours.	After the first 48/96 hours, whether inpatient (sick baby) or outpatient (well baby), the newborn must be enrolled for coverage as a DEPENDENT CHILD. For inpatient services following the first 48/96 hours, PRIOR REVIEW and CERTIFICATION are required in order to avoid a penalty.	If the newborn must remain in the HOSPITAL beyond the mother's prescribed length of stay for any reason, the newborn is considered a sick baby and these charges are subject to the BENEFIT PERIOD deductible if the newborn is added and covered under the policy.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any HOSPITAL length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending PROVIDER (e.g., your DOCTOR, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a DOCTOR or other health care PROVIDER obtain CERTIFICATION for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain PROVIDERS or facilities, or to reduce your out-of-pocket costs, you may be required to obtain CERTIFICATION.

Termination of Pregnancy (Abortion)

Benefits for abortion are available through the first 16 weeks of a pregnancy for all female MEMBERS

COMPLICATIONS OF PREGNANCY

Benefits for COMPLICATIONS OF PREGNANCY are available to all female MEMBERS. Please see "Glossary" for an explanation of COMPLICATIONS OF PREGNANCY.

INFERTILITY Services

Benefits are provided for certain services related to the diagnosis, treatment and correction of any underlying causes of INFERTILITY for all MEMBERS except DEPENDENT CHILDREN. Such services include conception by artificial means, including in-vitro fertilization.

SEXUAL DYSFUNCTION Services

The PLAN provides benefits for certain services related to the diagnosis, treatment and correction of any underlying causes of SEXUAL DYSFUNCTION for all MEMBERS. Benefits may vary depending on where services are received.

Sterilization

This benefit is available for all MEMBERS except DEPENDENT CHILDREN. Sterilization includes female tubal occlusion and male vasectomy. Reversal of sterilization or attempted reversal of sterilization is not covered for any member. See **www.bcbsnc.com/preventive** or call BCBSNC Customer Service for information about procedures that are covered according to federal regulations and any limitations that may apply.

Family Planning Exclusions

- Assisted reproductive technologies as defined by the Centers for Disease Control and Prevention, including, but not limited to, ovum or embryo placement, intracytoplasmic sperm injection (ICSI), zygote intrafallopian transfer (ZIFT), specialized sperm retrieval techniques, and gamete intrafallopian (GIFT) and associated services
- Oocyte and sperm donation
- Cryopreservation of oocytes, sperm, or embryos
- Surrogate mothers
- Care or treatment of the following:
  - sterilizations for DEPENDENT CHILDREN
  - reversal of sterilization
  - INFERTILITY for DEPENDENT CHILDREN
- Elective termination of pregnancy (abortion) after 16 weeks of pregnancy
- Treatment for INFERTILITY or reduced fertility that results from a prior sterilization procedure or a normal physiological change such as menopause.

FACILITY SERVICES

Benefits are provided for:

- Outpatient services received in a HOSPITAL, a HOSPITAL-based facility, NONHOSPITAL FACILITY or a HOSPITAL-based or OUTPATIENT CLINIC
- Inpatient services received in a HOSPITAL or NONHOSPITAL FACILITY. You are considered an inpatient if you are admitted to the HOSPITAL or NONHOSPITAL FACILITY as a registered bed patient for whom a room and board charge is made. Your IN-NETWORK PROVIDER is required to use the PPO network HOSPITAL where he/she practices, unless that HOSPITAL cannot provide the services you need. If you are admitted before the EFFECTIVE DATE, benefits will not be available for services received prior to the EFFECTIVE DATE.

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from BCBSNC for inpatient admissions, except for maternity deliveries and EMERGENCIES. See "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information. **If PRIOR REVIEW is not requested and CERTIFICATION is not obtained for covered OUT OF NETWORK inpatient admissions, allowed charges will be reduced by 20%, then deductible and coinsurance will be applied.** Also, the PLAN requires notification for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified HOSPITAL or NONHOSPITAL FACILITY.

- Surgical services received in an AMBULATORY SURGICAL CENTER
- COVERED SERVICES received in a SKILLED NURSING FACILITY. SKILLED NURSING FACILITY services are limited to a combined IN- and OUT-OF-NETWORK day maximum per BENEFIT PERIOD. See "Summary of Benefits."

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance from BCBSNC or services will not be covered. However, CERTIFICATION is not required for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified SKILLED NURSING FACILITY.

Other Services

Ambulance Services

The PLAN covers services in a ground ambulance traveling:

- From a MEMBER'S home or scene of an accident or EMERGENCY to a HOSPITAL
- Between HOSPITALS
- Between a HOSPITAL and a SKILLED NURSING FACILITY

when such a facility is the closest one that can provide COVERED SERVICES appropriate to your condition. Benefits may also be provided for ambulance services from a HOSPITAL or SKILLED NURSING FACILITY to a MEMBER'S home when MEDICALLY NECESSARY.

The PLAN covers services in an air ambulance traveling from the site of an EMERGENCY to a HOSPITAL when such a facility is the closest one that can provide COVERED SERVICES appropriate to your condition. Air ambulance services are eligible for coverage only when ground transportation is not medically appropriate due to the severity of the illness or the pick-up point is inaccessible by land.

Nonemergency air ambulance services require PRIOR REVIEW and CERTIFICATION or services will not be covered.

Ambulance Service Exclusions

- No benefits are provided primarily for the convenience of travel.
- Transportation to or from a doctor's office or dialysis center
- Transportation for the purpose of receiving services that are not considered covered services, even if the destination is an appropriate facility.

Blood

The PLAN covers the cost of transfusions of blood, plasma, blood plasma expanders and other fluids injected into the bloodstream. Benefits are provided for the cost of storing a MEMBER'S own blood only when it is stored and used for a previously scheduled procedure.

Blood Exclusion

- Charges for the collection or obtainment of blood or blood products from a blood donor, including the MEMBER in the case of autologous blood donation.

Certain Drugs Covered under Your Medical Benefit

The PLAN covers certain drugs that must be dispensed under a PROVIDER'S supervision in an office, outpatient setting, or through home infusion. These drugs are covered under your medical benefit rather than your PRESCRIPTION DRUG benefit. Coverage of some of these drugs may be limited to certain PROVIDER settings (such as office, outpatient, AMBULATORY SURGICAL CENTER). For a list of drugs covered under your medical benefit that are covered only at certain PROVIDER settings, visit BCBSNC's website at **bcbsnc.com**

Clinical Trials

The PLAN provides benefits for participation in clinical trials phases I, II, III, and IV. Coverage is provided only for MEDICALLY NECESSARY costs of health care services associated with the trials, and only to the extent such costs have not been or are not funded by other resources. The MEMBER must meet all protocol requirements and provide informed consent in order to participate. The trial must involve the treatment of cancer or a life-threatening medical condition with services that are medically indicated and preferable for that MEMBER compared to non-investigational alternatives. In addition, the trial must:

- Involve determinations by treating physicians, relevant scientific data and opinions of relevant medical specialists
- Be approved by centers or groups funded by the National Institutes of Health, the U.S. Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Department of Defense or the Department of Veterans Affairs
- Be conducted in a setting and by personnel of high expertise based on training, experience and patient volume.

Clinical Trials Exclusions

- Non-health care services, such as services provided for data collection and analysis
- INVESTIGATIONAL drugs and devices and services that are not for the direct clinical management of the patient.

Dental Treatment Covered Under Your Medical Benefit

The PLAN provides benefits for services provided by a duly licensed DOCTOR, DOCTOR of dental SURGERY or DOCTOR of dental medicine for diagnostic, therapeutic or surgical procedures, including oral SURGERY involving bones or joints of the jaw, when the procedure or dental treatment is related to one of the following conditions:

- Accidental injury of the sound teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth
- CONGENITAL deformity, including cleft lip and cleft palate
- Removal of:
  - tumors which are not related to teeth or associated dental procedures
  - cysts which are not related to teeth or associated dental procedures
  - exostoses for reasons other than preparation of dentures.

The PLAN provides benefits for dental implants and related procedures, such as bone grafting associated with the above three conditions.

Benefits are also provided for extractions, root canal therapy, crowns, bridges, and dentures necessary for treatment of accidental injury or for reconstruction for the conditions listed above. In addition, benefits may be provided for dentures and orthodontic braces if used to treat CONGENITAL deformity including cleft lip and cleft palate.

When any of the conditions listed above require surgical correction, benefits for SURGERY will be subject to MEDICAL NECESSITY review to examine whether or not the condition resulted in functional impairment. Examples of functional impairment include an impairment that affects speech or the ability to eat, or injury to soft tissue of the mouth.

In special cases, benefits are provided only for anesthesia and facility charges related to dental procedures performed in a HOSPITAL or AMBULATORY SURGICAL CENTER. This benefit is only available to DEPENDENT CHILDREN below nine years of age, persons with serious mental or physical conditions and persons with significant behavioral problems. The treating PROVIDER must certify that the patient's age, condition or problem requires hospitalization or general anesthesia in order to safely and effectively perform the procedure. Other DENTAL SERVICES, including the charge for SURGERY, are not covered unless specifically covered by the PLAN.

In addition, benefits will be provided if a MEMBER is treated in a HOSPITAL following an accidental injury, and COVERED SERVICES such as oral SURGERY or reconstructive procedures are required at the same time as treatment for the bodily injury.

Unless reconstructive DENTAL SERVICES following accidental injury are related to the bones or joints of the jaw, face, or head, reconstructive DENTAL SERVICES are covered only when provided within two years of the accident.

PRIOR REVIEW and CERTIFICATION are required for certain surgical procedures or services will not be covered, unless treatment is for an EMERGENCY.

Dental Treatment Excluded Under Your Medical Benefit

Treatment for the following conditions:

- Injury related to chewing or biting
- Preventive dental care, diagnosis or treatment of or related to the teeth or gums
- Periodontal disease or cavities and disease due to infection or tumor

And except as specifically stated as covered, treatment such as:

- Dental implants (except those stated above) or root canals
- Orthodontic braces
- Removal of teeth and intrabony cysts
- Procedures performed for the preparation of the mouth for dentures
- Crowns, bridges, dentures or in-mouth appliances.

Diabetes-Related Services

All MEDICALLY NECESSARY diabetes-related services, including equipment, supplies, and laboratory procedures are covered. Diabetic outpatient self-management training and educational services are also covered. Some diabetic

supplies, such as lancet syringes and test strips may be covered under the Prescription plan that is not administered by BCBSNC. Refer to the Prescription Drug Benefit Provision section of this SPD.

See "Summary of Benefits," depending on where services are received.

DURABLE MEDICAL EQUIPMENT

Benefits are provided for DURABLE MEDICAL EQUIPMENT and supplies required for operation of equipment when prescribed by a DOCTOR. Equipment may be purchased or rented at the discretion of the PLAN. If purchased and approved, the PLAN will pay for the rental equipment up to the purchase price. The PLAN provides benefits for repair or replacement of the covered equipment. Benefits will end when it is determined that the equipment is no longer MEDICALLY NECESSARY.

Certain DURABLE MEDICAL EQUIPMENT requires PRIOR REVIEW and CERTIFICATION or services will not be covered.

DURABLE MEDICAL EQUIPMENT Exclusions

- Appliances and accessories that serve no medical purpose or that are primarily for comfort or convenience
- Repair or replacement of equipment due to abuse or desire for new equipment.

Hearing Aids

The PLAN provides coverage for MEDICALLY NECESSARY hearing aids and related services that are ordered by a DOCTOR or a licensed audiologist for each MEMBER through the age of 22. Benefits are provided for one hearing aid per hearing-impaired ear, and replacement hearing aids when alterations to an existing hearing aid are not adequate to meet the MEMBER'S needs. This benefit is limited to once every 36 months for MEMBERS through age 22. For MEMBERS over age 22, hearing aid replacements will be allowed once every 5 years, up to a $1,500 maximum per hearing aid per ear. Benefits are also provided for the evaluation, fitting, and adjustments of hearing aids or replacement of hearing aids, and for supplies, including ear molds. A maximum applies; see "Other Services" in "Summary of Benefits."

Home Health Care

Home health care services are covered when ordered by your DOCTOR for a MEMBER who is HOMEBOUND due to illness or injury, and you need part-time or intermittent skilled nursing care from a REGISTERED NURSE (RN) or LICENSED PRACTICAL NURSE (LPN) and/or other skilled care services like REHABILITATIVE and HABILITATIVE THERAPIES. Usually, a HOME HEALTH AGENCY coordinates the services your DOCTOR orders for you. Services from a home health aide may be eligible for coverage only when the care provided supports a skilled service being delivered in the home.

Home health care requires PRIOR REVIEW and CERTIFICATION or services will not be covered.

Home Health Care Exclusions

- Dietitian services or meals
- Homemaker services, such as cooking, preparation of food and meals, and housekeeping
- Services that are provided by a close relative or a member of your household.

Home Infusion Therapy Services

Home infusion therapy is covered for the administration of PRESCRIPTION DRUGS directly into a body organ or cavity or via intravenous, intraspinal, intramuscular, subcutaneous or epidural routes, under a plan prescribed by a DOCTOR. These services must be provided under the supervision of an RN or LPN.

PRIOR REVIEW and CERTIFICATION are required for certain home infusion therapy services or services will not be covered.

HOSPICE Services

Your coverage provides benefits for HOSPICE services for care of a terminally ill MEMBER with a life expectancy of six months or less. Services are covered only as part of a licensed health care program centrally coordinated through an interdisciplinary team directed by a DOCTOR that provides an integrated set of services and supplies designed to give comfort, pain relief and support to terminally ill patients and their families.

HOSPICE Services Exclusion

- Homemaker services, such as cooking, housekeeping, and food or meal preparation.

Lymphedema-Related Services

Coverage is provided for the diagnosis, evaluation, and treatment of lymphedema. These services must be provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within their scope of practice. Benefits include MEDICALLY NECESSARY equipment, supplies and services such as complex decongestive therapy or self-management therapy and training. Gradient compression garments may be covered only with a PRESCRIPTION and when custom-fit for the patient.

Lymphedema-Related Services Exclusion

- Over-the-counter compression or elastic knee-high or other stocking products.

MEDICAL SUPPLIES

Coverage is provided for MEDICAL SUPPLIES.

To obtain MEDICAL SUPPLIES and equipment, please find a PROVIDER on BCBSNC website at **bcbsnc.com** or call BCBSNC Customer Service.

MEDICAL SUPPLIES Exclusion

- MEDICAL SUPPLIES not ordered by a DOCTOR for treatment of a specific diagnosis or procedure.

Orthotic Devices

Orthotic devices, which are rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or diseased body part, are covered if MEDICALLY NECESSARY and prescribed by a PROVIDER. Foot orthotics may be covered only when custom molded to the patient. Diabetic and custom molded orthopedic shoes are covered when MEDICALLY NECESSARY. Orthotic devices for correction of POSITIONAL PLAGIOCEPHALY, including dynamic orthotic cranioplasty (DOC) bands and soft helmets, are subject to a benefit limit of one device per MEMBER per lifetime.

Repair and replacement of covered orthotic devices will only be covered when required due to growth or development, MEDICAL NECESSITY because of a change in physical condition, or deterioration from normal wear and tear if recommended by the attending PROVIDER.

Orthotic Devices Exclusions

- Pre-molded foot orthotics
- Over-the-counter supportive devices.

Private Duty Nursing

The PLAN provides benefits for MEDICALLY NECESSARY private duty services of an RN or LPN when ordered by your DOCTOR for a MEMBER who may be receiving active care management. Private duty nursing provides more individual and continuous skilled care than can be provided in a skilled nursing visit through a HOME HEALTH AGENCY.

See "Care Management."

Private duty nursing requires PRIOR REVIEW and CERTIFICATION or services will not be covered. CERTIFICATION must be obtained in advance from the PLAN to receive full benefits. You should work with your DOCTOR to make sure that CERTIFICATION has been obtained. This service is always subject to the deductible and coinsurance, regardless of location of service.

Private Duty Nursing Exclusion

- Services provided by a close relative or a member of your household.

PROSTHETIC APPLIANCES

The PLAN provides benefits for the purchase, fitting, adjustments, repairs, and replacement of PROSTHETIC APPLIANCES. The PROSTHETIC APPLIANCES must replace all or part of a body part or its function. The type of PROSTHETIC APPLIANCE will be based on the functional level of the MEMBER. Therapeutic contact lenses may be covered when used as a

corneal bandage for a medical condition. Benefits include a one-time replacement of eyeglass or contact lenses due to a PRESCRIPTION change after cataract SURGERY.

Certain PROSTHETIC APPLIANCES require PRIOR REVIEW and CERTIFICATION or services will not be covered.

PROSTHETIC APPLIANCES Exclusions

- Dental appliances except when MEDICALLY NECESSARY for the treatment of temporomandibular joint disease or obstructive sleep apnea
- COSMETIC improvements, such as implantation of hair follicles and skin tone enhancements
- Lenses for keratoconus or any other eye procedure except as specifically covered under the PLAN.

Routine Hearing

Routine hearing exams, hearing aids and hearing aid replacements are covered. See "Summary of Benefits" for limits that apply. A medical PROVIDER or audiologist report must be submitted with the claim for reimbursement to be allowed for the hearing aids only. See "Summary of Benefits" for coverage and benefit maximums.

Routine Hearing Exclusions

- Hearing aid batteries.

Smoking Cessation

Charges specifically to treat tobacco addiction are covered. This includes treatment or services provided by a DOCTOR or PROVIDER, over-the-counter products or supplies, coinsurance or copay amounts charged for covered prescription drugs under the SAS prescription drug benefits. See "Summary of Benefits" for coverage. To obtain a smoking cessation claim form, contact the SAS Benefits Department.

Vision

Vision benefits for eyeglasses, contact lenses or examinations for prescriptions or fittings may be considered clinically eligible for coverage and covered under the SAS Medical Plan if prescribed by a licensed ophthalmologist or optometrist under the following conditions:

- To correct a change in vision directly resulting from an accidental bodily injury. The medical plan will cover the cost of the initial exam, pair of eyeglasses or contact lenses.
- To correct a change in vision directly resulting from SURGERY to treat a medical condition. The medical plan will cover the cost of the initial exam, pair of eyeglasses or contact lenses.
- For treatment of kerotoconus to correct blurry or distorted vision pre-SURGERY. The medical plan will cover the cost of the initial exam, pair of contact lenses or eyeglasses during a BENEFIT PERIOD.
- For treatment of kerotoconus post-SURGERY. The medical plan will cover the cost of the initial exam, pair of eyeglasses or contact lenses.
- Following each cataract surgery, with or without insertion of an intraocular lens(es) implant, the medical plan will cover the cost of one pair of eyeglasses or contact lenses. If a MEMBER has cataract surgery with an IOL insertion in one eye and subsequently has cataract surgery with IOL insertion in the other eye and does not receive eyeglasses or contact lenses between the two surgical procedures, the medical plan will only cover one pair of eyeglasses or contact lenses after the second surgery. If a MEMBER already has a pair of eyeglasses, then has a cataract surgery with IOL insertion and receives only new lenses but not new frames following the surgery, the medical plan will not cover new frames at a later time unless it follows subsequent cataract surgery in the other eye.

Replacement contact lenses or eyeglasses, sunglasses of any type, sport lenses/frames and scratch-resistant coating are not covered benefits.

The medical plan annual deductibles, copays and coinsurance will apply to the vision benefits under the medical plan.

Surgical Benefits

Surgical services by a professional or facility PROVIDER on an inpatient or outpatient basis, including pre-operative and post-operative care and care of complications, are covered. Surgical benefits include diagnostic SURGERY, such as biopsies, and reconstructive SURGERY performed to correct CONGENITAL defects that result in functional impairment of newborn, adoptive, and FOSTER CHILDREN.

Certain surgical procedures, including those that are potentially COSMETIC, require PRIOR REVIEW and CERTIFICATION or services will not be covered.

Multiple surgical procedures performed on the same date of service and/or during the same patient encounter may not be eligible for separate reimbursement.

For information about coverage of multiple surgical procedures, please refer to BCBSNC's reimbursement policies, which are on the BCBSNC website at **bcbsnc.com,** or call BCBSNC Customer Service at the number listed in "Who to Contact?"

Anesthesia

Your anesthesia benefit includes coverage for general, spinal block or monitored regional anesthesia ordered by the attending DOCTOR and administered by or under the supervision of a DOCTOR other than the attending surgeon or assistant at SURGERY.

Benefits are not available for charges billed separately by the PROVIDER which are not eligible for additional reimbursement. Also, your coverage does not provide additional benefits for local anesthetics, which are covered as part of your surgical benefit.

Mastectomy Benefits

Under the Women's Health and Cancer Rights Act of 1998, the PLAN provides for the following services related to mastectomy SURGERY:

- Reconstruction of the breast on which the mastectomy has been performed
- SURGERY and reconstruction of the nondiseased breast to produce a symmetrical appearance without regard to the lapse of time between the mastectomy and the reconstructive SURGERY
- Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

See PROVIDER'S Office, or for external prostheses, see PROSTHETIC APPLIANCES in Other Services in the "Summary of Benefits."

Please note that the decision to discharge the patient following mastectomy SURGERY is made by the attending physician in consultation with the patient.

The benefits described above are subject to the same applicable deductibles, copayment or coinsurance and limitations as applied to other medical and surgical benefits provided under the PLAN.

Temporomandibular Joint (TMJ) Services

The PLAN provides benefits for services provided by a duly licensed DOCTOR, DOCTOR of dental SURGERY, or DOCTOR of dental medicine for diagnostic, therapeutic or surgical procedures, including oral SURGERY involving bones or joints of the jaw, face or head when the procedure is related to TMJ disease. Therapeutic benefits for TMJ disease include splinting and use of intra-oral PROSTHETIC APPLIANCES to reposition the bones. Surgical benefits for TMJ disease are limited to SURGERY performed on the temporomandibular joint. If TMJ is caused by malocclusion, benefits are provided for surgical correction of malocclusion when surgical management of the TMJ is MEDICALLY NECESSARY. Please have your PROVIDER contact BCBSNC before receiving surgical treatment for TMJ.

PRIOR REVIEW and CERTIFICATION are required for certain surgical procedures or these services will not be covered, unless treatment is for an EMERGENCY.

Temporomandibular Joint (TMJ) Services Exclusions

- Treatment for periodontal disease
- Dental implants or root canals
- Crowns and bridges
- Orthodontic braces
- Occlusal (bite) adjustments
- Extractions.

Therapies

The PLAN provides coverage for the following therapy services for an illness, disease or injury when ordered by a DOCTOR or OTHER PROFESSIONAL PROVIDER.

REHABILITATIVE AND HABILITATIVE THERAPIES

The following therapies are covered:

- Occupational therapy and/or physical therapy (including chiropractic services and osteopathic manipulation) up to a one-hour session per day
- Chiropractic services, including chiropractic maintenance
- Speech therapy.

Benefits are limited to a combined IN-NETWORK and OUT-OF-NETWORK BENEFIT PERIOD visit maximum for each of these two categories of therapies: (1) occupational and/or physical therapy, or any combination of these therapies; and (2) speech therapy. These visit limits apply in all places of service except inpatient (e.g., outpatient, office and

home) regardless of the type of PROVIDER (chiropractors, other DOCTORS, physical therapists). REHABILITATIVE and HABILITATIVE THERAPIES received while an inpatient is not included in the BENEFIT PERIOD MAXIMUM.

Benefits may vary depending on where services are received. See "Summary of Benefits" for additional information and any visit maximums.

OTHER THERAPIES

The PLAN covers:

- Cardiac rehabilitation therapy
- Pulmonary and respiratory therapy
- Dialysis treatment
- Radiation therapy
- Massage therapy (see note)
- Acupuncture (see note)
- Chemotherapy, including intravenous chemotherapy.

Chemotherapy benefits are based on where services are received. For chemotherapy received in conjunction with bone marrow or peripheral blood stem cell transplants, follow transplant guidelines described in "Transplants."

NOTE: For Massage Therapy and Acupuncture, referral from a medical PROVIDER is required. (Self-referrals or referrals from a Massage Therapist, Chiropractor or Acupuncturist are not eligible). All COVERED SERVICES provided will be considered IN-NETWORK and paid at the IN-NETWORK benefit level.

Therapy Exclusions

- Cognitive therapy
- Group classes for pulmonary rehabilitation
- Acupuncture and massage therapy without provider referral.

Transplants

The PLAN provides benefits for transplants, including HOSPITAL and professional services for covered transplant procedures. The PLAN provides care management for transplant services and will help you find a HOSPITAL or Blue Distinction Centers for Transplants that provides the transplant services required. Travel and lodging expenses may be reimbursed up to a $10,000 maximum per transplant based on BCBSNC guidelines that are available upon request from a transplant coordinator.

A transplant is the surgical transfer of a human organ, bone marrow, tissue, or peripheral blood stem cells taken from the body and returned or grafted into another area of the same body or into another body.

For a list of covered transplants, call BCBSNC Customer Service at the number listed in "Who to Contact?" to speak with a transplant coordinator and request PRIOR REVIEW. CERTIFICATION must be obtained in advance from BCBSNC for all transplant-related services in order to assure coverage of these services. Grafting procedures associated with reconstructive SURGERY are not considered transplants.

If a transplant is provided from a living donor to the recipient MEMBER who will receive the transplant:

- Benefits are provided for reasonable and necessary services related to the search for a donor up to a maximum of $10,000 per transplant.
- Both the recipient and the donor are entitled to benefits of this coverage when the recipient is a MEMBER. Benefits provided to the donor will be charged against the recipient's coverage.

Some transplant services are INVESTIGATIONAL and are not covered for some or all conditions or illnesses. Please see "Glossary" for an explanation of INVESTIGATIONAL.

Transplants Exclusions

- The purchase price of the organ or tissue if any organ or tissue is sold rather than donated to the recipient MEMBER
- The procurement of organs, tissue, bone marrow or peripheral blood stem cells or any other donor services if the recipient is not a MEMBER
- Transplants, including high dose chemotherapy, considered EXPERIMENTAL or INVESTIGATIONAL
- Services for or related to the transplantation of animal or artificial organs or tissues.

Mental Health and Substance Abuse Services

The PLAN provides benefits for the treatment of MENTAL ILLNESS and substance abuse by a HOSPITAL, DOCTOR or OTHER PROVIDER.

Coverage for IN-NETWORK inpatient and certain outpatient services is coordinated through Magellan Behavioral Health. BCBSNC delegates administration of these benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. To understand more about when you need to contact Magellan Behavioral Health, see "How to Access Mental Health and Substance Abuse Services."

OFFICE VISIT Services

The following professional services are covered when provided in an office setting:

- Evaluation and diagnosis
- MEDICALLY NECESSARY biofeedback and neuropsychological testing
- Individual and family counseling
- Group therapy.

Outpatient Services

Covered outpatient services when provided in a mental health or substance abuse treatment facility include:

- Each service listed in this section under OFFICE VISIT services
- Partial-day/night hospitalization services (minimum of four hours per day and 20 hours per week)
- Intensive therapy services (less than four hours per day and minimum of nine hours per week).

Certain IN-NETWORK outpatient services, such as partial hospitalization and intensive therapy, require PRIOR REVIEW and CERTIFICATION or services will not be covered. However, PRIOR REVIEW and CERTIFICATION are not required for OUT-OF-NETWORK outpatient services. See "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information..

Inpatient Services

Covered inpatient treatment services also include:

- Each service listed in this section under OFFICE VISIT services
- Room and board
- Detoxification to treat substance abuse.

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance for IN-NETWORK inpatient services or services will not be covered, except for EMERGENCIES. However, PRIOR REVIEW and CERTIFICATION are not required for OUT-OF-NETWORK inpatient services. See "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information.

RESIDENTIAL TREATMENT FACILITY Services

PRIOR REVIEW must be requested and CERTIFICATION must be obtained in advance for IN--NETWORK mental health and substance abuse services received in a RESIDENTIAL TREATMENT FACILITY or services will not be covered. However, PRIOR REVIEW and CERTIFICATION are not required for OUT-OF-NETWORK RESIDENTIAL TREATMENT FACILITY services. See "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information.

How to Access Mental Health and Substance Abuse Services

PRIOR REVIEW by Magellan Behavioral Health is not required for any OFFICE VISIT services or in EMERGENCY situations; however, please notify Magellan Behavioral Health of an EMERGENCY inpatient admission as soon as reasonably possible.

When you need inpatient or certain outpatient services that require PRIOR REVIEW and CERTIFICATION, call a Magellan Behavioral Health customer service representative at the number listed in "Who to Contact?" The Magellan Behavioral Health customer service representative can also help you find an appropriate IN-NETWORK PROVIDER and give you information about PRIOR REVIEW and CERTIFICATION requirements. See "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information.

Mental Health and Substance Abuse Services Exclusion

- Counseling with relatives about a patient.

Exclusions for a specific type of service are stated along with the benefit description in "COVERED SERVICES." Exclusions that apply to many services are listed in this section, starting with general exclusions and then the remaining exclusions are listed in alphabetical order. To understand all the exclusions that apply, read "COVERED SERVICES," "Summary of Benefits" and "What Is Not Covered?" The PLAN does not cover services, supplies, drugs or charges for:

- Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or persons are eligible for coverage under Title XVIII of the Social Security Act of 1965, including amendments, except as otherwise provided by federal law
- Conditions that federal, state or local law requires to be treated in a public facility
- Any condition, disease, illness or injury that occurs in the course of employment, if the EMPLOYEE, EMPLOYER or carrier is liable or responsible for the specific medical charge (1) according to a final adjudication of the claim under a state's workers' compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement
- Benefits that are provided by any governmental unit except as required by law
- Services that are ordered by a court that are otherwise excluded from benefits under this PLAN
- Any condition suffered as a result of any act of war or while on active or reserve military duty
- A dental or medical department maintained by or on behalf of an EMPLOYER, a mutual benefit association, labor union, trust or similar person or group
- Services in excess of any BENEFIT PERIOD MAXIMUM or LIFETIME MAXIMUM
- A benefit, drug, service or supply that is not specifically listed as covered in this benefit booklet.

In addition, the PLAN does not cover the following services, supplies, drugs or charges:

A

Administrative charges billed by a PROVIDER, including charges for failure to keep a scheduled visit, completion of a claim form, obtaining medical records, late payments, and telephone charges

Costs in excess of the **ALLOWED AMOUNT** for services usually provided by one DOCTOR, when those services are provided by multiple DOCTORS or medical care provided by more than one DOCTOR for treatment of the same condition

Alternative medicine services, which are unproven preventive or treatment modalities, also described as alternative, integrative, or complementary medicine, whether performed by a physician or any OTHER PROVIDER.

Ambulance service for the convenience of travel

B

Collection and storage of **blood** and stem cells taken from the umbilical cord and placenta for future use in fighting a disease

C

Claims not submitted to BCBSNC within 18 months of the date the charge was INCURRED, except in the absence of legal capacity of the MEMBER

Side effects and **complications** of noncovered services, except for EMERGENCY SERVICES in the case of an EMERGENCY

Oral and injectable **contraceptives.** These items may be covered under the PRESCRIPTION DRUG plan that is not administered by BCBSNC.

Convenience items such as, but not limited to, devices and equipment used for environmental control, urinary incontinence devices (including bed wetting devices) and equipment, heating pads, hot water bottles, ice packs and personal hygiene items

COSMETIC services, which include the removal of excess skin from the abdomen, arms or thighs, skin tag excisions, cryotherapy or chemical exfoliation for active acne scarring, superficial dermabrasion, injection of dermal fillers, services for hair transplants, electrolysis, and SURGERY for psychological or emotional reasons, except as specifically covered by the PLAN

Services received either before or after the **coverage period** of the PLAN, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination

Custodial care designed essentially to assist an individual with activities of daily living, with or without routine nursing care and the supervisory care of a DOCTOR. While some skilled services may be provided, the patient does not require

continuing skilled services 24 hours daily. The individual is not under specific medical, surgical, or psychiatric treatment to reduce a physical or mental disability to the extent necessary to enable the patient to live outside either the institution or the home setting with substantial assistance and supervision, nor is there reasonable likelihood that the disability will be reduced to that level even with treatment. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over medications that could otherwise be self-administered. Such services and supplies are custodial as determined by BCBSNC without regard to the place of service or the PROVIDER prescribing or providing the services.

D

Dental care, dentures, dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by the PLAN (refer to Dental Treatment Covered Under Your Medical Benefit in the "COVERED SERVICES" section).

DENTAL SERVICES provided in a HOSPITAL, except as described in "Dental Treatment Covered Under Your Medical Benefit"

The following **drugs**:

- PRESCRIPTION DRUGS except as specifically covered by the PLAN
- Injections by a health care professional of injectable PRESCRIPTION DRUGS which can be self-administered, unless medical supervision is required
- EXPERIMENTAL drugs or any drug not approved by the U.S. Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to PRESCRIPTION DRUGS used in covered phases I, II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the treatment of any type of cancer for which the drug has been proven as effective and accepted in any one of the following:
  - The National Comprehensive Cancer Network Drugs & Biologics Compendium
  - The ThomsonMicromedex DrugDex
  - The Elsevier Gold Standard's Clinical Pharmacology
  - Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

E

Services primarily for **EDUCATIONAL TREATMENT** including, but not limited to, books, tapes, pamphlets, seminars, classroom, Web or computer programs, individual or group instruction and counseling, except as specifically covered by the PLAN, such as smoking cessation

The following **equipment**:

- Air conditioners, furnaces, humidifiers, dehumidifiers, vacuum cleaners, electronic air filters and similar equipment
- Devices and equipment used for environmental accommodation requiring vehicle and/or building modifications such as, but not limited to, chair lifts, stair lifts, home elevators, and ramps
- Repair or replacement of equipment due to abuse or desire for new equipment
- Physical fitness equipment, hot tubs, Jacuzzis, heated spas, pools or memberships to health clubs
- Personal computers
- Standing frames.

EXPERIMENTAL services including services whose efficacy has not been established by controlled clinical trials, or are not recommended as a preventive service by the U.S. Public Health Service, except as specifically covered by the PLAN

F

Donation, preservation and/or storage of sperm, eggs, or embryos in connection with artificial insemination and in-vitro **fertilization**

ROUTINE **FOOT CARE** for the treatment of corns, calluses, fallen arches, flat feet and routine trimming of toenails that is palliative or COSMETIC, except when MEDICALLY NECESSARY

G

Genetic testing, except for high risk patients when the therapeutic or diagnostic course would be determined by the outcome of the testing

H

Hearing aid batteries

Hearing aids or examinations for the fitting of hearing aids, except as specifically covered by the PLAN.

Hypnosis except when used for control of acute or chronic pain or smoking cessation

I

Immunizations required for occupational hazard

INFERTILITY services related to and including Gamete Intra-Fallopian Transfer (GIFT) and Zygote Intra-Fallopian Transfer (ZIFT) are not eligible for coverage under this PLAN. DEPENDENT CHILDREN are not eligible for INFERTILITY benefits.

Inpatient admissions primarily for the purpose of receiving diagnostic services or a physical examination. Inpatient admissions primarily for the purpose of receiving therapy services, except when the admission is a continuation of treatment following care at an inpatient facility for an illness or accident requiring therapy.

Inpatient confinements that are primarily intended as a change of environment

Services that are **INVESTIGATIONAL** in nature or obsolete, including any service, drugs, procedure or treatment directly related to an INVESTIGATIONAL treatment, except as specifically covered by the PLAN

L

Lenses for keratoconus or any other eye procedure except as specifically covered under the PLAN

M

Maintenance programs such as drills, techniques, and exercises that preserve the patient's present level of function and prevent regression of that function

MAINTENANCE THERAPIES including when the therapeutic goals of a treatment plan have been achieved and when no further functional progress is apparent or expected to occur except as specifically covered by the PLAN

Services or supplies deemed not **MEDICALLY NECESSARY**

N

Services that would not be necessary if a **noncovered service** had not been received, except for EMERGENCY SERVICES in the case of an EMERGENCY. This includes any services, procedures or supplies associated with COSMETIC services, INVESTIGATIONAL services, services deemed not MEDICALLY NECESSARY, or elective termination of pregnancy, if not specifically covered by the PLAN.

O

Any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the weight of a MEMBER or for treatment of **obesity**, except for surgical treatment of morbid obesity, or as specifically covered by the PLAN

Premolded foot **orthotics** or over-the-counter supportive devices

P

Body **piercing**

INFERTILITY of a DEPENDENT CHILD or the DEPENDENT CHILD'S pregnancy or non-life threatening complications of **pregnancy**

Care or services from a **PROVIDER** who:

- Cannot legally provide or legally charge for the services or services are outside the scope of the PROVIDER'S license or certification
- Provides and bills for services from a licensed health care professional who is in training
- Is in a MEMBER'S immediate family
- Is not recognized by BCBSNC as an eligible PROVIDER

R

The following **residential care** services:

- Care in a self-care unit, apartment or similar facility operated by or connected with a HOSPITAL
- Domiciliary care or rest cures, care provided and billed for by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments, in RESIDENTIAL TREATMENT FACILITIES (except for mental health and substance abuse treatment) or any similar facility or institution

RESPITE CARE, whether in the home or in a facility or inpatient setting, except as specifically covered by the PLAN

S

Services or **supplies** that are:

- Not performed by or upon the direction of a DOCTOR or OTHER PROVIDER
- Not generally accepted in the United States as being necessary and appropriate for the treatment of the patient's illness or injury
- Available to a MEMBER without charge.

Treatment or studies leading to or in connection with **sex changes or modifications** and related care

SEXUAL DYSFUNCTION not due to organic disease

Shoe lifts, and shoes of any type unless part of a brace

Sterilization of DEPENDENT CHILDREN

Reversal or attempted reversal of **sterilization**

Surrogate mothers

T

The following types of **therapy**:

- Music therapy, remedial reading, recreational or activity therapy, all forms of special education and supplies or equipment used similarly
- Cognitive therapy
- Acupuncture and massage therapy without PROVIDER referral.

The following **transplant** services:

- The purchase price of the organ or tissue if any organ or tissue is sold rather than donated to the recipient MEMBER
- The procurement of organs, tissue, bone marrow or peripheral blood stem cells or any other donor services if the recipient is not a MEMBER
- Transplants, including high dose chemotherapy, considered EXPERIMENTAL or INVESTIGATIONAL
- Transplants performed outside the United States
- Services for or related to the transplantation of animal or artificial organs or tissues

Travel, whether or not recommended or prescribed by a DOCTOR or other licensed health care professional, except when approved in advance for transplants

V

The following **vision** services:

- Radial keratotomy and other refractive eye SURGERY, and related services to correct vision except for surgical correction of an eye injury. Also excluded are premium intraocular lenses or the services related to the insertion of premium lenses beyond what is required for insertion of conventional intraocular lenses, which are small, lightweight, clear disks that replace the distance-focusing power of the eye's natural crystalline lens, except as specifically covered by the PLAN.
- Eyeglasses or contact lenses, except as specifically covered in "PROSTHETIC APPLIANCES"
- Orthoptics, vision training, and low vision aids.

Vitamins, food supplements or replacements, nutritional or dietary supplements, formulas or special foods of any kind, except for certain over-the-counter medications that may be available under your PREVENTIVE CARE benefits for certain individuals

To make sure you have access to high quality, cost-effective health care, BCBSNC has a UTILIZATION MANAGEMENT (UM) program. The UM program requires that certain health care services be reviewed and approved by BCBSNC in order to receive benefits. As part of this process, BCBSNC looks at whether health care services are MEDICALLY NECESSARY, provided in the proper setting and provided for a reasonable length of time. BCBSNC will honor a CERTIFICATION to cover medical services or supplies under the PLAN unless the CERTIFICATION was based on a material misrepresentation about your health condition or you were not eligible for these services under the PLAN due to termination of coverage (including your voluntary termination of coverage) or nonpayment of premiums.

Rights and Responsibilities Under the UM Program

Your MEMBER Rights

Under the UM program, you have the right to:

- A UM decision that is timely, meeting applicable state and federal time frames
- The reasons for BCBSNC's ADVERSE BENEFIT DETERMINATION of a requested treatment or health care service, including an explanation of the UM criteria and treatment protocol used to reach the decision
- Have a medical director from BCBSNC make a final determination of all ADVERSE BENEFIT DETERMINATIONS that were based upon MEDICAL NECESSITY
- Request a review of an ADVERSE BENEFIT DETERMINATION through the appeals process (see "What if You Disagree With a Decision?")
- Have an authorized representative pursue payment of a claim or make an appeal on your behalf.

An authorized representative may act on the MEMBER'S behalf with the MEMBER'S written consent. In the event you appoint an authorized representative, references to "you" under the "UTILIZATION MANAGEMENT" section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

BCBSNC's Responsibilities

As part of all UM decisions, BCBSNC will:

- Provide you and your PROVIDER with a toll-free telephone number to call UM review staff when CERTIFICATION of a health care service is needed. See "Who to Contact?"
- Limit what BCBSNC requests from you or your PROVIDER to information that is needed to review the service in question
- Request all information necessary to make the UM decision, including pertinent clinical information
- Provide you and your PROVIDER prompt notification of the UM decision consistent with applicable state and federal law and the PLAN.

In the event that BCBSNC does not receive sufficient information to approve coverage for a health care service within specified time frames, BCBSNC will notify you of an ADVERSE BENEFIT DETERMINATION in writing. The notice will explain how you may appeal the ADVERSE BENEFIT DETERMINATION.

PRIOR REVIEW (Pre-Service)

The PLAN requires that certain health care services receive PRIOR REVIEW and CERTIFICATION as noted in "COVERED SERVICES." These types of reviews are called pre-service reviews.

Certain services require PRIOR REVIEW and CERTIFICATION by the PLAN in order to receive benefits. IN-NETWORK PROVIDERS in North Carolina will request PRIOR REVIEW when necessary. IN-NETWORK inpatient FACILITIES outside of North Carolina will also request PRIOR REVIEW for you, except for Veterans' Affairs (VA) and military providers. If you go to any other PROVIDER outside of North Carolina or to an OUT-OF-NETWORK PROVIDER in North Carolina, you are responsible for ensuring that you or your PROVIDER requests PRIOR REVIEW by BCBSNC. The PLAN delegates administration of your mental health and substance abuse benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. **Failure to request PRIOR REVIEW and receive CERTIFICATION may result in allowed charges being reduced or a full denial of benefits**

If PRIOR REVIEW is required by the PLAN, you or your PROVIDER must request PRIOR REVIEW regardless of whether this health benefit plan is your primary or secondary coverage (see "Coordination of Benefits (OVERLAPPING COVERAGE)"). Also, the PLAN requires notification for MEMBERS who have Medicare as their primary coverage and who are admitted to a Medicare-certified HOSPITAL or NONHOSPITAL FACILITY. If neither you nor your PROVIDER requests PRIOR REVIEW and receives CERTIFICATION, this may result in an ADVERSE BENEFIT DETERMINATION.

To request PRIOR REVIEW, please call the numbers in "Who to Contact?"

General categories of services with this requirement are noted in "COVERED SERVICES." You may also visit the BCBSNC website at **mybcbsnc.com** or call BCBSNC Customer Service at the number listed in "Who to Contact?" for a detailed list of these services. The list of services that require PRIOR REVIEW may change from time to time.

If you fail to follow the procedures for filing a request for CERTIFICATION, BCBSNC will notify you of the failure and the proper procedures to be followed in filing your request within five days of receiving the request.

BCBSNC will make a decision on your request for CERTIFICATION within a reasonable amount of time taking into account the medical circumstances. The decision will be made and communicated to you and your PROVIDER within three business days after BCBSNC receives all necessary information but no later than 15 days from the date BCBSNC received the request. BCBSNC may extend this period one time for up to 15 days if additional information is required and will notify you and your PROVIDER before the end of the initial 15-day period of the information needed and the date by which BCBSNC expects to make a decision. You will have 45 days to provide the requested information. As soon as BCBSNC receives all the requested information, or at the end of the 45 days, whichever is earlier, BCBSNC will make a decision within three business days. BCBSNC will notify you and the PROVIDER of an ADVERSE BENEFIT DETERMINATION electronically or in writing.

Urgent PRIOR REVIEW

You have a right to an urgent review when the regular time frames for a decision: (i) could seriously jeopardize your or your DEPENDENT'S life, health, or ability to regain maximum function; or (ii) in the opinion of your PROVIDER, would subject you or your DEPENDENT to severe pain that cannot be adequately managed without the requested care or treatment. BCBSNC will notify you and your PROVIDER of its decision as soon as possible, taking into account the medical circumstances. BCBSNC will notify you and your PROVIDER of its decision within 72 hours after receiving the request. Your PROVIDER will be notified of the decision, and if the decision results in an ADVERSE BENEFIT DETERMINATION, written notification will be provided to you and your PROVIDER. If BCBSNC needs more information to process your urgent review, BCBSNC will notify you and your PROVIDER of the information needed as soon as possible but no later than 24 hours following the receipt of your request. You will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the time period specified for you to provide the information, whichever is earlier, BCBSNC will make a decision on your request within a reasonable time but no later than 48 hours after receipt of requested information or the end of the time period given to the PROVIDER to submit necessary clinical information.

An urgent review may be requested by calling BCBSNC Customer Service at the number given in "Who to Contact?"

Concurrent Reviews

BCBSNC will also review health care services at the time you receive them. These types of reviews are concurrent reviews.

If a request for an extension of treatment is non-urgent, a decision will be made and communicated to the requesting HOSPITAL or other facility within three business days after receipt of all necessary clinical information, but no later than 15 days after we receive the request. In the event of an ADVERSE BENEFIT DETERMINATION, BCBSNC will notify you, your HOSPITAL'S or other facility's UM department and your PROVIDER within three business days after receipt of all necessary clinical information, but no later than 15 days after BCBSNC receives the request. Written confirmation of the decision will also be sent to your home by U.S. mail. For concurrent reviews, BCBSNC will remain responsible for COVERED SERVICES you are receiving until you or your representatives have been notified of the ADVERSE BENEFIT DETERMINATION.

Urgent Concurrent Review

If a request for an extension of treatment is urgent, and the request is received at least 24 hours before the expiration of a previously approved inpatient stay or course of treatment at the requesting HOSPITAL or other facility, a decision will be made and communicated to the requesting HOSPITAL or other facility as soon as possible, but no later than 24 hours after we receive the request.

If a request for extension of treatment is urgent, and the request is not received at least 24 hours before the expiration of a previously approved inpatient stay or course of treatment at the requesting HOSPITAL or other facility, a decision will

be made and communicated as soon as possible, but no later than 72 hours after we receive the request. If BCBSNC needs more information to process your urgent review, BCBSNC will notify the requesting HOSPITAL or other facility of the information needed as soon as possible but no later than 24 hours after we receive the request. The requesting HOSPITAL or other facility will then be given a reasonable amount of time, but not less than 48 hours, to provide the requested information. BCBSNC will make a decision within 48 hours of the earlier of receipt of the requested information, or the end of the time period given to the requesting HOSPITAL or other facility to provide the information.

Retrospective Reviews (Post-Service)

BCBSNC also reviews the coverage of health care services after you receive them (retrospective/post-service reviews). Retrospective review may include a review to determine if services received in an EMERGENCY setting qualify as an EMERGENCY. BCBSNC will make all retrospective review decisions and notify you and your PROVIDER of its decision within a reasonable time but no later than 30 days from the date BCBSNC received the request. In the event of an ADVERSE BENEFIT DETERMINATION, BCBSNC will notify you and your PROVIDER in writing within five business days of the decision. All decisions will be based on MEDICAL NECESSITY and whether the service received was a benefit under this PLAN. If more information is needed before the end of the initial 30-day period, BCBSNC will notify you of the information needed. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days. Services that were approved in advance by BCBSNC will not be subject to denial for MEDICAL NECESSITY once the claim is received, unless the CERTIFICATION was based on a material misrepresentation about your health condition or you were not eligible for these services under the PLAN due to termination of coverage or nonpayment of premiums. All other services may be subject to retrospective review and could be denied for MEDICAL NECESSITY or for a benefit limitation or exclusion.

Care Management

MEMBERS with complicated and/or chronic medical needs may be eligible for care management services.

Care management (or case management) encourages MEMBERS with complicated or chronic medical needs, their PROVIDERS, and the PLAN to work together to meet the individual's health needs and promote quality outcomes.

To accomplish this, MEMBERS enrolled in or eligible for care management programs may be contacted by BCBSNC or by a representative of BCBSNC. The PLAN is not obligated to provide the same benefits or services to a MEMBER at a later date or to any other MEMBER. Information about these services can be obtained by contacting an IN-NETWORK PCP or IN-NETWORK SPECIALIST or by calling BCBSNC Customer Service.

In addition to our care management programs for MEMBERS with complicated and/or chronic medical needs, MEMBERS may receive a reduced or waived copayment and/or coinsurance in connection with programs and/or promotions designed to encourage members to seek appropriate, high quality, efficient care based on BCBSNC criteria.

Continuity of Care

Continuity of care is a process that allows you to continue receiving care from an OUT-OF-NETWORK PROVIDER for ongoing special conditions at the IN-NETWORK benefit level when the MEMBER or EMPLOYER changes plans or when your PROVIDER is no longer in the PPO network.

If your PCP or SPECIALIST leaves the BCBSNC PROVIDER network and they are currently treating you for an ongoing special condition that meets BCBSNC continuity of care criteria, BCBSNC will notify you 30 days before the PROVIDER'S termination, as long as BCBSNC receives timely notification from the PROVIDER. To be eligible for continuity of care, the MEMBER must be actively being seen by the OUT-OF-NETWORK PROVIDER for an ongoing special condition and the PROVIDER must agree to abide by the BCBSNC requirements for continuity of care.

An ongoing special condition means:

- in the case of an acute illness, a condition that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm;
- in the case of a chronic illness or condition, a disease or condition that is life-threatening, degenerative, or disabling, and requires medical care or treatment over a prolonged period of time;
- in the case of pregnancy, the second and third trimesters of pregnancy;
- in the case of a terminal illness, an individual has a medical prognosis that the MEMBER'S life expectancy is six months or less.

The allowed transitional period shall extend up to 90 days, as determined by the PROVIDER, except in the cases of:

- scheduled SURGERY, organ transplantation, or inpatient care which shall extend through the date of discharge and post-discharge follow-up care or other inpatient care occurring within 90 days of the date of discharge; and
- second trimester pregnancy which shall extend through the provision of postpartum care; and
- terminal illness which shall extend through the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness.

Continuity of care requests will be reviewed by a medical professional based on the information provided about specific medical conditions. Claims for approved continuity of care services will be subject to the IN-NETWORK benefit. In these situations, benefits are based on the billed amount. However, you may be responsible for charges billed separately by the PROVIDER which are not eligible for additional reimbursement. Continuity of care will not be provided when the PROVIDER'S contract was terminated for reasons relating to quality of care or fraud. Such a decision may not be reviewed on appeal.

Please call BCBSNC Customer Service at the number listed in "Who to Contact?" for more information.

Delegated UTILIZATION MANAGEMENT

BCBSNC delegates UM and the first level appeal for inpatient and outpatient mental health and substance abuse services to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. Claims determinations and second level appeals, if eligible, are provided by BCBSNC.

Evaluating New Technology

In an effort to allow for continuous quality improvement, BCBSNC has processes in place to evaluate new medical technology, procedures and equipment. These policies allow BCBSNC to determine the best services and products to offer MEMBERS. They also help BCBSNC keep pace with the ever-advancing medical field. Before implementing any new or revised policies, BCBSNC reviews professionally supported scientific literature as well as state and federal guidelines, regulations, recommendations, and requirements. BCBSNC then seeks additional input from PROVIDERS who know the needs of the patients they serve.

In addition to the UM program, BCBSNC offers an appeals process for MEMBERS.

If you want to appeal an ADVERSE BENEFIT DETERMINATION, you have the right to request that BCBSNC review the decision through the appeals process. The appeals process is voluntary and may be requested by the MEMBER or an authorized representative acting on the MEMBER'S behalf with the MEMBER'S written consent. In the event you appoint an authorized representative, references to "you" under this section mean "you or your authorized representative" (i.e., the authorized representative may pursue your rights and shall receive all notices and benefit determinations).

You may request, at no charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Steps to Follow in the Appeals Process

For each step in this process, there are specified time frames for filing an appeal and for notifying you or your PROVIDER of the decision. The type of ADVERSE BENEFIT DETERMINATION will determine the steps that you will need to follow in the appeals process. For all appeals, the review must be requested in writing, within 180 days of an ADVERSE BENEFIT DETERMINATION or by the date indicated on your Explanation of Benefits.

Any request for review should include:

- MEMBER'S ID number
- MEMBER'S name
- Patient's name
- The nature of the appeal
- Any other information that may be helpful for the review.

> To request a form to submit a request for review, visit the BCBSNC website at **mybcbsnc.com** or call BCBSNC Customer Service at the number given in "Who to Contact?"

All correspondence related to a request for a review through BCBSNC's appeals process should be sent to:
BCBSNC
Appeals Department
PO Box 30055
Durham, NC 27702-3055

You may also receive assistance from the Employee Benefits Security Administration at 1-866-444-3272.

Following such request for review, a review will be conducted by BCBSNC, by someone who is neither the individual who made the original claims denial that is the subject of the appeal, nor the subordinate of such individual. The denial of the initial claim will not have an effect on the review. If a claims denial is based on medical judgment, including determinations with respect to whether a particular treatment, drug or other item is EXPERIMENTAL, INVESTIGATIONAL, or not MEDICALLY NECESSARY or appropriate, BCBSNC shall consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved (as determined by BCBSNC) who was not involved in the initial claims denial and who is not a subordinate of any such individual.

You will have exhausted the PLAN'S internal appeal process after pursuing a first level appeal. Unless otherwise noted below, upon completion of the first level appeal you may: pursue a second level appeal; or pursue an external review; or pursue a civil action under 502(a) of ERISA. You will also be deemed to have exhausted the PLAN'S internal appeal process at any time it is determined that BCBSNC failed to strictly adhere to all claim determinations and appeal requirements under Federal law (other than minor violations). In the event you are deemed to have exhausted the PLAN'S internal appeal process, and unless otherwise noted below, you may pursue an external review.

Delegated Appeals

BCBSNC delegates responsibility for the first level appeal for inpatient and outpatient mental health and substance abuse services to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. Please forward written appeals to:
Magellan Behavioral Health
Appeals Department
PO Box 1619
Alpharetta, GA 30009

Second level appeal is provided by BCBSNC.

Quality of Care Complaints

For quality of care complaints, an acknowledgement will be sent by BCBSNC within ten business days.

First Level Appeal

BCBSNC will provide you with the name, address and phone number of the appeals coordinator within three business days after receipt of a review request. BCBSNC will also give you instructions on how to submit written materials.

Although you are not allowed to attend a first level appeal, you may provide and/or present written evidence and testimony. BCBSNC asks that you send all of the written material you feel is necessary to make a decision. BCBSNC will use the material provided in the request for review, along with other available information, to reach a decision. If your appeal is due to a NONCERTIFICATION, your appeal will be evaluated by a licensed medical DOCTOR who was not involved in the initial NONCERTIFICATION decision. You may receive, in advance, any new information that BCBSNC may use in making a decision or any new or additional rationale so that you have an opportunity to respond prior to the notice of an ADVERSE BENEFIT DETERMINATION.

You will be notified in clear written terms of the decision, within a reasonable time but no later than 30 days from the date BCBSNC received the request. You may then request all information that was relevant to the review.

Second Level Appeal

If you are dissatisfied with the first level appeal decision, you have the right to a second level appeal. Second level appeals are not allowed for benefits or services that are clearly excluded by this benefit booklet, or quality of care complaints. Within ten business days after BCBSNC receives your request for a second level appeal, BCBSNC will send you an acknowledgement letter which will include the following:

- Name, address and telephone number of the appeals coordinator
- A statement of your rights, including the right to:
  - request and receive all information that applies to your appeal from BCBSNC
  - participate in the second level appeal meeting
  - present your case to the review panel
  - submit supporting material before and during the review meeting
  - ask questions of any member of the review panel
  - be assisted or represented by a person of your choosing, including a family member, an EMPLOYER representative, or an attorney
  - pursue other voluntary alternative dispute resolution options as applicable.

The second level appeal meeting, which will be conducted by a review panel coordinated by BCBSNC using external physicians and/or benefit experts, will be held within 45 days after BCBSNC receives a second level appeal request. You will receive notice of the meeting date and time at least 15 days before the meeting, which will be held by teleconference. You have the right to a full review of your appeal even if you do not participate in the meeting. A written decision will be issued to you within seven business days of the review meeting.

Notice of Decision

If any claim (whether expedited or nonexpedited) shall be wholly or partially denied at either the first level appeal or the second level appeal, a written notice shall be provided to the MEMBER worded in an understandable manner and shall set forth:

- The specific reason(s) for the denial
- Reference to the specific health benefit plan provisions on which the decision is based
- A statement that the MEMBER is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information relevant to the MEMBER'S claim for benefits
- If applicable, a statement describing any voluntary appeals procedures and the MEMBER'S right to receive information about the procedures as well as the MEMBER'S right to bring a civil action under Section 502(a) of ERISA following an adverse determination upon review
- A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the decision or a statement that such specific rule, guideline, protocol, or other similar criteria was relied upon in making the decision and that this will be provided without charge upon request
- Instructions on how to request an external, independent review from an independent review organization (IRO) upon completion of this review if not satisfied with the decision (available for NONCERTIFICATIONS only)
- The right to pursue other voluntary alternative dispute resolution options as applicable

- If the decision is based on MEDICAL NECESSITY or EXPERIMENTAL treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the PLAN to the MEMBER'S medical circumstances, or a statement that such explanation will be provided without charge upon request; and
- The following statement: "You may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

Expedited Appeals (Available only for NONCERTIFICATIONS)

You have the right to a more rapid or expedited review of a NONCERTIFICATION if a delay: (i) would reasonably appear to seriously jeopardize your or your DEPENDENT'S life, health or ability to regain maximum function; or (ii) in the opinion of your PROVIDER, would subject you or your DEPENDENT to severe pain that cannot be adequately managed without the requested care or treatment. You can request an expedited second level review even if you did not request that the initial review be expedited. An expedited review may be initiated by calling BCBSNC Customer Service at the number given in "Who to Contact?" An expedited review will take place in consultation with a medical DOCTOR. All of the same conditions for a first level or second level appeal apply to an expedited review. BCBSNC will communicate the decision by phone to you and your PROVIDER as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receiving the request. A written decision will be communicated within four days after receiving the request for the expedited appeal. Information initially given by telephone must also be given in writing.

After requesting an expedited review, BCBSNC will remain responsible for covered health care services you are receiving until you have been notified of the review decision.

External Review

Federal law provides for an external review of certain ADVERSE BENEFIT DETERMINATIONS by an external, independent review organization (IRO). This service is administered by the PLAN at no charge to you. The PLAN will notify you of your right to request an external review each time you receive:

- an ADVERSE BENEFIT DETERMINATION
- an appeal decision upholding an ADVERSE BENEFIT DETERMINATION, or
- a final internal ADVERSE BENEFIT DETERMINATION.

In order to request an external review, BCBSNC must receive your request within four (4) months after the date of receipt of a notice of an ADVERSE BENEFIT DETERMINATION or final internal ADVERSE BENEFIT DETERMINATION. To request an external appeal, send your request to the following:

BCBSNC
Appeals Department
PO Box 30055
Durham, NC 27702-3055

> Expedited External Review - An expedited external review may be available if (1) the time required to complete either an expedited internal appeals review or a standard external review would reasonably be expected to jeopardize your life or health or ability to regain maximum function, or (2) the final internal ADVERSE BENEFIT DETERMINATION concerns an admission, availability of care, continued stay, or health care item or service for which you received EMERGENCY SERVICES, but have not been discharged from a facility. If your request is not accepted for expedited review, the PLAN may: (1) accept the case for standard external review if the internal appeals process has been exhausted; or (2) require the completion of the internal appeals process and another request for an external review.

Within five (5) business days of (or, for an expedited review, immediately upon) receiving your request for an external review, the PLAN must determine whether the external review is eligible (“preliminary review”). The request is eligible if it meets the following requirements:

- Your request is about a NONCERTIFICATION or a rescission of coverage
- You are or were covered under the PLAN at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the PLAN at the time the health care item or service was provided;
- The ADVERSE BENEFIT DETERMINATION or the final ADVERSE BENEFIT DETERMINATION does not relate to your failure to meet the requirements for eligibility under the terms of the PLAN (e.g., worker classification or similar determination);
- You have exhausted, or have been deemed to have exhausted (as defined above), the PLAN'S internal appeal process; and
- You provided all the information and forms required to process an external review.

Within one (1) business day of (or, for expedited review, immediately upon) completing the preliminary review, the PLAN will notify you in writing of whether your request is complete and whether it has been accepted. If the PLAN notifies you that the request is incomplete, you must provide all requested information to the PLAN within the four (4) month filing period or within 48 hours following the receipt of the notice, whichever is later.

If the PLAN accepts your request, the assigned IRO will timely notify you in writing of the acceptance of the external review. The notice will include a notification that you may submit additional written information and supporting documentation relevant to the ADVERSE BENEFIT DETERMINATION to the assigned IRO within ten (10) business days following the date of receipt of the notice. Within five (5) business days (for an expedited review, as expeditiously as possible) after the date of assignment of the IRO, the PLAN shall provide the IRO the documents and any information considered in making the ADVERSE BENEFIT DETERMINATION.

The IRO will send you and the PLAN written notice of its decision within 45 days. If the request is expedited, the IRO will notify you and the PLAN as expeditiously as possible, but in no event more than 72 hours after the IRO receives the request. If the notice is not in writing, the IRO shall provide written confirmation to you and the PLAN within 48 hours after the date of providing the notice. If the IRO's decision is to reverse the ADVERSE BENEFIT DETERMINATION, the PLAN will immediately provide coverage or payment for the requested services or supplies. If you are no longer covered by the PLAN at the time the PLAN receives notice of the IRO's decision to reverse the ADVERSE BENEFIT DETERMINATION, the PLAN will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been denied when first requested.

The IRO's external review decision is binding on you and the PLAN, except to the extent you may have other remedies available under applicable federal law. You may not file a subsequent request for an external review involving the same ADVERSE BENEFIT DETERMINATION, for which you have already received an external review decision.

Benefits to which MEMBERS are Entitled

The benefits described in this benefit booklet are provided only for MEMBERS. These benefits and the right to receive payment under this health benefit plan cannot be transferred or assigned to any other person or entity, including PROVIDERS. Under the PLAN, BCBSNC may pay a PROVIDER directly. For example, BCBSNC pays IN-NETWORK PROVIDERS directly under applicable contracts with those PROVIDERS. However, any PROVIDER'S right to be paid directly is through such contract with BCBSNC, and not through the PLAN. Under the PLAN, BCBSNC has the sole right to determine whether payment for services is made to the PROVIDER, to the SUBSCRIBER, or allocated among both. BCBSNC's decision to pay a PROVIDER directly in no way reflects or creates any rights of the PROVIDER under the PLAN, including but not limited to benefits, payments or procedures.

If a MEMBER resides with a custodial parent or legal guardian who is not the EMPLOYEE, the PLAN will, at its option, make payment to either the PROVIDER of the services or to the custodial parent or legal guardian for services provided to the MEMBER. If the EMPLOYEE or custodial parent or legal guardian receives payment, it is his or her responsibility to pay the PROVIDER. The party who receives payment is responsible for paying the PROVIDER.

Benefits for COVERED SERVICES specified in the PLAN will be provided only for services and supplies that are performed by a PROVIDER as specified in the PLAN and regularly included in the ALLOWED AMOUNT. BCBSNC establishes coverage determination guidelines that specify how services and supplies must be billed in order for payment to be made under the PLAN.

Any amounts paid by the PLAN for noncovered services or that are in excess of the benefit provided under your Blue Options coverage may be recovered by BCBSNC. BCBSNC may recover the amounts by deducting from a MEMBER'S future claims payments. This can result in a reduction or elimination of future claims payments. In addition, under certain circumstances, if BCBSNC pays the PROVIDER amounts that are your responsibility, such as deductible, copayments or coinsurance, BCBSNC may collect such amounts directly from you.

Amounts paid by the PLAN for work-related accidents, injuries, or illnesses covered under state workers' compensation laws will be recovered upon final adjudication of the claim or an order of the applicable state agency approving a settlement agreement. It is the legal obligation of the MEMBER, the EMPLOYER or the workers' compensation insurer (whoever is responsible for payment of the medical expenses) to notify BCBSNC in writing that there has been a final adjudication or settlement.

PROVIDERS are independent contractors, and they are solely responsible for injuries and damages to MEMBERS resulting from misconduct or negligence.

BCBSNC's Disclosure of Protected Health Information (PHI)

The privacy of your protected health information is very important. BCBSNC will only use or disclose your protected health information in accordance with applicable privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA).

Administrative Discretion

BCBSNC has the authority to use its discretion to make reasonable determinations in the administration of coverage. These determinations will be final. Such determinations include decisions concerning coverage of services, care, treatment or supplies, and reasonableness of charges. BCBSNC medical policies are guides considered when making coverage determinations.

North Carolina PROVIDER Reimbursement

BCBSNC has contracts with certain PROVIDERS of health care services for the provision of, and payment for, health care services provided to all MEMBERS entitled to health care benefits. BCBSNC’s payment to PROVIDERS may be based on an amount other than the billed charges, including without limitation, an amount per confinement or episode of care, agreed upon schedule of fees, or other methodology as agreed upon by BCBSNC and the PROVIDER. Under certain circumstances, a contracting PROVIDER may receive payments from BCBSNC greater than the charges for services provided to an eligible MEMBER, or BCBSNC may pay less than charges for services, due to negotiated contracts. The MEMBER is not entitled to receive any portion of the payments made under the terms of contracts with PROVIDERS. The MEMBER'S liability when defined as a percent of charge shall be calculated based on the lesser of the ALLOWED AMOUNT or the PROVIDER'S billed charge for COVERED SERVICES provided to a MEMBER.

Some OUT-OF-NETWORK PROVIDERS have other agreements with BCBSNC that affect their reimbursement for COVERED SERVICES provided to Blue Options MEMBERS. These PROVIDERS agree not to bill MEMBERS for any charges higher than their agreed upon, contracted amount. In these situations, MEMBERS will be responsible for the difference between the Blue

Options ALLOWED AMOUNT and the contracted amount. OUT-OF-NETWORK PROVIDERS may bill you directly. If you are billed, you will be responsible for paying the bill and filing a claim with BCBSNC.

Services Received Outside of North Carolina

BCBSNC has a variety of relationships with other Blue Cross and/or Blue Shield licensees, generally referred to as "Inter-Plan Programs." As a MEMBER of the PLAN, you have access to PROVIDERS outside the state of North Carolina. Your ID CARD tells PROVIDERS that you are a MEMBER of the PLAN. While the PLAN maintains its contractual obligation to provide benefits to MEMBERS for COVERED SERVICES, the Blue Cross and/or Blue Shield licensee in the state where you receive services ("Host Blue") is responsible for contracting with and generally handling all interactions with its participating PROVIDERS.

Whenever you obtain health care services outside the area in which the BCBSNC network operates, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include Negotiated National Account Arrangements available between BCBSNC and other Blue Cross and/or Blue Shield licensees.

Under the BlueCard Program, the amount you pay toward such COVERED SERVICES, such as deductibles, copayments or coinsurance, is usually based on the **lesser** of:

- The billed charges for your COVERED SERVICES, or
- The negotiated price that the "Host Blue" passes on to BCBSNC.

This "negotiated price" can be:

- A simple discount that reflects the actual price paid by the Host Blue to your PROVIDER
- An estimated price that factors in special arrangements with your PROVIDER or with a group of PROVIDERS that may include types of settlements, incentive payments, and/or other credits or charges
- An average price, based on a discount that reflects the expected average savings for similar types of health care PROVIDERS after taking into account the same types of special arrangements as with an estimated price.

The estimated or average price may be adjusted in the future to correct for over- or underestimation of past prices. However, such adjustments will not affect the price that BCBSNC uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered health care services according to applicable law.

As an alternative to the BlueCard Program and depending on your geographic location, your claim may be processed through a Negotiated National Account Arrangement with a Host Blue. In these situations, the amount you pay for COVERED SERVICES will be calculated based on the negotiated price made available to BCBSNC by the Host Blue.

If you receive COVERED SERVICES from a nonparticipating PROVIDER outside the state of North Carolina, the amount you pay will generally be based on either the Host Blue's nonparticipating PROVIDER local payment or the pricing arrangements required by applicable state law. However, in certain situations, the PLAN may use other payment bases, such as billed charges, to determine the amount the PLAN will pay for COVERED SERVICES from a nonparticipating PROVIDER. In any of these situations, you may be liable for the difference between the nonparticipating PROVIDER'S billed amount and any payment the PLAN would make for the COVERED SERVICES.

Right of Recovery Provision

Immediately upon paying or providing any benefit under the PLAN, the PLAN shall be subrogated to all rights of recovery a MEMBER has against any party potentially responsible for making any payment to a MEMBER due to a MEMBER'S injuries, illness or condition, to the full extent of benefits provided or to be provided by the PLAN.

In addition, if a MEMBER receives any payment from any potentially responsible party as a result of an injury, illness or condition, the PLAN has the right to recover from, and be reimbursed by, the MEMBER for all amounts the PLAN has paid and will pay as a result of that injury or illness, up to and including the full amount the MEMBER receives from all potentially responsible parties. The MEMBER agrees that if the MEMBER receives any payment from any potentially responsible party as a result of an injury or illness, the MEMBER will serve as a constructive trustee over the funds for the benefit of the PLAN. Failure to hold such funds in trust will be deemed a breach of the MEMBER'S fiduciary duty to the PLAN.

Further, the PLAN will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a MEMBER receives from the third party, the third party's insurer or any other source

as a result of the MEMBER'S injuries. The lien is in the amount of benefits paid by the PLAN for the treatment of the illness, injury or condition for which another party is responsible.

As used throughout this provision, the term responsible party means any party possibly responsible for making any payment to a MEMBER due to a MEMBER'S injuries or illness or any insurance coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The lien can be filed with or enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the PLAN including, but not limited to, the MEMBER; the MEMBER'S representative or agent; the custodial parent or legal guardian of MEMBER; responsible party; responsible party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the PLAN.

The MEMBER acknowledges that the PLAN'S recovery rights are a first priority claim against all potentially responsible parties and are to be paid to the PLAN before any other claim for the MEMBER'S damages. The PLAN shall be entitled to full reimbursement first from any potentially responsible party payments, even if such payment to the PLAN will result in a recovery to the MEMBER which is insufficient to make the MEMBER whole or to compensate the MEMBER in part or in whole for the damages sustained. It is further understood that the PLAN will pay all fees associated with counsel it hires to represent its interests related to any recovery it may be entitled to, but it is agreed that the PLAN is not required to participate in or pay court costs or attorney fees to any attorney hired by the MEMBER.

The terms of this entire right of recovery provision shall apply and the PLAN is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the MEMBER identifies the medical benefits the PLAN provided. The PLAN is entitled to recover from **any and all** settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The MEMBER acknowledges that BCBSNC has been delegated authority by the PLAN ADMINISTRATOR to assert and pursue the right of subrogation and/or reimbursement on behalf of the PLAN. The MEMBER shall fully cooperate with BCBSNC's efforts to recover benefits paid by the PLAN. It is the duty of the MEMBER to notify BCBSNC in writing of the MEMBER'S intent to pursue a claim against any potentially responsible party, within 30 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the MEMBER. The MEMBER shall provide all information requested by BCBSNC or its representative including, but not limited to, completing and submitting any applications or other forms or statements as BCBSNC may reasonably request.

The MEMBER shall do nothing to prejudice the PLAN'S recovery rights as herein set forth. This includes, but is not limited to, refraining from entering into any settlement or recovery that attempts to reduce, waive, bar or exclude the full cost of all benefits provided by the PLAN.

In the event that any claim is made that any part of this right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the MEMBER and the PLAN agree that the PLAN ADMINISTRATOR shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

The MEMBER agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction as BCBSNC may elect. Upon receiving benefits under the PLAN, the MEMBER hereby submits to each such jurisdiction, waiving whatever rights may correspond to the MEMBER by reason of the MEMBER'S present or future domicile.

Notice of Claim

The PLAN will not be liable for payment of benefits unless proper notice is furnished to BCBSNC that COVERED SERVICES have been provided to a MEMBER. If the MEMBER files the claim, written notice must be given to BCBSNC within 18 months after the MEMBER INCURS the COVERED SERVICE, except in the absence of legal capacity of the MEMBER. The notice must be on an approved claim form and include the data necessary for BCBSNC to determine benefits.

Notice of Benefit Determination

BCBSNC will provide an explanation of benefits determination to the MEMBER or the MEMBER'S authorized representative within 30 days of receipt of a notice of claim if the MEMBER has financial liability on the claim other than a copayment or other services where payment was made at the point of service (unless the PLAN has chosen to provide an explanation of benefits for additional claims where the MEMBER does not have a financial liability other than a copayment).

BCBSNC may take an extension of up to 15 more days to complete the benefits determination if additional information is needed. If BCBSNC takes an extension, BCBSNC will notify the MEMBER or the MEMBER'S authorized representative

of the extension and of the information needed. You will then have 90 days to provide the requested information. As soon as BCBSNC receives the requested information, or at the end of the 90 days, whichever is earlier, BCBSNC will make a decision within 15 days.

Such notice will be worded in an understandable manner and will include:

- The specific reason(s) for the denial of benefits
- Reference to the benefit booklet section on which the denial of benefits is based
- A description of any additional information needed for you to perfect the claim and an explanation of why such information is needed
- A description of the review procedures and the time limits applicable to such procedures, including the MEMBER'S right to bring a civil action under Section 502(a) of ERISA following a denial of benefits
- A copy of any internal rule, guideline, protocol or other similar criteria relied on, if any, in making the benefit determination or a statement that it will be provided without charge upon request
- If the denial of benefits is based on MEDICAL NECESSITY or EXPERIMENTAL treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the PLAN to the MEMBER'S medical circumstances, or a statement that this will be provided without charge upon request; and
- In the case of a denial of benefits involving URGENT CARE, a description of the expedited review process available to such claims.

Upon receipt of a denial of benefits, you have the right to file an appeal with BCBSNC. See "What if You Disagree with a Decision?" for more information.

Limitation of Actions

No legal action may be taken to recover benefits for 60 days after the Notice of Claim has been given as specified above and until you have exhausted all administrative remedies, including following the appeals process. If the PLAN is subject to ERISA, you must only exhaust the first level appeal process following the Notice of Claim requirement.

Please see "What if You Disagree with a Decision?" for details regarding the appeals process.

No legal action may be taken later than three years from the date services are INCURRED. However, if you are authorized to pursue an action in federal court under ERISA, and you choose to pursue a second level appeal, the three-year limitation is temporarily suspended until that review has been resolved.

Coordination of Benefits (Overlapping Coverage)

If a MEMBER is also enrolled in another group health plan, the PLAN may take into account benefits paid by the other plan.

Coordination of benefits (COB) means that if a MEMBER is covered by more than one group insurance plan, benefits under one group insurance plan are determined before the benefits are determined under the second group insurance plan. The group insurance plan that determines benefits first is called the primary group insurance plan. The other group insurance plan is called the secondary group insurance plan.

Benefits paid by the secondary group insurance plan may be reduced to avoid paying benefits between the two plans that are greater than the cost of the health care service. Most group health insurance plans include a COB provision. Payment by BCBSNC under the PLAN takes into account whether or not the PROVIDER is a participating PROVIDER. If the PLAN is the secondary plan, and the MEMBER uses a participating PROVIDER, the PLAN will coordinate up to the ALLOWED AMOUNT. The participating PROVIDER has agreed to accept the ALLOWED AMOUNT as payment in full.

If you receive services from an OUT-OF-NETWORK PROVIDER, you are responsible for any charges not paid by either group insurance plan. You may wish to check with the primary group insurance plan to find out if an OUT-OF-NETWORK PROVIDER participates in the primary group insurance plan's network and whether this affects your responsibility for paying up to the PROVIDER'S charges.

If either the primary or the secondary health benefit plan covers a particular service, where the PLAN is the secondary plan, the PLAN will coordinate benefits for that service based on the benefits of the secondary coverage. However, if neither the primary nor secondary plan covers a particular service, the MEMBER will be responsible for payment for that service.

BCBSNC, on behalf of the PLAN may request information about the other plan from the MEMBER. A prompt reply will help BCBSNC process payments quickly. There will be no payment until primary coverage is determined. It is important to remember that even when benefits from other group health plans are taken into account, **benefits for COVERED SERVICES under this PLAN are still subject to program requirements, such as PRIOR REVIEW and CERTIFICATION procedures.**

Important Information for MEMBERS Eligible for Medicare

If you or your DEPENDENTS become eligible for Medicare, you should apply for and enroll in Medicare Part A and B, and use PROVIDERS who accept Medicare in order to ensure that you receive full benefits coverage. The PLAN will assume you have enrolled in Medicare and use PROVIDERS who accept Medicare once eligible for benefits thereunder. If you or your DEPENDENTS are covered under the PLAN, and are eligible for Medicare **the PLAN may take into account the benefits that you or your dependents are eligible for under Medicare, regardless of whether you have actually enrolled for such coverage**. In other words, even if you have not enrolled in Medicare, the PLAN may reduce your claim by the benefits you are eligible for under Medicare, and then pay the remaining claim amount under the terms of the PLAN and in accordance with the Medicare Secondary Payer rules. As a result, your OUT-OF-POCKET costs may be higher if you do not enroll in Medicare.

The rules by which a plan is determined primary or secondary are listed in the following chart. The "participant" is the person who is signing up for group health insurance coverage.

MEMBERS are not eligible to enroll in this PLAN if they have primary coverage that is a HDHP/HSA. If the PLANbecomes aware that a MEMBER has an HDHP/HSA as primary, this PLAN will deny benefits, reprocess claims and seek reimbursement from the MEMBER retroactive to the date of primary coverage in the HDHP/HSA.

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without the provision is	√	
	The plan with the provision is		√
The person is the participant under one plan and a DEPENDENT under the other	The plan covering the person as the participant is	√	
	The plan covering the person as a DEPENDENT is		√
The person is covered as a DEPENDENT CHILD under both plans and parents are either: 1) married or living together; or 2) divorced/separated or not living together and a court decree* states that they have joint custody without specifying which parent is responsible for the DEPENDENT CHILD'S health care coverage; or 3) divorced/separated or not living together and a court decree* states that both parents have responsibility for the DEPENDENT CHILD'S health care coverage	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	√	
	The plan of the parent whose birthday is later in the calendar year is		√
	Note: When the parents have the same birthday, the plan that covered the parent longer is	√	

When a person is covered by 2 group health plans, and	Then	Primary	Secondary
The person is covered as a DEPENDENT CHILD under both plans and parents are divorced/separated or not living together with no court decree* for coverage	The custodial parent's plan is	√	
	The plan of the spouse of the custodial parent is		√
	Or, if the custodial parent covers the child through their spouse's plan, the plan of the spouse is	√	
	The non-custodial parent's plan is		√
	Note: The custodial parent is considered to be the parent awarded custody of a child by a court decree; or in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year.*		
The person is covered as a DEPENDENT CHILD under both plans and parents are divorced/separated or not living together, and coverage is stipulated in a court decree*	The plan of the parent primarily responsible for health coverage under the court decree is	√	
	The plan of the other parent is		√
	Note: If there is a court decree that requires a parent to assume financial responsibility for the child's health care coverage, and BCBSNC has actual knowledge of those terms of the court decree, benefits under that parent's plan are	√	
The person is covered as a laid-off or retired MEMBER or that MEMBER'S DEPENDENT on one of the plans, including coverage under COBRA	The plan that covers a person other than as a laid-off or retired MEMBER or as that MEMBER'S DEPENDENT is	√	
	The plan that covers a person as a laid-off or retired MEMBER or the DEPENDENT of a laid-off or retired MEMBER is		√
	Note: This rule does not apply if it results in a conflict with any of the other rules for determining order of benefits		
The person is the participant in two active group health plans and none of the rules above apply	The plan that has been in effect longer is	√	
	The plan that has been in effect the shorter amount of time is		√

Note: You may be required to submit a copy of the court order or legal documentation in these instances.

Programs Outside Your Regular Benefits

The PLAN ADMINISTRATOR and BCBSNC may add programs that are outside your regular benefits. These programs may be changed from time to time. Following are examples of programs that may be included outside your regular benefits:

- Health and wellness programs, including discounts on goods and services from other companies including certain types of PROVIDERS
- Service programs for MEMBERS identified with complex health care needs, including a dedicated administrative contact, consolidated claims data information, and supportive gift items
- Clinical Opportunities Notification Program involves the analysis of claims and subsequent notification to PROVIDERS suggesting consideration of certain patient-specific treatment options along with medical literature addressing these treatment options
- Rewards or drawings for gifts based on activities related to online tools found on BCBSNC's website
- Quarterly, semi-annual, and/or annual drawings for gifts, which may include club memberships and trips to special events, based on submitting activity diaries
- Charitable donations made on your behalf by BCBSNC
- Discounts or other savings on retail goods and services.

These discounts on goods and services may not be provided directly by the PLAN or BCBSNC, but may instead be arranged for your convenience. These discounts are outside the PLAN benefits. Neither the PLAN nor BCBSNC is liable for problems resulting from goods and services it does not provide directly, such as goods and services not being provided or being provided negligently. The gifts and charitable donations are also outside the PLAN benefits. Neither the PLAN nor BCBSNC is liable for third party PROVIDERS' negligent provision of the gifts. The PLAN ADMINISTRATOR or BCBSNC may stop or change these programs at any time.

Healthy Outcomes

BCBSNC offers health and wellness programs at no additional cost to MEMBERS. These confidential programs are designed to provide MEMBERS with targeted information and support services, which can help them improve their health as well as manage specific health care needs.

MEMBERS may receive comprehensive educational materials, tools and other resources. These programs also provide the opportunity to work one-on-one with a specially trained nurse, and offer benefits for MEMBERS with certain conditions who agree to engage. The Healthy Outcomes program includes the following components:

Healthy Outcomes Case Management – provides support to MEMBERS with various high-risk health conditions to better manage the daily challenges of those conditions. MEMBERS are able to work one-on-one with a nurse coach.

Health Line Blue – provides a toll-free, nurse-driven telephonic support program that empowers MEMBERS to better manage their health and make informed healthcare decisions. Highly trained registered nurses are available 24/7 to provide cost-effective solutions for MEMBERS coping with chronic and acute illnesses, episodic or injury-related events and other healthcare issues.

Full details on these programs, including a description of what's available and how to get started, are located on the website at **bcbsnc.com**. Programs are available at the discretion of your EMPLOYER. To determine which programs are available to you, log into **BlueConnectNC.com**. You can also call 1-800-260-0091 to learn more about these programs and find out which ones are included in the PLAN.

Health Information Services

If you have certain health conditions, BCBSNC or a representative of BCBSNC may contact you to provide information about your condition, answer questions and tell you about resources that may be available to you. Your participation is voluntary, and your medical information will be kept confidential.

GLOSSARY

These definitions will help you understand the PLAN. Please note that some of these terms may not apply to the PLAN.

ADVERSE BENEFIT DETERMINATION
A denial, reduction, or termination of, or failure to provide or make full or partial payment for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be EXPERIMENTAL or INVESTIGATIONAL or not MEDICALLY NECESSARY or appropriate. Rescission of coverage and initial eligibility determinations are also included as adverse benefit determinations.

ALLOWED AMOUNT
The maximum amount that BCBSNC determines is reasonable for COVERED SERVICES provided to a MEMBER. The allowed amount includes any BCBSNC payment to the PROVIDER, plus any deductible, coinsurance or copayment. For PROVIDERS that have entered into an agreement with BCBSNC, the allowed amount is the negotiated amount that the PROVIDER has agreed to accept as payment in full. Except as otherwise specified in "EMERGENCY Care," for PROVIDERS that have not entered into an agreement with BCBSNC, the allowed amount will be the lesser of the PROVIDER'S billed charge or an amount based on an OUT-OF-NETWORK fee schedule established by BCBSNC that is applied to comparable PROVIDERS for similar services under a similar health benefit plan. Where BCBSNC has not established an OUT-OF-NETWORK fee schedule amount for the billed service, the allowed amount will be the lesser of the PROVIDER'S billed charge or a charge established by BCBSNC using a methodology that is applied to comparable PROVIDERS who may have entered into an agreement with BCBSNC for similar services under a similar health benefit plan. Calculation of the allowed amount is based on several factors including BCBSNC's medical, payment and administrative guidelines. Under the guidelines, some procedures charged separately by the PROVIDER may be combined into one procedure for reimbursement purposes.

AMBULATORY SURGICAL CENTER
A NONHOSPITAL FACILITY with an organized staff of DOCTORS, which is licensed or certified in the state where located, and which:
a) Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis
b) Provides nursing services and treatment by or under the supervision of DOCTORS whenever the patient is in the facility
c) Does not provide inpatient accommodations
d) Is not other than incidentally, a facility used as an office or clinic for the private practice of a DOCTOR or OTHER PROVIDER.

ANCILLARY PROVIDER
Independent clinical laboratories, durable/home medical equipment and supply providers, or specialty pharmacies. Ancillary providers are considered IN-NETWORK if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, based on the following criteria:
a) For independent clinical laboratories, services are received in the state where the specimen is drawn
b) For durable/home equipment and supply PROVIDERS, services are received in the state where the equipment or supply is shipped (receiving address) or if purchased at a retail store the vendor must be contracted with the plan in the state where the retail store is located
c) For specialty pharmacies, services are received in the state where the ordering physician is located.

BENEFIT PERIOD
The period of time, as stated in the "Summary of Benefits," during which charges for COVERED SERVICES, provided to a MEMBER must be INCURRED in order to be eligible for payment by the PLAN. A charge shall be considered INCURRED on the date the service or supply was provided to a MEMBER.

BENEFIT PERIOD MAXIMUM
The maximum amount of charges or number of visits in a BENEFIT PERIOD that will be covered on behalf of a MEMBER. Services in excess of a benefit period maximum are not COVERED SERVICES and MEMBERS may be responsible for the entire amount of the PROVIDER'S billed charge.

CERTIFICATION
The determination by BCBSNC that an admission, availability of care, continued stay, or other services, supplies or drugs have been reviewed and, based on the information provided, satisfy BCBSNC's requirements for MEDICALLY NECESSARY services and supplies, appropriateness, health care setting, level of care and effectiveness.

COMPLICATIONS OF PREGNANCY

Medical conditions whose diagnoses are distinct from pregnancy, but are adversely affected or caused by pregnancy, resulting in the mother's life being in jeopardy or making the birth of a viable infant impossible and which require the mother to be treated prior to the full term of the pregnancy (except as otherwise stated below), including, but not limited to: abruption of placenta; acute nephritis; cardiac decompensation; documented hydramnios; eclampsia; ectopic pregnancy; insulin dependent diabetes mellitus; missed abortion; nephrosis; placenta previa; Rh sensitization; severe pre-eclampsia; trophoblastic disease; toxemia; immediate postpartum hemorrhage due to uterine atony; retained placenta or uterine rupture occurring within 72 hours of delivery; or, the following conditions occurring within ten days of delivery: urinary tract infection, mastitis, thrombophlebitis, and endometritis. EMERGENCY cesarean section will be considered eligible for benefit application only when provided in the course of treatment for those conditions listed above as a complication of pregnancy. Common side effects of an otherwise normal pregnancy, conditions not specifically included in this definition, episiotomy repair and birth injuries are not considered complications of pregnancy.

CONGENITAL
Existing at, and usually before, birth referring to conditions that are apparent at birth regardless of their causation.

COSMETIC
To improve appearance. This does not include restoration of physiological function resulting from accidental injury, trauma or previous treatment that would be considered a COVERED SERVICE. This also does not include reconstructive SURGERY to correct CONGENITAL or developmental anomalies that have resulted in functional impairment.

COVERED SERVICE(S)
A service, drug, supply or equipment specified in this benefit booklet for which MEMBERS are entitled to benefits in accordance with the terms and conditions of the PLAN. Any services in excess of a BENEFIT PERIOD MAXIMUM or LIFETIME MAXIMUM are not covered services.

CREDITABLE COVERAGE
Accepted health insurance coverage carried prior to BCBSNC coverage can be group health insurance, an employee welfare benefit plan to the extent that the plan provides medical care to employees and/or their dependents directly or through insurance, reimbursement, or otherwise, individual health insurance, short-term limited duration health insurance coverage, public health plan, Children's Health Insurance Program (CHIP), Medicare, Medicaid, and any other coverage defined as creditable coverage under state or federal law. Creditable coverage does not include coverage consisting solely of excepted benefits.

DENTAL SERVICE(S)
Dental care or treatment provided by a DENTIST or OTHER PROFESSIONAL PROVIDER in the DENTIST'S office to a covered MEMBER while the policy is in effect, provided such care or treatment is recognized by BCBSNC as a generally accepted form of care or treatment according to prevailing standards of dental practice.

DENTIST
A dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to provide DENTAL SERVICES, perform dental SURGERY or administer anesthetics for dental SURGERY. All services performed must be within the scope of license or certification to be eligible for reimbursement.

DEPENDENT
A MEMBER other than the EMPLOYEE.

DEPENDENT CHILD(REN)
A child until the end of the month of their 26th birthday, who is either: 1) the EMPLOYEE'S biological child, stepchild, legally adopted child (or child placed with the EMPLOYEE and/or spouse or domestic partner for adoption), FOSTER CHILD, or 2) a child for whom legal guardianship has been awarded to the EMPLOYEE and/or spouse or domestic partner, or 3) a child for whom the EMPLOYEE and/or spouse or domestic partner has been court-ordered to provide coverage. The spouse or children of a dependent child are not considered DEPENDENTS.

DOCTOR
Includes the following: a doctor of medicine, a doctor of osteopathy, licensed to practice medicine or SURGERY by the Board of Medical Examiners in the state of practice, a doctor of dentistry, a doctor of podiatry, a doctor of chiropractic, a doctor of optometry, or a doctor of psychology who must be licensed or certified in the state of practice and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting or has met the standards of the National Register of Health Service Providers in Psychology. All of the above must be duly licensed to practice by the state in which any service covered by the contract is performed, regularly charge and collect fees as a personal right,

subject to any licensure or regulatory limitation as to location, manner or scope of practice. All services performed must be within the scope of license or certification to be eligible for reimbursement.

DURABLE MEDICAL EQUIPMENT
Items designated by BCBSNC which can withstand repeated use, are used primarily to serve a medical purpose, are not useful to a person in the absence of illness, injury or disease, and are appropriate for use in the patient's home.

EDUCATIONAL TREATMENT
Services provided to foster acquisition of skills and knowledge to assist development of an individual's cognitive independence and personal responsibility. These services include academic learning, socialization, adaptive skills, communication, amelioration of interfering behaviors, and generalization of abilities across multiple environments.

EFFECTIVE DATE
The date on which coverage for a MEMBER begins.

EMERGENCY(IES)
The sudden or unexpected onset of a condition of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of an individual or with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy, serious physical impairment to bodily functions, serious dysfunction of any bodily organ or part, or death. Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock, and other severe, acute conditions are examples of emergencies.

EMERGENCY SERVICES
Health care items and services furnished or required to screen for or treat an EMERGENCY medical condition until the condition is STABILIZED, including pre-hospital care and ancillary services routinely available in the EMERGENCY department.

EMPLOYEE
The person who is eligible for coverage under the PLAN due to employment with the EMPLOYER and who is enrolled for coverage.

EMPLOYER
SAS Institute Inc.

ERISA
The Employee Retirement Income Security Act of 1974.

ESSENTIAL HEALTH BENEFITS
The core set of services as defined by federal law that includes the following ten categories: (1) ambulatory patient services, (2) EMERGENCY SERVICES, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance abuse services, including behavioral health treatment, (6) PRESCRIPTION DRUGS, (7) REHABILITATIVE and HABILITATIVE SERVICES and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. No annual or lifetime dollar limits can apply to essential health benefits.

EXPERIMENTAL
See INVESTIGATIONAL.

FACILITY SERVICES
COVERED SERVICES provided and billed by a HOSPITAL or NONHOSPITAL FACILITY. All services performed must be within the scope of license or certification to be eligible for reimbursement.

FOSTER CHILD(REN)
Children under age 18 i) for whom a guardian has been appointed by any clerk of superior court, or ii) whose primary or sole custody has been assigned by order of a court with proper jurisdiction and who are residing with a person appointed as guardian or custodian for so long as the guardian or custodian has assumed the legal obligation for total or partial support of the children with the intent that the children reside with the guardian or custodian on more than a temporary or short-term basis.

HABILITATIVE SERVICES
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational

therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

HOMEBOUND
A MEMBER who cannot leave their home or temporary residence due to a medical condition which requires both the assistance of another person and the aid of supportive devices or the use of special transportation. To be homebound means that leaving home takes considerable and taxing effort. A MEMBER is not considered homebound solely because the assistance of another person is required to leave the home.

HOME HEALTH AGENCY
A NONHOSPITAL FACILITY which is primarily engaged in providing home health care services, medical or therapeutic in nature, and which:
a) Provides skilled nursing and other services on a visiting basis in the MEMBER'S home,
b) Is responsible for supervising the delivery of such services under a plan prescribed by a DOCTOR,
c) Is accredited and licensed or certified in the state where located,
d) Is certified for participation in the Medicare program, and
e) Is acceptable to BCBSNC.

HOSPICE
A NONHOSPITAL FACILITY that provides medically related services to persons who are terminally ill, and which:
a) Is accredited, licensed or certified in the state where located,
b) Is certified for participation in the Medicare program, and
c) Is acceptable to BCBSNC.

HOSPITAL
An accredited institution for the treatment of the sick that is licensed as a hospital by the appropriate state agency in the state where located. All services performed must be within the scope of license or certification to be eligible for reimbursement.

IDENTIFICATION CARD (ID CARD)
The card issued to MEMBERS upon enrollment which provides EMPLOYER/MEMBER identification numbers, names of the MEMBERS, and key benefit information, phone numbers and addresses.

INCURRED
The date on which a MEMBER receives the service, drug, equipment or supply for which a charge is made.

INFERTILITY
The inability after 12 consecutive months of unsuccessful attempts to conceive a child.

IN-NETWORK
Designated as participating in the PPO network. BCBSNC's payment for in-network COVERED SERVICES is described in this benefit booklet as in-network benefits or in-network benefit levels.

IN-NETWORK PROVIDER
A HOSPITAL, DOCTOR, other medical practitioner or PROVIDER of medical services and supplies that has been designated as a Blue Options PROVIDER by BCBSNC or a PROVIDER participating in the BlueCard program. ANCILLARY PROVIDERS outside North Carolina are considered IN-NETWORK only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, even if they participate in the BlueCard program.

INVESTIGATIONAL (EXPERIMENTAL)
The use of a service or supply including, but not limited to, treatment, procedure, facility, equipment, drug, or device that BCBSNC does not recognize as standard medical care of the condition, disease, illness, or injury being treated. The following criteria are the basis for BCBSNC's determination that a service or supply is investigational:
a) Services or supplies requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the U.S. Food and Drug Administration (FDA) or final approval from any other governmental regulatory body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
b) There is insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit BCBSNC's evaluation of the therapeutic value of the service or supply
c) There is inconclusive evidence that the service or supply has a beneficial effect on health outcomes
d) The service or supply under consideration is not as beneficial as any established alternatives

e) There is insufficient information or inconclusive scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives.

If a service or supply meets one or more of the criteria, it is deemed investigational except for clinical trials as described under the PLAN. Determinations are made solely by BCBSNC after independent review of scientific data. Opinions of experts in a particular field and/or opinions and assessments of nationally recognized review organizations may also be considered by BCBSNC but are not determinative or conclusive.

LICENSED PRACTICAL NURSE (LPN)
A nurse who has graduated from a formal practical nursing education program and is licensed by the appropriate state authority.

LIFETIME MAXIMUM
The benefit maximum of certain COVERED SERVICES that will be reimbursed on behalf of a MEMBER while covered under the PLAN. Services in excess of any lifetime maximum are not COVERED SERVICES, and MEMBERS may be responsible for the entire amount of the PROVIDER'S billed charge. See "Summary of Benefits" for any limits that may apply.

MEDICAL SUPPLIES
Health care materials that include ostomy supplies, catheters, oxygen and diabetic supplies.

MEDICALLY NECESSARY (or MEDICAL NECESSITY)
Those COVERED SERVICES or supplies that are:

a) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except for clinical trials as described under the PLAN, not for EXPERIMENTAL, INVESTIGATIONAL, or COSMETIC purposes,
b) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms,
c) Within generally accepted standards of medical care in the community, and
d) Not solely for the convenience of the insured, the insured's family, or the PROVIDER.

For medically necessary services, BCBSNC may compare the cost-effectiveness of alternative services, settings or supplies when determining which of the services or supplies will be covered and in what setting medically necessary services are eligible for coverage.

MEMBER
An EMPLOYEE or DEPENDENT, who is currently enrolled in the PLAN and for whom premium is paid.

MENTAL ILLNESS
(1) When applied to an adult MEMBER, an illness which so lessens the capacity of the individual to use self-control, judgment, and discretion in the conduct of his/her affairs and social relations as to make it necessary or advisable for him/her to be under treatment, care, supervision, guidance, or control; and (2) when applied to a DEPENDENT CHILD, a mental condition, other than mental retardation alone, that so impairs the DEPENDENT CHILD'S capacity to exercise age adequate self-control or judgment in the conduct of his/her activities and social relationships so that he/she is in need of treatment; and a mental disorder defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, DC ("DSM-V"). Those mental disorders coded in the DSM-V as substance-related disorders, SEXUAL DYSFUNCTION not due to organic disease, and those coded as "V" codes are not included in the definition of mental illness.

NONCERTIFICATION
An ADVERSE BENEFIT DETERMINATION by BCBSNC that a service covered under the PLAN has been reviewed and does not meet BCBSNC's requirements for MEDICAL NECESSITY /CLINICAL NECESSITY, appropriateness, health care setting, level of care or effectiveness or the prudent layperson standard for coverage of EMERGENCY SERVICES and, as a result, the requested service is denied, reduced or terminated. The determination that a requested service is EXPERIMENTAL, INVESTIGATIONAL or COSMETIC is considered a noncertification. A noncertification is not a decision based solely on the fact that the requested service is specifically excluded under your benefits.

NONHOSPITAL FACILITY
An institution or entity other than a HOSPITAL that is accredited and licensed or certified in the state where located to provide COVERED SERVICES, and is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.

OFFICE VISIT
Medical care, SURGERY, diagnostic services, REHABILITATIVE and HABILITATIVE THERAPY services and MEDICAL SUPPLIES provided in a PROVIDER'S office.

OTHER PROFESSIONAL PROVIDER
A person or entity other than a DOCTOR who is accredited and licensed or certified in the state where located to provide COVERED SERVICES, and which is acceptable to BCBSNC. Examples may include physician assistants (PAs), nurse practitioners (NPs), or certified registered nurse anesthetists (CRNAs). All services performed must be within the scope of license or certification to be eligible for reimbursement.

OTHER PROVIDER
An institution or entity other than a HOSPITAL, which is accredited and licensed or certified in the state where located to provide COVERED SERVICES, and which is acceptable to BCBSNC. All services performed must be within the scope of license or certification to be eligible for reimbursement.

OTHER THERAPY(IES)
The following services and supplies, both inpatient and outpatient, ordered by a DOCTOR or OTHER PROVIDER to promote recovery from an illness, disease or injury when provided by a DOCTOR, OTHER PROVIDER or professional employed by a PROVIDER licensed in the state of practice.

a) Cardiac rehabilitative therapy - reconditioning the cardiovascular system through exercise, education, counseling and behavioral change
b) Chemotherapy (including intravenous chemotherapy) - the treatment of malignant disease by chemical or biological antineoplastic agents which have received full, unrestricted market approval from the U.S. Food and Drug Administration (FDA)
c) Dialysis treatments - the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis
d) Pulmonary therapy - programs that combine exercise, training, psychological support and education in order to improve the patient's functioning and quality of life
e) Radiation therapy - the treatment of disease by x-ray, radium, or radioactive isotopes
f) Respiratory therapy - introduction of dry or moist gases into the lungs for treatment purposes.

OUT-OF-NETWORK
Not designated as participating in the PPO network, and not certified in advance by BCBSNC to be considered as IN-NETWORK. Payment for out-of-network COVERED SERVICES is described in this benefit booklet as out-of-network benefits or out-of-network benefit levels.

OUT-OF-NETWORK PROVIDER
A PROVIDER that has not been designated as a Blue Options PROVIDER by BCBSNC.

OUT-OF-POCKET LIMIT
The maximum amount listed in "Summary of Benefits" that is payable by the MEMBER in a BENEFIT PERIOD before the PLAN pays 100% of COVERED SERVICES. It includes deductible, coinsurance, and any applicable copayments.

OUTPATIENT CLINIC(S)
An accredited institution/facility associated with or owned by a HOSPITAL. An outpatient clinic may bill for outpatient visits, including professional services and ancillary services, such as diagnostic tests. These services may be subject to the Outpatient Services benefit. All services performed must be within the scope of the professional or facility license or certification to be eligible for reimbursement.

PLAN
The EMPLOYER health benefit plan established by SAS Institute Inc. to provide health benefits for participants.

PLAN ADMINISTRATOR
SAS Institute Inc.

PLAN SPONSOR
SAS Institute Inc.

POSITIONAL PLAGIOCEPHALY
The asymmetrical shape of an infant's head due to uneven external pressures on the skull in either the prenatal or postnatal environment. This does not include asymmetry of an infant's head due to premature closure of the sutures of the skull.

PREVENTIVE CARE
Medical services provided by or upon the direction of a DOCTOR or OTHER PROVIDER that detect disease early in patients who do not show any signs or symptoms of a disease. Preventive care services include immunizations, medications that

delay or prevent a disease, and screening and counseling services. Screening services are specific procedures and tests that identify disease and/or risk factors before the beginning of any signs and symptoms.

PRIMARY CARE PROVIDER (PCP)
An IN-NETWORK PROVIDER who has been designated by BCBSNC as a PCP.

PRIOR REVIEW
The consideration of benefits for an admission, availability of care, continued stay, or other services, supplies or drugs, based on the information provided and requirements for a determination of MEDICAL NECESSITY of services and supplies, appropriateness, health care setting, or level of care and effectiveness. Prior review results in CERTIFICATION or NONCERTIFICATION of benefits.

PROSTHETIC APPLIANCES
Fixed or removable artificial limbs or other body parts, which replace absent natural ones following permanent loss of the body part.

PROVIDER
A HOSPITAL, NONHOSPITAL FACILITY, DOCTOR, or OTHER PROVIDER, accredited, licensed or certified where required in the state of practice, performing within the scope of license or certification. All services performed must be within the scope of license or certification to be eligible for reimbursement.

REGISTERED NURSE (RN)
A nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program), and is licensed by the appropriate state authority in the state of practice.

REHABILITATIVE THERAPY
Services and supplies both inpatient and outpatient, ordered by a DOCTOR or OTHER PROVIDER to promote the recovery of the MEMBER from an illness, disease or injury when provided by a DOCTOR, OTHER PROVIDER or professional employed by a PROVIDER licensed by the appropriate state authority in the state of practice and subject to any licensure or regulatory limitation as to location, manner or scope of practice.

a) Occupational therapy - treatment by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role after such ability has been impaired by disease, injury or loss of a body part
b) Physical therapy - treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles and devices to relieve pain, restore maximum function and prevent disability following disease, injury or loss of a body part
c) Speech therapy - treatment for the restoration of speech impaired by disease, SURGERY, or injury; certain significant physical CONGENITAL conditions such as cleft lip and palate; or swallowing disorders related to a specific illness or injury.

RESIDENTIAL TREATMENT FACILITY
A residential treatment facility is a facility that either: (1) offers treatment for patients that require close monitoring of their behavioral and clinical activities related to their chemical dependency or addiction to drugs or alcohol, or (2) offers treatment for patients that require psychiatric services for the diagnosis and treatment of MENTAL ILLNESS. All services performed must be within the scope of license or certification to be eligible for reimbursement.

RESPITE CARE
Services provided by an alternate caregiver or facility to allow the primary caregiver time away from those activities. Respite care is provided in-home or at an alternative location for a short stay. Services include support of activities of daily living such as feeding, dressing, bathing, routine administration of medicines, and can also include intermittent skilled nursing services that the caregiver has been trained to provide.

ROUTINE FOOT CARE
Hygiene and preventive maintenance of feet such as trimming of corns, calluses or nails that do not usually require the skills of a qualified PROVIDER of foot care services.

SEXUAL DYSFUNCTION
Any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.

SKILLED NURSING FACILITY

A NONHOSPITAL FACILITY licensed under state law that provides skilled nursing, rehabilitative and related care where professional MEDICAL SERVICES are administered by a registered or LICENSED PRACTICAL NURSE. All services performed must be within the scope of license or certification to be eligible for reimbursement.

SPECIALIST
A DOCTOR who is recognized by BCBSNC as specializing in an area of medical practice.

SPECIALTY DRUG(S)
Those medications classified by BCBSNC that generally have unique indications or uses, or require special dosing or administration, or are typically prescribed by a SPECIALIST, or are significantly more expensive than alternative therapies. Specialty drugs may be classified as GENERIC, BRAND-NAME, BIOLOGIC, or BIOSIMILAR.

STABILIZE
To provide medical care that is appropriate to prevent a material deterioration of the MEMBER'S condition, within reasonable medical certainty.

SURGERY
The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures, such as:
a) The correction of fractures and dislocations
b) Usual and related pre-operative and post-operative care
c) Other procedures as reasonable and approved by BCBSNC.

URGENT CARE
Services provided for a condition that occurs suddenly and unexpectedly, requiring prompt diagnosis or treatment, such that in the absence of immediate care the individual could reasonably be expected to suffer chronic illness, prolonged impairment, or require a more hazardous treatment. Fever over 101 degrees Fahrenheit, ear infection, sprains, some lacerations and dizziness are examples of conditions that would be considered urgent.

UTILIZATION MANAGEMENT (UM)
A set of formal processes that are used to evaluate the MEDICAL NECESSITY, quality of care, cost-effectiveness and appropriateness of many health care services, including procedures, treatments, medical devices, PROVIDERS and facilities.

WAITING PERIOD
The amount of time that must pass before a MEMBER is eligible to be covered for benefits under the terms of the PLAN.

Summary Plan Description

The following information, together with the information contained in the benefit booklet furnished to EMPLOYEES by the PLAN ADMINISTRATOR, is intended to furnish the Summary Plan Description required by Section 102 of the Employee Retirement Income Security Act of 1974 (**ERISA**):

Name and Number of PLAN(S)
Plan Number 501 - SAS Institute Inc. Medical Plan

Name, Address and Telephone Number of PLAN SPONSOR
SAS Institute Inc.
100 SAS Campus Drive
Cary, NC 27513
919-677-8000

Other EMPLOYERS Adopting the Plan(s)
Vision Systems & Technology, Inc.
SAS Federal LLC
Integrated Decisions and Systems, Inc.

EMPLOYER Identification Number of PLAN SPONSOR
56-1133017

Identification of PLAN ADMINISTRATOR
SAS Benefits Department
100 SAS Campus Drive
Cary, NC 27513

Benefits Provided by PLAN(S)
Medical Insurance - The specific coverages provided by the PLAN are set forth in your benefit booklet.

Type of PLAN Administration
The general administration of the PLAN is provided by the PLAN SPONSOR under Policy Number 008539 issued to the PLAN SPONSOR by Blue Cross and Blue Shield of North Carolina.

Contributions to the Cost of the PLAN(S)
The cost of the medical plan is paid by the EMPLOYER and the EMPLOYEES.

Financial Records
The financial records of the PLAN(S) are kept on a Plan Year basis. Each PLAN year ends December 31.

Agent for Service of Legal Process
It is not anticipated that it will ever be necessary to have a lawsuit; however, if a lawsuit is to be brought, legal process may be served on the PLAN ADMINISTRATOR at:
SAS Institute Inc.
SAS Campus Drive
Cary, NC 27513
(919) 677-8000
Attn: Office of General Counsel

ERISA Rights Statement

As a participant in the PLAN, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all MEMBERS shall be entitled to:

- Examine, without charge, at the PLAN ADMINISTRATOR'S office and at other specified locations, such as worksites, all PLAN documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the PLAN with the U.S. Department of Labor.
- Obtain, upon written request to the PLAN ADMINISTRATOR, copies of documents governing the operation of the PLAN, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary PLAN Descriptions. The PLAN ADMINISTRATOR may make a reasonable charge for the copies.
- Receive a summary of the PLAN'S financial report. The PLAN ADMINISTRATOR is required by law to furnish each MEMBER with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or DEPENDENTS if there is a loss of coverage under the PLAN as a result of a qualifying event. You or your DEPENDENTS may have to pay for such coverage. Review this Summary Plan Description and the documents governing the PLAN on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for MEMBERS, ERISA imposes duties upon the people who are responsible for the operation of the PLAN. The people who operate the PLAN, called "fiduciaries" of the PLAN, have a duty to do so prudently and in the interest of you and other PLAN MEMBERS and beneficiaries. No one, including your EMPLOYER or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the PLAN and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the PLAN ADMINISTRATOR to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the PLAN ADMINISTRATOR. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the PLAN'S decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the PLAN fiduciaries misuse the PLAN'S money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the PLAN, you should contact the PLAN ADMINISTRATOR. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

BCBSNC MEMBER RIGHTS AND RESPONSIBILITIES

As a Blue Cross and Blue Shield of North Carolina (BCBSNC) member, you have the right to:

- Receive information about your coverage and your rights and responsibilities as a member
- Receive, upon request, facts about your plan, including a list of doctors and health care services covered
- Receive polite service and respect from BCBSNC
- Receive polite service and respect from the doctors who are part of the BCBSNC networks
- Receive the reasons why BCBSNC denied a request for treatment or health care service, and the rules used to reach those results
- Receive, upon request, details on the rules used by BCBSNC to decide whether a procedure, treatment, site, equipment, drug or device needs prior approval
- Receive clear and correct facts to help you make your own health care choices
- Play an active part in your health care and discuss treatment options with your doctor without regard to cost or benefit coverage
- Participate with practitioners in making decisions about your health care
- Expect that BCBSNC will take measures to keep your health information private and protect your health care records
- Voice complaints and expect a fair and quick appeals process for addressing any concerns you may have with BCBSNC
- Make recommendations regarding BCBSNC's member rights and responsibilities policies
- Receive information about BCBSNC, its services, its practitioners and providers and members' rights and responsibilities
- Be treated with respect and recognition of your dignity and right to privacy.

As a BCBSNC member, you should:

- Present your BCBSNC ID card each time you receive a service
- Read your BCBSNC benefit booklet and all other BCBSNC member materials
- Call BCBSNC when you have a question or if the material given to you by BCBSNC is not clear
- Follow the course of treatment prescribed by your doctor. If you choose not to comply, advise your doctor.
- Provide BCBSNC and your doctors with complete information about your illness, accident or health care issues, which may be needed in order to provide care
- Understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- Make appointments for non-emergency medical care and keep your appointments. If it is necessary to cancel an appointment, give the doctor's office at least 24-hours' notice.
- Play an active part in your health care
- Be polite to network doctors, their staff and BCBSNC staff
- Tell your place of work and BCBSNC if you have any other group coverage
- Tell your place of work about new children under your care or other family changes as soon as you can
- Protect your BCBSNC ID card from improper use
- Comply with the rules outlined in your member benefit guide.

V. SCHEDULE OF PRESCRIPTION DRUG BENEFITS

Effective January 1, 2016, all eligible health care (medical and prescription) out-of-pocket expenses count toward the accumulation of your annual medical out-of- pocket (OOP) maximum. The 2016 OOP maximums are as follows:

OOP Maximum		
	Individual Coverage	**Family Coverage**
In Network	$1,500	$3,000
Out of Network	$3,000	$6,000

Outpatient prescription drugs will be covered in the following manner, through the Prescription Drug benefit administered by PharmAvail:

Type of Drug	**HCC Pharmacy Cary, NC**	**Community Retail Pharmacy Prescriptions for Non-Cary Employees and Covered**	**Community Retail Pharmacy Prescriptions for Cary Employees and Covered**
Retail Prescription Drugs	Covered Person out-of-pocket cost per prescription (up to a 34-day supply)		
Generic	$5 copay	$5 copay	$10 copay
Brand Name*	20% coinsurance with a $20 minimum and $60 maximum per prescription		
Brand-Name Non-Preferred**	20% coinsurance with a $20 minimum and $60 maximum, **plus** a $30 copay, per prescription		
Mail-Order Prescription Drugs or 90-Day Supply at HCC Pharmacy	Covered Person out-of-pocket cost per prescription (up to a 90-day supply)		
Generic	$15 copay	N/A	N/A
Brand Name*	20% coinsurance with a $40 minimum and $120 maximum per prescription		
Brand-Name Non-Preferred**	20% coinsurance with a $40 minimum and $120 maximum, **plus** a $30 copay, per prescription		
Specialty Prescription Drugs	Covered Person out-of-pocket cost per prescription (up to a 30-day supply)		
Generic	$5 copay	$5 copay	$10 copay
Brand Name*	20% coinsurance with a $20 minimum and $60 maximum per prescription		

*** Generic Incentive Program Applies**
Covered Persons who choose to fill a prescription for a brand-name medication when a lower cost generic equivalent is available will be responsible for the generic copay plus the difference in cost between the brand-name medication and the generic medication. This will apply even if the Covered Person's health care provider indicates "no substitutions" or "dispense as written" on the prescription. In addition, only the generic copay will count toward the annual OOP maximum.

**** Brand-Name Non-Preferred Drugs**
High-cost brand-name medications that have lower-cost therapeutic alternative medications available.

If the Covered Person pays for a prescription in full, a claim form can be obtained from the PharmAvail Web site (www.pharmavail.com) or the SWW Benefits Web site and submitted for

reimbursement through the Prescription Drug benefit administered by PharmAvail. Except in emergency situations (as determined in the sole discretion of the Plan Administrator), reimbursement amounts are limited to the amount that would have been paid had the claim initially been processed under the Plan.

VI. PRESCRIPTION DRUG BENEFIT PROVISIONS

All prescription drug benefits will be subject to all provisions and exclusions of the Plan. Prescription drug benefits are subject to the minimums and maximums as listed in the "**Schedule of Prescription Drug Benefits**".

Your prescription benefit coverage is subject to certain coverage requirements, including, but not limited to, the following:

1. **PRIOR AUTHORIZATION FOR SPECIALTY MEDICATIONS**: All prescriptions for specialty drugs require prior authorization in order to be covered.

2. **NON-PREFERRED BRAND-NAME MEDICATIONS:** If you choose to fill a prescription for a non-preferred brand-name medication when a lower-cost therapeutic alternative is available, you will pay the brand-name coinsurance plus a $30 copay.

3. **STEP THERAPY PROGRAM:** Under this program, a "step" approach is required to receive coverage for certain high-cost medications. This means that to receive coverage you will need to first try a more cost-effective medication (step 1 medication) before using a more costly treatment (step 2 medication). If you choose to fill a step 2 medication before you have tried a step 1 medication you will be responsible for paying the full cost of the medication.

4. **QUANTITY LIMITS:** A quantity limit is the maximum amount of a medication that can be dispensed over a given period of time (for example, 30 tablets per 30 days). If you choose to fill a prescription for an amount that exceeds the quantity limit, you will be responsible for paying the full cost of the amount of medication that exceeds the covered quantity limit.

5. **GENERIC INCENTIVE PROGRAM:** If you choose to fill a prescription for a brand-name medication when a lower-cost, generic equivalent is available, you will pay the generic copay plus the difference between the cost of the brand-name drug and the cost of the generic drug.

For more detailed information about these programs, please the SAS Benefits Department website on the SWW.

The Plan provides coverage for prescription drugs including, but not limited to, charges for the following:

1. **PRESCRIPTION DRUG BENEFITS**: Drugs and medicines prescribed by a licensed medical Provider and dispensed by a licensed pharmacist are covered under the Prescription

Drug benefit. Such prescription drugs must be Medically Necessary for the treatment of an Illness or injury or for methods of birth control or smoking cessation. Outpatient prescription drugs will be covered subject to the applicable coinsurance or Copay amounts and any limitations as stated in the "**What is Not Covered**" section of the BlueCross BlueShield Member Guide and "**Prescription Drug Exclusions"**.

2. **INJECTABLE AND INTRAVENOUS PRESCRIPTION MEDICATIONS (OTHER THAN INSULIN)**: Injectable prescription medications are only covered through the Prescription Drug benefit. Intravenous prescription medications are covered through the medical plan on the same basis as any other Illness.

3. **INSULIN AND DIABETIC SUPPLIES**: Injectable insulin, insulin syringes, chemstrips, alcohol swabs and blood lancets are covered through the Prescription Drug benefit. Blood glucose monitors, insulin pumps, infusion sets and reservoirs are covered through the Medical Plan if not used as convenience items.

4. **WEIGHT REDUCTION DRUGS**: Requiring the written prescription of an eligible medical Provider, weight reduction drugs shall be covered under the Prescription Drug benefit. Prescriptions shall not exceed a 34-day supply for prescriptions purchased at a participating Pharmacy or not to exceed a 90-day supply. The prescribing medical Provider must submit a statement of Medical Necessity and a complete patient profile for approval before benefits are paid.

5. **NUTRITIONAL PRODUCTS AS MEDICAL FOOD:** Select nutritional products approved by the FDA (such as Neocate) for use as medical food for treatment of malabsorption may be considered for coverage on the pharmacy drug benefit through prior authorization when prescribed by a physician. The Plan will cover a maximum of $3,600 per year, and approval of the benefit must be reevaluated by PharmAvail on an annual basis. Requests for coverage must be accompanied by the prescriber's justification as a medical necessity and may be submitted for consideration to the pharmacy benefit manager, PharmAvail, via fax at 678-236-0415 or initiated by telephone at 800-933-3734.

6. **CONTRACEPTION FOR WOMEN:** Medications and devices FDA- approved for prescription use as contraception in women are covered on the Prescription Drug benefit, including (1) Oral Contraception, also known as "the birth control pill;" (2) Non-Oral Systemic Contraception, such as NuvaRing and OrthoEvra; and (3) prescription Contraceptive Devices such as Diaphragms and Cervical Caps. These prescriptions are covered at a 100% benefit with no cost-share to the member (zero co-payment) when purchased as a generic. Brand-name prescriptions will only be covered at a 100% benefit if there is no generic equivalent or if the generic drug is deemed medically inappropriate by the member's health care provider. Over the counter medications and devices are not covered on the plan.

7. **DEPO-PROVERA INJECTIONS**: Depo-Provera injections dispensed and/or administered at a medical Provider's office if Medically Necessary (or for contraceptive purposes). Depo-Provera injections prescribed by a medical Provider and dispensed by a pharmacist are covered through the Prescription Drug benefit.

8. **NORPLANT AND CONTRACEPTIVE DEVICES**: Charges for Norplant are covered through the Prescription Drug benefit. Professional fees to insert or remove the Norplant implants or intrauterine contraceptive devices will be covered under the Medical Plan. The NuvaRing vaginal contraceptive and contraceptive patch are covered through the Prescription Drug benefit.

9. **INTERNATIONAL CLAIMS**: Prescription medications obtained outside of the United States will be subject to full reimbursement (less the member copay or coinsurance) if the prescription was required due to an emergency situation (as determined in the sole discretion of the Plan Administrator). For prescriptions filled outside the United States in non-emergency situations, reimbursement amounts are limited to the amount that would have been paid had the claim initially been processed under the Plan. Refer to **"Prescription Drug Exclusions"** for further information on international claims.

PRESCRIPTION DRUG EXCLUSIONS

The prescription drug benefit does not cover any expenses or charges Incurred for services, supplies, care or treatment relating to, arising out of or given in connection with, the following:

1. Charges that are excluded under the Plan's medical benefits exclusions as listed in the in the "**What is Not Covered**" section of the BlueCross BlueShield Member Guide.

2. Charges Incurred for Illness or injury, including prescription drugs, caused during service in the armed forces in any country.

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

4. Charges Incurred as the result of missed appointments or for completing claim forms.

5. Charges Incurred outside the United States if the Covered Person traveled to such a location for the sole purpose of obtaining prescription drugs or supplies.

6. Charges for which the Covered Person has no legal obligation to pay.

7. Charges for services rendered by a provider that is a member of the patient's Immediate Family or by a provider that is the patient's Domestic Partner or rendered in the same household as the patient.

8. Charges which are not Medically Necessary for the diagnosis and treatment of an Illness or injury, unless stated otherwise as covered in the Plan.

9. Charges which are not generally accepted in the United States as being necessary and appropriate for the treatment of the patient's Illness or injury.

10. Charges which are still considered Experimental or Investigational (as defined by the Plan), whether or not such treatment, services or supplies are "generally accepted" by the medical profession. The fact that an experimental or investigative service, procedure, device, or drug is the only available treatment for a particular condition will not result in coverage if the service, procedure, device or drug is considered to be experimental or investigative in the treatment of that particular condition, except as approved by the Claims Administrator and as specified under "**Prescription Drug Benefit Provisions**".

11. Charges related to or in connection to dietary control or weight reduction except as specified under "**Prescription Drug Benefit Provisions**", including but not limited to, nutritional supplements or weight loss programs and supplies.

12. Charges for any claims filed more than 18 months after covered service or supply was Incurred.

13. Brand-name drugs in the Tetracycline antibiotic class.

14. Prescription strength Nexium.

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

If a particular charge is a covered Prescription Drug expense and could also be a covered expense as a Medical Benefit, such charge will be paid under the appropriate benefit as determined by the Claims Administrator.

VII. CORPORATE HEALTH CARE CENTERS

The Employer makes available an on-site Health Care Center (HCC) at the Cary, North Carolina (Company headquarters) location. The HCC provides a wide range of health services and wellness programs. Primary care is offered at the Cary location in addition to a variety of other health care services including, but not limited to, drawing blood, performing laboratory tests, and administering childhood and adult immunizations. The HCC staff emphasizes patient education and the prevention of illness, injury and disability.

Covered Employees who work in the Cary, North Carolina location and their covered Dependents under the Plan may elect the Cary on-site HCC as their primary health care provider. Covered Cary Employees and their covered Dependents that are not primary care patients may use the HCC to supplement the care they receive from their primary care provider (e.g., emergency care, assessment and treatment of minor acute illnesses, health education, and screening). The HCC staff refers patients who require specialist care to outside providers. Care provided by an outside provider is subject to the terms and conditions of the Plan, as outlined in this Summary Plan Description. It is the responsibility of the patient to ensure that providers used outside of the HCC are participating in the BlueCross BlueShield PPO network in order for in-network benefits to apply.

All other covered Employees and their covered Dependents working in locations other than Cary, North Carolina may utilize the HCC for supplemental care and emergencies, if applicable, when they are physically at the Cary location at the time care is needed.

HCC providers cannot fill out paperwork for Covered Employees for purposes of certifying medical conditions for Leaves of Absence (e.g. the Family Medical Leave Act or Americans with Disabilities Act), where the requested leave is greater than ten (10) days.

VIII. COORDINATION OF BENEFITS

Except as noted below, the following Coordination of Benefits provisions apply to Prescription Drug benefits. Refer to the "**Coordination of Benefits**" section of the BlueCross BlueShield Member Guide for a discussion regarding coordination of medical 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 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 health 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.

IX. SUBROGATION, REIMBURSEMENT, AND THIRD PARTY RECOVERY PROVISIONS

The following provisions apply to prescription drug benefits. Refer to the BlueCross BlueShield Member Guide for a discussion regarding the effect of subrogation, reimbursement and recovery of medical benefits.

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.

X. 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 within **60** days after the qualifying event occurs. The notice must be mailed or faxed to the COBRA Administrator at the following address:

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 COBRA 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 COBRA 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 COBRA 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 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 COBRA Administrator. 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 COBRA Administrator. 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 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, 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, 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 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.

XI. 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.

XII. 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).

XIII. 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), step-children 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 BlueCross BlueShield of North Carolina for Medical benefits, and PharmAvail for Prescription Drug 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.

"**Copay**" means a dollar amount that must be paid in order to receive a covered service, supply or treatment, such as for or a prescription. The Plan's Copay amounts are specified in the "**Summary of Benefits**" section of the BlueCross BlueShield Member Guide and the "**Schedule of Prescription Drug Benefits**" section of this Summary Plan Description.

"**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 health care provider 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.

"**Generic Drug**" means a prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

"**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 medical and prescription drugs benefits.

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

"**Hospital**" means an institution that:

a. Is licensed to provide and is engaged primarily in providing on an Inpatient basis, for compensation from its patients, diagnostic and therapeutic facilities for the surgical, medical diagnosis, treatment and care of ill and injured persons.
b. Operates 24 hours a day every day under continuous supervision of a staff of doctors (MD, DO).
c. Continuously provides on the premises of the facility 24 hours a day skilled nursing services by licensed nurses under the direction of a full-time registered nurse (R.N.).
d. Provides, or has a written agreement with another hospital in the area for the provision of, generally accepted diagnostic or therapeutic services that may be required during a confinement.
e. Is not, other than incidentally, a place for rest, a place for the aged, a nursing home, a place for alcoholics, or a convalescent hospital.
f. Qualifies as a Hospital, a psychiatric Hospital, or a tuberculosis Hospital and is accredited by the Joint Commission on the Accreditation of Hospitals (JCAH).

g. Is a provider of services under Medicare.

"**Illness**" means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, Pregnancy or complication of Pregnancy. The term "Illness" when used in connection with a newborn child includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

"**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.

"**Inpatient**" refers to the classification of a Covered Person when that Person is admitted to a Hospital, Hospice, Residential Treatment Facility or Skilled Nursing Facility for a period 24 hours or longer for treatment, and charges are made for room and board to the Covered Person as a result of such treatment.

"**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.

"**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 non-resident 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.

"**Pharmacy**" means a licensed establishment where prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices.

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

"**Plan**" means the SAS Institute Inc. Medical 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.

Eligible Providers for the treatment of mental disorders or Substance Abuse conditions include Psychiatrists, Licensed Psychologists, Certified Clinical Social Workers and Psychiatric and Mental Health Clinical Nurse specialist. Medical expenses Incurred for treatment by other certified counselors may be eligible for reimbursement based upon their credentials. Covered Persons can verify credentials with the Employer's Health Care Center or the Plan Administrator, via the SAS Benefits Department prior to seeing these Providers.

"**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.

"**Residential Treatment Facility**" means an institution which meets all of the following conditions:

a. It is engaged primarily in providing Medically Necessary care and treatment modalities for mental Illness and Substance Abuse on an Inpatient basis at the patient's expense;
b. It qualifies as an extended treatment facility for mental Illness or Substance Abuse, and is accredited by the Joint Commission on the Accreditation of Hospitals (JCAH) and/or is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located which pertains to Hospital;

c. It maintains on its premises all the services necessary to provide for the diagnosis and medical treatment, including counseling services, for mental Illness and Substance Abuse;
d. Such treatment is provided for compensation by or under the direct supervision of medical Provider(s);
e. It is a provider of services under Medicare; and
f. It is not, other than incidentally a place for rest, a place for the aged, a nursing home, a half-way house, group home or therapeutic boarding school or a recreational therapeutic camp.

The term Residential Treatment Facility shall also include any institution referring to itself as Substance Abuse Inpatient Rehabilitative Facility.

"**Skilled Nursing Facility**" (this term also applies to a facility which refers to itself as an extended care facility or convalescent facility) means a facility that:

a. Is licensed to provide professional nursing services on an Inpatient basis to patients convalescing from injury or Illness to help restore patients to self-care in essential daily living activities; and
b. Provides continuous nursing services by licensed nurses for 24 hours of every day, under the direction of a full-time registered nurse (R.N.); and
c. Provides services for compensation and under the full-time supervision of a medical Provider; and
d. Maintains a complete medical record on each patient; and
e. Has an effective utilization review plan; and
f. Is not, other than incidentally, a clinic, a place for rest, a place devoted to care of the aged, a place for treatment of mental disorders or mental retardation, or a place for custodial care.

"**Specialty Pharmacy Drugs**" means a drug, typically injectable, used to treat certain chronic medical conditions as outlined in the Prescription Drug benefit section.

"**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.

"**Substance Abuse**" means the condition caused by physical and/or emotional dependence on drugs, narcotics, alcohol or other addictive substances resulting in a chronic disorder which affects physical health and/or personal or social functioning. This does not include dependence on tobacco or ordinary caffeine-containing beverages.

"**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.

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

XIV. ERISA RIGHTS

A. RECEIVING INFORMATION ABOUT THE PLAN AND ITS BENEFITS

As a Participant in the 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 health care 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 X. 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.

XV. CLAIMS PROVISIONS FOR PRESCRIPTION DRUG BENEFITS

If your request for a prescription drug benefit is denied, you will have the right to a full and fair review process. The procedures outlined in this section apply only to claims for prescription drug benefits.

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.

A. 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.

B. CLAIM FILING

The Plan Administrator 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.

The following Claims Filing Instructions apply to prescription drug benefits. Refer to the "How to File a Claim" section of the BlueCross BlueShield Member Guide for Medical benefits.

When to File a Claim

A Covered Person or Provider should file a claim as soon as health expenses are incurred for which the Plan provides benefits. Please note that 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. Please complete the form carefully, and include all requested information. This will help avoid unnecessary delays in processing your claim. Remember to always include the group number on the claim form. The group number can be found on the Insurance Identification Card.

2. Attach itemized bills to the claim form for covered services. Bills must be complete. Each bill, other than for drugs, 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

Prescription Drug Claims should be submitted to:

PharmAvail
3380 Trickum Road
Building 400, Unit 100
Woodstock, GA 30188
Fax: 678-236-0415

C. 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.

D. URGENT CARE CLAIM RULES

In the case of an urgent care claim, the claimant will be notified of the Claims Administrator's determination, whether adverse or not, as soon as possible taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Claims Administrator. However, the 72 hour deadline will not apply if the claimant fails to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan. If more information is needed the Claims Administrator will notify the claimant no later than 24 hours after receiving the request. The claimant will be given a reasonable amount of time, but not less than 48 hours, to provide the requested information.

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.

E. 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 72 hours provided that the claim is made at least 72 hours prior to the expiration of the initially prescribed period.

F. 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, pre-approval under utilization review or for a prior authorization).

G. 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.

H. 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.

I. MANNER AND CONTENT OF CLAIMS 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.

J. APPEAL OF DENIED CLAIM AND REVIEW PROCEDURE

A claimant will be notified in writing by the Claims Administrator of any adverse benefit determination. For purposes of this Plan, the term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, even if it is based on a determination of a claimant's eligibility to participate in the Plan, including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, or on account of a Plan provision or exclusion relating to medical necessity, or experimental or investigational treatments. The term "adverse benefit determination" also includes a rescission of coverage (within the meaning of Section 2712 of the Public Health Service Act).

If a claimant does not agree with the decision of the Claims Administrator and wishes to appeal, he must file an appeal in writing with the appeals administrator. The claimant must file his appeal within 180 days after he receives notice of denial of the claim from the Claims Administrator. In the appeal, the claimant should submit all information identified in the notice of denial as necessary to perfect the claim and any additional information that he believes would support the claim. The written appeal should state the reason(s) why the claimant feels the claim should not have been denied.

The appeals administrator or its designee will review relevant information that the claimant submits even if it is new information. The claimant will have the opportunity to ask additional questions and make written comments. On request, the appeals administrator will give the claimant access to and provide copies of documents and other information relevant to the appeal.

The following rules apply to the appeal:

- The appeals administrator will not be the same as the Claims Administrator, and will not be subordinate to the Claims Administrator.

- The appeals administrator will conduct a fresh review of the claim, and no deference will be given to the Claims Administrator's initial determination.

- If the adverse benefit determination is based in whole or in part on a medical judgment, the appeals administrator will consult with an appropriately trained health care professional that is different from any professional consulted in connection with the initial claim determination.

- The appeals administrator will identify any medical or vocational experts consulted in connection with the initial determination, regardless of whether the decision maker relied on the professional in making the benefit determination.

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).

The second level appeal will be conducted by an external independent review organization and will be conducted in accordance with the applicable State external review process or the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners. The second level appeal is only available for adverse benefit determinations that involve medical judgment or rescissions of coverage. Decisions regarding legal or contractual interpretations of Plan terms are not eligible for a second level appeal.

K. 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 adverse benefit determination notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reasons for the adverse determination.
2. Reference to specific Plan provisions on 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 the material or information is necessary
4. a description of the Plan's claims review or grievance procedures and the time limits applicable to such procedures (including, a statement of the claimant's right—to the extent ERISA applies to the claimant—to bring a civil action under ERISA Section 502(a) following an adverse determination on review).

5. A description of the expedited review process if the claim involves urgent care
6. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse 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 in making the determination and that a copy will be provided free of charge upon request.
7. If the decision is a "noncertification determination", a statement informing the claimant that if the claimant has a medical condition where the time frame for completion of an expedited review of a grievance would reasonably be expected to seriously jeopardize the life or health of the claimant or jeopardize the claimant's ability to regain maximum function, the claimant may file a request for an expedited external review at the same time the claimant files a request for expedited review of the grievance.
8. Any other information that is required by applicable regulations under Section 503 of ERISA or Section 2719 of the Public Health Service Act, or under applicable guidance thereunder.

Notwithstanding the foregoing, in the case of an adverse benefit determination involving urgent care, the required information may be provided orally within the applicable time frame prescribed above, provided that a written or electronic notification is furnished not later than three days after the oral notification.

L. DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND THE CLAIMS ADMINISTRATOR

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.

M. 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.

N. 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.

With respect to the Medical and Prescription benefits under this Plan, where benefits under the Plan are paid by check and the Participant does not cash the check by the end of the Plan year after the Plan year in which services were provided, such check shall be void and the Plan shall have no requirement to make any payment with respect to such benefits.

O. 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.

P. RECOVERY OF OVERPAYMENTS

If an overpayment is made under this Plan, the Plan Administrator reserves the right to determine and exercise one or all of the following options that it deems necessary to recover the overpayment to the Plan. The Plan Administrator may:

- Request the overpayment from any Covered Person to whom such overpayment was made;
- Request the overpayment from any Provider to whom such overpayment was made; and/or
- Deduct the overpayment of benefits from subsequent benefits payable to the Covered Person.

Each Covered Person is deemed, through participation in the Plan, to authorize recovery of overpayments as described above.

Q. ADMINISTRATIVE DISCRETION GUIDELINE – FINANCIAL RECOVERY OF MEDICAL CLAIM OVERPAYMENTS

Benefits for treatment, services and supplies covered under the SAS Medical Plan must be clinically eligible for coverage, provided in a proper setting and for a reasonable length of time. Information about whether a certain medical service is covered can be found in this SPD. A financial recovery is established when a member or the member's provider receives an overpayment for medical services not covered under the SAS medical Plan. This Administrative Discretion Guideline only applies to medical benefits covered under SAS Blue Options PPO medical plan. It does not apply to prescription drug benefits under the SAS Medical Plan.

The Plan Administrator may instruct its third party claims administrator not to pursue reimbursement for claim overpayments less than $5,000 when the Plan Administrator discovers an overpayment an determines that all of the following apply:

- The overpayment was caused by third party claims administrator omission or error.
- The claims administrator did not discover and communicate, to the member and/or provider, the error and recovery action within 90 days of receiving the claim(s) for processing.
- Neither the member nor someone acting on behalf of the member caused the error to be made through causes including, but not limited to, material misrepresentation about the member's health condition or eligibility for benefits under the plan.
- Neither the member nor someone acting on behalf of the member could reasonably be expected to have realized that an overpayment was being made.

Only overpaid claims will fall under this provision for consideration by the Plan Administrator. Once the member is notified of the overpayment of benefits and/or ineligibility for coverage under the plan, all payments for related future claims will be the member's responsibility.

R. 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 ERISA section 502(a) to enforce their rights.