
Martin Marietta Materials, Inc.
Personal Choice Benefits Program Medical Plan Summary Plan Description

January 2011

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Introduction

This booklet is the "Summary Plan Description" for the Martin Marietta Materials, Inc., Medical Plan (the "Plan" or the "Medical Plan"). This booklet summarizes the medical benefits provided by the Personal Choice Benefits Program as in effect for the calendar year beginning January 1, 2011. The Personal Choice Benefits Program is the flexible benefits program for eligible full-time salaried and hourly employees of Martin Marietta Materials, Inc. (the "Company"). This SPD serves as the official Plan Document as required under the Employee Retirement Income Security Act (ERISA) of 1974. If there is any conflict between other plan description materials and this document, terms outlined in this SPD will govern. This booklet does not give you any rights to benefits that are not expressly provided under the terms of this document. You can receive a copy of this Plan Document from the Corporate Human Resources Department.

Nothing in this booklet creates an employment contract between Martin Marietta Materials, Inc. and any employee, or prevents the Company from terminating or changing the terms of any employee's employment.

Martin Marietta Materials, Inc. reserves the right to amend or terminate the Plan at any time and in any manner, at its sole discretion. Amendments to the Plan may be made by the Vice President of Human Resources of the Company or through a written document identified as an amendment to the Plan. When such changes occur before the material in this booklet can be revised, you will be notified in writing. Please keep such "Summary of Material Modifications" communications with this Summary Plan Description until such time as new booklets are distributed.

Benefit provisions described herein may not be applicable for collectively bargained groups. Union employees should refer to their specific labor agreements for a description of their benefits.

Purpose

If you elect to participate, the Medical Plan provides for the payment or reimbursement of certain medical expenses incurred by you or your covered eligible dependents.

In addition to describing the benefits available under the Plan, this summary explains how the Medical Plan works, when and how you and your eligible dependents become covered, when coverage is effective, how to file your claims and when coverage ends.

This Plan is subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Your Medical Plan Coverage At A Glance

- Eligibility:** You are eligible to participate in the Plan on the day you start work as a regular full-time salaried or hourly employee in a Participating Business Unit of Martin Marietta Materials, Inc. You may also elect coverage for your eligible dependents.
- Categories of Coverage:** You may select from four categories of coverage:
- Employee
 - Employee plus one dependent
 - Employee plus two dependents
 - Employee plus three dependents
 - Employee plus four or more dependents
- Enrollment:** You may enroll in the Medical Plan within 30 days of your date of hire, during any applicable "special enrollment period", or during the annual open enrollment period.
- Benefits:** The Medical Plan provides medical benefits through the Blue Cross Blue Shield (BCBS) Personal Choice Preferred Provider Organization (PPO). The BCBS PPO includes the Traditional PPO and the Rural PPO, depending on location. The Plan pays part of your covered medical expenses, in some cases after you pay applicable deductibles. For BCBS PPO participants, the Plan includes mental health and substance abuse services through Magellan Behavioral Health and prescription drug services through Caremark. Employee Assistance Program (EAP) services are provided through Cigna Behavioral Health.
- Cost:** Premiums for this coverage will be automatically deducted from your paycheck. The Plan is self-insured, so after your applicable co-pays, deductibles and co-insurance rates for services have been paid, the Company pays the remainder of the costs of the Plan. Your premiums are set forth in enrollment materials provided during the applicable open enrollment period and may be changed from time to time at the Company's discretion.
- Case & Disease Mgmt Surcharge:** Non-compliance in a case management or disease management program offered by BCBSNC to a covered employee or covered spouse will result in a \$50 per month surcharge per incidence (maximum of \$100 per family – surcharge not to exceed maximum amount allowed under Federal regulations to include the smoker surcharge). The surcharges will be applied monthly and will continue until you and/or your covered spouse are compliant with the disease and/or case management program requirements or are no longer eligible for the program. These requirements will be determined by Blue Cross and Blue Shield of North Carolina. All

**Smoker
Surcharge:**

program information is confidential and all program terms comply with federal law.

The smoker surcharge is an additional pre-tax contribution you make because you and/or your covered spouse use tobacco products on a frequent or daily basis.

- The surcharge is equal to \$70.00 per month or \$840.00 per year *and applies in addition to the standard medical contribution for your category of coverage*
- Tobacco products include cigarettes, clove cigarettes, cigars, pipe tobacco and smokeless tobacco.
- If you waive medical coverage, the smoker surcharge does not apply
- Only one smoker surcharge applies, even if both you and your covered spouse use tobacco
- Frequent or daily use includes using any tobacco products at least once a day or on a frequent regular basis in the past 12 months (as measured from your date of enrollment).
- Surcharge can only be removed during Open Enrollment with 12 months no tobacco use prior to current Open Enrollment. Ex: for the 2011 benefit year, you will need to be tobacco free for 12 months prior or October 2010 but your payroll deductions will continue through December 31st of the current plan year

Anyone found falsifying his/her smoking status will be subject to disciplinary action up to and including termination of benefits in accordance with the Martin Marietta Code of Ethics and Standards of Conduct Policy.

If it is unreasonably difficult due to a medical condition for you to achieve the standards to avoid the surcharges under these programs, or if it is medically inadvisable to attempt to achieve these standards, call us at 1-877-651-5353 and we will work with you to develop options for discontinuing the surcharges.

**Working Spouse
Surcharge:**

If you have a working spouse, who has medical coverage available to him/her from another employer and/or who is Medicare eligible and he/she chooses to elect the Martin Marietta Materials medical coverage, you will pay a pre-tax surcharge equal to \$110.00 per month or \$1320.00 per year, in addition to the standard medical contribution for your category of coverage.

**Claims
Administrators:**

Medical: Blue Cross Blue Shield (BCBS)
Mental Health and Substance Abuse: Magellan Health Services
Prescription Drugs: Caremark

Employee Assistance Program (EAP): Cigna Behavioral Health (CBH)

If you have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please see page 53 for more details.

How Your Medical Plan Coverage Works

Eligibility

You can elect to have Medical Plan coverage for yourself, you and your spouse and/or eligible dependents or you can elect the Waived Coverage Option. You may participate in the Plan if:

- You are an active, full-time salaried or hourly employee who works for a Participating Business Unit;
- You properly enroll yourself (and, where applicable, your spouse and eligible dependents); and
- You pay any required premium.

Medical coverage is effective on the day you commence employment at that business unit, for you, your spouse (if enrolled) and any eligible dependents (if enrolled). Full time employment is defined as follows:

- During “regular business conditions”, you must work (or be regularly scheduled to work) at least 40 hours per week. Your Participating Business Unit will define regular business conditions. If your hours (actually worked or regularly scheduled to work) fall below the 40-hour weekly minimum, you will lose eligibility for coverage under the Plan. You may then become eligible to elect continuation of coverage under COBRA
- During “special business conditions”, you must work (or be regularly scheduled to work) at least 32 hours per week. Special business conditions will be defined by your Participating Business Unit and may be adopted from time to time without advance notice. Coverage levels and required contributions under special business conditions will generally remain the same as under regular business conditions, except that coverage and contributions for life insurance and LTD benefits (salaried employees only) based on your pay will be adjusted to reflect your pay under a 32-hour work week. If your hours (actually worked or regularly scheduled to work) fall below the 32-hour weekly minimum, you will lose eligibility for coverage under the Plan. You may then become eligible to elect continuation of coverage under COBRA

Eligible dependents include your spouse and any unmarried or married dependent children up to 26 years of age. No spouse or dependents of the married dependent may be covered. Coverage terminates on the 26th birthday for any eligible dependent.

The term "children" includes your natural and adopted children, stepchildren or other children who live with you in a parent-child relationship.

You can extend coverage to any child who is dependent on you because of a physical or mental disability beyond age 26 if unmarried. To extend coverage, you must submit proof of your child's incapacity to the plan administrator within 30 days after the date coverage would normally end. You may also be asked to provide proof of the child's continuing incapacity.

If you and your spouse work for the Company, each of you can elect the coverage option and category you want. However, you cannot be covered as a dependent if you are covered as an employee. Only one parent may cover a dependent child.

Enrollment

New Employees

You are automatically enrolled into coverage under the Blue Cross Blue Shield PPO medical plan at no charge on your first day of work. You will then be eligible to enroll your spouse, if applicable any eligible dependents and select the Medical Plan option you want beginning the day you start work and during the first 30 days after you start work. Provided you properly enroll yourself and any family members, medical coverage for you, your spouse (if applicable) and any eligible dependents will be effective on your first day of work. Your premium contributions to the Plan will commence with the first payroll, after the 1st of the month following 30 days of employment. Coverage and any required contributions for coverage will stay in effect until December 31 of the calendar year in which you start work, unless you have a qualified event status change that allows you to change your Medical Plan coverage category.

Your elections will apply to you, a spouse and any eligible dependents you enroll in your coverage.

Annual Open Enrollment

Annual open enrollment takes place each year. Elections made during annual open enrollment will be in effect for the next calendar year. This is the Medical Plan coverage period. For example:

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Annual Open Enrollment	Medical Coverage Period
Fall 2010	January 1, 2011- December 31, 2011
Fall 2011	January 1, 2012- December 31, 2012

The coverage categories for the Medical Plan are: employee only, employee plus one dependent, employee plus two dependents, employee plus three or employee plus four or more dependents. This coverage is separate from vision and dental coverage, so you can choose a different coverage category. You may also choose the "waived coverage" option.

You will not be able to change your coverage until the next annual open enrollment, unless you have a qualified event status change that allows you to change your Medical coverage category.

Special Enrollment

If you waive coverage solely because you are insured through another source, you and/or your spouse and eligible dependents may qualify for "special enrollment." Should you lose coverage under the other health plan, you may enroll in this Plan during the calendar year. You must apply for coverage within 30 days of your date of loss of other coverage and you must contact Benefits Connection at 1-877-651-5353 or go to their web-site at: <https://mmm.benefitcenter.com>, to make your plan changes.

To qualify as a special enrollee you must be covered either:

- Under a COBRA continuation provision and have used up the coverage under that provision, or
- Not under a COBRA provision and have lost coverage because eligibility was lost or employer contributions were terminated

If you believe you qualify for special enrollment based on other conditions not listed above, please contact the Corporate Human Resources Department for further information.

Children’s Health Insurance Program (CHIP):

This law amends ERISA, the Internal Revenue Code and the Public Health Service Act allowing an employee who is eligible, but not enrolled for coverage under the medical plan, to enroll outside of open enrollment if either:

- o The employee or dependent covered under Medicaid or CHIP has coverage terminated as a result of loss of eligibility, and the employee requests coverage under the group medical plan within 60 days after such termination; or

- The employee or dependent becomes eligible for Medicaid or CHIP premium assistance if the employee requests coverage within 60 days after the eligibility determination date

**Medicaid and the Children’s Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families**

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of March 3, 2010. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone: 1-800-866-3513 CHIP Website: http:// www.CHPplus.org
ARIZONA – CHIP	

Website: http://www.azahcccs.gov/applicants/default.aspx Phone: 602-417-5422	CHIP Phone: 303-866-3243
ARKANSAS – CHIP	FLORIDA – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237
GEORGIA – Medicaid	MONTANA – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
IDAHO – Medicaid and CHIP	NEBRASKA – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 208-334-5747 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
INDIANA – Medicaid	NEVADA – Medicaid and CHIP
Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
IOWA – Medicaid	
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: https://www.khpa.ks.gov Phone: 800-766-9012	Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: www.dhh.louisiana.gov/offices/?ID=92 Phone: 1-888-342-6207	
MAINE – Medicaid	NEW MEXICO – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid	NEW YORK – Medicaid

Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 800-657-3739	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	UTAH – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	VERMONT – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.oregon.gov/DHS/healthplan/index.shtml Medicaid Phone: 1-800-359-9517 CHIP Website: http://www.oregon.gov/DHS/healthplan/app_benefits/ohp4u.shtml CHIP Phone: 1-800-359-9517	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	WASHINGTON – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtml Phone: 1-877-543-7669
RHODE ISLAND – Medicaid	WEST VIRGINIA – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html

	Telephone: 307-777-7531
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To see if any more States have added a premium assistance program since March 3, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Status Changes

You may make certain changes to your Medical Plan coverage during the coverage period if you experience a qualified status change, including:

- You or an eligible dependent experience loss of other medical coverage (including through exhaustion of COBRA continuation coverage), and the loss was not due to a failure to pay premiums or to your misconduct
- Your legal marital status changes for reasons of marriage or divorce (requires a copy of the divorce decree). If the decree mandates the employee must pay for continuous coverage for the ex-spouse, coverage must be obtained from a source out-side of Martin Marietta Materials benefit plan, legal separation (requires a copy of the separation agreement – same rules apply as the divorce decree pertaining to payment of continuous coverage), annulment, or death of a spouse
- A Common Law spouse may be added with a completed Affidavit for Common Law Marriage only if the employee resides in a State that acknowledges Common Law Marriage (see the affidavit form for a listing of those states or contact Benefits Connection at 1-877-651-5353)
- You gain dependent(s) due to marriage, birth, adoption or placement for adoption of a child
- You lose dependent(s) by divorce, legal separation, annulment, death of a dependent, or loss of dependent child eligibility
- You or an eligible dependent begins or terminates employment, experiences a change in his or her hours of employment or changes residences, which results in a loss or gain of medical coverage

Medical coverage is extended under the following terms if you are absent from work under an approved Short-Term Disability (STD) and/or Sickness and Accident (S&A) leave:

-
- Your medical coverage while on Short-Term Disability (STD) and/or Sickness and Accident (S&A) continues on the same basis (coverage election) as your coverage during active employment
 - You will be able to change your coverage election only if you experience a qualified status change or are eligible for a special enrollment right as described in this document, Page 10
 - Your contributions will continue to be withheld from your pay on a pre-tax basis under the Company's salary continuation Short-Term Disability (STD) and/or Sickness & Accident (S&A) program
 - Contributions will be based on the premiums applicable at that time for active employees enrolled in the same level of coverage
 - If you are disabled during annual enrollment, you are allowed to change your coverage election during the enrollment period
 - For **Salaried** employees, coverage can continue for up to six months (based upon length of service) from your date of Short Term Disability (STD) as long as you remain disabled under the plan
 - For **Hourly** employees, coverage can continue for up to the maximum duration of your Sickness and Accident (S&A) coverage allowable based on your years of service as long as you remain disabled under the plan
 - Your employment with Martin Marietta Materials continues during STD and/or S&A absence

For **Salaried** employees, if you qualify for income payments under the Company's Long Term Disability (LTD) insurance plan, medical coverage will be continued under the following terms:

- Your medical coverage while on LTD continues on the same basis (coverage election) as your coverage while on STD
- Your contributions will be frozen at the level that applied at the end of your period of STD absence and will stay at this level as long as you remain disabled and do not change your coverage election
- Your medical contributions will be billed to you through the COBRA administrator (currently Ceridian Benefits Billing Services)
- You may change your coverage level in certain circumstances as described in the Special Enrollment section of this document. If under Special Enrollment

you increase your coverage election (e.g., by adding coverage for an eligible spouse), then the contribution you pay will be set at the level applicable for active employees with the same coverage level at the time of your election change. This new contribution level will then be frozen for the duration of your LTD absence, or until another medical election change

- If the employee's spouse has waived Martin Marietta Materials coverage and then loses other employer coverage, they are eligible to re-enroll while the employee is on LTD
- Employees on LTD are also eligible for these rights on the same basis as active employees (since active and disabled employees are covered under the same ERISA medical plan)
- You are eligible to change your coverage level due to a qualified status event change as described earlier in this SPD

For **Hourly** employees, if your disability extends beyond the duration of your Sickness and Accident (S&A) benefit, the following medical coverage terms apply:

- At the end of your approved S&A absence, your employment with Martin Marietta Materials will cease
- You may then qualify for continued medical coverage under COBRA as described in this document
- The Company may pay the full COBRA premium for **you** only for up to 12 months, subject to Company review and approval of information documenting your disability
- If you continue COBRA coverage beyond 12 months, you will be responsible for paying the full COBRA premium

You are responsible for paying any additional cost of COBRA for your dependents through your entire COBRA coverage period

In addition, except as provided in regulations, the following are deemed to be changes in status:

- Commencement of unpaid leave;
- Return to work after unpaid leave;
- Entry of a Qualified Medical Child Support Order (QMCSO) or Qualified Domestic Relations Order (QDRO) (a copy of the procedures governing QMCSO and QDRO determinations may be obtained without charge from the Corporate Human Resources Department)

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- A significant increase or decrease in the cost of coverage under this Plan or a plan you or your dependents are currently covered under
 - A significant decrease in or termination of the coverage provided under this Plan or a plan you or your dependents are currently covered under
 - The addition (or elimination) of a benefit option providing similar coverage; and
 - Entitlement of a covered person to Medicare or Medicaid benefits

The change in coverage resulting from a qualified status change must be consistent with the change in status. This is called the Consistency Rule. Generally, the event has to affect you or your family member's eligibility for coverage for that benefit.

Certain events have the following special Consistency Rules:

- Changes due to Loss of Dependent Eligibility:** If the event is divorce, annulment, death of a spouse or dependent, or a dependent ceasing to satisfy the eligibility requirements and you are enrolled in the health plan, you may only cancel the coverage for that particular spouse or dependent. Coverage may not be cancelled for you or any other covered family member, unless some other permitted election change applies
- Gaining Eligibility Under Another Employer Plan:** If, due to a change in marital status or employment status, you or your spouse and dependent become eligible for coverage under a plan sponsored by your spouse's or dependent's employer, you may decrease or cancel coverage for yourself, your spouse, or dependent as long as a corresponding election to add or increase coverage is made under the other employer's plan
- Tag Along Rule:** If, due to a permitted election change event, you elect to increase health care coverage, at that time you may enroll your spouse or dependents who were not previously covered (regardless of whether they experienced the event)
- Special Consistency Rules:** In addition to these rules, there are additional special consistency rules that apply to some of the permitted election change events. Contact Human Resources if you have questions about a change you want to make to your enrollment election

You must complete a status change form within 30 days after the event in order to elect your new coverage. Contact Benefits Connection at once if you need to change your coverage at 1-877-651-5353. If you do not make the change within 30 days, you must wait until the next annual open enrollment.

Overview of Medical Plan Coverage

Benefits	Blue Cross Blue Shield PPO	
	In-Network	Out-of-Network ²
Deductible/ Minimum¹	Employee Employee + one Employee + two Employee + three Employee + four or more	\$350 \$700 \$1,050 \$1,050 \$1,050
		\$500 \$1,000 \$1,500 \$1,500 \$1,500
Out-of Pocket Annual Maximum:	Individual Family	\$4,000 \$6,000
		\$10,000 \$15,000
Office Visits	\$20 co-pay for primary care physicians \$30 co-pay for specialists	70% of R&C ³ after deductible
Lab Tests	100%	70% of R&C ³ after deductible
Surgical Services/Diagnostic X-Rays	80% after deductible (Employee pays 20% co-insurance)	70% of R&C ³ after deductible
Outpatient Surgery	80% after deductible (Employee pays 20% co-insurance)	70% of R&C ³ after deductible
Hospitalization	80% after deductible and \$500 per admission co-pay (Employee pays 20% co-insurance) ⁴	70% of R&C ³ after deductible and \$500 per admission co-pay (Employee pays 30% co-insurance) ⁴
Emergency Care	\$115 co-pay, waived if admitted	\$115 co-pay, waived if admitted
Maternity	1 time \$20/\$30 Provider office visit co-pay, 80% hospital care, after \$500 per admission co-pay & deductible (Employee pays 20% co-insurance)	70% of R&C ³ after deductible
Preventive Care	\$20 co-pay	Not covered
Well-Child Care	\$20 co-pay	Not covered
Skilled Nursing Facility	80% after deductible (Employee pays 20% co-insurance); up to 120 days a year must be pre-approved	70% after deductible; up to 120 days a year must be pre-approved
Home Health Care	80% after deductible (Employee pays 20% co-insurance); alternative to hospital care up to 60 visits a year and medically necessary	70% after deductible; up to 60 visits a year and medically necessary

Benefits	MAGELLAN Health Services (Mental Health Substance Abuse)	
	In-Network	Out-of-Network
Mental Health	Member pays 20% co-insurance after deductible, \$30 office visit co-pay and \$500 in-service stay co-pay (per admission);	Member pays 30% after deductible, and \$500 in-service stay co-pay (per admission);
Substance Abuse	Member pays 20% co-insurance after deductible and \$30 office visit co-pay and \$500 in-service stay co-pay (per admission);	Member pays 30% after deductible, and \$500 in-service stay co-pay (per admission);

Benefits	Caremark Prescription Drugs	
	In-Network	Out-of-Network
Annual Deductible⁵	\$100 per person \$300 family maximum	
Retail Pharmacy 30 day supply	Participating pharmacy: \$15 co-pay - generic \$40 co-pay - primary brand \$60 co-pay - non-primary brand	Non-participating pharmacy: 50% of retail price
Mail Service Pharmacy 90 day supply	\$25 co-pay - generic \$80 co-pay - primary brand \$120 co-pay - non-primary brand	Not available
Specialty Drugs	20% coinsurance up to a maximum annual out-of-pocket expense of \$1,500 (includes annual deductible)	Not available

¹ Annual medical deductible must be met before normal co-insurance applies. Deductibles do not apply to inpatient hospital admissions or other services subject to co-pays such as normal physician office visits

² The percentage paid by the plan for out-of-network coverage is 80% of R&C for employees enrolled in the Blue Cross Blue Shield Rural PPO Plan

³ Reasonable & Customary charges

⁴ Pre-certification required

⁵ Annual prescription drug deductible must be met before normal co-pays apply

⁶ Deductibles, co-pays and dispense as written (DAW) penalties do not apply to the lifetime maximum

The BCBS PPO

How the PPO Works

The BCBS PPO includes both the Traditional PPO and the Rural PPO, and participants in the Plan have access to one of these programs depending upon their place of residence.

Participants in the BCBS PPO may receive services from in-network and out-of-network providers. The network offers the services of providers, hospitals and other health care professionals who meet the professional standards of BCBS. While the Plan provides you with the flexibility to see the provider of your choice each time you need care, when you use in-network providers you will pay a co-pay for most of your care. If you prefer, you may use providers that are outside the network, but you are required to pay a larger share of your costs. If you elect to participate in the BCBS PPO, you may request a directory free of charge that lists the providers, hospitals and other providers in your area that belong to the network.

In most ways, the Traditional and Rural PPO work the same way. Employees who do not have access to BCBS in-network doctors within a certain distance of their home will be offered the Rural PPO. The Rural PPO offers less access to in-network providers, as a result, the out-of-network co-insurance for the Rural PPO program is 20%, while it is 30% under the Traditional PPO. When using out-of-network providers, you must pay some of your medical bills in full each year before the Plan starts paying benefits for you. The Plan limits the amount you have to pay out-of-pocket for covered services each year.

Reasonable and Customary Charges

Benefits under both the BCBS Traditional and Rural PPO's out-of-network services are based on the reasonable and customary (R&C) charge for a covered service. R&C generally reflects the fee normally charged for a service by a majority of the providers in your area. For a more detailed definition, see the *Definitions* section of this summary plan description.

You must pay any part of a bill that exceeds the R&C charge, along with your deductible and co-pay. For this reason, it is important to find out in advance of the proposed treatment if your physician's charges for treatment will be within the R&C limit. You may call BCBS to find out if your physician's charge is within the R&C limit.

Your ID card gives you access to participating providers outside the state of North Carolina through the BlueCard Program. Your ID card tells participating providers

that you are a member of BCBS North Carolina.

By taking part in this program, you may receive discounts from out-of-state providers who participate in the BlueCard Program.

When you obtain health care services through the BlueCard Program outside the area in which the BCBS North Carolina network operates, the amount you pay toward such covered services, such as deductibles, co-payments or co-insurance is usually based on the lesser of:

- The billed charges for your covered services
- The negotiated price that the out of-state Blue Cross and /or Blue Shield licensee ("Host Blue") passes on to BCBS North Carolina

This "negotiated price" can be:

- A simple discount which reflects the actual price paid by the Host Blue
- An estimated price that factors in expected settlements, withholds, contingent payment arrangements, or other non-claim transactions, with your health care provider or with a group of providers
- A discount from billed charges that reflect the average expected savings with your health care provider or with a group of providers

The estimated or average price may be adjusted in the future to correct for over- or under-estimation of past prices. However, the amount you pay is considered the final price.

Should any state enact a law that mandates liability calculation methods that differ from the usual BlueCard Program method or requires a surcharge, your required payment for services in that state will be based upon the method required by that state's law.

The Co-pay, Deductible and Co-insurance

In-Network: If you use a network provider, then you will pay a "co-pay" for the services (e.g., \$20 for an office visit with your primary care physician and \$30 for a specialist).

There is a \$500 per admission co-pay amount for inpatient hospital services. This is separate from any other "co-pays" that might apply.

Generally, if you use an in-network provider for services where co-insurance applies, you must pay a deductible each calendar year for each covered person. Except for inpatient hospital admissions and physician office visits, each covered

person must satisfy an individual deductible before receiving Plan benefits. The annual medical deductible amount is \$350 per person, up to a maximum of \$1,050 per family.

Out-of-Network: Generally, if you use an out-of-network provider, you must pay a deductible each calendar year for each covered person. Except for inpatient hospital admissions and certain preventive services, each covered person must satisfy an individual deductible before receiving Plan benefits. There is a \$500 per admission co-pay that must be met before any co-insurance benefits are paid for inpatient hospital admissions. The annual medical deductible amount is \$500 per person, up to a maximum of \$1,500 per family for services received from out-of-network providers.

You may not carry over any deductible expenses from one calendar year to the next.

After you have paid the annual deductible, the Plan begins to pay part of your eligible expenses; this is known as your co-insurance. For most covered medical and surgical services under the out-of-network BCBS Traditional PPO program benefit, you pay 30% of the reasonable and customary (R&C) cost. Those employees who qualify for the BCBS Rural PPO (as determined by their home zip code) will pay 20% of the R&C cost for most out-of-network covered medical and surgical services.

Out-of-Pocket Limit

The Plan limits the amount you pay out of your own pocket for covered health care services in a calendar year. Under the Plan, the in-network individual out-of-pocket limit is \$4,000 and the family out-of-pocket limit is \$6,000; the out-of-network individual out-of-pocket limit is \$10,000 and the out-of-network family out-of-pocket limit is \$15,000. Deductibles, inpatient hospital per admission copays and co-insurance amounts will go towards satisfying your out-of-pocket limits.

The following costs cannot be used to meet this out-of-pocket limit:

- Charges for prescription drugs
- Co-pays (except for the inpatient hospital per admission co-pay of \$500) for medical or mental health
- Any part of a bill that exceeds R&C limits
- Any extra amount you must pay as a result of your failure to get required pre-admission certification (PAC) or comply with any PAC requirements
- Charges for medically unnecessary care or treatment

When your share of covered costs (deductibles, inpatient hospital per admission co-pays and co-insurance) reaches the out-of-pocket limit in a calendar year, the Plan will pay 100% of R&C charges for your covered expenses for the rest of the year. However, the 100% benefit will not apply to covered expenses for prescription drugs, or to any of the other expenses listed above.

Pre-admission Certification (PAC)

The PAC feature of the BCBS PPO is designed to help you and your family get the appropriate level of medical care you need and to control the cost of that care. When your physician recommends that you or a family member go to the hospital, you must get pre-admission certification (PAC) through BCBS or Magellan Health Services (for MHSA). It is your responsibility to contact BCBS/MHS or request that your doctor or the hospital contact BCBS/MHS before you or your family utilize any inpatient care. Emergency admissions should be certified by BCBS/MHS within 24 hours of admission (48 hours for weekend admissions). Please contact BCBS or Magellan Health Services by calling the 800-number's found on your BCBS ID card.

If BCBS/MHS finds that hospital care is not medically necessary, it may recommend other treatments like outpatient surgery, home health or skilled nursing care. You or your physician can ask for another review by a specialist.

Penalties for Noncompliance

Benefits for hospital care will be limited if you do not use Pre-Admission Certification (PAC). The following penalties will apply if PAC is not obtained according to the guidelines listed above, or if PAC is not approved and you elect to be admitted anyway:

The Plan will not pay the first \$500 of hospital charges

or

The Plan will not pay any inpatient hospital room and board charges

Charges you incur as a result of noncompliance with PAC are not applicable towards your deductible or out-of-pocket limit.

Second Opinion for Surgery

If your physician advises surgery for you or a covered eligible dependent, you may wish to see another physician for a second opinion. The Plan covers the cost of a second opinion including consultation and diagnostic tests. These costs will be covered whether you have the surgery or not.

In-Network Benefits

When you use an in-network hospital, the BCBS PPO will usually cover 80% of your costs after meeting the inpatient hospital per admission co-pay amount of \$500. For other in-network services where co-insurance benefits apply, the BCBS PPO will cover 80% of your costs after meeting the deductible of \$350 per person up to a maximum of \$1,050 per family. In addition, you will pay a specified fee, or co-pay, for office visits (\$20 for primary care physicians, \$30 for specialists). For more detailed definitions of specialist and primary care physicians, see the Definitions section of this summary plan description. Be sure to show your BCBS PPO identification card to the health care provider so you will get network benefits. The benefit limits shown on the following pages apply to in-network and out-of-network services combined.

In-network coverage for medical services includes:

- ❑ Inpatient hospital care
 - semiprivate room and board
 - services and supplies
 - physician's visits
 - surgeon's and anesthesiologist's services
 - maternity costs: are covered in full with in-network providers after the initial \$20 co-pay for Primary care physician or \$30 co-pay for Specialist office visit. Stay at an in-network hospital or other facility (such as a childbirth center) for childbirth is covered at 80% after \$500 per admission co-pay and deductible (employee pays 20% co-insurance)
 - nursery care for a newborn child. Generally, under federal law, group health plans may not limit benefits for inpatient hospital care connected with childbirth or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the following periods. The Newborns' and Mothers' Health Protection Act (NMHPA) requires that a mother's length of stay cannot be less than 48 hours following normal delivery or less than 96 hours following a cesarean section. However, a mother and her physician can work together for an earlier release

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- private room and private duty nurse only if considered medically necessary by the network administrator

- ☐ The Women's Health and Cancer Rights Act (WHCRA) of 1998 requires that health plans cover post-mastectomy reconstructive breast surgery if they provide medical and surgical coverage for mastectomies.

Specifically, health plans must cover:

- Re-construction of the breast on which the mastectomy has been performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- prostheses and physical complications of all stages of mastectomy, including lymphedemas

Benefits required under the WHCRA will be provided in consultation between the patient and attending physician. These benefits are subject to the Plan's regular copays and deductibles.

- ☐ Emergency care
 - \$115 co-pay for treatment in hospital emergency room or outpatient facility; fee waived if you are hospitalized for the same condition
 - \$20 co-pay for treatment in a primary care physician's office or \$30 for a specialist
- ☐ Outpatient care at a hospital or other outpatient facility
 - surgery: 80% coverage of charges in physician's office or surgical facility (employee pays 20% co-insurance)
 - diagnostic tests and X-rays: 80% coverage of lab charges and \$20 fee for a primary care physician office visit or \$30 for a specialist (employee pays 20% co-insurance)
- ☐ Professional services
 - physician: \$20 fee per visit for home or office visits, \$30 fee per specialist visit
 - nurse, other than family member (80% after deductible)
 - physical therapist: \$30 fee per visit maximum 60 visits per year (total combined visits with Occupational, and speech therapy); coverage limited to short-term rehabilitation
 - chiropractor: \$30 fee per visit for 15 visits per benefit period (combined in- and out-of-network) each calendar year; no referral needed

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- ❑ Cardiac rehabilitation (Phase 1 & 2 only)
 - inpatient: treatment of medically supervised physical exercise; physical therapy; instruction for dealing with cardiac condition
 - outpatient program: after inpatient hospital discharge: active treatment directed by physician; EKG monitoring 80% coverage after deductible, maximum 36 visits per benefit period
 - ❑ Preventive care
 - routine physical exam needed for health reasons for covered persons age 17 and older: \$20 fee per visit, limited to one per year
 - well-child care, including immunizations for covered dependent children up to age 16: \$20 fee per visit
 - annual well-woman exam (no referral needed for exam visit) and one follow-up exam, including one pap smear per year; one baseline mammogram per year for women age 35 and over or otherwise as prescribed by your physician: \$20 co-pay per visit for Primary Care Physician and \$30 co-pay per visit for Specialist
 - prostate and colon screening for those age 40 and older, once yearly; \$20 co-pay per visit for Primary Care Physician and \$30 co-pay per visit for Specialist
 - allergy injections provided in a Primary Care Physician's office are covered at \$20 co-pay or less (if cost of injection is less than \$20 co-pay, you pay the actual amount) \$30 co-pay for Specialist visit
 - ❑ Treatment of mental health and substance abuse conditions: with Magellan referral \$30 office visit co-pay, maybe subject to co-insurance, deductibles and in-service hospital stay co-pays
 - outpatient care: group and individual therapy
 - inpatient care: hospital room and board, medication, X-ray, providers' charges and laboratory expenses
 - ❑ Hospice care instead of hospital care
 - room and board, professional services, supplies and outpatient care provided by a hospice for the treatment of a terminal illness
 - 210 days in a calendar year (combined in and out of network)
 - up to \$2,500 for other services, including \$100 for bereavement counseling
 - care must be provided according to a hospice care program under a physician's supervision
 - ❑ Home health care plan instead of hospital care
 - provided according to home health care plan approved by a physician

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- up to 60 visits during a calendar year for: intermittent or part-time nursing care by or under the supervision of a nurse
 - intermittent or part-time services of a home health aide, up to plan limits (60 visits combined with home health care visits) physical, occupational and speech therapy
 - \$20 co-pay, 60 consecutive visits per condition (combined in- and out-of-network maximum)
- Skilled nursing care or extended care instead of hospital care
- Semi-private room and board, services and supplies at a skilled nursing facility for up to 120 days each calendar year
 - not for confinements primarily for custodial care
 - determined to be medically necessary by a physician and must be pre-authorized by BCBS
- Prescription drugs: retail pharmacy and mail service (Caremark coverage, see page 46)
- Other covered services
- ambulance: covered in full when determined to be an emergency
 - nutritional visits: up to 6 visits per benefit period covered at 100%
 - prosthetic medical appliances: initial fitting, purchase and replacement if pre-certified through BCBS (80% after deductible)
 - rental of durable medical equipment: up to six months (80% after deductible)
 - pre-admission testing
 - second surgical opinions: \$20 fee for a primary care physician office visit or \$30 for a specialist
 - one hearing exam and evaluation per year
 - hearing aids and exams; 100% up to \$1,000 lifetime maximum
 - dental treatment of an injury to sound, natural teeth if injured while you or your eligible dependent is covered
 - Bariatric surgeries for the morbid obese, when approved by BCBS and performed at a Blue Distinction Center otherwise benefit coverage may be reduced. Coverage for gastric bypass, lap band and stapling only (covered at 80% after deductible and 20% coinsurance); mini bypass and gastric bubbles not covered
 - examinations, diagnostic X-rays and testing performed to diagnose temporomandibular joint syndrome (TMJ); treatment may be covered if due to organic cause

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- tubal ligation and vasectomy: 80% coverage; \$20 co-pay for a primary care physician office visit or \$30 for a specialist
 - chemotherapy/radiation therapy for a malignancy when pre-approved by BCBS
 - acupuncture & massage therapy: performed by a licensed acupuncturist or massage therapist for the treatment of chronic pain:\$30 co-pay for office visit/combined 15 visits maximum per benefit period
 - bariatric surgery, knee/hip replacement, spine surgery and any organ transplants when approved by BCBS and performed at Blue Distinction Center otherwise benefit coverage may be reduced to out of network benefits. You must obtain certification from BCBS in advance for all transplant-related services, in order to assure maximum coverage. Covered transplant services include: heart, lung (single & bilateral), combined heart & lung, pancreas, kidney (in-network services), simultaneous pancreas & kidney, liver, cornea, small bowel (pediatric only), simultaneous small bowel & liver, high dose chemotherapy with bone marrow or peripheral blood stem cell rescue (includes autologous [self-donor] and allogeneic [other donor] bone marrow transplant, and allogeneic bone marrow transplants for aplastic anemia). Unless otherwise noted, benefits are available only when transplant services are provided at a Blue Distinction Center for Transplant. For more detailed definition of a Blue Quality Center for Transplant, see the *Definitions* section of this summary plan description. Travel, lodging, and parking charges will be covered by the BCBS PPO **only** if you travel more than 100 miles to a Blue Distinction Center for Transplant. Reimbursement for these services will be allowed for the time period at which your transplant service begins through one year after the surgery
 - oxygen therapy and administration equipment when associated with an inpatient confinement, within an outpatient facility, or when administered for an approved home health care service

Out-of-Network Benefits

If you receive care outside of the BCBS PPO network, you will pay part of the cost.

- ❑ First, you will pay an annual deductible: \$500 for each covered person, up to a family maximum of \$1,500 per year. Deductibles do not apply to inpatient hospital admissions
- ❑ After meeting the \$500 per admission co-pay for inpatient hospital services, the Traditional BCBS PPO program will pay 70% of the R&C charges, while the Rural BCBS PPO program will pay 80% of the R&C charges. You are responsible for paying 30% co-insurance under the Traditional PPO or 20% under the Rural PPO, plus the amount, if any, the out-of-network provider charges in excess of the R&C fee for the services you received

❑ If your expenses reach the annual out-of-pocket limit, the Plan will pay 100% of the R&C charges for your covered costs for the rest of the calendar year. The out-of-pocket limit is \$10,000 per person, up to a family maximum of \$15,000 per calendar year. Deductibles, inpatient hospital per admission co-pays and co-insurance amounts will all go towards satisfying your out-of-pocket limit. Out-of-pocket expenses you incur for the following items will not count towards satisfying your out-of-pocket limit:

- charges for prescription drugs
- any part of a bill that exceeds R&C charges
- any extra amount you must pay as a result of your failure to get required pre-admission certification for hospital care
- charges for medically unnecessary care or treatment

It is also important to note that non-covered expenses incurred after you reach your out-of-pocket limit will not be covered.

Out-of-Network coverage for medical services includes:

❑ Inpatient hospital care: the Plan pays 70% after the \$500 inpatient hospital per admission co-pay under the Traditional PPO/ 80% under the Rural PPO; subject to preadmission certification (PAC) for the following services:

- Semi-private room and board
- services and supplies
- physician's visits
- surgeon's and anesthesiologist's services
- maternity costs
- maternity hospital or birthing center services
- nursery care for a newborn child. Generally, under federal law, group health plans may not limit benefits for inpatient hospital care connected with childbirth or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the following periods. The Newborns' and Mothers' Health Protection Act (NMHPA) requires that a mother's length of stay cannot be less than 48 hours following normal delivery or less than 96 hours following a cesarean section. However, a mother and her physician can work together for an earlier release
- private room and private duty nurse only if considered medically necessary by the network administrator

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- ❑ The Women's Health and Cancer Rights Act (WHCRA) of 1998 requires that health plans cover post-mastectomy reconstructive breast surgery if they provide medical and surgical coverage for mastectomies

Specifically, health plans must cover:

- reconstruction of the breast on which the mastectomy has been performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- prostheses and physical complications of all stages of mastectomy, including lymphedemas

Benefits required under the WCHRA will be provided under the Plan in consultation between the patient and attending physician. These benefits are subject to the Plan's regular co-pays and deductibles.

- ❑ Outpatient care at a hospital or other outpatient facility: at 70% Traditional/80% rural
- ❑ Professional services for treatment of injury or illness: at 70% Traditional/80% Rural (except for chiropractor; see other covered services)
- ❑ Hospice care instead of hospital care
 - room and board, professional services, supplies and outpatient care provided by a hospice for the treatment of a terminal illness
 - up to 210 days in a calendar year
 - up to \$2,500 for other services, including \$100 for bereavement counseling
 - care must be provided according to a hospice care program under a physician's supervision
- ❑ Home health care plan instead of hospital care
 - up to 60 visits during a calendar year for: intermittent or part-time nursing care by or under the supervision of a nurse determined to be medically necessary by a physician
 - intermittent or part-time services of a home health aide, up to Plan limits (60 visits combined with home health care visits)
 - physical, occupational and speech therapy provided according to a home health care plan approved by a physician (60 visits combined)
- ❑ Skilled nursing care or extended care instead of hospital care
 - Semi-private room and board, services and supplies at a skilled nursing facility for up to 120 days each calendar year

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- not for confinements primarily for custodial care
 - determined to be medically necessary by a physician and pre-authorized by BCBS
 - Outpatient pre-admission or post-release testing: at 70% Traditional/80% Rural
 - Outpatient chemotherapy or radiation therapy: at 70% Traditional/80% Rural
 - Prescription benefits: retail pharmacy only, no mail service available out-of-network
 - Preventive care exams are not covered, except for the following:
 - mammograms, covered for one baseline exam ages 35 and over every year or as prescribed by a physician
 - pap smear, one exam per year covered
 - prostate screening (digital rectal examination), one exam per year from age 40 and older
 - colon screening, from age 50 and older, sigmoidoscopy covered once for every three years, hemocult covered once per year
 - Mental health and substance abuse benefits without Magellan referral; 70% co-insurance after deductible and \$500 in-service co-pay per admission
 - outpatient: group and individual coverage
 - inpatient: hospital room and board, medication, X-ray, providers' charges, laboratory expenses
 - \$500 penalty for uncertified inpatient care
 - Other covered services: at 70% of the R&C charge for the BCBS Traditional PPO and 80% of the R&C charge for the BCBS Rural PPO after deductible, with the following additions also covered at 70% Traditional/80% Rural after deductible:
 - Surgeries listed below when approved by BCBS and not performed at a Blue Distinction Center will be covered at 70% after deductible and \$500 in hospital stay co-pay for gastric bypass, lap band surgeries and stapling only; mini bypass and gastric bubbles are not covered
 - bariatric surgery, knee/hip replacement, spine surgeries and any organ transplants when approved by BCBS and not performed at a Blue Distinction Center will be reduced to 70% co-insurance after deductible and \$500 in hospital stay co-pay
 - ambulance service in emergency
 - temporomandibular joint syndrome (TMJ): examinations, diagnostic X-rays, and testing performed to diagnose TMJ
 - tubal ligation and vasectomy
 - reversal of voluntary sterilization

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- chiropractor: up to 15 visits per calendar year (combined in- and out-of-network)

Benefit Limits and Maximums

You will find that there are coverage limits and benefit maximums for some covered services under the BCBS PPO. These limits and maximums may differ, depending on whether you use an in- or out-of-network provider. However, **all** benefits you receive -- whether in- or out-of-network -- will apply to the limits and maximums.

For example, let's say you need skilled nursing care and receive 70 days of care from an in-network provider. If you changed to an out-of-network provider for further skilled nursing care, the 70 days of care you received in-network would apply to the 120-day out-of-network annual limit. Therefore, the plan would cover only 50 days of skilled nursing care for the rest of the year from the out-of-network provider.

Emergency Care

The BCBS PPO has special rules for coverage of emergency care. For emergency care received in-network, you will pay a \$20 co-pay at a primary care physician's office or \$30 at a specialist and a \$115 co-pay in the hospital emergency room or at an outpatient facility. The \$115 co-pay will be waived if you are admitted to the hospital for the same condition.

If you or a covered eligible dependent receives emergency medical care outside the network, contact BCBS within 48 hours or as soon as possible after being treated or admitted to a hospital. Your physician may have you moved to a network hospital if you need inpatient care; in this event, you will have to pay \$115 of the costs for emergency care; the rest of the emergency care costs will generally be covered in full.

What Is Not Covered

Your Personal Choice Benefits Program Medical Plan (BCBS PPO) covers a wide range of health care expenses. However, benefits are limited in certain cases. Take the time to read this section carefully.

General Limitations

The following limits apply to the Personal Choice Benefits Program Medical Plan. This Plan does not cover:

- Hospital care, surgery or other medical treatment before coverage becomes effective
- Treatment of an occupational injury, which would be covered by Workers' Compensation
- Treatment of sickness covered by Workers' Compensation, except in a hospice care program
- Any medical care covered by a public program other than Medicare
- Confinement in, or treatment by, a hospital owned or operated by the United States government if charges are directly related to a military service-connected injury or illness
- Treatment for which you or your covered eligible dependents are not legally required to pay
- Treatment for which you would not have been charged if you had not had health plan coverage
- Nursing care provided by a member of your family or someone who normally lives in your house
- Custodial care, education or training, except in a hospice care program
- Experimental services, defined as the use of any treatment, procedure, facility, equipment, drugs, device or supply not accepted as standard medical treatment of the condition being treated, or any of such items requiring federal or other government agency approval not granted at the time services were rendered

In addition, no benefits will be paid by this Plan for charges that exceed the reasonable and customary (R&C) limits for your area, or if:

- Payment is prohibited by any law to which you or your covered eligible dependents are subject at the time of treatment
- Benefits are payable under coordination of benefits (COB)
- Benefits are payable through no-fault automobile insurance

Benefit Limitations for BCBS PPO

In addition to the limitations already listed, the BCBS PPO will not cover charges for these services:

- Any services determined by the BCBS PPO to be medically unnecessary
- Long-term rehabilitation services or long-term physical therapy
- Any durable medical equipment that is not medically necessary, authorized and approved by BCBS
- Treatment of the teeth or structures directly supporting the teeth, including dental
- X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion
- Gastric bubbles or intestinal bypass for non-medically necessary weight loss
- Transsexual surgery (including counseling and hormonal therapy before or after surgery)
- Penile implants for sexual purposes
- Services of midwives or medical services connected with home delivery of a newborn
- Corrective orthopedic shoes and arch supports
- Adjustment or manipulation of the spine except as provided under short-term rehabilitation
- Hospital care, surgery or other medical treatment that is not medically necessary, except in a hospice care program (includes any part of a hospital stay found to be unnecessary through PAC)
- Cosmetic surgery except for
 - accidental injury received
 - breast reconstruction after a radical mastectomy

The Women's Health and Cancer Rights Act (WHCRA) of 1998 requires that health plans cover post-mastectomy reconstructive breast surgery if they provide medical and surgical coverage for mastectomies.

Specifically, health plans must cover:

- reconstruction of the breast on which the mastectomy has been performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- prostheses and physical complications of all stages of mastectomy,

including lymphedemas

Benefits required under the WCHRA will be provided under the Plan in consultation between the patient and attending physician. These benefits are subject to the Plan's regular co-payments and deductibles.

- Eyeglasses or examinations for prescription or fitting
- Experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society
- Vitamins and nutritional supplements
- Hospice care services for curative or life-prolonging procedures
- Dental treatment, unless it is needed because of an injury to sound natural teeth and the injury that is received while you or your eligible dependent is covered
- Second surgical opinions for cosmetic or dental procedures, for procedures normally performed in a physician's office, or for an opinion obtained more than six months after the surgery is first recommended
- Actual or attempted impregnation or fertilization, including in vitro fertilization and artificial insemination; medical expenses (including initial testing and office visits) ARE covered up to point of diagnosis
- Cardiac rehabilitation phases 3 and 4
- Reports, evaluations, physical examinations or hospital care required for employment, insurance or governmental licenses and court-ordered evaluations, etc.
- Routing refraction, eye exercises and surgical treatment for the correction of a refraction error, including radial keratotomy
- Amniocentesis, ultrasound or any other procedure performed only to determine the sex of a fetus
- Routine foot care
- Consumable medical supplies except diabetic supplies (syringes, insulin strips)
- Any treatment listed under General Limitations

For further limitations related to out-of-network services, see "Out of the Network Benefits".

The following charts summarize your coverages under the BCBS PPO:

BCBS Preferred Provider Organization Coverage - Traditional and Rural PPOs						
	Hospital Care	Physician's Services	Emergency Care	Preventive Care	Prescriptions	Mental Health/Substance Abuse
In-network	80% after the \$500 inpatient hospital per admission co-pay; PAC required for inpatient admission	100% after \$20 co-pay for primary care physician office visits \$30 co-pay for specialist office visits	Emergency: \$115 fee for ER, waived if admitted	100% after \$20 co-pay for office visits; includes routine physicals for health reasons, screenings, annual OB/Gyn visit, well-child care, prostate and colon screenings	<p><u>Caremark Annual deductible:</u> \$100 per person annual deductible \$300 family maximum</p> <p><u>Retail Pharmacy:</u> \$15 generic* \$40 primary brand name, \$60 non-primary brand name co-pay for 30 day supply</p> <p><u>Mail Service:</u> \$25 generic* \$80 primary brand name \$120 non-primary brand co-pay for 90 day supply</p> <p>Specialty Type Drugs 20% coinsurance up to a maximum annual out of pocket expense of \$1,500 (includes annual deductible)</p> <p><i>*Generic provided if available, unless physician orders brand name. If you elect brand name drug when generic is available (regardless of physician direction), you pay generic co-pay plus the cost difference.</i></p> <p><u>Infertility medications</u> are covered with a \$5,000 annual/ \$25,000 lifetime maximum per family.</p>	<p>Magellan provider, In-network: <u>Outpatient mental health:</u> office visit \$30 co-pay, then 80% after deductible</p> <p><u>Outpatient substance abuse:</u> office visit \$30 co-pay then, 80% after deductible</p> <p><u>Inpatient mental health:</u> office visit \$30 co-pay then 80% after the \$500 inpatient per admission co-pay and deductible, PAC required for inpatient admission</p> <p><u>Inpatient substance abuse:</u> Substance Abuse office visit \$30 co-pay then 80% after the \$500 inpatient per admission co-pay and deductible, PAC required for inpatient admission</p>

BCBS Preferred Provider Organization Coverage - Traditional and Rural PPOs						
	Hospital Care	Physician's Services	Emergency Care	Preventive Care	Prescriptions	Mental Health/Substance Abuse
Out-of-network	After the \$500 inpatient hospital per admission co-pay, then 70% of R&C traditional, 80% Rural PPO; PAC/CSR required to receive full benefits: \$500 penalty or denial of room & board charges for not getting review; no benefits for medically unnecessary care	After deductible, 80% of R&C, 80% Rural PPO	Same as In-network	Not covered	<p><i>Annual deductible:</i> \$100 per person annual deductible \$300 family maximum</p> <p><i>Retail Pharmacy:</i> Non-participating pharmacy: 50% of retail price.</p> <p><i>Mail Service:</i> Not applicable</p> <p>Specialty type drugs Not Applicable</p>	<p><i>Non-Magellan provider (out-of-network):</i> Per person</p> <p><u>Outpatient mental health and substance abuse:</u> 70% after deductible and \$500 co-pay per admission Traditional Plan and 80% after deductible and \$500 co-pay per admission Rural Plan</p> <p><u>Inpatient mental health:</u> 70% after deductible and \$500 co-pay per admission for Traditional Plan and 80% after deductible and \$500 co-pay per admission for Rural Plan</p> <p>PAC/CSR required to receive full benefits: \$500 penalty or denial of room & board charges for not getting review; no benefits for medically unnecessary care</p> <p><u>Inpatient substance abuse:</u> 70% after deductible and \$500 co-pay per admission Traditional Plan and 80% after deductible and \$500 co-pay per admission Rural Plan PAC/CSR required to receive full benefits:</p> <p>\$500 penalty or denial of room & board charges for not getting review; no benefits for medically unnecessary care</p>

Cigna EAP/Magellan Health Services (MHSA)

Employee Assistance Program (EAP)-Cigna

The Employee Assistance Program (EAP) is available to all employees of the Company and to members of their households. You do not have to be enrolled in the Medical Plan to utilize the EAP.

The EAP is a confidential and voluntary program that you and your family can use when you need help with personal problems -- stress, depression, workplace problems, legal matters, finances, child or elder care, etc. Call the toll-free Cigna EAP number any time and a specialist will talk with you and help you decide what to do next, 1-800-628-6619.

The EAP is confidential, and short-term counseling is provided at no cost to you. If you need long-term support or other professional services, the EAP can refer you.

There are no EAP claims filing requirements.

The EAP is provided by Cigna Behavioral Health (CBH) and can be reached at 1-800-628-6619.

Mental Health and Substance Abuse (MHSA)-Magellan Health Services

When you enroll in the BCBS PPO, your benefits for Mental Health and Substance Abuse (MHSA) treatment will be provided through **Magellan Health Services**. It provides a national network of psychiatrists, psychologists, social workers, hospitals and rehabilitation centers.

You can call Magellan at 1-800-288-3976 or thru BCBS at 1-877-258-3334. When you call, you will speak with a trained coordinator about your problem. Coordinators are available 24 hours a day, seven days a week. They can help you decide how to proceed and can recommend participating providers in your community who offer the treatment you need. Your call -- and any referral or treatment you receive -- will be strictly confidential.

When you or covered eligible dependents receive care from a participating Magellan provider, you pay a portion of the covered cost:

- You will pay a \$30 office visit co-pay for covered outpatient services, such as private counseling sessions, a \$500 co-pay and 20% co-insurance and

deductible for covered inpatient services, such as hospital expenses. Regular eligible medical expenses such, CAT scans, lab tests, etc., are covered under the BCBS PPO, per plan provisions

When you or a covered eligible dependent receive care from a participating provider, you will not have to file any claims for benefits received through Magellan. If you or a covered eligible dependent receive care from a non-participating provider, you will have to file your own claim and the services will be covered at a lower level than services received through a participating provider.

For inpatient treatment of mental health and substance abuse conditions, Magellan covers:

- Hospital room and board
- Medication
- X-ray
- Physicians' charges
- Laboratory expenses

Magellan covers only medically necessary services and supplies that are recommended by a participating provider. You pay any charges that exceed R&C. Keep in mind that mental health or substance abuse care recommended or approved by Magellan will be covered only if it is within the limits of what the plan provides. The two charts that follow show how to use Magellan and the benefits that are paid for covered treatment under the Plan.

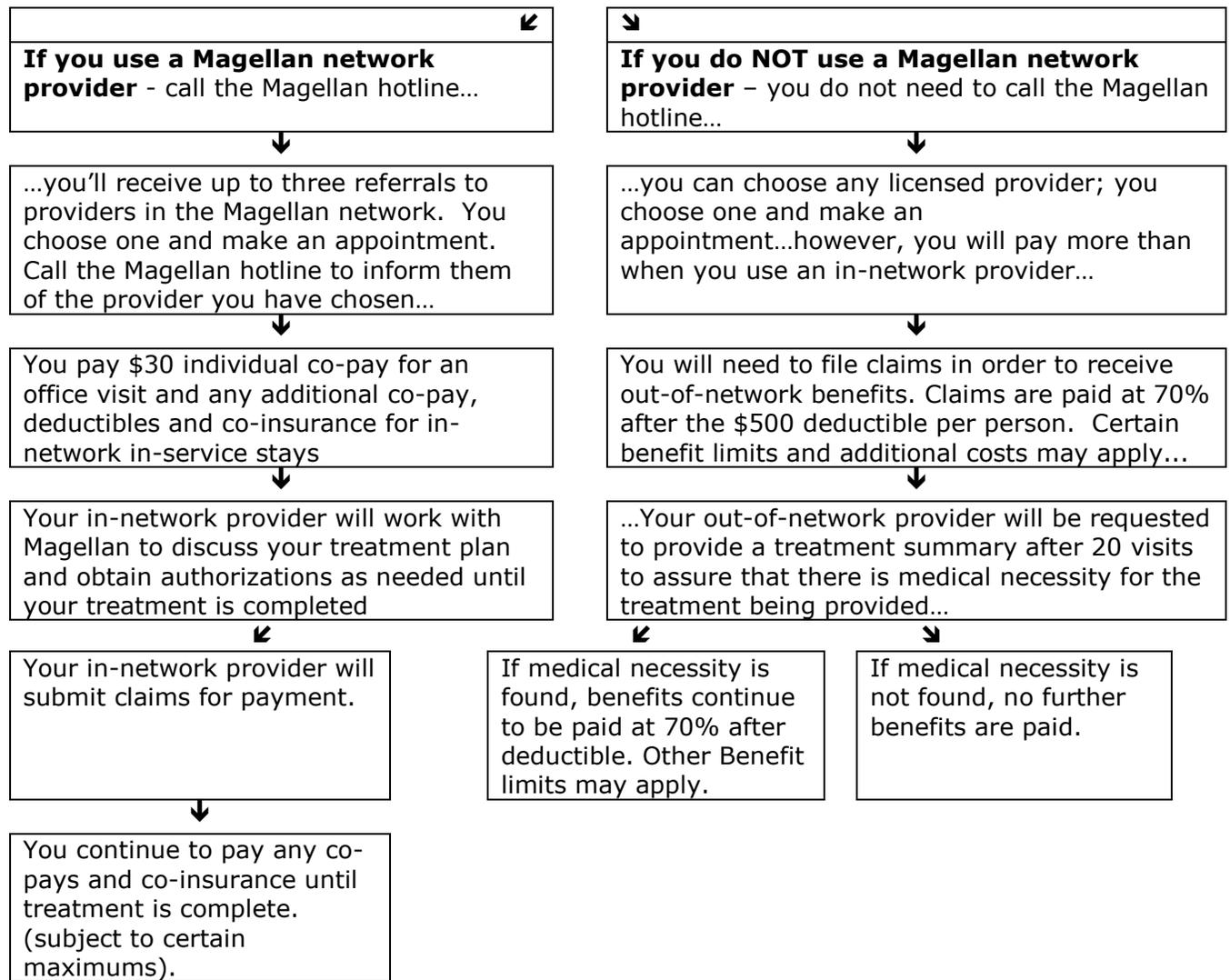
If you live in an area without Magellan Health Services providers, the MHSA coordinator can recommend a provider in the community. You will pay an out-of-network co-insurance after deductible is met and an in-service co-pay.

Magellan Health Services is a voluntary program. You do not have to call Magellan or use a Magellan Health Services provider. However, if you do not, you will pay a larger share of the cost of treatment, usually 30% for the Traditional and 20% for the Rural plans. You also have to satisfy an annual deductible of \$500 per person. You must call Magellan Health Services for approval of any inpatient mental health or substance abuse hospital care before you are admitted. If you do not call, your benefit for hospital care will be reduced.

Using Magellan for Mental Health/Substance Abuse

ALL inpatient care must be authorized in advance or within 48 hours in an emergency.
Call the Magellan hotline 1-800-288-3976

For Magellan MHSB or Outpatient Care



* *If you do not make the first call to the Magellan hotline, your share of all costs will be higher.*

** *If you are in an area where Magellan does not have any in-network providers, an out-of-network provider will be contacted and added to the network for your treatment and you will receive in-network benefit levels. Call the Magellan hotline prior to your first visit to discuss.*

Covered Services- Magellan - Mental Health/Substance Abuse

- The following services are covered under the mental health/substance abuse component of the program administered by Magellan

Medically necessary services which are:

- Consistent with the diagnosis or treatment of a mental health or substance abuse diagnosis, as defined by the current Diagnostic and Statistical Manual published by the American Psychiatric Association
- Not primarily for the convenience of the patient or provider
- In accordance with the most appropriate standard or level of services or supplies which are in accord with good medical practice and can be safely provided to the patient; and
- Not experimental as to the diagnosis or primarily for research
- Treatment must be provided by a psychiatrist, psychologist, therapist or clinical social worker who is licensed to practice independently at the master's level or above
- Laboratory work must be prescribed by a psychiatrist
- Treatment must be delivered in a goal-oriented manner that produces observable and measurable improvement in the patient's condition
- A number of days per calendar year for inpatient psychiatric care, when pre-certified by Magellan Behavioral Health (network and out-of-network combined)
- A number of days per calendar year for inpatient substance abuse care, when pre-certified by Magellan Behavioral Health (network and out-of-network combined). This benefit includes services for medical detoxification
- A number of outpatient mental health office visits per calendar year for individual, family or group counseling, (network and out-of-network combined)
- A number of outpatient substance abuse office visits per calendar year for individual, family or group counseling sessions (network and out-of-network combined). This benefit includes services for social detoxification

Non-Covered Services –Magellan- Mental Health/Substance Abuse

Mental health and substance abuse includes treatment rendered in connection with conditions classified in the Diagnosis and Statistical Manual of Mental Disorders (Fourth Edition-Revised) of the American Psychiatric Association. This diagnostic classification represents that which is generally and universally employed by mental health and substance abuse clinicians in the United States at this time.

Two general categories of exclusions cover the obligations of Magellan Health Services to deliver mental health/substance abuse services to members/participants. The first is that care which is normally, traditionally and most importantly, most appropriately delivered by neurologists is excluded. Examples would include, but not be limited to, such conditions as dementias secondary to organic processes, such as Parkinson's Disease and the seizure disorders. Nothing in this general exclusion, however, limits the responsibility of Magellan Health Services to provide adequate and appropriate psychiatric and psychological consultation and support to participants and members with these conditions under the specific terms of the Mixed Services Protocol (Exhibit I).

The second general category of care excluded by Magellan Health Services is all care for which Magellan Health Services is unable to directly determine the medical appropriateness. Examples of this general exclusionary category include, but are not limited to, care driven by outside agencies, such as courts, school systems, occupational concerns, etc., care driven by research of experimental protocols; and care driven by programmatic considerations (i.e., the psychological and/or psychiatric component of specialized pain program, weight loss programs, self-help programs, etc.). Nothing under this general exclusionary category should be construed to relieve Magellan Behavioral Health of the responsibility of making an independent clinical evaluation of the members/participants where required by the contract and making appropriate treatment recommendations.

Mixed Services Protocol

Mixed services protocols are guidelines intended to distinguish mental health and substance abuse costs incurred from medical surgical costs in order to clarify claim payment responsibilities.

Behavioral Care is defined to include mental health and substance abuse services.

Inpatient Care

The clinician providing primary treatment for which the patient has been hospitalized will be the primary determining factor for claim processing responsibility and/or for the financial liability of the hospital room and board charges. If patient is on a medical floor, the medical carrier is responsible. If the patient is on a psychiatric floor, Magellan Health Services is responsible within the constraints of the existing benefit plan. Individual physician charges and charges for tests the physician orders will be the responsibility of the carrier through which the physician received authorization.

The following guidelines will be used in processing claims when the services rendered include a combination of behavioral care and medical care:

1. When a patient is admitted with a primary medical diagnosis and a behavioral care consultation is requested, Magellan Health Services will be responsible for claim processing and/or financial liability for any behavioral care consultation.
2. When a patient is on a mental health unit, the medical services rendered, including tests ordered by the medical consultant will be the responsibility of the medical carrier.
3. When a patient is admitted for the treatment of a medical problem and there is an identified psychiatric problem, or the medical evaluation leads to a psychiatric diagnosis, the medical care rendered will be the responsibility of the medical carrier. When the patient is medically cleared or is transferred to a mental health unit, Magellan Health Services will assume responsibility for claim processing and/or financial liability at that point.
4. When a patient is admitted with multiple diagnoses, including both psychiatric and medical, the medical carrier (BCBS) and Magellan Health Services will be responsible for their respective portions of the claim. Financial responsibility for the hospital room and board will be determined by the unit in which the patient resides. The ancillary charges will be the responsibility of the carrier through which the physician ordering the services received authorization.
5. When a patient is admitted primarily for a medical or neurological problem, but is placed in a mental health unit because the patient has a secondary

psychiatric diagnosis or is a management problem, the medical carrier will be financially responsible. The operative criteria for determining claim-paying responsibility will be the primary diagnosis, which required inpatient treatment.

6. Magellan Health Services will be responsible for claim processing and/or financial liability for detoxification.
7. Any prescription drug charges ordered during an inpatient stay in a mental health unit will be the claim payment and/or financial responsibility of Magellan Health Services except medication ordered by a medical/surgical physician for non-mental health/substance abuse treatment. Outpatient prescription drugs and take home drugs will be the responsibility of the Medical Carrier or carved out to Caremark prescription services.
8. The following guidelines summarize the determination of claim responsibility and or financial liability:
 - a. What is the primary cause of hospitalization?
 - b. What does the cover sheet on the medical record list as the primary diagnosis for this admission?
 - c. Is the attending physician of record a psychiatrist, or a medical surgical doctor?
 - d. Has the patient been admitted to a mental health unit or to a medical/surgery unit?

Emergency

When a patient is referred to an emergency room or self admits to an emergency room and the primary diagnosis is behavioral care, emergency room charges will be the responsibility of Magellan Health Services/BCBS for claim processing and/or financial liability. When a patient is referred to an emergency room or self admits, and the primary diagnosis is medical, the medical carrier will be responsible for emergency room charges.

Claims should be mailed to:

BCBSNC
PO Box 35 Durham
NC 27702 1-877-258-3334

Mixed Service Protocols Examples

Services

Claim processing and/or financial liability

Inpatient Room Charges

Mental Health and Substance Abuse (including detoxification).

Magellan Health Services

Other medical services:

BCBS Medical Carrier

Inpatient/Outpatient X-ray and Lab Work

Prescribed by Magellan Behavioral Health network provider such as VDRL, SMA, CBC, UA (urinalysis), Cortisol, x-rays for admission physicals, therapeutic drug levels.

Magellan Health Services

Ordered for evaluation of medical problems or to establish organic pathology, cat scans thyroid studies, EKG etc. or any tests ordered prior to having a patient medically cleared.

BCBS Medical Carrier

Other tests ordered by non-Magellan Behavioral Health physician

BCBS Medical Carrier

Drugs

Outpatient prescription drugs and take home drugs.

BCBS Medical Carrier

Ambulance

Transport to the hospital when the primary diagnosis is behavioral care

Magellan Health Services

Transport to a hospital prior to a medical emergency when the primary diagnosis is medical

BCBS Medical Carrier

Transfers authorized by Magellan Behavioral Health from non-network facility to a network facility

Magellan Health Services

Alcohol Withdrawal Syndrome and Delirium Tremens

Alcohol withdrawal syndrome. Ordinary pharmacologic syndrome characterized by elevated vital signs, agitation, perspiration, anxiety and tremor that is associated with the abrupt cessation of alcohol or other addictive substances. Detoxification services authorized by Magellan Behavioral Health. Magellan Health Services

Delirium tremens (DDS), which is a complication of chronic alcoholism associated with poor nutritional status. This is characterized by a major physiologic and metabolic disruption and is accompanied by delirium (after persecutory hallucination), agitation, tremors (frequently seizures) high temperatures and may be life-threatening. BCBS Medical Carrier

Caremark Prescription Drugs

Caremark administers prescription drug benefits for the BCBS PPO.

You will have to meet a \$100 individual deductible to receive benefits; the family deductible is limited to a \$300 aggregate charge (i.e., no one individual would need to meet the single deductible). To reach the aggregate amount, you can count expenses incurred by two or more family members. You will have to meet the annual prescription drug deductible *before* the normal co-pays will apply (e.g., a member would pay the \$100 individual deductible plus the applicable co-pay).

Your prescription drug benefit includes a formulary drug list. Caremark refers to this as the "Primary Drug List". A formulary or "Primary Drug List" is a list of preferred brand name and generic drugs selected based on their clinical effectiveness and cost; higher co-pays are charged for use of non-primary drugs.

In connection with primary drug list, the prescription plan design includes a three-tier co-pay design. Your co-pay will differ depending on whether you purchase a generic, primary brand name, or non-primary brand name drug at the retail pharmacy or through mail service. If the actual cost of your chosen drug is less than the applicable co-pay, you will pay the cost of the drug. Specialty Type drugs will have a 20% coinsurance amount up to an annual maximum out of pocket expense of \$1,500 which includes the annual deductible.

Caremark provides prescriptions through both a retail pharmacy network and a mail service program. You will need to have your prescription drug program ID card with you to use the benefit at a Caremark network pharmacy. For up to a 30-day supply at the retail pharmacy, you will be required to pay a \$15 co-pay for generic drugs, a \$40 co-pay for primary brand name drugs and a \$60 co-pay for non-primary brand name drugs. You will not have to file any claims if you use a Caremark network pharmacy to fill your prescription.

At a non-participating pharmacy, you will pay the pharmacy's charge for the prescription. To receive your reimbursement, which equals 50% of Caremark's retail network pharmacy price, you will need to attach your receipt to the paper claim form included in your Caremark benefit kit and submit the claim to Caremark.

You will pay less if you fill prescriptions through the Caremark mail-service option. For up to a 90-day supply, your co-pay is \$25 for a generic drug, \$80 for a primary brand name drug and \$120 for a non-primary brand name drug.

When possible, you should select a generic drug; this will save you money and still provide you with an effective drug. If no generic is available, request a brand name drug that is on the primary drug list.

If you elect to purchase a brand name drug when a generic equivalent is available, you will be charged the generic co-pay plus the difference between the cost of the brand name drug and the generic equivalent; you will pay this cost difference regardless of whether your physician indicates "Dispense as Written".

There are some prescriptions, such as oral contraceptives, that must be filled through the mail service program. Contact Caremark for a list of those mandatory mail service drugs.

Caremark also provides comprehensive services for your specialty pharmacy needs designed to help you manage chronic disorders; this primarily involves treatment with biotech injectable medications. Comprehensive services include delivery of time-sensitive, temperature-controlled pharmaceuticals to your home. Caremark has a nationwide network of specialty pharmacies accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). These Specialty drugs will have a 20% coinsurance rate up to an annual maximum out of pocket expense of \$1,500 which includes the annual deductible.

Beginning in 2005, most biotech drugs will only be covered by Caremark and no longer will be covered under BCBS. You must verify coverage with both Caremark and BCBS before receiving benefits to ensure proper coverage. Due to their expense, biotech drugs will require prior authorization and step therapy prior to being dispensed. This will ensure that the right drugs get to the right person at the right cost. Caremark can provide assistance in education, counseling and coordination of injection training. Through Caremark's specialty pharmacy services you have access to emergency pharmacist consultation and refill order convenience 24 hours a day, 365 days a year.

Covered Services – Caremark Prescription Drugs

The prescription drug benefit administered by Caremark covers medicines that are FDA-approved and prescribed to treat an illness or injury. New and experimental medicines that are not FDA-approved are not covered [this includes experimental birth control medications]. The following services are covered under the prescription drug component of the MMM medical program.

- ❑ Diabetic supplies, including:
 - prescription insulin
 - syringes and needles are covered through mail service and at the retail pharmacy (Novopen/P-D Pen not covered, see page 47)
 - test strips (diagnostic) are covered through mail service only
 - all other diabetic ancillary supplies are not covered under the benefit (See Non Covered Services – Caremark Prescription Drugs on page 47)

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- Contraceptives, including:
 - oral contraceptives covered through mail service only
 - patches covered through mail service only
 - rings covered through mail service only
 - injectables covered through mail service only (Norplant is excluded)
 - diaphragms
 - Erectile Dysfunction drugs, including:
 - oral medication (Viagra/Levitra) injectables covered through retail and mail service
 - inter-urethral
 - Infertility medications covered with a \$5,000 annual maximum and a \$25,000 lifetime maximum per family; once you reach either dollar limit, you will pay 100% of the additional cost
 - Prescription pre-natal vitamins covered with a medical diagnosis
 - Emergency allergic kits
 - Acne medications covered with a diagnosis, including:
 - Retin A covered through mail service only; over age 35 requires a medical diagnosis
 - Differin
 - Anabolic and Androgen medications covered through mail service only
 - Influenza treatments
 - Migraine medications
 - injectables only 1 fill allowed at Retail, remainder must be filled through mail service only
 - Nail fungal treatment
 - Genetically engineered drugs (contact Caremark for specific limitations)

New drugs are developed and introduced into the marketplace almost daily. As the U.S. Food and Drug Administration approves these new drugs for use in the United States, these medicines will be assessed to determine the feasibility of covering these drugs as well as the application of any coverage limitations or restrictions.

Non-Covered Services – Caremark Prescription Drugs

The following services are not covered under the prescription drug component of the MMM medical program:

- Over-the-counter medications (except diabetic supplies)
- Nutritional supplements, prescription vitamins (except pre-natal with a medical diagnosis), and food supplements
- Drugs dispensed by nursing home, physician or hospital that are covered through the medical plan
- Allergy serums
- Cosmetic products (excluding acne medications and those medically necessary and with diagnosis)
- Contraceptive intrauterine devices (covered through the medical plan)
- Diabetic supplies including:
 - pumps (covered through the medical plan as Durable Medical Equipment (DME))
 - alcohol wipes
 - glucose monitors
 - lancets or lancet devices
 - diagnostic strips (except through mail service only)
 - Novopen/P-D Pen
- Renova
- Fluoride
- Rogaine
- Smoking cessation, deterrents or nicotine replacement products

Your Caremark booklet has more details about this coverage. You may also contact Caremark Customer Service at 1-800-831-4440 or Benefits Connection at 1-877-651-5353 if you have questions.

Notice of Credible Coverage

Important Notice from Martin Marietta Materials, Inc. about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Martin Marietta Materials, Inc. and new prescription drug coverage available, for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

- **As of January 1, 2006, new Medicare prescription drug coverage became available to everyone with Medicare.**
- **Martin Marietta Materials, Inc. has determined that the prescription drug coverage offered by the Martin Marietta Materials, Inc. Active Medical Plan is, on average for all plan participants, expected to pay out more than the standard Medicare prescription drug coverage will pay.**
- **Read this notice carefully – it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.**

You may have heard about Medicare's new prescription drug coverage, and wondered how it would affect you. Martin Marietta Materials, Inc. has determined that your prescription drug coverage with the Martin Marietta Materials, Inc. Active Medical Plan is, on average for all plan participants, expected to pay out more than the standard Medicare prescription drug coverage will pay.

As of January 1, 2006, prescription drug coverage became available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Because your existing coverage is much better than the standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

You can join a Medicare drug plan when you first become eligible for Medicare and each plan year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no

fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan

Members who currently have Medicare coverage can enroll in a Medicare prescription drug plan from November 15 through December 31st of each new plan year. Because you have an existing prescription drug coverage that, on average, is better than Medicare prescription drug coverage, you can enroll in an alternative Medicare prescription drug plan each new plan year between November 15th and December 31st, if you so choose. By doing this you will terminate your current prescription coverage under the Martin Marietta Materials plan.

If you do decide to enroll in a Medicare prescription drug plan and drop your Martin Marietta Materials, Inc. Active Medical Plan prescription drug coverage, be aware that you will not be able to get this coverage back.

If you drop your prescription coverage with Martin Marietta Materials, Inc. and enroll in a Medicare prescription drug plan, you will not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. You can find more information about your current coverage in the Prescription Drug section of this Summary Plan Description (SPD). Furthermore, your current coverage pays for other health expenses, in addition to prescription drugs, and you will not be eligible to receive any of your current medical health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with Martin Marietta Materials, Inc. and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more in premiums to enroll in Medicare prescription drug coverage later. If, you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than the Medicare base beneficiary premium (what most other people pay). You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage...

Contact Martin Marietta Benefits Connection at 877-651-5353. Note: You may receive this Credible Notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is currently available in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep the Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of that notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 1st, 2011

Name of Entity/Sender: Martin Marietta Materials, Inc.

Contact—Position/Office: Benefits Manager

Address: 2710 Wycliff Road, Raleigh, NC 27607

Phone Number: 877-781-8757

Waived Coverage Option

You can elect the Waived coverage Option for medical benefits. If you do, neither you, a spouse nor your dependents will have any medical coverage under the Personal Choice Benefits Program. You will submit all your claims to any other plan you have coverage through, or pay them yourself.

Like all your other Personal Choice Benefits Program elections, the Waived coverage Option will stay in effect for the entire calendar year, unless your status changes. For example, if your spouse loses his or her employer-sponsored medical coverage, you can elect coverage under a Personal Choice Benefits Program medical option.

Coordination of Benefits (COB)

If you or one of your covered eligible dependents is covered under another group health care plan, you and those dependents should file claims under each plan. You must indicate on your claim form any other coverage you have. The coordination of benefits (COB) provision applies to medical and mental health/substance abuse benefits you or your covered eligible dependents may receive from other health care coverage such as:

- Group, blanket or franchise insurance coverage
- Pre-paid coverage for hospital or medical care provided by an HMO or other type of health care facility
- Coverage under labor-management trusted plans, union welfare plans, employer organizations or employee benefit plans
- Medicare*

The claims administrators have the right to get benefit information from or share information with other organizations, carriers and individuals to determine what other coverage you have. They may also recover any overpayment made to you or your covered eligible dependents because you fail to report any other group coverage.

*If you are enrolled in Medicare Part D due to an extended disability, the Plan will not coordinate for prescription drug benefits. You will no longer be eligible for medical or prescription drug benefits under the Plan if you are enrolled in Medicare Part D.

How COB Works

Under COB, one plan is considered primary and the other secondary. The primary plan pays benefits first, and then the secondary plan pays, depending on its COB policy. Here is how to know which plan is primary:

- Your Plan is primary for your claims
- Your spouse's employer group health plan is primary for his or her claims
- Your children's primary plan is the plan of the parent whose birthday falls earliest in the year

The Personal Choice Benefits Program PPO Medical Plan uses the same COB rule when it is secondary. The payment equals the difference between the amount the Plan would have paid normally and the benefit paid by the primary plan. So, if your other plan has benefits equal to or higher than your Personal Choice Benefits Program, your Personal Choice Benefits Program will not pay anything when it is secondary. This is called *non-duplication of benefits*.

Here is an example. Your spouse had \$800 of covered expenses and received \$350 in benefits from his or her employer's plan. If you are enrolled in the BCBS PPO and your individual deductible is \$350, here is how the BCBS PPO would pay:

\$800	Covered costs
<u>-350</u>	BCBS PPO individual deductible
\$450	
\$450	BCBS PPO benefit as primary
<u>-350</u>	Benefit from spouse's plan
\$100	Benefit from BCBS PPO as secondary

If your spouse's plan had paid, your Plan would not have paid any benefit.

COB with Medicare

When you or your spouse reaches age 65, you and or your spouse will be eligible for Medicare. If you keep working for the company beyond age 65, your medical coverage under the Personal Choice Benefits Program stays the same. Your coverage under the Personal Choice Benefits Program Medical Plan will be primary and will pay benefits before Medicare for you and your spouse if you continue to carry the spouse under MMM's medical plan.

Payments from a Third Party

The Plan also coordinates benefits if another person is liable for your injury or illness. This liability could result from events such as an automobile accident or injury on someone else's property. If the third party has not paid when you file your claim, the Medical Plan will cover those expenses.

When payment is received from the third party, you must reimburse the Medical Plan for benefits previously paid. Otherwise, the Medical Plan may offset future benefit payments until you make a direct reimbursement. Under the terms of the Plan, you are required to:

- Secure the Plan's recovery rights, signing a subrogation agreement and all other necessary forms
- Inform BCBS of claims you may have against a third party before you agree to a settlement
- Notify BCBS in writing if you file a lawsuit against a third party
- Identify the third party and the date of the accident or event, and
- Repay BCBS after a third party makes payment. You may be required to sign a statement agreeing to reimburse BCBS for any duplicate payment you receive from a third party

How to File Your Medical Claims

One of the goals of the Personal Choice Benefits Program is to process your claims for benefits as quickly as possible. You will receive your payments more quickly if you or your covered eligible dependents file a complete form promptly and include all the necessary supporting material. You can get the forms you need from the Corporate Human Resources Department.

- BCBS will handle claims for the Medical BCBS PPO, including the Traditional and Rural PPOs as well as Mental Health and Substance Abuse Claims:

BCBSNC
PO Box 35 Durham
NC 27702 1-877-275-9787

- Caremark will handle claims for prescription drugs:

Caremark
PO Box 686005
San Antonio, TX 78268-6005 1-800-808-9331

When you or a covered eligible dependent receives any medical care, keep a copy of the itemized bills, including those for deductible charges. You will need these bills to file with your claim.

BCBS PPO

If you visit an in-network physician, you do not have to file any claims.

Out-of-network Claims

You must use an out-of-network claim form. This form is available from BCBS or the Corporate Human Resources Department. As soon as you have expenses for out-of-network services, send copies of itemized bills along with a claim form to the BCBS office listed above.

When you send in your claim form, include:

- Itemized copies of your bills
- Employee's social security number
- Patient's name
- Date of service and the type of service given

PPO Emergency Treatment Claims

As soon as you receive a bill for emergency treatment of an illness or injury, send a copy of the bill to the address shown on the back of your ID card. Attach a letter stating that this is an emergency treatment claim. You do not need a claim form.

Caremark Prescription Drugs

Retail Pharmacy

If you use a Caremark participating pharmacy, all you have to do is show your Caremark prescription drug card and pay the co-pay for your prescription. You file no claims.

If you do not use a Caremark participating pharmacy or do not present your prescription drug card at a Caremark pharmacy, you must pay the total cost of the prescription and file a claim. Follow the steps listed below:

1. Take your prescription, prescription drug card and a claim form to the Caremark participating pharmacy.
2. Get an itemized receipt showing the name of the patient, the date of purchase, the name of each prescription drug and the name of the prescribing physician. Also, be sure that the prescription number and the pharmacy's NABP number are on the receipt. If they are not, ask the pharmacist to complete and sign the Pharmacist Information Section of the claim form.
3. Complete the claim form and sign it.
4. Send the form and the itemized receipt to:

Caremark
P. O. Box 686005
San Antonio, TX 78268-6005

Mail Service Prescription Drug Program

To order a new prescription through the Caremark mail service program, send your prescription, a completed Mail Service Order Form/Patient Profile and payment in the envelope provided to:

Caremark
P.O. Box 659451
San Antonio, TX 78238
1-800-808-9331

Include a check or money order for the payment, or write your VISA, Discover Card or MasterCard account number on the order form.

Minimum Standards for Claims Procedures

Urgent Care Claims

In the event of a claim that involves urgent care (see the *Definitions* section for a detailed definition of an Urgent Care Claim), you will be notified as soon as possible whether your claim has been approved or denied but not later than 72 hours after the plan receives your claim. If your claim is incomplete, the plan will notify you as soon as possible, but no later than 24 hours after the plan receives the claim of the additional information you need to complete your claim and the deadline for providing this information. The deadline for providing the additional information will give you a reasonable period of time, but will be at least 48 hours after you are notified. In this instance, you will be notified of the claim determination as soon as possible, but no later than 48 hours after the plan receives the information or, if later, within 48 hours after the deadline for submitting the additional information. Notification may be provided orally or in writing. In the case of oral notification, you will receive a formal written notice within three days after the oral notice.

Concurrent Care Decisions

Special rules apply where the plan has approved an ongoing course of treatment either for a specific period of time or for a specific number of treatments.

A reduction or termination of the course of treatment before the approved time period or number of treatments will be considered a claim denial (except for plan amendment or termination). In this case, the plan will notify you in advance so you can appeal the decision before the benefit is reduced or terminated.

You may request to extend the course of treatment beyond the approved time period or number of treatments. If this involves urgent care, the plan will notify you whether your request has been approved or rejected within 24 hours of receiving your request, as long as you make your request at least 24 hours before the approved time period or number of treatments expires.

Pre-service Claims

A pre-service claim is any request for approval of a benefit where the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care (for example for pre-certification). The plan will notify you whether a pre-service claim has been approved or denied within a reasonable period of time, but not later than 15 days of receiving your claim. If you fail to follow the plan procedures for filing a pre-service claim, you'll be notified that you did not follow the procedures and be provided with an explanation of the proper procedures. Please see the *Pre-Admission Certification (PAC)* section on page 19 for information on the proper pre-certification procedures. You'll be notified as soon as possible, but no later than 5 days after the original claim is filed.

The original 15-day period to respond to your claim may be extended for another 15 days if you are notified that the extension is necessary due to matters beyond the control of the plan, before the end of the original 15-day period. The notice will explain the reason for the extension and when the plan expects to rule on your claim. If the extension is needed because you failed to provide the information needed to decide the claim, the notice will tell you what additional information you need to furnish. In this event, you will have 45 days from the date you receive the notice to provide the additional information.

Post-service Claims

Post-service claims refer to all other claims that cannot be categorized as urgent care claims or pre-service claims. The plan will notify you whether a post-service claim has been denied within a reasonable period of time, but no later than 30 days of receiving your claim. This period may be extended for another 15 days if you are notified that the extension is necessary due to matters beyond the control of the plan, before the end of the original 30-day period. The notice will explain the reason for the extension and when the plan expects to rule on your claim. If the extension is needed because you failed to provide the information needed to decide the claim, the notice will tell you what additional information you need to furnish. In this event, you will have 45 days from the date you receive the notice to provide the additional information.

If Your Claim Is Denied

If a claim for a benefit is denied in full or in part, you will be notified in writing or electronically within the above time periods of:

- The specific reason for denial
- The Plan provisions on which the denial is based
- Any additional material or information needed to support your claim and an explanation of why such material or information is necessary
- An explanation of the Plan's claim review appeals process and the time limits applicable, including your right to bring a civil action in court following a claims denial on review
- A description of any internal rules, guidelines, protocols, or other similar criteria that were relied upon in the decision-making, or a statement that the decision was based on the applicable items mentioned above, and that copies of the applicable material will be provided upon request, free of charge
- An explanation of the scientific or clinical judgment used in the decision in the case of a decision regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the plan to your medical

circumstances, or a statement that such explanation will be provided upon request, free of charge

- For a claims denial involving an urgent care claim, a description of the expedited review process applicable to such claims

You, or another person on your behalf, may ask for an appeal of a denied claim within 180 days after receiving the denial notice.

To appeal a medical and/or a Mental Health Substance Abuse claim, you should write to the medical claims administrator at:

Claims Appeals

BCBSNC Customer Services
PO Box 2291
Durham, NC 27702-2291
1-877-275-9787

To appeal a prescription drug claim, you should write to the prescription drug claims administrator at:

Caremark
ATTN: MATRL
2211 Sanders Road; NBT-5
Northbrook, IL 60062
800-841-5550

This request should state why you feel your claim should not have been denied. Be sure to include any additional information (medical records, etc.) which you feel supports your claim. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You may also submit questions or comments that you feel are appropriate, and you may review pertinent Plan documents.

Your appeal will be reviewed by a named plan fiduciary who had no role in the initial claim denial and the review will be an independent one without giving the original denial any special consideration. The named plan fiduciary is the MMM, Inc. Benefit Plan Committee or such person or persons designated from time to time by the Committee. If a medical judgment is involved, the person reviewing your appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who had no role in the initial claim denial. The medical or vocational experts whose advice was obtained will be identified.

Urgent Care Claims

There is an expedited review process for urgent care cases where you can call or write the Claims Administrator (see above the list of claims administrators' names and addresses) and where all necessary information regarding the review will be promptly provided to you. For more detailed definition of an Urgent Care Claim, see the *Definitions* section of this summary plan description. You will be notified of the decision on your appeal as soon as possible, taking into account medical requirements, but no later than 72 hours after the plan receives your request for review.

Pre-Service Claims

You will be notified of the decision on your appeal within a reasonable period that is appropriate for your medical condition, but no later than 30 days after the plan receives your request for review.

Post-Service Claims

You will be notified of the decision on your appeal within 60 days after the plan receives your request for review.

In the event that your appeal is denied, you will be notified electronically or in writing. Such notice will include the following:

- The specific reasons for the denial
- The specific plan provisions on which the decision was based
- Your right to request access to or copies of all information relevant to your claim
- Your right to bring a civil action in court
- A description of any specific internal rules, guidelines, protocols, or other similar criteria that were relied on in making the decision, or a statement that the decision was based on the applicable items mentioned above, and copies of the applicable material will be provided upon request, free of charge
- An explanation of the scientific or clinical judgment used in the decision in the case of decisions regarding medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided upon request, free of charge

How Long Coverage Lasts

Medical Plan coverage is elected for one year. Your coverage will remain in effect for that one-year period or until the earliest of the following:

- You retire
- You terminate your employment with the Company
- You are no longer an eligible employee
- You stop making Plan contributions
- The amount of benefits paid for you by the Plan equals your maximum benefit
- The Company discontinues the Plan

Once an eligible dependent is covered, he or she will remain so until any one of the following events takes place:

- Your coverage terminates for any reason
- You fail to make the required contributions for your covered eligible dependent's coverage
- The dependent no longer fulfills one of the requirements for being an eligible dependent
- The amount of benefits paid for that particular covered eligible dependent by the Plan equals his or her maximum benefit

If You are Disabled

If you terminate your employment due to disability by an illness or injury, MMM may pay up to the first year of Medical Plan coverage under COBRA for you only. Your physician will need to complete a form and submit it to Corporate Human Resources.

Special Continuation for Covered Eligible Dependents of a Deceased Employee

If you have Medical coverage for eligible dependents and die while covered, your surviving covered eligible dependents will continue to have Medical coverage. Medical coverage will continue at no cost to them, for six months after your death. To continue coverage beyond this six-month period, your covered eligible dependents must elect either COBRA continuation of health coverage or the Medical Plan conversion discussed on page 61, despite the fact that they pay nothing during the first six months. Elected COBRA coverage would begin immediately after their election. Normal billing for elected coverage will begin in the seventh month.

Continuation Coverage Under the Consolidated Omnibus Budget Reconciliation Act (COBRA)

Coverage under your elected Medical option may be continued for up to 18 months if you leave the Company for reasons other than your gross misconduct, or if your coverage stops because you are no longer working full time. The continuation coverage is available to you and your covered eligible dependents who lose coverage due to such an event. You will have to pay the full monthly premiums -- both the Company and employee cost -- plus an administrative charge of 2% for this coverage.

If you or a covered eligible dependent are disabled or become disabled within 60 days after becoming eligible for COBRA, coverage may be extended for an additional 11 months for up to a total of 29 months from the original qualifying event. You must notify the Corporate Human Resources Department about the disability within 60 days of a disability determination by the Social Security Administration and within the initial 18-month continuation coverage period. You will pay up to 150% of the monthly premium amount for these 11 additional months, if the disabled person continues coverage. If the disabled person does not continue coverage, the premium will remain at 102% of the cost of coverage for the entire continuation coverage period.

Medical coverage for your covered eligible dependents may be continued up to 36 months if coverage is lost due to one of the following events:

- You die
- You and your spouse divorce or become legally separated
- Your child(ren) loses dependent status under the Plan (reaching the maximum age, for example)

If Medical coverage is lost because of death, divorce, legal separation or loss of dependent status, you or your eligible dependents must notify the Corporate Human Resources Department. You or your covered eligible dependent will have 60 days from the date of the event to notify the Company by filling out a status change form. The Company will then notify the COBRA administrator. If your coverage ends because of termination of employment or reduction in work hours, the Company will notify the COBRA administrator.

The COBRA Administrator, Interactive Medical Systems, will give you an election form for Medical Plan continued coverage. You must elect continuation coverage within 60 days after your regular Plan coverage ends or the election form is received -- whichever is later. You will have an additional 45 days to pay any back premium necessary to avoid a gap in coverage.

The continuation of Medical Plan coverage can stop before the normal 18-, 29- or 36-month period in the following cases:

- The premium for continued coverage is not paid within 30 days of the due date
- The person is covered under a group health plan that provides medical coverage for pre-existing conditions
- The person becomes entitled to Medicare benefits
- The disabled person is determined by the Social Security Administration to no longer be disabled. The person must notify the COBRA Administrator within 30 days if the Social Security Administration makes such a determination. Coverage will end on the first day of the month following 30 days after the Social Security Administration's decision
- The Company stops offering Medical coverage to all its employees

Continuation of Coverage for Employees in the Uniformed Services (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

If your military leave is for less than 31 days, you may continue your medical

coverage by paying the same amount charged to active employees for the same coverage. If your leave is for a longer period of time, you will be charged up to the full cost of coverage plus a 2% administrative fee.

The maximum period of continuation coverage available to you and your eligible dependents is the lesser of 18 months after the leave begins or the day the leave ends.

When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

If you choose not to continue your medical coverage while on military leave, you are entitled to reinstated health coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home and an eight-hour rest period if you are on a military leave of less than 31 days
- Return to or reapply for reemployment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days
- Return to or reapply for reemployment within 90 days of completion of your period of duty, if your military service lasts more than 180 days

If You Go on Family or Medical Leave

Under the Family and Medical Leave Act of 1993 (FMLA), you may be entitled to up to 12 weeks of unpaid leave during any 12-month period. You may qualify for this leave because of:

- The birth of a baby or need to care for a newborn (within the first 12 months of such birth)
- The placement of a child in your home for adoption or foster care (within the first 12 months of such placement)
- A spouse, child or parent with a serious health condition whom you need to care for
- A serious health condition that makes you unable to work

While you are on leave, the Company will continue the Medical coverage you

elected before your leave. During this period you pay your contributions through a process set up with the Company's Corporate Human Resources Department. If you decide not to continue Medical coverage during your leave, you may regain coverage when you return to work.

For more information about FMLA and how it may affect any paid leave policy or your benefits, contact the Corporate Human Resources Department.

If You Retire

Medical coverage may be offered to you and your covered eligible dependents if you retire from active service with a normal or early pension benefit from the Company. Retiree medical coverage is no longer available to those employees hired after December 31st, 2001. Contact the Corporate Human Resources Department for more information on eligibility for medical coverage upon retirement.

HIPAA Certificate of Creditable Coverage

If you lose your coverage under the Personal Choice Plan, you will automatically be sent a certificate of coverage showing how long you had been covered under the plan. This document will provide the proof of coverage you may need to reduce any subsequent medical plan's pre-existing medical condition limitation period that might otherwise apply. If you elect COBRA continuation coverage, you will also receive another certificate of coverage within the 24 months after your coverage has ended. You may also request a certificate of coverage within the last 24 months after your coverage has ended.

Definitions

Birthing center An institution that is constituted, licensed and operated in accordance with the applicable laws to furnish room and board, services of qualified nurses and a certified nurse midwife to expectant mothers. One or more nurses must be on duty at all times, under the supervision of a physician or a registered graduate nurse. To qualify as a birthing center, an institution must:

- Have the services of a physician available at all times, under an established agreement
- Maintain daily medical records on all patients
- Have agreements with hospitals that will accept patients who need immediate inpatient hospital care

Blue Distinction Centers for Transplants These are Transplant institutions which belong to the Blue Cross and Blue Shield Association's national transplant network. To join the program, the transplant institutions are required to meet Association standards. For example, each institution must meet rigorous quality criteria developed by independent clinical experts.

Co-insurance Your share of any covered cost, other than your deductible. This applies to the BCBS PPO and to certain expenses for mental health and substance abuse care under MBH.

Co-pay A fixed amount that you pay for services under the BCBS PPO in-network or for prescription drugs through Caremark.

Custodial Care Services related to watching or protecting a person or helping a person perform daily activities, such as walking, grooming, bathing, dressing, toileting, eating, or taking medications. The services do not have to be performed by trained or skilled medical or paramedical personnel. The services cannot primarily treat a specific injury or sickness (including mental illness or substance abuse).

Deductible A set amount of your covered health care costs that you must pay in full before Plan benefits begin. This applies to the out-of-network care under the BCBS PPO, certain mental health and substance abuse care provided under MBH, and the annual prescription drug deductible under Caremark.

Durable medical equipment Any equipment that can withstand repeated use, is medically essential to treat an injury or a sickness, and is generally of no use to a person who is not injured or sick.

Emergency admission Any hospital admission for an inpatient stay for a condition that:

- Has a sudden and unexpected onset, and
- Requires prompt care to protect life, relieve severe pain or to diagnose and treat symptoms that if delayed, could result in serious injury.

Emergency services - Emergency services are medical, surgical, hospital and related health care services and testing, including ambulance service, required to treat a sudden unexpected onset of a bodily injury or a serious illness that, if not treated immediately, may result in serious medical complications, loss of life or permanent impairment to bodily functions. Included are conditions that produce loss of consciousness or excessive bleeding, or which may otherwise be determined by the network administrator in accordance with generally accepted medical standards, to have been an acute condition requiring immediate medical attention.

Family Deductible — The deductible you pay for the entire family, regardless of its size, is specified under "family" deductible. To reach this total, you can count the expenses incurred by two or more family members. However, the deductible contributed toward the total by any one family member cannot be more than the amount of the individual deductible. If one family member meets the individual deductible and again needs to use benefits, the program would begin to pay for that person's covered services even if the deductible for the entire family has not been met.

When two or more family members are injured in the same accident, only one deductible will be applied to the aggregate of such charges.

Home health aide A person who provides medical or therapeutic care. He or she must report to and be under the direct supervision of a home health care agency.

Home health care plan A plan for home care and treatment established and approved in writing by a physician. The physician must certify that the patient would need to be in a hospital or a skilled nursing home without the care and treatment specified in the plan.

Home health care visit A visit by an employee of a home health care agency, or four or more hours of care provided by a home health aide.

Hospice An institution or part of one which primarily provides care for terminally ill patients and meets any licensing requirements of the state or locality in which it operates.

Hospice care program A coordinated, interdisciplinary program designed to meet the physical, psychological, spiritual and social needs of dying persons and their families. A hospice care program may also provide palliative and supportive

medical, nursing and other health services through home or inpatient care during the terminal illness.

Hospice care services Any services provided by a hospital, skilled nursing home, home health agency, hospice, or any other licensed facility or agency under a hospice care program.

Hospital A hospital is an institution that is constituted, licensed and operated in accordance with the laws pertaining to hospitals, and that maintains on its premises all the facilities needed to diagnose and treat injury and sickness. It is an institution, which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital and a provider of services under Medicare, and is accredited by the Joint Commission for the Accreditation of Healthcare Organizations.

A hospital can specialize in treatment of mental illness, alcoholism, drug addiction or other related illness. It can also provide residential treatment programs, but only if it is constituted, licensed and operated in accordance with the applicable laws. It must provide all treatment for a fee, by or under the supervision of providers on an inpatient basis, with continuous 24-hour nursing service by qualified nurses.

Any institution that is, other than incidentally, a place for rest, a place for the aged, or a nursing home will not be considered a hospital.

Medicare The program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Necessary services and supplies Any services or supplies, other than bed and board, that are necessary for your treatment and are administered during a hospital stay. Necessary services and supplies will also include professional ambulance service to or from the nearest hospital where the necessary medical treatment can be provided, and any charges for the administration of anesthetics during hospital confinement.

Non-duplication of benefits This is a kind of coordination of benefits (COB). If you are covered by a Personal Choice Benefits Program option and another medical plan, reimbursement will not total more than the amount your Plan would have paid. You will not receive full reimbursement for a covered claim under both plans. Also, if your other plan has benefits equal to or higher than the Personal Benefits Choice Program option, the Personal Choice Benefits Program option will not pay anything if it is the secondary plan.

Nurse A nurse is a Registered Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse. A nurse is a professional who has the right to use the respective title and abbreviation R.N., L.P.N. or L.V.N.

Out-of-pocket limit The maximum amount you must pay out-of-pocket for covered services during the calendar year. This amount applies to the out-of-network coverage under the BCBS PPO.

Participating Pharmacy A pharmacy that has a contract with Caremark's retail pharmacy network program. When you use your Caremark ID card at a participating pharmacy, the pharmacist will bill Caremark directly and accept the Caremark payment amount as payment in full. You will only be responsible for your applicable deductible, co-payment, co-insurance, if applicable and applicable pay-the-difference amount or DAW penalty (see below). You will not have any additional expenses or claim forms to file.

Pay-the-difference feature (dispensed as written-DAW) If a member chooses to receive a brand name drug when a generic equivalent is available, member will be charged the generic co-pay plus the difference between the cost of the brand name drug and the generic equivalent; member will pay this difference regardless of whether their physician indicates, "Dispense as Written".

Primary Care Physician A physician or other medical professional who provides primary medical care in the areas of Family Practice, General Practice, Internist, Pediatrician, or OB/GYN designation.

Primary Drug List Caremark's list of preferred medications chosen for their clinical and cost effectiveness, amended from time to time; generally referred to as a formulary.

Reasonable and customary (R&C) charges Charges made for medical services or supplies essential to the care of the individual will be considered reasonable and customary if they are the amount normally charged by a physician, hospital or dentist for similar services and supplies. In addition, they must not exceed the amount ordinarily charged by a majority of the providers of comparable services and supplies in the geographical area where the services or supplies are received. In determining whether charges are reasonable and customary, BCBS will consider the nature and severity of the condition being treated, and any medical complications or unusual circumstances that require additional time, skill or experience to treat.

If two or more surgical procedures are performed during the same operative session, the amount which will be considered in determining the reasonable and customary charge will be the sum of:

- 100% of the R&C charge for the primary surgical procedure plus
- 50% of the R&C charge for each of the less expensive procedures

Room and board All charges commonly made by a hospital for room and meals and all general services and activities needed for the care of registered bed patients.

Short-term rehabilitation Short-term rehabilitation therapy, including physical, speech and occupational therapy, is provided on an inpatient or outpatient basis. Services provided on an outpatient basis are limited to 60 visits per condition a year if significant improvement for the condition can be expected within 60 days of the first treatment, as determined by the network administrator. Coverage is available only for rehabilitation following injuries, surgery or acute medical conditions such as a stroke. Occupational therapy is provided only for the purpose of training individuals to perform the activities of daily living.

Sickness A physical or mental illness.

Skilled nursing facility An institution that is not a hospital, as defined, but that is primarily engaged in providing, on an inpatient basis, skilled nursing care and related services for patients who require medical or nursing care. A skilled nursing facility may also provide rehabilitation services for injured or sick persons. To do so, it must be constituted, licensed and operated in accordance with the laws of legally authorized agencies, and must maintain on its premises all the facilities needed to provide medical treatment of injury or sickness. All skilled nursing care must be provided for a fee by or under the supervision of providers, with nursing services by nurses.

Social worker An individual licensed and certified as a social worker who has completed at least two years or 3,000 hours of post-masters supervised clinical social work practice in a clinical program as established by the Board of Social Work Examiners.

Specialist A healthcare professional whose practice is limited to a certain branch of medicine, specific procedures, certain age categories of patients, specific body systems, or certain types of diseases, and who provides medical care other than that provided by a Primary Care Physician (see definition listed above).

Terminal illness A terminal illness will be considered to exist if a person becomes ill and is given 12 months or less to live, as diagnosed by a physician.

Total disability You will be considered totally disabled when, as a result of injury, sickness or pregnancy, you are unable to perform any job for a wage. A dependent will be considered totally disabled when, as a result of injury, sickness or pregnancy, he or she is unable to participate in the normal activities of people of the same sex and age.

Urgent Care Claim Any claim for medical care or treatment where the time periods for making non-urgent care decisions could seriously jeopardize the claimant's life or health or ability to regain maximum function, or in the opinion of a physician with the 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. This determination will be made by an individual acting on behalf of the plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. A physician's opinion, with knowledge of the claimant's medical condition, that the claim is one involving "urgent care" must be treated as such.

Other Reference Information

This Plan, regulated by the Employee Retirement Income Security Act of 1974 (ERISA), is required to make available to all Plan participants specific information with respect to the Plan. The following describes the basic Plan information and your rights under ERISA.

Plan Name: Martin Marietta Materials, Inc. Medical Plan

Plan Sponsor: Martin Marietta Materials, Inc.
2710 Wycliff Road
Raleigh, NC 27607
1-877-781-8757

EIN # 56-1848578

Agent for Service of Legal Process: Agent for Service of Legal Process
Benefit Committee
Martin Marietta Materials, Inc.
2710 Wycliff Road
Raleigh, NC 27607

Service of legal process may also be made upon the Plan Administrator.

Plan Administrator: Martin Marietta Materials, Inc.
2710 Wycliff Road
Raleigh, NC 27607
1-877-781-8757

Medical & Mental Health Substance Abuse Claims Administrator: Blue Cross Blue Shield North Carolina
PO Box 35 Durham, NC 27702
1-877-275-9787

Prescription Drug Claims Administrator: Caremark, Inc.
PO Box 686005
San Antonio, TX 78268-6005
1-800-808-9331

COBRA Administrator:	Interactive Medical Systems, Corp 11635 Northpark Drive Suite 330 Wake Forest, NC 27587 Phone: 1-800-426-8739
Plan Type and Number:	This is a welfare benefit plan that offers Medical benefits to certain employees and their eligible dependents. The Plan Number is 513.
Plan Funding:	This Plan is self-funded. Benefits are paid by contributions from the employer and employees. Benefits are paid from the general assets of the Company. Employee contributions are calculated annually and are used to pay claims. The premium for coverage is based on the expected cost of claims that will be incurred during the year plus claim administrator charges for processing claims. The employer sets an annual budget and, on an annual basis, will establish a total amount it will pay toward the cost of health care coverage and then will pay a percentage, to be determined annually, of the cost for employee only, employee plus one, and family coverage. Your cost for coverage will be provided to you during annual enrollment. Your share of the premium is paid on a pre-tax basis through payroll deduction, to the extent allowed by law.
Plan Year:	The benefits records for the Plan are kept from January 1 through December 31 for the processing of claims.
Participating Business Units:	Employees of Martin Marietta Materials, Inc. excluding collective bargaining groups that have not adopted the Plan.

Statement of ERISA Rights

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 plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration
- 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 description. The 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
- Martin Marietta Materials believes our medical plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA - the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. A grandfathered health plan means that our medical plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator, Thomas M. Spangler at 1-877-781-8757 or by mail at P.O. Box 30013, Raleigh North Carolina 27622-0013. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

CONTINUE GROUP HEALTH PLAN COVERAGE

- ❑ 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
- ❑ Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage

Prudent Actions by Plan Fiduciaries

- ❑ In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, 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

Enforce Your Rights

- ❑ If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules
- ❑ Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 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 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 domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that 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

ASSISTANCE WITH YOUR QUESTIONS

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

If you have questions about your Plan, you should contact the Human Resources Department or the Plan Administrator. If you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration (PWBA), U.S. Department of Labor listed in your telephone directory.

Otherwise, you may contact the:

Division of Technical Assistance and Inquiries
Pension and Welfare Benefits Administration
U.S. Department of Labor
2 Constitution Avenue Northwest
Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.