

Your Health Care Benefit Program

Nabors Industries, Inc.

Group #80189

Managed Health Care
Traditional Benefits
Prescription Drug Program

Administered by:



BlueCross BlueShield of Texas

Experience. Wellness. Everywhere.SM

80189JAN.12A

TABLE OF CONTENTS

	Page No.
Schedule(s) of Coverage(s)	Enclosure
Introduction	
Managed Health Care Coverage	1
Managed Health Care - In-Network Benefits	1
Managed Health Care - Out-of-Network Benefits	1
Out-of-Area Medical Benefits	2
Prescription Drug Program Benefits	2
Important Contact Information	2
Customer Service Helpline	3
BCBSTX Website	3
Mental Health/Chemical Dependency Preauthorization Helpline	3
Medical Preauthorization Helpline	3
Who Gets Benefits	
Eligibility Requirements for Coverage	4
Rehired Employees	4
Effective Dates of Coverage	5
Enrollment Documentation	7
Changes In Your Family	7
Leave of Absence Including FMLA	7
How the Plan Works	
Allowable Amount	8
Case Management	8
Freedom of Choice	8
Identification Card	9
Medical Necessity	9
ParPlan	10
Preexisting Conditions Provision	10
Specialty Care Providers	11
Use of Non-Contracting Providers (Applies to Managed Health Care Only)	11
Preauthorization Requirements	
Preauthorization Requirements	12
Failure to Preauthorize	14
Claim Filing and Appeals Procedures	
Claim Filing Procedures	15
Filing of Claims Required	15
Who Files Claims	15
Where to Mail Completed Claim Forms	16
Who Receives Payment	16
When to Submit Claims	17
Receipt of Claims by the Claim Administrator	17
Review of Claim Determinations	17
Claim Determinations	17
Claim Appeal Procedures	19
Standard External Review	22
Expedited External Review	24
Exhaustion	25
Interpretation of Employer's Plan Provisions	25
Eligible Expenses, Payment Obligations, and Benefits	
Eligible Expenses	26
Copayment Amounts	26
Deductibles	26
Co-Share Stop-Loss Amount (Out-of-Pocket Maximum)	27
Annual Maximum Benefits	27
Changes In Benefits	28
Covered Medical Services	

Inpatient Hospital Expenses	29
Medical-Surgical Expenses	29
Extended Care Expenses	30
Special Provisions Expenses	31
Benefits for Treatment of Complications of Pregnancy	32
Benefits for Maternity Care	32
Benefits for Emergency Care and Treatment of Accidental Injury	32
Benefits for Speech and Hearing Services	33
Benefits for Cosmetic, Reconstructive, or Plastic Surgery	33
Benefits for Dental Services	33
Benefits for Organ and Tissue Transplants	34
Benefits for Treatment of Acquired Brain Injury	35
Benefits for Treatment of Diabetes	35
Benefits for Preventive Care Services	36
Benefits for Mammography Screening	37
Benefits for Detection and Prevention of Osteoporosis	37
Benefits for Tests for Detection of Colorectal Cancer	37
Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer	38
Benefits for Certain Tests for Detection of Prostate Cancer	38
Benefits for Childhood Immunizations	38
Benefits for Other Routine Services	38
Benefits for Physical Medicine Services	38
Benefits for Chiropractic Services	38
Benefits for Behavioral Health Services	39
Benefits for Morbid Obesity	39

Medical Limitations and Exclusions	40
---	-----------

Definitions	44
--------------------------	-----------

Prescription Drug Program

How the Program Works	58
Participating Pharmacy	58
Non-Participating Pharmacy	58
Mail Service Prescription Drug Program	58
Preferred Brand Name Drug List	59
Injectable Drugs	59
Prior Authorizations	59
Step Therapy	59
Limitations on Quantities Dispensed-Day Supply	60
Right of Appeal	60
Deductibles and Copayment Amounts	60
Prescription Drug Program Limitations and Exclusions	61
Definitions	63

General Provisions

Agent	66
Amendments	66
Assignment and Payment of Benefits	66
Claims Liability	66
Disclosure Authorization	66
Medicare	66
Participant/Provider Relationship	66
Refund Of Benefit Payments	67
Subrogation and Reimbursement	67
Coordination of Benefits	69
Termination of Coverage	72
Continuation Privilege	73
Information Concerning Employee Retirement Income Security Act Of 1974 (ERISA)	74

Amendments

Notices

Information Provided by Your Employer

SCHEDULE OF COVERAGE PPO PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
<i>All services must be Medically Necessary in order for benefits to be considered for payment.</i>		
Deductibles		
<ul style="list-style-type: none"> • Calendar Year Deductible <i>Combined In-Network and Out-of-Network</i> 	\$600 – per individual \$1,800 – per family	\$600 – per individual \$1,800 – per family
<ul style="list-style-type: none"> • Per-admission Deductible 	\$500 per-admission	\$500 per-admission
Co-Share Stop-Loss Amounts (Out-of-Pocket Maximum)		
<i>In-Network and Out-of-Network Benefits have separate out-of-pocket maximums and do not cross apply.</i>	\$4,500 – per individual \$9,000 – per family	\$4,500 – per individual \$9,000 – per family
Copayment Amounts Required		
<ul style="list-style-type: none"> • Office visit/consultation with a Primary Care Provider 	\$25 per visit	Does Not Apply
<ul style="list-style-type: none"> • Office visit/consultation with a Specialty Care Provider 	\$35 per visit	Does Not Apply
<ul style="list-style-type: none"> • Outpatient Hospital Emergency Room visit (Illness only) 	\$100 per visit	\$100 per visit
Annual Maximum on Covered Medical Services	\$2,000,000 per Participant each Calendar Year	
Co-Share Amounts (Coinsurance)	80% unless otherwise noted	50% unless otherwise noted
Inpatient Hospital Expenses		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	80% of Allowable Amount after Calendar Year Deductible No penalty for failure to Preauthorize services \$500 Per-admission Deductible applies	50% of Allowable Amount after Calendar Year Deductible \$500 penalty for failure to Preauthorize services \$500 Per-admission Deductible applies
Outpatient Hospital Expenses		
<ul style="list-style-type: none"> • Emergency Room services for the treatment of an Illness (includes ancillary services) 	80% of Allowable Amount after Calendar Year Deductible and \$100 Copayment (Copayment waived if admitted)	50% of Allowable Amount after Calendar Year Deductible and \$100 Copayment (Copayment waived if admitted)
<ul style="list-style-type: none"> • Emergency Room, Treatment Room and Ancillary services for all other causes (e.g., Accidental Injury, Emergency Care, Surgery, Dialysis, Chemotherapy, Radiation Therapy, Respiratory Therapy, and Speech & Hearing Therapy) 	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Ground and Air Ambulance Services	80% of Allowable Amount after Calendar Year Deductible	

SCHEDULE OF COVERAGE PPO PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Medical-Surgical Expenses		
<ul style="list-style-type: none"> • Office visit services for Accidental Injury or Emergency Care -Primary Care/Specialty Care Provider -Any other Physician/Professional Other Provider 	100% of Allowable Amount after \$25/\$35 Copayment	
	80% of Allowable Amount after Calendar Year Deductible	
<ul style="list-style-type: none"> • Non-emergency Primary Care/Specialty Care Provider office visit/consultation, including lab and x-rays (for Medically Necessary services only) 	100% of Allowable Amount after \$25/\$35 Copayment	50% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> • Physician/Professional Other Provider (Specialty Care Provider) office visit/consultation, including lab &x-rays, except as provided above • Inpatient Physician/Professional Other Provider visits • Physician/Professional Other Provider charges for Certain Diagnostic Procedures (in any setting) • Physician/Professional Other Provider surgical services (in any setting) • Physician/Professional Other Provider services (Outpatient Hospital setting) • Durable Medical Equipment • Orthotics, Prosthetics, covered medical supplies • Independent Laboratory & X-ray • Allergy Injections (without office visit) • Other Covered expenses not listed 	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Extended Care Expenses		
<ul style="list-style-type: none"> • Skilled Nursing Facility Limited to a combined 120 days each Calendar Year 	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> • Home Health Care Limited to a combined 80 visits each Calendar Year (one visit equals two hours) 	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> • Hospice Care 	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE PPO PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Preventive Care Services <ul style="list-style-type: none"> • Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”) • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved • Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents • With respect to women, such additional preventive care and screenings, not described in the first bullet above, as provided for in comprehensive guidelines supported by the HRSA • Routine physical examinations, well baby care, immunizations (for Participants age 6 and over) and routine lab • X-Ray • Annual Hearing Examination • Annual Vision Examination 	100% of Allowable Amount	100% of Allowable Amount up to \$500 per Participant each Calendar Year, then 80% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> • Immunizations for Participants under 6 years of age 	100% of Allowable Amount	
<ul style="list-style-type: none"> • Colonoscopy Professional (physician charges) 	Paid same as any other Preventive Care service	
<ul style="list-style-type: none"> • Colonoscopy facility charges 	Paid same as any other Preventive Care service	
<ul style="list-style-type: none"> • Healthy diet counseling and obesity screening/counseling 	Paid same as any other Preventive Care service	
Chiropractic Services (in any setting) including Occupational Therapy Limited to a combined \$1000 each Calendar Year for muscle manipulation	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE PPO PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Physical Medicine Services (Physical Therapy)		
<ul style="list-style-type: none"> • Office visit/consultation (includes Occupational Therapy and all other services in the office) <ul style="list-style-type: none"> -Primary Care/Specialty Care Provider -Any other Physician/Professional Other Provider 	100% of Allowable Amount after \$25/\$35 Copayment	50% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> • All services in an Outpatient setting including Occupational Therapy 	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Behavioral Health Services (Mental Health Care, Treatment of Serious Mental Illness and Treatment of Chemical Dependency)	Benefits determined on the same basis as for any other sickness	Benefits determined on the same basis as for any other sickness

SCHEDULE OF COVERAGE PPO PLAN

PRESCRIPTION DRUG PROGRAM

Plan Provisions	Participating Pharmacy	Non-Participating Pharmacy
Prescription Drug Deductible	\$100 per Participant each Calendar Year	
Retail Pharmacy* no more than a 30-Day Supply	Copayment Amounts: Generic Drugs - 20% but not less than \$10 Preferred Brand Name Drug - 35% but not to exceed \$500 Non-Preferred Brand Name Drug - 50% but not to exceed \$1,000	80% of Allowable Amount minus the applicable Copayment Amount shown under "Participating Pharmacy"
Mail Service* up to a 60-Day Supply See Note below	Copayment Amounts: Generic Drugs - \$20 Preferred Brand Name Drug - \$50 Non-Preferred Brand Name Drug - \$100	
Prior Authorization Provision	Applies	
Step Therapy Provision	Applies	

*Generic oral contraceptive drugs that are packaged in a 90-day supply that cannot be broken will be allowed. The Copayment Amount will be equal to three times the Copayment Amount if obtained from a Retail Pharmacy and one and one-half times the Copayment Amount if obtained through the Mail Service Prescription Drug Program.

SCHEDULE OF COVERAGE OUT-OF-AREA PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
<i>All services must be Medically Necessary in order for benefits to be considered for payment.</i>		
Deductibles		
<ul style="list-style-type: none"> Calendar Year Deductible <i>Combined In-Network and Out-of-Network</i> 	\$600 – per individual \$1,800 – per family	\$600 – per individual \$1,800 – per family
<ul style="list-style-type: none"> Per-admission Deductible 	\$500 per-admission	\$500 per-admission
Co-Share Stop-Loss Amounts (Out-of-Pocket Maximum)		
<i>In-Network and Out-of-Network Benefits have separate out-of-pocket maximums and do not cross apply.</i>	\$4,500 – per individual \$9,000 – per family	\$4,500 – per individual \$9,000 – per family
Copayment Amounts Required		
<ul style="list-style-type: none"> Office visit/consultation with a Primary Care Provider 	\$25 per visit	\$25 per visit
<ul style="list-style-type: none"> Office visit/consultation with a Specialty Care Provider 	\$35 per visit	\$35 per visit
<ul style="list-style-type: none"> Outpatient Hospital Emergency Room visit (Illness only) 	\$100 per visit	\$100 per visit
Co-Share Amounts (Coinsurance)	80% unless otherwise noted	80% unless otherwise noted
Annual Maximum on Covered Medical Services	\$2,000,000 per Participant each Calendar Year	
Inpatient Hospital Expenses		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	80% of Allowable Amount after Calendar Year Deductible No penalty for failure to Preauthorize services \$500 Per-admission Deductible applies	80% of Allowable Amount after Calendar Year Deductible \$500 penalty for failure to Preauthorize services \$500 Per-admission Deductible applies
Outpatient Hospital Expenses		
<ul style="list-style-type: none"> Emergency Room services for the treatment of an Illness (includes ancillary services) 	80% of Allowable Amount after Calendar Year Deductible and \$100 Copayment (Copayment waived if admitted)	80% of Allowable Amount after Calendar Year Deductible and \$100 Copayment (Copayment waived if admitted)
<ul style="list-style-type: none"> Emergency Room, Treatment Room and Ancillary services for all other causes (e.g., Accidental Injury, Emergency Care, Surgery, Dialysis, Chemotherapy, Radiation Therapy, Respiratory Therapy, and Speech & Hearing Therapy) 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE OUT-OF-AREA PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Medical-Surgical Expenses		
<ul style="list-style-type: none"> • Office visit services for Accidental Injury or Emergency Care -Primary Care/Specialty Care Provider -Any other Physician/Professional Other Provider 	100% of Allowable Amount after \$25/\$35 Copayment	100% of Allowable Amount after \$25/\$35 Copayment
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> • Non-Emergency Primary Care/Specialty Care Provider office visit/consultation, including lab and x-rays (for Medically Necessary services only) 	100% of Allowable Amount after \$25/\$35 Copayment	100% of Allowable Amount after \$25/\$35 Copayment
<ul style="list-style-type: none"> • Physician/Professional Other Provider (Specialty Care Provider) office visit/consultation, including lab & x-rays, except as provided above • Inpatient Physician/Professional Other Provider visits • Physician/Professional Other Provider charges for Certain Diagnostic Procedures (in any setting) • Physician/Professional Other Provider surgical services (in any setting) • Physician/Professional Other Provider services (Outpatient Hospital setting) • Durable Medical Equipment • Orthotics, Prosthetics, covered medical supplies • Independent Laboratory & X-ray • Allergy Injections (without office visit) • Other Covered expenses not listed 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Ground and Air Ambulance Services	80% of Allowable Amount after Calendar Year Deductible	
Extended Care Expenses		
<ul style="list-style-type: none"> • Skilled Nursing Facility Limited to a combined 120 days each Calendar Year 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> • Home Health Care Limited to a combined 80 visits each Calendar Year (one visit equals two hours) 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> • Hospice Care 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE OUT-OF-AREA PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Preventive Care Services <ul style="list-style-type: none"> • Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”) • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved • Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents • With respect to women, such additional preventive care and screenings, not described in the first bullet above, as provided for in comprehensive guidelines supported by the HRSA • Routine physical examinations, well baby care, immunizations (for Participants age 6 and over) and routine lab • X-Ray • Annual Hearing Examination • Annual Vision Examination 	100% of Allowable Amount	100% of Allowable Amount up to \$500 per Participant each Calendar Year, then 80% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> • Immunizations for Participants under 6 years of age 	100% of Allowable Amount	
<ul style="list-style-type: none"> • Colonoscopy Professional (physician charges) 	Paid same as any other Preventive Care service	
<ul style="list-style-type: none"> • Colonoscopy facility charges 	Paid same as any other Preventive Care service	
<ul style="list-style-type: none"> • Healthy diet counseling and obesity screening/counseling 	Paid same as any other Preventive Care service	
Chiropractic Services (in any setting) including Occupational Therapy Limited to a combined \$1000 each Calendar Year for muscle manipulation	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE OUT-OF-AREA PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Physical Medicine Services (Physical Therapy) <ul style="list-style-type: none"> • Office visit/consultation (includes Occupational Therapy and all other services in the office) <ul style="list-style-type: none"> -Primary Care/Specialty Care Provider -Any other Physician/Professional Other Provider • All services in an Outpatient setting including Occupational Therapy 	<p style="text-align: center;">100% of Allowable Amount after \$25/\$35 Copayment</p> <p style="text-align: center;">80% of Allowable Amount after Calendar Year Deductible</p> <p style="text-align: center;">80% of Allowable Amount after Calendar Year Deductible</p>	<p style="text-align: center;">100% of Allowable Amount after \$25/\$35 Copayment</p> <p style="text-align: center;">80% of Allowable Amount after Calendar Year Deductible</p> <p style="text-align: center;">80% of Allowable Amount after Calendar Year Deductible</p>
Behavioral Health Services (Mental Health Care, Treatment of Serious Mental Illness and Treatment of Chemical Dependency)	Benefits determined on the same basis as for any other sickness	Benefits determined on the same basis as for any other sickness

SCHEDULE OF COVERAGE OUT-OF-AREA PLAN
PRESCRIPTION DRUG PROGRAM

Plan Provisions	Participating Pharmacy	Non-Participating Pharmacy
Prescription Drug Deductible	\$100 per Participant each Calendar Year	
Retail Pharmacy* no more than a 30-Day Supply	Copayment Amounts: Generic Drugs - 20% but not less than \$10 Preferred Brand Name Drug - 35% but not to exceed \$500 Non-Preferred Brand Name Drug - 50% but not to exceed \$1,000	80% of Allowable Amount minus the applicable Copayment Amount shown under "Participating Pharmacy"
Mail Service* up to a 60-Day Supply See Note below	Copayment Amounts: Generic Drugs - \$20 Preferred Brand Name Drug - \$50 Non-Preferred Brand Name Drug - \$100	
Prior Authorization Provision	Applies	
Step Therapy Provision	Applies	

*Generic oral contraceptive drugs that are packaged in a 90-day supply that cannot be broken will be allowed. The Copayment Amount will be equal to three times the Copayment Amount if obtained from a Retail Pharmacy and one and one-half times the Copayment Amount if obtained through the Mail Service Prescription Drug Program.

SCHEDULE OF COVERAGE

Waiting Period

The waiting period for hourly employees is 90 consecutive days of employment. You should enroll in the plans from your 30th through your 80th day of employment.

The waiting period for salaried employees is 30 consecutive days of employment. You should enroll in the plans from your 1st through your 29th day of employment.

Effective Date

The effective date is the first day of the first pay period following the completion of the waiting period.

Dependent Eligibility

Dependent children are not eligible for Maternity Care benefits

Preexisting Conditions

Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the 12-month period following the Participant's initial Effective Date, or if a Waiting Period applies, the first day of the Waiting Period (typically the date you are hired). Credit will be given for time served under Creditable Coverage.

Preexisting Conditions for Dependent children under age 19 and all other eligible individuals under age 19 will be covered without any waiting periods.

INTRODUCTION

This Plan is offered by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your health care expenses for Medically Necessary services and supplies. There are provisions throughout this Benefit Booklet that affect your health care coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan. In the event of any conflict between any components of this Plan, the Administrative Service Agreement provided to your Employer by BCBSTX prevails, and is available upon your request.

The defined terms in this Benefit Booklet are capitalized and shown in the appropriate provision in the Benefit Booklet or in the **DEFINITIONS** section of the Benefit Booklet. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may be section headings describing provisions or they may be defined terms.

The terms “you” and “your” as used in this Benefit Booklet refer to the Employee. Use of the masculine pronoun “his,” “he,” or “him” will be considered to include the feminine unless the context clearly indicates otherwise.

Managed Health Care Coverage

Managed Health Care Coverage includes both In-Network and Out-of-Network Benefits and is for those Participants who reside and/or work within the Managed Health Care Coverage Plan Service Area.

Managed Health Care - In-Network Benefits

To receive In-Network Benefits as indicated on your Schedule of Coverage, **you must** choose Providers within the Network for all care (**other than for emergencies**). The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Participants throughout the Network Plan Service Area. Refer to your Provider directory or visit the BCBSTX website at www.bcbstx.com to make your selections. The listing may change occasionally, so make sure the Providers you select are still Network Providers. An updated directory will be available from BCBSTX at least annually or you may access our website, www.bcbstx.com, for the most current listing to assist you in locating a Provider.

To receive In-Network Benefits for Mental Health Care, Serious Mental Illness, and treatment of Chemical Dependency, services and supplies must be provided by Network Providers that have specifically contracted with the Claim Administrator to treat those types of conditions to be considered for In-Network Benefits.

If you choose a Network Provider, the Provider will bill the Claim Administrator - not you - for services provided.

Network Providers have agreed to accept as payment in full the least of...

- The billed charges, or
- The Allowable Amount as determined by the Claim Administrator, or
- Other contractually determined payment amounts.

You are responsible for paying any Deductibles, Copayment Amounts, and Co-Share Amounts. You may be required to pay for limited or non-covered services. No claim forms are required.

Managed Health Care - Out-of-Network Benefits

If you choose Out-of-Network Providers, only Out-of-Network Benefits will be available. If you go to a Provider outside the Network, benefits will be paid at the Out-of-Network Benefits level. If you choose a health care Provider outside the Network, the Provider may bill the Claim Administrator. If not, you may have to submit claims for the services provided.

You will be responsible for paying...

- Billed charges above the Allowable Amount as determined by the Claim Administrator,
- Co-Share Amounts, Copayment Amounts and Deductibles,
- Any penalty for failure to Preauthorize, and
- Limited or non-covered services.

Out-of-Area Medical Benefits

Out-of-Area Benefits are provided through a traditional indemnity arrangement for Participants residing outside of the Managed Health Care coverage Plan Service Area and, therefore, do not have access to Network Providers.

You may have to submit claims for the services provided and *you will be responsible for paying...*

- Billed charges above the Allowable Amount as determined by the Claim Administrator,
- Co-Share Amounts, Copayment Amounts and Deductibles,
- Any penalty for failure to Preauthorize, and
- Limited or non-covered services.

Prescription Drug Program Benefits

Benefits are provided for those Covered Drugs as explained in the **PRESCRIPTION DRUG PROGRAM** section and shown on your Schedule of Coverage in this Benefit Booklet. The amount of your payment under the Plan depends on whether:

- the Prescription Order is filled at a Participating Pharmacy, or at a Non-Participating Pharmacy, or through the Mail Service Prescription Drug Program; or
- a Generic Drug is dispensed; or
- a Preferred or Non-Preferred Brand Name Drug is dispensed; or
- your Plan includes a separate Prescription Drug Deductible.

Important Contact Information

Resource	Contact Information	Accessible Hours
Customer Service Helpline (for Participants)	1-888-233-6724	Monday – Friday 8:00 a.m. – 8:00 p.m.
Mental Health/Chemical Dependency Preauthorization Helpline	1-888-233-6724 or 1-800-528-7264	24 hours a day 7 days a week
Websites	<u>www.bcbstx.com/nabors</u> <u>www.myrxhealth.com</u>	24 hours a day 7 days a week
Medical Preauthorization Helpline (for Providers)	1-800-441-9188	Monday – Friday 7:30 a.m. – 6:00 p.m.

Customer Service Helpline

Customer Service Representatives can:

- Identify your Plan Service Area
- Give you information about *ParPlan* Providers
- Distribute claim forms
- Answer your questions on claims
- Assist you in identifying a Network Provider (but will not recommend specific Network Providers)
- Provide information on the features of the Plan
- Record comments about Providers
- Assist you with questions regarding the **PRESCRIPTION DRUG PROGRAM**

BCBSTX Website

Visit the BCBSTX website at www.bcbstx.com/nabors for information about BCBSTX, access to forms referenced in this Benefit Booklet, and much more. Some features may not be available on your Plan.

Mental Health/Chemical Dependency Preauthorization Helpline

To satisfy Preauthorization requirements for Participants seeking Behavioral Health Services (Mental Health Care, treatment of Serious Mental Illness, and treatment of Chemical Dependency), you, your Behavioral Health Practitioner, or a family member may call the Mental Health/Chemical Dependency Preauthorization Helpline at any time, day or night.

Medical Preauthorization Helpline

To satisfy all medical Preauthorization requirements for inpatient Hospital Admissions, Extended Care Expenses, or Home Infusion Therapy, call the Medical orization Helpline.

WHO GETS BENEFITS

Eligibility Requirements for Coverage

The Eligibility Date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when he becomes an Employee or a Dependent and is in a class eligible to be covered under the Plan. The Eligibility Date is:

1. The first day of the appropriate pay period following completion of the Waiting Period; or
2. Described in the *Dependent Enrollment Period* section for a new Dependent of an Employee already having coverage under the Plan.

Employee Eligibility

Any person eligible under this Plan and covered by the Employer's previous Health Benefit Plan on the date prior to the Plan Effective Date, including any person who has continued group coverage under applicable federal or state law, is eligible on the Plan Effective Date. Otherwise, you are eligible for coverage under the Plan when you satisfy the definition of an Employee. For participation in the Managed Health Care Coverage, an Employee must reside or work in the Plan Service Area.

Rehired Employees

Employees Who Did Not Complete the Waiting Period

If you elected coverage but did not complete the Waiting Period as shown on your Schedule of Coverage, your coverage never began and if you are rehired you will be treated as if you are a new hire for eligibility and enrollment.

Employees Rehired Within 90 Days after Coverage Terminated

If you were covered by the Program at the time of your termination and you are rehired within 90 days of termination, your coverage under this Program will automatically be reinstated the first pay period following your date of rehire. You are not required to complete an online enrollment unless you want to change your previous elections. You may not make changes to your coverage if you are rehired less than 30 days from your termination. If you are rehired more than 30 days from your termination and want to make changes, you must complete an online enrollment within 30 days of rehire via the Employee Portal. If you do not make changes at this time, you must wait until the next Annual Election or until you have a qualified mid-year election change. For the purpose of satisfying the Pre-existing Condition provision, previous enrollment in the Health Program will be counted, unless you have a break in coverage of 63 or more consecutive days during which you or your eligible Dependents had no Creditable Coverage

Employees Rehired More than 90 Days after Coverage Terminated

If you are rehired more than 90 days **after** your termination, you will have to meet the eligibility requirements of the Plan before the coverage becomes effective. You must also complete a new online enrollment as if you are a new hire. **Hourly Employees** must complete a new online enrollment between the 30th and 80th day of rehire via the Employee Portal, and **Salaried Employees** must complete a new online enrollment within 30 days of date of rehire.

Dependent Eligibility

If you apply for coverage, you may include your Dependents. Eligible Dependents are:

1. Your legal spouse of the opposite sex, including a common-law spouse (if recognized in your state of residence), if not eligible for health coverage through their employer. A certification declaring you are married is required when you request coverage for your common-law spouse. Since the Common Law Certificate is a legal document, signing it means that you may be required to obtain a legal divorce to dissolve the marriage in the future;
2. A child under the limiting age shown in the Schedule of Coverage;
3. Any other child included as an eligible Dependent under the Plan.

A detailed description of Dependent is in the **DEFINITIONS** section of this Benefit Booklet.

An Employee must be covered first in order to cover his eligible Dependents. No Dependent shall be covered hereunder prior to the Employee's Effective Date. If you are married to another Employee, you may not cover your spouse as a Dependent, and only one of you may cover any Dependent children.

Effective Dates of Coverage

In order for an Employee's coverage to take effect, the Employee must apply for coverage by submitting the required online enrollment for coverage for himself and any Dependents. The Effective Date is the date the coverage for a Participant actually begins. The Effective Date under the Plan may be different from the Eligibility Date.

Timely Applications

It is important that your online enrollment is received timely by the the Plan Administrator.

If you apply for coverage and make the required contributions for yourself or for yourself and your eligible Dependents and if you:

1. Are eligible on the Plan Effective Date and the online enrollment is received by the Plan Administrator prior to or within 30 days following such date, your coverage will become effective on the Plan Effective Date;
2. Enroll for coverage for yourself or for yourself and your Dependents during an Open Enrollment Period, coverage shall become effective on the Plan Anniversary Date; and/or
3. Become eligible after the Plan Effective Date and if the online enrollment is received by the the Plan Administrator within the first 30 days following your Eligibility Date, the coverage will become effective in accordance with eligibility information provided by your Employer.

Effective Dates - Late Enrollee

If your application is not received within 30 days from the Eligibility Date, you will be considered a Late Enrollee. You will become eligible to apply for coverage during your Employer's next Open Enrollment Period. Your coverage will become effective on the Plan Anniversary Date. If you are a Late Enrollee, you may be subject to an 18-month Preexisting Condition limitation beginning on the Plan Anniversary Date.

Qualified Mid-Year Status Changes

Loss of Other Health Insurance Coverage

An Employee who is eligible, but not enrolled for coverage under the terms of the Plan (and/or a Dependent, if the Dependent is eligible, but not enrolled for coverage under such terms) shall become eligible to apply for coverage if each of the following conditions is met:

1. The Employee or Dependent was covered under a Health Benefit Plan, self-funded Health Benefit Plan, or had other health insurance coverage at the time this coverage was previously offered; and
2. Coverage was declined under this Plan in writing, on the basis of coverage under another Health Benefit Plan or self-funded Health Benefit Plan; and
3. There is a loss of coverage under such prior Health Benefit Plan or self-funded Health Benefit Plan as a result of:
 - a. Exhaustion of continuation under Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended; or
 - b. Cessation of Dependent status (such as divorce or attaining the maximum age to be eligible as a dependent child under the Plan), termination of employment, a reduction in the number of hours of employment, or employer contributions toward such coverage were terminated; or
 - c. Termination of the other plan's coverage, a situation in which the other plan no longer offers any benefits to the class of similarly situated individuals that include you or your Dependent, or, in the case of coverage offered through an HMO, you or your Dependent no longer reside, live, or work in the service area of that HMO and no other benefit option is available; and

4. You request to enroll no later than 30 days after the date coverage ends under the prior Health Benefit Plan or self-funded Health Benefit Plan. Coverage will become effective the day after prior coverage terminated.

If all conditions described above are not met, you will be considered a Late Enrollee.

Loss of Governmental Coverage

An individual who is eligible to enroll and who has lost coverage under Medicaid (Title XIX of the Social Security Act), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s) or under a state Children's Health Insurance Program (CHIP), Chapter 62, Health and Safety Code, is not a Late Enrollee provided appropriate online enrollment and applicable contributions are received by the Plan Administrator within sixty (60) days after the date on which such individual loses coverage. Coverage will be effective the day after prior coverage terminated.

Health Insurance Premium Payment (HIPP) Reimbursement Program

An individual who is eligible to enroll and who is a recipient of medical assistance under a state Medicaid Program or enrolled in CHIP, and who is a participant in the state of Texas HIPP Reimbursement Program (or similar program of another participating state), may enroll with no enrollment period restrictions. If the individual is not eligible unless a family member is enrolled, both the individual and family member may enroll. The Effective Date of Coverage is on the first day of the pay period after the Plan Administrator receives online enrollment from you, provided such enrollment and applicable contributions are received by the Plan Administrator within sixty (60) days after the date the individual becomes eligible for participation in the HIPP Reimbursement Program (or similar state program).

Dependent Enrollment Period

1. Special Enrollment Period for Newborn Children

Coverage of a newborn child will become effective on the date of birth if online enrollment is submitted within 30 days following the date of birth. If online enrollment is submitted after that 30-day period, the child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period. New online enrollment will be required.

2. Special Enrollment Period for Adopted Children or Children Involved in a Suit for Adoption

Coverage of an adopted child or child placed with you for adoption will become effective on the date of adoption or the date the child is placed with you for adoption, provided online enrollment is submitted no later than 30 days following that date. If an online enrollment is submitted after that 30-day period, the child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period. New online enrollment will be required.

3. Court Ordered Dependent Children

If a court has ordered an Employee to provide coverage for a child pursuant to a Qualified Medical Child Support Order, coverage will become effective on the first day of the pay period following receipt of the court order.

4. Other Dependents

Online enrollment must be submitted within 30 days of the date that a spouse or child first qualifies as a Dependent. If the online enrollment is received within 30 days, coverage will become effective on the date the child or spouse first becomes an eligible Dependent. If submitted after the initial 30 days, then your Dependent's coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period. New online enrollment will be required.

If you ask that your Dependent be provided health care coverage after having canceled his or her coverage while your Dependent was still entitled to coverage, your Dependent's coverage will become effective in accordance with the provisions of the Plan.

In no event will your Dependent's coverage become effective prior to your Effective Date.

Other Employee Enrollment Period

1. As a special enrollment period event, if you acquire a Dependent through birth, adoption, or placement for adoption, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance***

Coverage, as described above, you may apply for coverage for yourself, your spouse, and a newborn child, adopted child, or child placed with you for adoption. If the application is received within 30 days of the birth, adoption, or placement for adoption, coverage for the child, you, or your spouse will become effective on the date of the birth, adoption, or date of placement for adoption.

If you marry and you previously declined coverage for reasons other than under **Loss of Other Health Insurance Coverage** as described above, you may apply for coverage for yourself, your spouse, and any other Dependents you may have. If the online enrollment is submitted within 30 days of the marriage, coverage for you, your spouse, and other Dependents will become effective on the date of marriage.

2. If you are required to provide coverage for a child as described in **Court Ordered Dependent Children** above, and you previously declined coverage for reasons other than under **Loss of Other Health Insurance Coverage**, you may apply for coverage for yourself. If the application is received within 30 days of the date your Employer receives notification of the court order, coverage for you will become effective on the first day of the pay period following the date your Employer receives notification of the court order.

Enrollment Documentation

You will be required to provide appropriate documentation if you want to:

- Add Dependents
- Drop Dependents
- Cancel all or a portion of your coverage

Contact Nabors Corporate Service (NCS) for details regarding documentation requirements.

Changes In Your Family

You should promptly notify the Plan Administrator in the event of a birth or follow the instructions below when events, such as but not limited to, the following take place:

- If you are adding a Dependent due to marriage, adoption, or placement for adoption, or your Employer receives a court order to provide health coverage for a Participant's child or your spouse, you must submit the appropriate documentation and the coverage of the Dependent will become effective as described in **Dependent Enrollment Period**.
- When you divorce, your child reaches the age indicated on the Schedule of Coverage as "Dependent Child Age Limit," or a Participant in your family dies, coverage under the Plan terminates in accordance with the **Termination of Coverage** provisions selected by your Employer.

Notify NCS promptly if any of these events occur. Benefits for expenses incurred after termination are not available. If your Dependent's coverage is terminated, refund of contributions will not be made for any period before the date of notification. If benefits are paid prior to notification to the Plan Administrator, refunds will be requested.

Please refer to the **Continuation Privilege** subsection in this Benefit Booklet for additional information.

Leave of Absence Including FMLA

If you are granted a leave of absence pursuant to the Company's Leave of Absence Policy, coverage may continue under the Plan during your leave of absence if you elect to continue such coverage and if you continue to make the payments you elected at your enrollment. You will receive further details when you are granted a leave of absence.

HOW THE PLAN WORKS

Allowable Amount

The Allowable Amount is the maximum amount determined by the Claim Administrator to be eligible for consideration of payment for a particular service, supply or procedure. The Claim Administrator has established an Allowable Amount for Medically Necessary services, supplies, and procedures provided by Providers that have contracted with the Claim Administrator or any other Blue Cross and/or Blue Shield Plan, and Providers that have not contracted with the Claim Administrator or any other Blue Cross and/or Blue Shield Plan. When you choose to receive services, supplies, or care from a Provider that does not contract with the Claim Administrator, you will be responsible for any difference between the Claim Administrator’s Allowable Amount and the amount charged by the non-contracting Provider. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan, and any applicable Deductibles, Co-Share Amounts, and Copayment Amounts.

Review the definition of Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet to understand the guidelines used by the Claim Administrator.

Case Management

Under certain circumstances, the Plan allows the Claim Administrator the flexibility to offer benefits for expenses which are not otherwise Eligible Expenses. The Claim Administrator may offer such benefits if:

- The Participant, his family, and the Physician agree;
- Benefits are cost effective; and
- The Claim Administrator anticipates future expenditures for Eligible Expenses which may be reduced by such benefits.

Any decision by the Claim Administrator to provide such benefits shall be made on a case-by-case basis. The case coordinator for the Claim Administrator will initiate case management in appropriate situations.

Freedom of Choice

<i>Each time you need medical care, you can choose to:</i>		
See a Network Provider	See an Out-of-Network Provider	
	ParPlan Provider <i>(refer to ParPlan, below, for more information)</i>	Out-of-Network Provider that is not a contracting Provider
<ul style="list-style-type: none"> • You receive the higher level of benefits (In-Network Benefits) • You are not required to file claim forms • You are not balance billed; Network Providers will not bill for costs exceeding the Claim Administrator’s Allowable Amount for covered services • Your Provider will Preauthorize necessary services 	<ul style="list-style-type: none"> • You receive the lower level of benefits (Out-of-Network Benefits) • You are not required to file claim forms in most cases; <i>ParPlan</i> Providers will usually file claims for you, however, you will be required to file a claim if your Par Plan Provider does not file for you • You are not balance billed; <i>ParPlan</i> Providers will not bill for costs exceeding the Claim Administrator’s Allowable Amount for covered services • In most cases, <i>ParPlan</i> Providers will Preauthorize necessary services 	<ul style="list-style-type: none"> • You receive Out-of-Network Benefits (the lower level of benefits) • You may be required to file your own claim forms • You may be billed for charges exceeding the Claim Administrator’s Allowable Amount for covered services • You must Preauthorize necessary services

Identification Card

The Identification Card tells Providers that you are entitled to benefits under your Employer's Health Benefit Plan. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- ***Your Subscriber identification number.*** This unique identification number is preceded by a three character alpha prefix that identifies Blue Cross and Blue Shield of Texas as your Claim Administrator.
- ***Your group number.*** This is the number assigned to identify your Employer's Health Benefit Plan with the Claim Administrator.
- ***Copayment Amounts that may apply to your coverage.***
- ***Important telephone numbers.***

Always remember to carry your Identification Card with you and present it to your Providers or Participating Pharmacies when receiving health care services or supplies.

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, the Claim Administrator will provide a new Identification Card.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered Dependents will include, but not be limited to, the following actions, when intentional:
 - a. Use of the Identification Card prior to your Effective Date;
 - b. Use of the Identification Card after your date of termination of coverage under the Plan;
 - c. Obtaining prescription drugs or other benefits for persons not covered under the Plan;
 - d. Obtaining prescription drugs or other benefits that are not covered under the Plan;
 - e. Obtaining Covered Drugs for resale or for use by any person other than the person for whom the Prescription Order is written, even though the person is otherwise covered under the Plan;
 - f. Obtaining Covered Drugs without a Prescription Order or through the use of a forged or altered Prescription Order;
 - g. Obtaining quantities of prescription drugs in excess of Medically Necessary or prudent standards of use or in circumvention of the quantity limitations of the Plan;
 - h. Obtaining prescription drugs using Prescription Orders for the same drugs from multiple Providers;
 - i. Obtaining prescription drugs from multiple Pharmacies through use of the same Prescription Order.
2. The fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:
 - a. Denial of benefits;
 - b. Cancellation of coverage under the Plan for **all** Participants under your coverage;
 - c. Limitation on the use of the Identification Card to one designated Physician, Other Provider, or Participating Pharmacy of your choice;
 - d. Recoupment from you or any of your covered Dependents of any benefit payments made;
 - e. Pre-approval of drug purchases and medical services for all Participants receiving benefits under your coverage;
 - f. Notice to proper authorities of potential violations of law or professional ethics.

Medical Necessity

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by the Claim Administrator. Charges for services and supplies which the Claim Administrator determines are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy Deductibles or to apply to the Co-Share Stop-Loss Amount (also called the Out-of-Pocket Maximum).

ParPlan

When you consult a Physician or Professional Other Provider who does not participate in the Network, you should inquire if he participates in the Claim Administrator's *ParPlan*...a simple direct-payment arrangement. If the Physician or Professional Other Provider participates in the *ParPlan*, he agrees to:

- File all claims for you,
- Accept the Claim Administrator's Allowable Amount determination as payment for Medically Necessary services, and
- Not bill you for services over the Allowable Amount determination.

You will receive Out-of-Network Benefits and be responsible for:

- Any Deductibles,
- Any Co-Share Amounts and Copayment Amounts, and
- Services that are limited or not covered under the Plan.

NOTE: If you have a question regarding a Physician's or Professional Other Provider's participation in the *ParPlan*, please contact the Claim Administrator's Customer Service Helpline.

Preexisting Conditions Provision

Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during (i) the 12-month period following the Participant's initial Effective Date of Coverage, or if a Waiting Period applies, the first day of the Waiting Period (typically the date you are hired), if the Participant is not a late enrollee, or (ii) the 18-month period following the Participant's initial Effective Date of Coverage, if the Participant is a late enrollee.

The Preexisting Condition exclusion **will not apply** to:

1. Any individual under age 19; or
2. A newborn child who is added as described in *Dependent Enrollment Period* within the first 30 days after the date of birth; or
3. A child who is adopted or placed with you for adoption before attaining the limiting age shown in the Schedule of Coverage if the Employee applies for coverage for such child under this Plan, as described in *Dependent Enrollment Period*; or
4. A court ordered Dependent of a covered Employee, if the Employee applies for coverage for such child under this Plan as described in *Dependent Enrollment Period*; or
5. An individual who was continuously covered for an aggregate period of at least twelve months under Creditable Coverage that was in effect up to a date not more than 63 days before the Effective Date of coverage under the Health Benefit Plan, excluding any Waiting Periods.

The Claim Administrator will credit the time you were covered under Creditable Coverage if the previous coverage was in effect under a Health Benefit Plan or self-funded Health Benefit Plan at any time during the twelve months prior to the Effective Date of coverage under this Plan. If the previous coverage was issued under a Health Benefit Plan, any waiting period that applied before that coverage became effective also will be credited against the Preexisting Condition exclusion.

Pregnancy and genetic information without a diagnosis of a specific condition shall not be considered a Preexisting Condition.

All other terms, provisions, limitations, and exclusions will apply to all Participants even if any Preexisting Condition exclusion is not applicable for the reasons set out above.

Specialty Care Providers

A wide range of Specialty Care Providers is included in the Network. When you need a specialist's care, In-Network Benefits will be available, but only if you use a Network Provider.

There may be occasions however, when you need the services of an Out-of-Network Provider. This could occur if you have a complex medical problem that cannot be taken care of by a Network Provider.

- If the services you require are not available from Network Providers, In-Network Benefits will be provided when you use Out-of-Network Providers.
- If you elect to see an Out-of-Network Provider and if the services could have been provided by a Network Provider, only Out-of-Network Benefits will be available.

Use of Non-Contracting Providers (Applies to Managed Health Care Only)

When you choose to receive services, supplies, or care from a Provider that does not contract with BCBSTX (a non-contracting Provider), you receive Out-of-Network Benefits (the lower level of benefits). Benefits for covered services will be reimbursed based on the BCBSTX non-contracting Allowable Amount, which in most cases is less than the Allowable Amount applicable for BCBSTX contracted Providers. Please see the definition of non-contracting Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet. **The non-contracted Provider is not required to accept the BCBSTX non-contracting Allowable Amount as payment in full and may balance bill you for the difference between the BCBSTX non-contracting Allowable Amount and the non-contracting Provider's billed charges. You will be responsible for this balance bill amount, which may be considerable.** You will also be responsible for charges for services, supplies and procedures limited or not covered under the Plan and any applicable Deductibles, Co-Share Amounts, and Copayment Amounts.

PREAUTHORIZATION REQUIREMENTS

Preauthorization Requirements

Preauthorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the Preauthorized care and services described below will not be denied on the basis of Medical Necessity or Experimental/Investigational. However, Preauthorization does not guarantee payment of benefits.

Coverage is always subject to other requirements of the Plan, such as Preexisting Conditions, limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided.

The following types of services require Preauthorization:

- All inpatient Hospital Admissions,
- Extended Care Expenses,
- Home Infusion Therapy,
- All inpatient treatment of Chemical Dependency,
- All inpatient treatment of Mental Health Care,
- All inpatient treatment of Serious Mental Illness, and
- If you transfer to another facility or to or from a specialty unit within the facility.
- The following outpatient treatment of Chemical Dependency, and Serious Mental Illness and Mental Health Care:
 - Psychological testing,
 - Neuropsychological testing,
 - Electroconvulsive therapy, and
 - Intensive Outpatient Program.

Intensive Outpatient Program means a freestanding or Hospital-based program that provides services for at least three hours per day, two or more days per week, to treat mental illness, drug addiction, substance abuse or alcoholism, or specializes in the treatment of co-occurring mental illness with drug addiction, substance abuse or alcoholism. These programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe or complex co-occurring conditions which make it unlikely that the Participants will benefit from programs that focus solely on mental illness conditions.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. In-Network Providers will Preauthorize services for you, when required.

If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid.

However, if care is not available from Network Providers as determined by the Claim Administrator, and the Claim Administrator acknowledges your visit to an Out-of-Network Provider **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjusted, if appropriate.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Physician, Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in the section entitled *Failure to Preauthorize*.

Preauthorization for Inpatient Hospital Admissions

In the case of an elective inpatient Hospital Admission, the call for Preauthorization should be made at least two working days before you are admitted unless it would delay Emergency Care. In an emergency, Preauthorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

To satisfy Preauthorization requirements, on business days between 7:30 a.m. and 6:00 p.m. Central Time, you, your Physician, Provider of services, or a family member should call one of the Customer Service toll-free numbers listed on the back of your Identification Card. After working hours or on weekends, please call the **Medical Preauthorization Helpline** toll-free number listed on the back of your Identification Card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. In-Network and Out-of-Network Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

However, if care is not available from Network Providers as determined by BCBSTX, and BCBSTX authorizes your visit to an Out-of-Network Provider to be covered at the In-Network Benefit level **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid.

When an inpatient Hospital Admission is Preauthorized, a length-of-stay is assigned. If you require a longer stay than was first Preauthorized, your Provider may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days.

Preauthorization not Required for Maternity Care and Treatment of Breast Cancer Unless Extension of Minimum Length of Stay Requested

Your Plan is required to provide a minimum length-of-stay in a Hospital facility for the following:

- Maternity Care
 - 48 hours following an uncomplicated vaginal delivery
 - 96 hours following an uncomplicated delivery by caesarean section
- Treatment of Breast Cancer
 - 48 hours following a mastectomy
 - 24 hours following a lymph node dissection

You or your Provider will not be required to obtain Preauthorization from BCBSTX for a length of stay less than 48 hours (or 96 hours) for Maternity Care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer. If you require a longer stay, you or your Provider must seek an extension for the additional days by obtaining Preauthorization from BCBSTX.

Preauthorization for Extended Care Expenses and Home Infusion Therapy

Preauthorization for Extended Care Expenses and Home Infusion Therapy may be obtained by having the agency or facility providing the services contact the Claim Administrator to request Preauthorization. The request should be made:

- Prior to initiating Extended Care Expenses or Home Infusion Therapy;
- When an extension of the initially Preauthorized service is required; and
- When the treatment plan is altered.

The Claim Administrator will review the information submitted prior to the start of Extended Care Expenses or Home Infusion Therapy and will send a letter to you and the agency or facility confirming Preauthorization or denying benefits. If Extended Care Expenses or Home Infusion Therapy is to take place in less than one week, the agency or facility should call the Claim Administrator's **Medical Preauthorization Helpline** telephone number indicated in this Benefit Booklet or shown on your Identification Card.

If the Claim Administrator has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

Preauthorization for Mental Health Care, Serious Mental Illness, and Treatment of Chemical Dependency

In order to receive maximum benefits, all inpatient treatment for Mental Health Care, Serious Mental Illness, and Chemical Dependency must be Preauthorized by the Plan. Preauthorization is also required for certain outpatient

services. Outpatient services requiring Preauthorization include psychological testing, neuropsychological testing, Intensive Outpatient Programs and electroconvulsive therapy. Preauthorization is not required for therapy visits to a Physician, Behavioral Health Practitioner and/or Professional Other Provider..

To satisfy Preauthorization requirements, you, a family member or your Behavioral Health Practitioner must call the **Mental Health/Chemical Dependency Preauthorization Helpline** toll-free number indicated in this Benefit Booklet or shown on your Identification Card. The **Mental Health/Chemical Dependency Preauthorization Helpline** is available 24 hours a day, 7 days a week. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. In-Network and Out-of-Network Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

However, if care is not available from Network Providers as determined by BCBSTX, and BCBSTX authorizes your visit to an Out-of-Network Provider to be covered at the In-Network Benefit level **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of Network Benefits will be paid.

When a treatment or service is Preauthorized, a length of stay or length of service is assigned. If you require a longer stay or length of service than was first Preauthorized, your Behavioral Health Practitioner may seek an extension for the additional days or visits. Benefits will not be available for medically unnecessary treatments or services.

Failure to Preauthorize

If Preauthorization for inpatient Hospital Admissions, Extended Care Expense, Home Infusion Therapy, all inpatient and the above specified outpatient treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Chemical Dependency is not obtained:

- BCBSTX will review the Medical Necessity of your treatment or service prior to the final benefit determination.
- If BCBSTX determines the treatment or service is not Medically Necessary or is Experimental/Investigational, benefits will be reduced or denied.
- You may be responsible for a penalty in connection with the following Covered Services, if indicated on your Schedule of Coverage:
 - Inpatient Hospital Admission
 - Inpatient treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Chemical Dependency

The penalty charge will be deducted from any benefit payment which may be due for Covered Services.

If an inpatient Hospital Admission, Extended Care Expense, Home Infusion Therapy, any treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Chemical Dependency or extension for any treatment or service described above is not Preauthorized and it is determined that the treatment, service, or extension was not Medically Necessary or Experimental/Investigational, benefits will be reduced or denied.

CLAIM FILING AND APPEALS PROCEDURES

CLAIM FILING PROCEDURES

Filing of Claims Required

Claim Forms

When the Claim Administrator receives notice of claim, it will furnish to you, or to your Employer for delivery to you, the Hospital, or your Physician or Professional Other Provider, the claim forms that are usually furnished by it for filing Proof of Loss.

The Claim Administrator for the Plan must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits.

Who Files Claims

Providers that contract with the Claim Administrator and some other health care Providers (such as *ParPlan* Providers) will submit your claims directly to the Claim Administrator for services provided to you or any of your covered Dependents. At the time services are provided, inquire if they will file claim forms for you. To assist Providers in filing your claims, you should carry your Identification Card with you.

Contracting Providers

When you receive treatment or care from a Provider or Covered Drugs dispensed from a Pharmacy that contracts with the Claim Administrator, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to the Claim Administrator for you.

Non-Contracting Providers

When you receive treatment or care from a health care Provider or Covered Drugs dispensed from a Pharmacy that does not contract with the Claim Administrator, you may be required to file your own claim forms. Some Providers, however, will do this for you. If the Provider does not submit claims for you, refer to the subsection entitled *Participant-filed claims* below for instruction on how to file your own claim forms.

Mail-Order Program

When you receive Covered Drugs dispensed through the Mail-Order Program, you must complete and submit the mail service prescription drug claim form to the address on the claim form. Additional information may be obtained from your Employer, from the Claim Administrator, from the BCBSTX website at www.bcbstx.com/member/rx_drugs.html, or by calling the Customer Service Helpline.

Participant-filed claims

- Medical Claims

If your Provider does not submit your claims, you will need to submit them to the Claim Administrator using a Subscriber-filed claim form provided by the Plan. Your Employer should have a supply of claim forms or you can obtain copies from the BCBSTX website. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Copayment Amounts, Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the health care Providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

- Prescription Drug Claims

When you receive Covered Drugs dispensed from a non-Participating Pharmacy, a *Prescription Reimbursement Claim Form* must be submitted. This form can be obtained from the Claim Administrator or your Employer. This claim form, accompanied by an itemized bill obtained from the Pharmacy showing the prescription services you received, should be mailed to the address shown below or on the claim form.

Instructions for completing the claim form are provided on the back of the form. You may need to obtain additional information, which is not on the receipt from the pharmacist, to complete the claim form.

Bills for Covered Drugs should show the name, address and telephone number of the Pharmacy, a description and quantity of the drug, the prescription number, the date of purchase and most importantly, the name of the Participant using the drug.

VISIT THE BCBSTX WEBSITE FOR SUBSCRIBER CLAIM FORMS AND OTHER USEFUL INFORMATION
www.bcbstx.com

Where to Mail Completed Claim Forms

Medical Claims

Blue Cross and Blue Shield of Texas
Claims Division
P. O. Box 660044
Dallas, TX 75266-0044

Prescription Drug Claims

Blue Cross and Blue Shield of Texas
c/o Prime Therapeutics LLC
P. O. Box 14624
Lexington, KY 40512-4624

Mail-Order Program

Blue Cross and Blue Shield of Texas
c/o Prime Mail Pharmacy
P. O. Box 650041
Dallas, TX 75265-0041

Who Receives Payment

Benefit payments will be made directly to contracting Providers when they bill the Claim Administrator. Written agreements between the Claim Administrator and some Providers may require payment directly to them.

Any benefits payable to you, if unpaid at your death, will be paid to your surviving spouse, as beneficiary. If there is no surviving spouse, then the benefits will be paid to your estate.

Except as provided in the section **Assignment and Payment of Benefits**, rights and benefits under the Plan are not assignable, either before or after services and supplies are provided.

Benefit Payments to a Managing Conservator

Benefits for services provided to your minor Dependent child may be paid to a third party if:

- the third party is named in a court order as managing or possessory conservator of the child; and
- the Claim Administrator has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to the Claim Administrator, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator.

The Claim Administrator for the Health Benefit Plan may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to you or your Provider, or deduction by the Plan from benefit payments of amounts owed to it, will be considered in satisfaction of its obligations to you under the Plan.

An Explanation of Benefits summary is sent to you so you will know what has been paid.

When to Submit Claims

All claims for benefits under the Health Benefit Plan must be properly submitted to the Claim Administrator within twelve (12) months of the date you receive the services or supplies. Claims submitted and received by the Claim Administrator after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by the Claim Administrator

A claim will be considered received by the Claim Administrator for processing upon actual delivery to the Administrative Office of the Claim Administrator in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied or the Claim Administrator may contact either you or the Provider for the additional information.

After processing the claim, the Claim Administrator will notify the Participant by way of an *Explanation of Benefits* summary.

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations

When the Claim Administrator receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Health Benefit Plan provisions. The Claim Administrator will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between the Claim Administrator and the Plan Administrator.

You have the right to seek and obtain a full and fair review by the Claim Administrator of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

If a Claim Is Denied or Not Paid in Full

On occasion, the Claim Administrator may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the *Explanation of Benefits* summary prepared by the Claim Administrator; then review this Benefit Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to the Claim Administrator and request a review of the decision as described in **Claim Appeal Procedures** below.

If the claim is denied in whole or in part, you will receive a written notice from the Claim Administrator with the following information, if applicable:

- The reasons for determination;
- A reference to the Health Benefit Plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
- A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
- In certain situations, a statement in non-English language(s) that written notices of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);

- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an urgent care clinical claim, a description of the expedited review procedure applicable to such claims. An urgent care claim decision may be provided orally, so long as a written notice is furnished to the claimant within three days of oral notification
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of Claim. There are three types of Claims as defined below.

1. **Urgent Care Clinical Claim** is any pre-service Claim that requires Preauthorization, as described in this Benefit Booklet, for benefits for medical care or Treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or Treatment.
2. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
3. **Post-Service Claim** is notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If your Claim is incomplete, the Claim Administrator must notify you within:	24 hours
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	48 hours after receiving notice
<i>The Claim Administrator must notify you of the Claim determination (whether adverse or not):</i>	
if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than:	72 hours
after receiving the completed Claim (if the initial Claim is incomplete), within:	48 hours

* You do not need to submit appeals of Urgent Care-Clinical Claims in writing. You should call the Claim Administrator at the toll-free number listed on the back of your Identification Card as soon as possible to appeal an Urgent Care Clinical Claim.

Pre-Service Claims

Type of Notice or Extension	Timing
If your Claim is filed improperly, the Claim Administrator must notify you within:	5 days
If your Claim is incomplete, the Claim Administrator must notify you within:	15 days
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	45 days after receiving notice
<i>The Claim Administrator must notify you of the Claim determination (whether adverse or not):</i>	
if the initial Claim is complete, within:	15 days*
after receiving the completed Claim (if the initial Claim is incomplete), within:	30 days
If you require post-stabilization care after an Emergency within:	the time appropriate to the circumstance not to exceed one hour after the time of request

* This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

Post-Service Claims

Type of Notice or Extension	Timing
If your Claim is incomplete, the Claim Administrator must notify you within:	30 days
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	45 days after receiving notice
<i>The Claim Administrator must notify you of the Claim determination (whether adverse or not):</i>	
if the initial Claim is complete, within:	30 days*
after receiving the completed Claim (if the initial Claim is incomplete), within:	45 days

* This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

Concurrent Care

For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your Claim for benefits.

Claim Appeal Procedures

Claim Appeal Procedures - Definitions

An “**Adverse Benefit Determination**” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by

the Claim Administrator and the Claim Administrator reduces or terminates such treatment (other than by amendment or termination of the Employer's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

A "**Final Internal Adverse Benefit Determination**" means an Adverse Benefit Determination that has been upheld by the Claim Administrator at the completion of the Claim Administrator's internal review/appeal process.

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An **expedited clinical appeal** is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, the Claim Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claim Administrator shall render a determination on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by the Claim Administrator.

How to Appeal an Adverse Benefit Determinations

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your ID card.

If you believe the Claim Administrator incorrectly denied all or part of your benefits, you may have your claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of a denial or partial denial, you may call or write to the Claim Administrator's Administrative Office. The Claim Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Claim Review Section
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044

- You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.
- The Claim Administrator will honor telephone requests for information. However, such inquiries will not constitute a request for review.
- In support of your claim review, you have the option of presenting evidence and testimony to the Claim Administrator. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

The Claim Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. The appeal determination will be made by a Physician associated or contracted with the Claim Administrator and/or by external advisors, but who were not involved in making the initial denial of your claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator or your Employer.

- If you have any questions about the claims procedures or the review procedure, write to the Claim Administrator's Administrative Office or call the toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

Timing of Appeal Determinations

Upon receipt of a non-urgent pre-service appeal, the Claim Administrator shall render a determination of the appeal as soon as practical, but in no event more than 30 days after the appeal has been received by the Claim Administrator.

Upon receipt of a non-urgent post-service appeal, the Claim Administrator shall render a determination of the appeal as soon as practical, but in no event more than 60 days after the appeal has been received by the Claim Administrator.

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, by a written notice of the determination.

The written notice will include:

1. A reason for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Diagnosis/treatment codes with their meanings and the standards used are also available upon request;
4. An explanation of the Claim Administrator's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;
5. In certain situations, a statement in non-English language(s) that written notices of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
6. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
7. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
8. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
9. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
10. A description of the standard that was used in denying the claim and a discussion of the decision;
11. Contact information for applicable office of health insurance consumer assistance or ombudsman.

If the Claim Administrator's decision is to continue to deny or partially deny your claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review

the denial and issue a final decision. Your external review rights are described in the **Standard External Review** section below.

If You Need Assistance

If you have any questions about the claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1-800-521-2227. The Claim Administrator Customer Service Helpline is accessible from 8:00 A.M. to 8:00 P.M., Monday through Friday.

Claim Review Section
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may call the number on the back of your ID card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

STANDARD EXTERNAL REVIEW

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO).

1. **Request for external review.** Within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review.
2. **Preliminary review.** Within five business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:
 - a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
 - b. The Adverse Benefit Determination or the Final Adverse Internal Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
 - c. You have exhausted the Claim Administrator's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **Exhaustion** section below for additional information and exhaustion of the internal appeal process; and
 - d. You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within one business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

3. **Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, the Claim Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized

accrediting organization. Moreover, the Claim Administrator will take action against bias and to ensure independence. Accordingly, the Claim Administrator must contract with at least three IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- a. Utilization of legal experts where appropriate to make coverage determinations under the plan.
- b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
- c. Within five business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.
- d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider the Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.
- e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
 - (1) Your medical records;
 - (2) The attending health care professional's recommendation;
 - (3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;
 - (4) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
 - (5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - (6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
 - (7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

- f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claim Administrator and you or your authorized representative.
 - g. The notice of final external review decision will contain:
 - (1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - (2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - (3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - (4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - (5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator or you or your authorized representative;
 - (6) A statement that judicial review may be available to you or your authorized representative; and
 - (7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
 - h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.
4. **Reversal of plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim Administrator must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

EXPEDITED EXTERNAL REVIEW

1. **Request for expedited external review.** The Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:
 - a. An Adverse Benefit Determination, if the Adverse Benefit Determination involve a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
 - b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.
2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the **Standard External Review** section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in **Standard External Review** section above.
3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the

requirements set forth in the **Standard External Review** section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.

4. **Notice of final external review decision.** The Claim Administrator's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the **Standard External Review** section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

EXHAUSTION

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claim Administrator to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

Interpretation of Employer's Plan Provisions

The Plan Administrator has given the Claim Administrator the final authority to establish or construe the terms and conditions of the Health Benefit Plan and the discretion to interpret and determine benefits in accordance with the Health Benefit Plan's provisions.

The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Health Benefit Plan, including, but not limited to, a person's eligibility to be covered under the Health Benefit Plan.

All powers to be exercised by the Claim Administrator or the Plan Administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Expenses

The Plan provides coverage for four categories of Eligible Expenses:

- Inpatient Hospital Expenses,
- Medical-Surgical Expenses,
- Extended Care Expenses, and
- Special Provisions Expenses

Wherever Schedule of Coverage is mentioned, please refer to the Schedule(s) in this Benefit Booklet. Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

Copayment Amounts

Some of the care and treatment you receive under the Plan will require that a Copayment Amount be paid at the time you receive the services. Refer to your Schedule of Coverage under “Copayment Amounts Required” for your specific Plan information.

A Copayment Amount will be required for most Primary Care Physician office visits, including lab and x-rays performed in the Provider’s office. If the services provided require a return office visit (lab services for instance) on a different day, a new Copayment Amount will be required. A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits.

A Copayment Amount will also be required for facility charges for each Hospital outpatient emergency room visit for the treatment of an illness. If admitted to the Hospital as a direct result of the illness, the Copayment Amount will be waived.

Other services may also require a Copayment Amount. Your Schedule of Coverage will indicate which services are subject to the Copayment requirement.

Deductibles

The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your Schedule of Coverage. The Deductibles are explained as follows:

Calendar Year Deductible: The individual Deductible amount shown under “Deductibles” on your Schedule of Coverage must be satisfied by each Participant under your coverage each Calendar Year. This Deductible, unless otherwise indicated, will be applied to all categories of Eligible Expenses before benefits are available under the Plan.

Prescription Drug Deductible: The Prescription Drug Deductible amount indicated on your Schedule of Coverage must be satisfied by each Participant each Calendar Year before Covered Drug benefits are available under the Plan.

Per-admission Deductible: The Per-admission Deductible shown under “Deductibles” on your Schedule of Coverage will apply to **each** inpatient Hospital Admission of a Participant.

The following are exceptions to the Calendar Year Deductible described above:

If you have several covered Dependents, all charges used to apply toward a “per individual” Deductible amount will be applied toward the “per family” Deductible amount shown on your Schedule of Coverage. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year. No Participant may contribute more than the individual Deductible amount to the “per family” Deductible amount.

Eligible Expenses applied toward satisfying the “per individual” Deductible will apply toward both the In-Network and the Out-of-Network Deductible amounts shown on your Schedule of Coverage. Eligible Expenses applied toward satisfying the “per family” Deductible will apply toward both the In-Network and the Out-of-Network “per family” Deductible amount shown on your Schedule of Coverage.

Co-Share Stop-Loss Amount (Out-of-Pocket Maximum)

Most of your Eligible Expense payment obligations are considered Co-Share Amounts and are applied to the Co-Share Stop-Loss Amount maximum.

Your Co-Share Stop-Loss Amount will **not** include:

- Services, supplies, or charges limited or excluded by the Plan;
- Expenses not covered because a benefit maximum has been reached;
- Any Eligible Expenses paid by the Primary Plan when the Plan is the Secondary Plan for purposes of coordination of benefits;
- Deductible Amounts;
- Copayment Amounts;
- Penalties applied for failure to Preauthorize;
- Any Copayment Amounts paid under the Prescription Drug Program;
- Any remaining unpaid Medical-Surgical Expense in excess of the benefits provided for Covered Drugs if “Prescription Drug Program” is shown on your Schedule of Coverage.

Individual Co-Share Stop-Loss Amount

When the Co-Share Amount for the In-Network, Out-of-Network, or Out-of-Area Benefits level for a Participant in a Calendar Year equals the “per individual” “Co-Share Stop-Loss Amount” shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant for the remainder of that Calendar Year for that level.

Family Co-Share Stop-Loss Amount

When the Co-Share Amount for the In-Network, Out-of-Network, or Out-of-Area Benefits level for all Participants under your coverage in a Calendar Year equals the “per family” “Co-Share Stop-Loss Amount” shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants for the remainder of that Calendar Year for that level. No Participant may contribute more than the individual Co-Share Amount to the family “Co-Share Stop-Loss Amount.”

The following are exceptions to the Co-Share Stop-Loss Amounts described above:

There are separate Co-Share Stop-Loss Amounts for In-Network Benefits, Out-of-Network Benefits and Out-of-Area Benefits.

Copayment Amounts will continue to be required after the benefit percentages become 100%.

Annual Maximum Benefits

The total amount of benefits available to any one Participant for Covered Services for a Calendar Year shall not exceed the “Annual Maximum Benefits” amount shown on your Schedule of Coverage. This “Annual Maximum Benefits” amount includes all payments made by BCBSTX for Covered Services under any benefit provision of the Plan. However, in no event will the amount of “Annual Maximum Benefits” paid for Covered Services for a Calendar Year that are essential health benefits as determined by BCBSTX be less than the applicable restricted annual dollar limit for essential health benefits under the Affordable Care Act and applicable regulations.

At the end of a Calendar Year, a new benefit period starts for each Participant. Any unused amounts from the previous year do not accumulate.

Changes In Benefits

Changes to covered benefits will apply to all services provided to each Participant under the Plan. Benefits for Eligible Expenses incurred during an admission in a Hospital or Facility Other Provider that begins before the change will be those benefits in effect on the day of admission.

COVERED MEDICAL SERVICES

Inpatient Hospital Expenses

The Plan provides coverage for Inpatient Hospital Expenses for you and your covered Dependents. Each inpatient Hospital Admission requires Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for additional information.

The benefit percentage of your total eligible Inpatient Hospital Expense, in excess of any Deductible shown under “Inpatient Hospital Expenses” on the Schedule of Coverage is the Plan’s obligation. The remaining unpaid Inpatient Hospital Expense, in excess of any Deductible, is your obligation to pay.

Services and supplies provided by an Out-of-Network Provider will receive In-Network Benefits when those services and supplies are not available from a Network Provider provided the Claim Administrator acknowledges your visit to an Out-of-Network Provider **prior** to the visit. Otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate.

Refer to the Schedule of Coverage for information regarding Deductibles, Co-Share percentages, and penalties for failure to Preauthorize that may apply to your coverage.

Medical-Surgical Expenses

The Plan provides coverage for Medical-Surgical Expense for you and your covered Dependents. Some services require Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

Copayment Amounts must be paid to your Network Physician or other Network Providers at the time you receive services.

The benefit percentages of your total eligible Medical-Surgical Expense shown under “Medical-Surgical Expenses” on the Schedule of Coverage in excess of your Copayment Amounts, Co-Share Amounts, and any applicable Deductibles shown are the Plan’s obligation. The remaining unpaid Medical-Surgical Expense in excess of the Copayment Amounts, Co-Share Amounts, and any Deductibles is your obligation to pay.

Medical-Surgical Expense shall include:

1. Services of Physicians and Professional Other Providers. If services are received from a Licensed Professional Counselor, a Licensed Clinical Social Worker or Licensed Chemical Dependency Counselor, a professional recommendation should be obtained from a Physician and their services must be performed under the supervision of a Doctor of Medicine or a Licensed Psychologist.
2. Consultation services of a Physician and Professional Other Provider.
3. Services of a certified registered nurse-anesthetist (CRNA).
4. Diagnostic x-ray and laboratory procedures.
5. Radiation therapy.
6. Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
7. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by the Plan. The term “durable medical equipment (DME)” shall not include:

- a. Equipment primarily designed for alleviation of pain or provision of patient comfort; or
- b. Home air fluidized bed therapy.

Examples of non-covered equipment include, but are not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment.

8. Professional local ground ambulance service or air ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition.
9. Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider.
10. Oxygen and its administration provided the oxygen is actually used.
11. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant.
12. Prosthetic Appliances, including replacements necessitated by growth to maturity of the Participant.
13. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.
14. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Chemical Dependency Treatment Center, or scheduled services in the outpatient treatment room of a Hospital.
15. Certain Diagnostic Procedures.
16. Injectable drugs, administered by or under the direction or supervision of a Physician or Professional Other Provider.
17. Voluntary sterilizations.

Extended Care Expenses

The Plan also provides benefits for Extended Care Expenses for you and your covered Dependents. All Extended Care Expenses require Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

The Plan's benefit obligation as shown on your Schedule of Coverage will be:

1. At the benefit percentage under "Extended Care Expenses," and
2. Up to the amount of the combined benefit limits, if any, shown for each category of Extended Care Expenses on your Schedule of Coverage.

All payments made by the Plan, whether under the In-Network, Out-of-Network Benefit or Out-of-Area benefit level, will apply toward the benefit limits.

Out-of-Area benefits are not available unless services are rendered by a Contracting Facility and have been Preauthorized and approved by the Claim Administrator.

If shown on your Schedule of Coverage, the Calendar Year Deductible will apply. Any unpaid Extended Care Expenses in excess of the benefit maximums shown on your Schedule of Coverage will not be applied to any Co-Share Stop-Loss Amount.

Any charges incurred as Home Health Care or home Hospice Care for drugs (including antibiotic therapy) and laboratory services will not be Extended Care Expenses but will be considered Medical-Surgical Expenses.

Services and supplies for Extended Care Expenses:

1. For Skilled Nursing Facility:

- a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
- c. Physical, occupational, speech, and respiratory therapy services by licensed therapists.

2. For Home Health Care:

- a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- c. Physical, occupational, speech, and respiratory therapy services by licensed therapists;
- d. Supplies and equipment routinely provided by the Home Health Agency;
- e. Home Infusion Therapy (whether or not billed by the Home Health Agency).

Benefits will **not** be provided for Home Health Care for the following:

- Food or home delivered meals;
- Social case work or homemaker services;
- Services provided primarily for Custodial Care;
- Transportation services;
- Durable medical equipment.

3. For Hospice Care:

Home Hospice Care:

- a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- c. Physical, speech, and respiratory therapy services by licensed therapists;
- d. Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.

Facility Hospice Care:

- a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Room and board and all routine services, supplies, and equipment provided by the Hospice facility;
- c. Physical, speech, and respiratory therapy services by licensed therapists.

Benefits will **not** be provided for respite care.

Special Provisions Expenses

The benefits available under this **Special Provisions Expenses** subsection are generally determined on the same basis as other Inpatient Hospital Expenses, Medical-Surgical Expenses, and Extended Care Expenses, except to the

extent described in each item. Benefits for Medically Necessary expenses will be determined as indicated on your Schedule(s) of Coverage. Remember that certain services require Preauthorization and that any Copayment Amounts, Co-Share Amounts, and Deductibles shown on your Schedule(s) of Coverage will also apply. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

Benefits for Treatment of Complications of Pregnancy

Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be determined on the same basis as treatment for any other sickness for Employes and Dependent Spouses. Dependent children will not be eligible for treatment of Complications of Pregnancy.

Benefits for Maternity Care

Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness for Employees and Dependent Spouses.. A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits. Dependent children will not be eligible for Maternity Care benefits.

Services and supplies incurred by a Participant for delivery of a child shall be considered Maternity Care and are subject to all provisions of the Plan.

The Plan provides coverage for inpatient care for the mother and newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by caesarean section.

No Preauthorization is required for this inpatient care unless it exceeds the minimum period.

Charges for well-baby nursery care, including the initial examination, of a newborn child during the mother's Hospital Admission for the delivery will be considered Inpatient Hospital Expense of the child and will be subject to the benefit provisions as described under **Inpatient Hospital Expenses**. Benefits will also be subject to any Deductible amounts shown on your Schedule of Coverage.

Benefits for Emergency Care and Treatment of Accidental Injury

The Plan provides coverage for medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

If reasonably possible, contact your Physician before going to the Hospital emergency room. He can help you determine if you need Emergency Care or treatment of an Accidental Injury and recommend that care. If not reasonably possible, go to the nearest emergency facility.

Whether you require hospitalization or not, you should notify your Physician as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services.

Benefits for Eligible Expenses for Accidental Injury or Emergency Care will be determined as shown on your Schedule of Coverage. If admitted for the emergency condition immediately following the visit, Preauthorization of the inpatient Hospital Admission will be required.

Notwithstanding anything in this Benefit Booklet to the contrary, for Out-of-Network Emergency Care services rendered by non-contracting Providers, the Allowable Amount shall be equal to the greatest of the following three possible amounts--not to exceed billed charges:

1. the median amount negotiated with In-Network Providers for Emergency Care services furnished;
2. the amount for the Emergency Care service calculated using the same method the Plan generally uses to determine payments for Out-of-Network services but substituting the In-Network cost-sharing provisions for the Out-of-Network cost sharing provisions; or

3. the amount that would be paid under Medicare for the Emergency Care service.

Each of these three amounts is calculated excluding any In-Network Copayment Amount or Co-Share Amount imposed with respect to the Participant.

Benefits for Speech and Hearing Services

Benefits as shown on your Schedule of Coverage are available for the services of an Outpatient Hospital facility, Physician or Professional Other Provider to restore loss of or correct an impaired speech or hearing function. Hearing aids are not covered.

Benefits for Cosmetic, Reconstructive, or Plastic Surgery

The following Eligible Expenses described below for Cosmetic, Reconstructive, or Plastic Surgery will be the same as for treatment of any other sickness as shown on your Schedule of Coverage:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
- Treatment provided for reconstructive surgery following cancer surgery; or
- Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
- Surgery performed on a covered Dependent child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast; or
- Services and supplies for reduction mammoplasty when Medically Necessary and in accordance with the medical policy guidelines of the Claim Administrator; or
- Medically necessary reconstruction of the breast or reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; or
- Reconstructive surgery performed on a covered Dependent child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Benefits for Dental Services

Benefits for Eligible Expenses incurred by a Participant will be provided on the same basis as for treatment of any other sickness as shown on the Schedule of Coverage only for the following:

- Covered Oral Surgery;
- Services provided to a newborn child which are necessary for treatment or correction of a congenital defect; or
- The correction of damage caused solely by external, violent Accidental Injury to healthy, un-restored natural teeth and supporting tissues and limited to treatment provided within 24 months of the initial treatment, provided such initial treatment is sought within 24 hours of the Accidental Injury. An injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.
- Services or supplies provided for orthognathic surgery. Orthognathic surgery includes, but is not limited to, correction of congenital, developmental, or acquired maxillofacial skeletal deformities of the mandible and maxilla.

Any other dental services, except as excluded in the **MEDICAL LIMITATIONS AND EXCLUSIONS** section of this Benefit Booklet, for which a Participant incurs Inpatient Hospital Expenses for a Medically Necessary inpatient Hospital Admission, will be determined as described in **Benefits for Inpatient Hospital Expenses**.

Benefits for Organ and Tissue Transplants

- a. Subject to the conditions described below, benefits for covered services and supplies provided to a Participant by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:

- (1) The transplant procedure is not Experimental/Investigational in nature; and
- (2) Donated human organs or tissue or an FDA-approved artificial device are used; and
- (3) The recipient is a Participant under the Plan; and
- (4) The transplant procedure is Preauthorized as required under the Plan; and
- (5) The Participant meets all of the criteria established by the Claim Administrator in pertinent written medical policies; and
- (6) The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

Covered services and supplies “related to” an organ or tissue transplant include, but are not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

- b. Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all of the conditions cited above.

Benefits will be available for:

- (1) A recipient who is covered under this Plan; and
- (2) A donor who is a Participant under this Plan, but only if the recipient is covered under the Plan.

Benefits for the recipient and the donor will be provided up to the recipient’s “Maximum Lifetime Benefits” amount shown on the Schedule of Coverage. Once the lifetime maximum amount has been exhausted, no further benefits will be available under the Plan.

- c. Covered services and supplies include services and supplies provided for the:

- (1) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and
- (2) Removal of organs or tissues from living or deceased donors; and
- (3) Transportation and short-term storage of donated organs or tissues.

- d. No benefits are available for a Participant for the following services or supplies:

- (1) Donor search and acceptability testing of potential live donors;
- (2) Living and/or travel expenses of the recipient or a live donor;
- (3) Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
- (4) Purchase of the organ or tissue; or
- (5) Organs or tissue (xenograft) obtained from another species.

- e. Preauthorization is required for any organ or tissue transplant. Review the **PREAUTHORIZATION REQUIREMENTS** subsection in this Benefit Booklet for more specific information about Preauthorization.

- (1) Such specific Preauthorization is required even if the patient is already a patient in a Hospital under another Preauthorization authorization.
- (2) At the time of Preauthorization, the Claim Administrator will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if the Claim Administrator determines that an extension is Medically Necessary.

- f. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which the Claim Administrator considers to be Experimental/Investigational.

Benefits for Treatment of Acquired Brain Injury

Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Eligible Expenses include the following *services* as a result of and related to an Acquired Brain Injury:

- Neurobehavioral, Neurophysiological, Neuropsychological and Psychophysiological testing and treatment; and
- Remediation.

Benefits for Treatment of Diabetes

Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for *Diabetes Equipment* and *Diabetes Supplies* (for which a Physician or Professional Other Provider has written an order) and *Diabetic Management Services/Diabetic Self-Management Training*. Such items, when obtained for a *Qualified Participant*, shall include but not be limited to the following:

a. Diabetes Equipment

- (1) Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind);
- (2) Insulin pumps (both external and implantable) and associated appurtenances, which include:
 - Insulin infusion devices,
 - Batteries,
 - Skin preparation items,
 - Adhesive supplies,
 - Infusion sets,
 - Insulin cartridges,
 - Durable and disposable devices to assist in the injection of insulin, and
 - Other required disposable supplies.

b. Diabetes Supplies

- (1) Visual reading and urine test strips and tablets for glucose, ketones, and protein,
- (2) Insulin and insulin analog preparations,
- (3) Injection aids, including devices used to assist with insulin injection and needleless systems,
- (4) Biohazard disposable containers,
- (5) Insulin syringes,
- (6) Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
- (7) Glucagon emergency kits.

NOTE: Insulin and insulin analog preparations, insulin syringes necessary for self-administration, along with lancets and all required test strips and tablets for glucose, ketones, and protein, will be covered under the Prescription Drug Program.

- c. Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.

- d. As new or improved treatment and monitoring equipment or supplies become available and are approved by the U. S. Food and Drug Administration (FDA), such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider who issues the written order for the supplies or equipment.
- e. Medical-Surgical Expense provided for the nutritional, educational, and psychological treatment of the *Qualified Participant*. Such *Diabetic Management Services/Diabetic Self-Management Training* for which a Physician or Professional Other Provider has written an order to the Participant or caretaker of the Participant is limited to the following when rendered by or under the direction of a Physician:

Initial and follow-up instructions concerning:

- (1) The physical cause and process of diabetes;
- (2) Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
- (3) Prevention and treatment of special health problems for the diabetic patient;
- (4) Adjustment to lifestyle modifications; and
- (5) Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

Diabetes Self-Management Training for the *Qualified Participant* will include the development of an individualized management plan that is created for and in collaboration with the *Qualified Participant* (and/or his or her family) to understand the care and management of diabetes, including nutritional counseling and proper use of *Diabetes Equipment* and *Diabetic Supplies*.

Benefits for Diabetic Management and Self-Management Services (training and nutritional counseling) rendered while not a Hospital inpatient will be limited to three visits per Calendar Year.

A *Qualified Participant* means an individual eligible for coverage under this Plan who has been diagnosed with (a) insulin dependent or non-insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) another medical condition associated with elevated blood glucose levels.

Benefits for Preventive Care Services

Preventive care services will be provided for the following covered services:

- a. evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);
- b. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
- c. evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents; and
- d. with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The preventive care services described in items a through d above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the website at www.bcbstx.com or contact customer service at the toll-free number on your identification card.

Examples of covered services included are routine annual physicals, immunizations, well-child care, cancer screening mammograms, bone density test, screening for prostate cancer and colorectal cancer, smoking cessation counseling services, healthy diet counseling and obesity screening/counseling.

Examples of covered immunizations included are Diphtheria, Haemophilus influenzae type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella and any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

Preventive care services provided by an In-Network Provider for the items a. through d. above will not be subject to Co-Share Amounts, Deductibles, Copayment Amounts and/or dollar maximums.

Preventive care services provided by an Out-of-Network Provider for the items a. through d. above will be subject to Co-Share Amounts, Deductibles, Copayment Amounts and/or dollar maximums.

Covered services not included in items a. through d. above may be subject to Co-Share Amounts, Deductibles, Copayment Amounts and/or dollar maximums.

Benefits for Mammography Screening

Benefits are available for a screening by low-dose mammography for the presence of occult breast cancer for a Participant 35 years of age and older, as shown in ***Preventive Care Services*** on your Schedule of Coverage, except that benefits will not be available for more than one routine mammography screening each Calendar Year.

Benefits for Detection and Prevention of Osteoporosis

If a Participant is a *Qualified Individual*, benefits are available for medically accepted bone mass measurement for the detection of low bone mass and to determine a Participant's risk of osteoporosis and fractures associated with osteoporosis, as shown in ***Preventive Care Services*** on your Schedule of Coverage.

Qualified Individual means:

1. A postmenopausal woman not receiving estrogen replacement therapy;
2. An individual with:
 - vertebral abnormalities,
 - primary hyperparathyroidism, or
 - a history of bone fractures; or
3. An individual who is:
 - receiving long-term glucocorticoid therapy, or
 - being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Benefits for Tests for Detection of Colorectal Cancer

Benefits are available for a diagnostic, medically recognized screening examination for the detection of colorectal cancer, for Participants who are 50 years of age or older and who are at normal risk for developing colon cancer, include:

- A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or
- A colonoscopy performed every ten years.

Benefits will be provided for Physician Services, as shown in ***Preventive Care Services*** on your Schedule of Coverage.

Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer

Benefits are available for certain tests for detection of Human Papillomavirus and Cervical Cancer for each woman enrolled in the Plan who is 18 years of age or older, for an annual medically recognized diagnostic examination for the early detection of cervical cancer, as shown in ***Preventive Care Services*** on your Schedule of Coverage. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Benefits for Certain Tests for Detection of Prostate Cancer

Benefits are available, as shown in ***Preventive Care Services*** on your Schedule of Coverage, for an annual medically recognized diagnostic physical examination for the detection of prostate cancer and a prostate-specific antigen test used for the detection of prostate cancer for each male under the Plan who is at least:

- 50 years of age and asymptomatic; or
- 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Benefits for Childhood Immunizations

Benefits for Medical-Surgical Expenses incurred by a Dependent child for childhood immunizations will be determined at 100% of the Allowable Amount. Deductibles, Copayment Amounts, and Co-Share Amounts will not be applicable, as shown in ***Preventive Care Services*** on your Schedule of Coverage.

Benefits are available for:

- Diphtheria,
- Hemophilus influenza type b,
- Hepatitis B,
- Measles,
- Mumps,
- Pertussis,
- Polio,
- Rubella,
- Tetanus,
- Varicella, and
- Any other immunization that is required by law for the child.

Injections for allergies are not considered immunizations under this benefit provision.

Benefits for Other Routine Services

Benefits for other routine services are available for the following as indicated on your Schedule of Coverage as shown in ***Preventive Care Services*** on your Schedule of Coverage:

- x-rays;
- annual hearing examinations, except for benefits as provided under ***Benefits for Screening Tests for Hearing Impairment***; and
- annual vision examinations.

Benefits for Physical Medicine Services

Benefits for Medical-Surgical Expenses incurred for Physical Medicine Services (Physical Therapy) are available and will be determined as shown on your Schedule of Coverage.

Benefits for Chiropractic Services

Benefits for Medical-Surgical Expenses incurred for Chiropractic Services are available and will be determined as shown on your Schedule of Coverage.

All benefit payments made by the Claim Administrator for muscle manipulation, whether under the In-Network, Out-of-Network, or Out-of-Area Benefits level, will apply toward the benefit limit as shown on your Schedule of Coverage.

Benefits for Behavioral Health Services

Benefits for Eligible Expenses incurred for Mental Health Care, treatment of Serious Mental Illness and treatment of Chemical Dependency will be the same as for treatment of any other sickness. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection to determine what services require Preauthorization.

Any Eligible Expenses incurred for the services of a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents for Medically Necessary Mental Health Care or treatment of Serious Mental Illness in lieu of inpatient hospital services will, for the purpose of this benefit, be considered **Inpatient Hospital Expenses**.

Inpatient treatment of Chemical Dependency must be provided in a Chemical Dependency Treatment Center. However, treatment in a Hospital for the medical management of acute life-threatening intoxication (toxicity) will be an exception to this provision.

Benefits for Morbid Obesity

Benefits for Eligible Expenses incurred by a Participant for the Medically Necessary treatment of Morbid Obesity will be provided in accordance with the medical policy guidelines of the Claim Administrator.

MEDICAL LIMITATIONS AND EXCLUSIONS

The benefits as described in this Benefit Booklet are not available for:

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
2. Any Experimental/Investigational services and supplies.
3. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by the Claim Administrator.
4. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
5. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
6. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage.
7. Any services or supplies provided by a person who is related to the Participant by blood or marriage.
8. Any services or supplies provided for injuries sustained:
 - As a result of war, declared or undeclared, or any act of war; or
 - While on active or reserve duty in the armed forces of any country or international authority.
9. Any charges:
 - Resulting from the failure to keep a scheduled visit with a Physician or Professional Other Provider; or
 - For completion of any insurance forms; or
 - For acquisition of medical records.
10. Room and board charges incurred during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Participant's physical condition or the quality of medical care provided.
11. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage.
12. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for an inpatient nutritional assessment program provided in and by a Hospital and approved by the Claim Administrator or as part of Diabetes Management.
13. Any services or supplies provided for Custodial Care.

This exclusion does not apply to the following, as described in **Special Provisions Expenses**:

 - Mammography screenings; and
 - certain tests for the detection of prostate cancer,
 - Pap smears.
 - tests for the detection of colorectal cancer.
14. Any services or supplies provided for the treatment of the temporomandibular joint (including the jaw and craniomandibular joint) and all adjacent or related muscles and nerves except as a result of an accident or a trauma.

15. Any items of Medical-Surgical Expenses incurred for dental care and treatments, dental surgery, or dental appliances, except as provided for in the *Benefits for Dental Services* provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
16. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in the *Benefits for Cosmetic, Reconstructive, or Plastic Surgery* provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
17. Any services or supplies provided for:
 - Treatment of myopia and other errors of refraction, including refractive surgery; or
 - Orthoptics or visual training; or
 - Eyeglasses or contact lenses, provided that intraocular lenses shall be specific exceptions to this exclusion; or
 - Examinations for the prescription or fitting of eyeglasses or contact lenses; or
 - Restoration of loss or correction to an impaired speech or hearing function, including hearing aids, except as may be provided under the *Benefits for Speech and Hearing Services* provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
18. Except as specifically included as an Eligible Expense, any Medical Social Services, any outpatient family counseling and/or therapy, bereavement counseling, vocational counseling, or Marriage and Family Therapy and/or counseling.
19. Any services or supplies provided for treatment of adolescent behavior disorders, including conduct disorders and opposition disorders.
20. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function.
21. Travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a Physician or Professional Other Provider.
22. Any services or supplies provided primarily for:
 - Environmental Sensitivity;
 - Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
 - Inpatient allergy testing or treatment.
23. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
24. Any services or supplies provided for, in preparation for, or in conjunction with:
 - sterilization reversal (male or female);
 - Transsexual surgery;
 - Sexual dysfunctions;
 - In vitro fertilization; and
 - Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.
25. Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease.

26. Any services or supplies in connection with foot care for flat feet, fallen arches, and chronic foot strain.
27. Any services or supplies for foot orthotics even when necessary due to another medical condition such as diabetes.
28. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
29. Supplies for smoking cessation programs and the treatment of nicotine addiction. Contact the head of your HR department about services available for smoking cessation.
30. Any services or supplies provided for the following treatment modalities:
 - acupuncture;
 - intersegmental traction;
 - surface EMGs;
 - spinal manipulation under anesthesia; and
 - muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
31. Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician in a non-hospital setting or purchased “over the counter” for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts.
32. Any item of expense after any specified dollar, day/visit, or Calendar Year maximum or limit applicable to that expense has been paid.
33. Any services and supplies provided to a Participant incurred outside the United States if the Participant traveled to the location for the purposes of receiving medical services, supplies, or drugs.
34. Donor expenses for a Participant in connection with an organ and tissue transplant if the recipient is not covered under this Plan.
35. Replacement Prosthetic Appliances except those necessitated by growth due to maturity of the Participant.
36. Private duty nursing services, except for covered Extended Care Expenses.
37. Outpatient Contraceptive Services and prescription contraceptive devices.
38. Any Covered Drugs for which benefits are available under the Prescription Drug Program.
39. Any outpatient prescription or nonprescription drugs.
40. Any non-surgical services or supplies provided for reduction of obesity or weight, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight.
41. Any services or supplies provided for the following:
 - Cognitive rehabilitation therapy;
 - Cognitive communication therapy;
 - Neurocognitive rehabilitation;
 - Neurocognitive therapy;
 - Neurofeedback therapy;
 - Post-acute transition services; and
 - Community reintegration services.

42. Any *unapproved services or supplies* furnished by a Contracting Facility to the extent benefits would exceed the amount payable for those services or supplies at the Out-of-Network benefit level. *Unapproved services or supplies* are those services or supplies that have not been specifically approved to be furnished by a Contracting Facility under a written agreement between the Contracting Facility and the Claim Administrator.
43. Any services, supplies or treatment due to injuries resulting from alcohol Intoxication, drug induced impairment or felonious acts.
44. Any services, supplies or treatment due to injuries resulting from fighting, brawling or similar encounters unless sustained in necessary self-defense against unprovoked assault by a person not related to the Participant unless attributable to or caused by an incident of domestic violence, as defined and/or applied under the nondiscrimination provisions of the Health Insurance Portability and Accountability Act.
45. Any services or supplies not specifically defined as Eligible Expenses in this Plan.

DEFINITIONS

The definitions used in this Benefit Booklet apply to all coverage unless otherwise indicated.

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider.

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Allowable Amount means the maximum amount determined by the Claim Administrator (BCBSTX) to be eligible for consideration of payment for a particular service, supply, or procedure.

- ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with the Claim Administrator in Texas or any other Blue Cross and Blue Shield Plan*** – The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.
- ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers not contracting with the Claim Administrator in Texas*** – The Allowable Amount will be the lesser of: (i) the Provider's billed charges, or; (ii) the BCBSTX non-contracting Allowable Amount. Except as otherwise provided in this section, the non-contracting Allowable Amount is developed from base Medicare Participating reimbursements adjusted by a predetermined factor established by the Claim Administrator. Such factor shall be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

Notwithstanding the preceding sentence, the non-contracting Allowable Amount for Home Health Care is developed from base Medicare national per visit amounts for low utilization payment adjustment, or LUPA, episodes by Home Health discipline type adjusted for duration and adjusted by a predetermined factor established by the Claim Administrator. Such factor shall be not less than 75% and shall be updated on a periodic basis.

When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the Allowable Amount for non-contracting Providers will represent an average contract rate in aggregate for Network Providers adjusted by a predetermined factor established by the Claim Administrator. Such factor shall be not less than 75% and shall be updated not less than every two years.

The Claim Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by non-contracted Providers which may also alter the Allowable Amount for a particular service. In the event the Claim Administrator does not have any claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within ninety (90) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

The non-contracting Allowable Amount does not equate to the Provider's billed charges and Participants receiving services from a non-contracted Provider will be responsible for the difference between the non-contracting Allowable Amount and the non-contracted Provider's billed charge, and this difference may be considerable. To find out the BCBSTX non-contracting Allowable Amount for a particular service, Participants may call customer service at the number on the back of your BCBSTX Identification Card.

- ***For multiple surgeries*** – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other covered procedures performed.

- **For procedures, services, or supplies provided to Medicare recipients** - The Allowable Amount will not exceed Medicare's limiting charge.

Behavioral Health Practitioner means a Physician or Professional Other Provider who renders services for Mental Health Care, Serious Mental Illness or Chemical Dependency, only as listed in this Benefit Booklet.

Calendar Year means the period commencing on January 1 and ending on the next succeeding December 31, inclusive.

Certain Diagnostic Procedures means:

- Bone Scan
- Cardiac Stress Test
- CT Scan (with or without contrast)
- MRI (Magnetic Resonance Imaging)
- Myelogram
- PET Scan (Positron Emission Tomography)

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

Chemical Dependency Treatment Center means a facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and which facility is also:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
2. Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
3. Licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
4. Licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Chiropractic Services means any of the following services, supplies or treatment provided by or under the direction of a Doctor of Chiropractic acting within the scope of his license: general office services, general services provided in an outpatient facility setting, x-rays, supplies, and physical treatment. Physical treatment includes functional occupational therapy, physical/mechano therapy, muscle manipulation therapy and hydrotherapy.

Claim Administrator means Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX, as part of its duties as Claim Administrator, may subcontract portions of its responsibilities.

Clinical Ecology means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:

1. Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
2. Urine auto injection (injecting one's own urine into the tissue of the body);
3. Skin irritation by Rinkel method;
4. Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or
5. Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

Complications of Pregnancy means:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but *shall not include* false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy, and

2. Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution with which the Claim Administrator has executed a written contract for the provision of care, services, or supplies furnished within the scope of its license for benefits available under the Plan. A Contracting Facility shall also include a Hospital or Facility Other Provider located outside the State of Texas, and with which any other Blue Cross Plan has executed such a written contract; provided, however, any such facility that fails to satisfy each and every requirement contained in the definition of such institution or facility as provided in the Plan shall be deemed a Non-Contracting Facility regardless of the existence of a written contract with another Blue Cross Plan.

Copayment Amount means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for certain services at the time they are provided.

Co-Share Amount means the dollar amount of Eligible Expenses incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan. Refer to **Co-Share Stop-Loss Amount** in **ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS** of the Benefit Booklet for additional information.

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:

1. Can be expected or is intended to improve the physical appearance of a Participant; or
2. Is performed for psychological purposes; or
3. Restores form but does not correct or materially restore a bodily function.

Covered Oral Surgery means maxillofacial surgical procedures limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
2. Incision and drainage of facial abscess;
3. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; and
4. Removal of complete/partial bony impacted teeth.

Creditable Coverage means coverage provided under:

1. A group health plan that is a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974;
2. Health insurance coverage consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital, or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes:
 - a. group health insurance coverage;
 - b. individual health insurance coverage; and
 - c. short-term, limited-duration insurance;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid) other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines);
5. Title 10 Chapter 55, *United States Code* (medical and dental care for members and certain former members of the uniformed services and for their dependents);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program);
9. A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;
10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e)); or

11. Title XXI of the Social Security Act (State Children's Health Insurance Program).

Creditable Coverage does not include:

1. Coverage only for accident (including accidental death and dismemberment);
2. Disability income coverage;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Coverage issued as a supplement to liability insurance;
5. Workers' compensation or similar coverage;
6. Automobile medical payment insurance;
7. Credit-only insurance (for example, mortgage insurance);
8. Coverage for onsite medical clinics;
9. Limited scope dental benefits, vision benefits, or long-term care benefits if they are provided under a separate policy, certificate, or contract of insurance.
10. Flexible spending accounts (FSAs) if they meet the definition of a health FSA in IRC Sec. 106(c)(2) and (a) the maximum benefit payable for the employee under the FSA for the year does not exceed two times the employee's salary reduction election under the FSA for the year; and (b) the employee has other coverage available under a group health plan of the employer for the year; and (c) the other coverage is not limited to benefits that are excepted benefits;
11. Coverage for only a specified disease or illness or Hospital indemnity or other fixed indemnity insurance;
12. Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), also known as Medigap or MedSupp insurance);
13. Coverage supplemental to the coverage provided under Chapter 55, Title 10, *United States Code* (also known as TRICARE supplemental programs); and
14. Similar supplemental coverage provided to coverage under a group health plan.

Crisis Stabilization Unit or Facility means an institution which is appropriately licensed and accredited as a Crisis Stabilization Unit or Facility for the provision of Mental Health Care and Serious Mental Illness services to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care means care comprised of services and supplies, including room and board and other institutional services, provided to a Participant primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury. *Custodial Care* is care which is not a necessary part of medical treatment for recovery, and shall include, but not be limited to, helping a Participant walk, bathe, dress, eat, prepare special diets, and take medication.

Deductible means the dollar amount of Eligible Expenses that must be incurred by a Participant before benefits under the Plan will be available.

Dependent means your spouse as defined in the section **WHO GETS BENEFITS** in this Benefit Booklet. The term Dependent also means:

1. Your children under age 26. Children include natural children, adopted children, and step-children. As required by the Federal Omnibus Reconciliation Act of 1993, any child of a Plan Participant who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) will be considered as having a right to dependent coverage under this Plan.
2. Your child age 26 or over, if he or she is not capable of self-sustaining employment because of a mental or physical handicap and depends mainly on you for support. Satisfactory proof will be required.

For purposes of this Plan, the term *Dependent* will also include those individuals who no longer meet the definition of a Dependent, but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Dietary and Nutritional Services means the education, counseling, or training of a Participant (including printed material) regarding:

1. Diet;

2. Regulation or management of diet; or
3. The assessment or management of nutrition.

Durable Medical Equipment Provider means a Provider that provides therapeutic supplies and rehabilitative equipment and is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Effective Date means the date the coverage for a Participant actually begins. It may be different from the Eligibility Date.

Eligibility Date means the date a person satisfies the definition of either “Employee” or “Dependent” and is in a class eligible for coverage under the Plan as described in the **WHO GETS BENEFITS** section of this Benefit Booklet.

Eligible Expenses mean either, Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, or Special Provisions Expenses, as described in this Benefit Booklet.

Emergency Care means health care services provided in a Hospital emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that the person’s condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

1. placing the patient’s health in serious jeopardy;
2. serious impairment of bodily functions;
3. serious dysfunction of any bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Employee means a person who works for the Employer on a **full-time** basis.

For purposes of this plan, the term *Employee* will also include those individuals who are no longer an Employee of the Employer, but who are participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Employer means, the person, firm, or institution named on this Benefit Booklet.

Enrollment Documentation means that information required at enrollment or when changing coverage, that is in a format determined by and acceptable to the NCS Benefits Department.

Environmental Sensitivity means the inpatient or outpatient treatment of allergic symptoms by:

1. Controlled environment; or
2. Sanitizing the surroundings, removal of toxic materials; or
3. Use of special non-organic, non-repetitive diet techniques.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, *medical treatment* includes medical, surgical, or dental treatment.

Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or Facility Other Provider in which they were performed; and
- the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The Claim Administrator for the Plan shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination.

Although a Physician or Professional Other Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, the Claim Administrator still may determine such services or supplies to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational.

Extended Care Expenses means the Allowable Amount of charges incurred for those Medically Necessary services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in the **Extended Care Expenses** portion of this Benefit Booklet.

Group Health Plan (GHP) as it applies to this Benefit Booklet means a self-funded employee welfare benefit plan as defined in subsection 160.103 of HIPAA. For additional information, refer to the definition of Plan Administrator.

Health Benefit Plan means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a Health Maintenance Organization that provides benefits for health care services. The term does not include:

1. Accident only or disability income insurance, or a combination of accident-only and disability income insurance;
2. Credit-only insurance;
3. Disability insurance coverage;
4. Coverage for a specified disease or illness;
5. Medicare services under a federal contract;
6. Medicare supplement and Medicare Select policies regulated in accordance with federal law;
7. Long-term care coverage or benefits, home health care coverage or benefits, nursing home care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;
8. Coverage that provides limited-scope dental or vision benefits;
9. Coverage provided by a single service health maintenance organization;
10. Coverage issued as a supplement to liability insurance;
11. Workers' compensation or similar insurance;
12. Automobile medical payment insurance coverage;
13. Jointly managed trusts authorized under 29 U.S.C. Section 141, et seq., that;
 - contain a plan of benefits for employees
 - is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees, and
 - is authorized under 29 U.S.C. Section 157;
14. Hospital indemnity or other fixed indemnity insurance;
15. Reinsurance contracts issued on a stop-loss, quota-share, or similar basis;
16. Short-term major medical contracts;
17. Liability insurance, including general liability insurance and automobile liability insurance;
18. Other coverage that is:
 - similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits; and
 - specified in federal regulations;
19. Coverage for onsite medical clinics; or
20. Coverage that provides other limited benefits specified by federal regulations.

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Home Health Agency means a business that provides Home Health Care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or is certified by Medicare as a supplier of Home Health Care.

Home Health Care means the health care services for which benefits are provided under the Plan when such services are provided during a visit by a Home Health Agency to patients confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

Home Infusion Therapy means the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

1. Drugs and IV solutions;
2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery services;
5. Patient and family education; and
6. Nursing services.

Over-the-counter products which do not require a Physician's or Professional Other Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Home Infusion Therapy Provider means an entity that is duly licensed by the appropriate state agency to provide Home Infusion Therapy.

Hospice means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which is:

1. Licensed in accordance with state law (where the state law provides for such licensing); or
2. Certified by Medicare as a supplier of Hospice Care.

Hospice Care means services for which benefits are provided under the Plan when provided by a Hospice to patients confined at home or in a Hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

Hospital means a short-term acute care facility which:

1. Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital provider under Medicare;
2. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians for compensation from its patients;
3. Has organized departments of medicine and major surgery, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, and maintains clinical records on all patients;
4. Provides 24-hour nursing services by or under the supervision of a Registered Nurse;
5. Has in effect a Hospital Utilization Review Plan; and
6. Is not, other than incidentally, a Skilled Nursing Facility, nursing home, Custodial Care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of Chemical Dependency, Hospice, or place for the provision of rehabilitative care.

Hospital Admission means the period between the time of a Participant's entry into a Hospital or a Chemical Dependency Treatment Center as a *Bed patient* and the time of discontinuance of bed-patient care or discharge by the admitting Physician or Professional Other Provider, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Hospital Admission. If a Participant is admitted to and discharged from a Hospital within a 24-hour period but is confined as a *Bed patient* in a bed accommodation during the period of time he is confined in the Hospital, the admission shall be considered a Hospital Admission by the Claim Administrator.

Bed patient means confinement in a bed accommodation of a Chemical Dependency Treatment Center on a 24-hour basis or in a bed accommodation located in a portion of a Hospital which is designed, staffed, and operated to provide acute, short-term Hospital care on a 24-hour basis; the term does not include confinement in a portion of the Hospital (other than a Chemical Dependency Treatment Center) designed, staffed, and operated to provide long-term institutional care on a residential basis.

Identification Card means the card issued to the Employee by the Claim Administrator of the Plan indicating pertinent information applicable to his coverage.

Imaging Center means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the Department of State Health Services Certificate of Equipment Registration and/or Department of State Health Services Radioactive Materials License.

Independent Laboratory means a Medicare certified laboratory that provides technical and professional anatomical and/or clinical laboratory services.

In-Network Benefits means the benefits available under the Plan for services and supplies that are provided when acknowledged by the Claim Administrator.

Inpatient Hospital Expense means the Allowable Amount incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided that such items are:

1. Furnished at the direction or prescription of a Physician or Professional Other Provider; and
2. Provided by a Hospital or a Chemical Dependency Treatment Center; and
3. Furnished to and used by the Participant during an inpatient Hospital Admission.

An expense shall be deemed to have been incurred on the date of provision of the service for which the charge is made.

Inpatient Hospital Expense shall include:

1. Room accommodation charges. If the Participant is in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge *is not* an Eligible Expense.
2. All other usual Hospital services, including drugs and medications, which are Medically Necessary and consistent with the condition of the Participant. Personal items *are not* an Eligible Expense.

Medically Necessary Mental Health Care or treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents, in lieu of hospitalization, shall be Inpatient Hospital Expense.

Late Enrollee means any Employee or Dependent eligible for enrollment who requests enrollment in an Employer's Health Benefit Plan (1) after the expiration of the initial enrollment period established under the terms of the first plan for which that Participant was eligible through the Employer, (2) after the expiration of an Open Enrollment Period, or (3) after the expiration of a special enrollment period.

An Employee or a Dependent is *not* a Late Enrollee if:

1. The individual:
 - a. Was covered under another Health Benefit Plan or self-funded Health Benefit Plan at the time the individual was eligible to enroll; and
 - b. Declines in writing, at the time of initial eligibility, stating that coverage under another Health Benefit Plan or self-funded Health Benefit Plan was the reason for declining enrollment; and
 - c. Has lost coverage under another Health Benefit Plan or self-funded Health Benefit Plan as a result of:
 - (1) termination of employment;
 - (2) reduction in the number of hours of employment;
 - (3) termination of the other plan's coverage;
 - (4) termination of contributions toward the premium made by the Employer;
 - (5) COBRA coverage has been exhausted;
 - (6) cessation of Dependent status;
 - (7) the individual incurs a claim that would meet or exceed a lifetime limit on all benefits;
 - (8) the Plan no longer offers any benefits to the class of similarly situated individuals that include the individual; or
 - (9) in the case of coverage offered through an HMO, the individual no longer resides, lives, or works in the service area of the HMO and no other benefit option is available; and
 - d. Requests enrollment not later than the 31st day after the date on which coverage under the other Health Benefit Plan or self-funded Health Benefit Plan terminates or in the event of the attainment of a lifetime limit on all benefits, the individual must request to enroll not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits.
2. The request for enrollment is made by the individual within the 60th day after the date on which coverage under Medicaid or CHIP terminates.
3. The individual is employed by an Employer who offers multiple Health Benefit Plans and the individual elects a different Health Benefit Plan during an Open Enrollment Period.
4. A court has ordered coverage to be provided for a spouse under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued.
5. A court has ordered coverage to be provided for a child under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the Employer receives notice of the court order.
6. A Dependent child is not a Late Enrollee if the child:
 - a. Was covered under Medicaid or the Children's Health Insurance Program (CHIP) at the time the child was eligible to enroll;
 - b. The employee declined coverage for the child in writing, stating that coverage under Medicaid or CHIP was the reason for declining coverage;
 - c. The child has lost coverage under Medicaid or CHIP; and
 - d. The request for enrollment is made within the 60th day after the date on which coverage under Medicaid or CHIP terminates.

Marriage and Family Therapy means the provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

Maternity Care means care and services provided for treatment of the condition of pregnancy, other than Complications of Pregnancy.

Medical Social Services means those social services relating to the treatment of a Participant's medical condition. Such services include, but are not limited to assessment of the:

1. Social and emotional factors related to the Participant's sickness, need for care, response to treatment, and adjustment to care; and

2. Relationship of the Participant's medical and nursing requirements to the home situation, financial resources, and available community resources.

Medical-Surgical Expenses means the Allowable Amount for those charges incurred for the Medically Necessary items of service or supply listed under **COVERED MEDICAL SERVICES** in this Benefit Booklet for the care of a Participant, provided such items are:

1. Furnished by or at the direction or prescription of a Physician or Professional Other Provider; and
2. Not included as an item of Inpatient Hospital Expense or Extended Care Expense in the Plan.

A service or supply is furnished at the direction of a Physician or Professional Other Provider if the listed service or supply is:

1. Provided by a person employed by the directing Physician or Professional Other Provider; and
2. Provided at the usual place of business of the directing Physician or Professional Other Provider; and
3. Billed to the patient by the directing Physician or Professional Other Provider.

An expense shall have been incurred on the date of provision of the service for which the charge is made.

Medically Necessary or **Medical Necessity** means those services or supplies covered under the Plan which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
3. Not primarily for the convenience of the Participant, his Physician, the Hospital, or the Other Provider; and
4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

The medical staff of the Claim Administrator shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

Mental Health Care means any one or more of the following:

1. The diagnosis or treatment of a mental disease, disorder, or condition listed in the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*, as revised, or any other diagnostic coding system as used by the Claim Administrator, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;
2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a Physician or Professional Other Provider (or by any person working under the direction or supervision of a Physician or Professional Other Provider) when the Eligible Expense is:
 - a. Individual, group, family, or conjoint psychotherapy,
 - b. Counseling,
 - c. Psychoanalysis,
 - d. Psychological testing and assessment,
 - e. The administration or monitoring of psychotropic drugs, or
 - f. Hospital visits or consultations in a facility listed in subsection 5, below;
3. Electroconvulsive treatment;

4. Psychotropic drugs;
5. Any of the services listed in subsections 1 through 4, above, performed in or by a Hospital, Facility Other Provider, or other licensed facility or unit providing such care.

Morbid Obesity means a Body Mass Index (BMI) of greater than or equal to 40 kg/meter² or a BMI greater than or equal to 35 kg/meters² with at least two of the following co-morbid conditions which have not responded to a maximum medical management and which are generally expected to be reversed or improved by bariatric treatment:

- Hypertension
- Dyslipidemia
- Type 2 diabetes
- Coronary heart disease
- Sleep Apnea

Network means identified Physicians, Behavioral Health Practitioner, Professional Other Providers, Hospitals, and other facilities that have entered into agreements with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) for participation in a managed care arrangement.

Network Provider means a Hospital, Physician, Behavioral Health Practitioner, or Other Provider who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider.

Non-Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution which has not executed a written contract with BCBSTX for the provision of care, services, or supplies for which benefits are provided by the Plan. Any Hospital, Facility Other Provider, facility, or institution with a written contract with BCBSTX which has expired or has been canceled is a Non-Contracting Facility.

Open Enrollment Period means the period designated by the Plan Administrator preceding the next Plan Anniversary Date during which Employees and Dependents may enroll for coverage.

Other Provider means a person or entity, other than a Hospital or Physician, that is licensed where required to furnish to a Participant an item of service or supply described herein as Eligible Expenses. Other Provider shall include:

1. **Facility Other Provider** - an institution or entity, only as listed:
 - a. Chemical Dependency Treatment Center
 - b. Crisis Stabilization Unit or Facility
 - c. Durable Medical Equipment Provider
 - d. Home Health Agency
 - e. Home Infusion Therapy Provider
 - f. Hospice
 - g. Imaging Center
 - h. Independent Laboratory
 - i. Prosthetics/Orthotics Provider
 - j. Psychiatric Day Treatment Facility
 - k. Renal Dialysis Center
 - l. Residential Treatment Center for Children and Adolescents
 - m. Skilled Nursing Facility
 - n. Therapeutic Center
2. **Professional Other Provider** - a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
 - a. Advanced Practice Nurse
 - b. Doctor of Chiropractic
 - c. Doctor of Dentistry
 - d. Doctor of Optometry

- e. Doctor of Podiatry
- f. Doctor in Psychology
- g. Licensed Audiologist
- h. Licensed Chemical Dependency Counselor
- i. Licensed Clinical Social Worker
- j. Licensed Occupational Therapist
- k. Licensed Physical Therapist
- l. Licensed Professional Counselor
- m. Licensed Speech-Language Pathologist
- n. Licensed Surgical Assistant
- o. Nurse First Assistant
- p. Physician Assistant
- q. Psychological Associates who work under the supervision of a Doctor in Psychology
- r. Licensed Midwife (effective June 1, 2007)

In states where there is a licensure requirement, other Providers must be licensed by the appropriate state administrative agency. Licensed Clinical Social Workers, Licensed Professional Counselors, and Licensed Chemical Dependency Counselors must be providing covered services under the supervision of a Doctor of Medicine or Doctor of Psychology.

Out-of-Area Benefits means the benefits available under the Plan for services and supplies that are provided when a Participant resides outside of the Managed Care Plan Service Area and therefore does not have access to Network Providers.

Out-of-Network Benefits means the benefits available under the Plan for services and supplies that are provided by an Out-of-Network Provider .

Out-of-Network Provider means a Hospital, Physician, Behavioral Health Practitioner, or Other Provider who has not entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield Plan) as a managed care Provider.

Out-of-Pocket Maximum means the cumulative dollar amount of Eligible Expenses, including the Calendar Year Deductible, incurred by a Participant during a Calendar Year.

Outpatient Contraceptive Services means a consultation, examination, procedure, or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

Participant means an Employee or Dependent whose coverage has become effective under this Plan.

Physical Medicine Services means those modalities, procedures, tests, and measurements listed in the *Physicians' Current Procedural Terminology Manual* (Procedure Codes 97010-97799), whether the service or supply is provided by a Physician or Professional Other Provider, and includes, but is not limited to, physical therapy, occupational therapy, hot or cold packs, whirlpool, diathermy, electrical stimulation, massage, ultrasound, manipulation, muscle or strength testing, and orthotics or prosthetic training.

Physician means a person, when acting within the scope of his license, who is a Doctor of Medicine or Doctor of Osteopathy.

Plan means a program of health and welfare benefits established for the benefit of its Participants whether the plan is subject to the rules and regulations of the Employee Retirement Income Security Act (ERISA) or, for government and/or church plans, where compliance is voluntary.

Plan Administrator means the Group Health Plan (GHP) or a named administrator of the Plan having fiduciary responsibility for its operation. BCBSTX is not the Plan Administrator.

Plan Anniversary Date means the day, month, and year of the 12-month period following the Plan Effective Date and a corresponding date in each year thereafter for as long as this Benefit Booklet is in force.

Plan Effective Date means the date on which coverage for the Employer's Plan begins with the Claim Administrator.

Plan Month means each succeeding calendar month period, beginning on the Plan Effective Date.

Plan Service Area means the geographical area(s) in which a Network of Providers is offered and available and is used to determine eligibility for **Managed Health Care Plan** benefits.

Preauthorization/Preauthorize means the process that determines in advance the Medical Necessity or Experimental/Investigational nature of certain care and services under this Plan.

Preexisting Condition means a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 6 months before the earlier of the:

- Effective Date of Coverage; or
- First day of the Waiting Period.

Primary Care Provider means a Provider whose provider type is classified as Family Practice, Behavioral Health Practitioner, Obstetrics and Gynecology, Pediatrics, and Internal Medicine

Proof of Loss means written evidence of a claim including:

1. The form on which the claim is made;
2. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim, and
3. Correct diagnosis code(s) and procedure code(s) for the services and items.

Prosthetic Appliances means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). For purposes of this definition, a wig or hairpiece is not considered a Prosthetic Appliance.

Prosthetics/Orthotics Provider means a certified prosthetist that supplies both standard and customized prostheses and orthotic supplies.

Provider means a Hospital, Physician, Behavioral Health Practitioner, Other Provider, or any other person, company, or institution furnishing to a Participant an item of service or supply listed as Eligible Expenses.

Psychiatric Day Treatment Facility means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment Facility for the provision of Mental Health Care and Serious Mental Illness services to Participants for periods of time not to exceed eight hours in any 24-hour period. Any treatment in a Psychiatric Day Treatment Facility must be certified in writing by the attending Physician to be in lieu of hospitalization.

Renal Dialysis Center means a facility which is Medicare certified as an end-stage renal disease facility providing staff assisted dialysis and training for home and self-dialysis.

Residential Treatment Center for Children and Adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

Serious Mental Illness means the following psychiatric illnesses defined by the *American Psychiatric Association in the Diagnostic and Statistical Manual (DSM)*:

1. Bipolar disorders (hypomanic, manic, depressive, and mixed);

2. Depression in childhood and adolescence;
3. Major depressive disorders (single episode or recurrent);
4. Obsessive-compulsive disorders;
5. Paranoid and other psychotic disorders;
6. Pervasive developmental disorders;
7. Schizo-affective disorders (bipolar or depressive); and
8. Schizophrenia.

Skilled Nursing Facility means a facility primarily engaged in providing skilled nursing services and other therapeutic services and which is:

1. Licensed in accordance with state law (where the state law provides for licensing of such facility); or
2. Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care.

Specialty Care Provider means a Physician or Professional Other Provider who has entered into an agreement with the Claim Administrator (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of specialty services with the exception of those Providers designated as a Primary Care Provider.

Therapeutic Center means an institution which is appropriately licensed, certified, or approved by the state in which it is located and which is:

1. An ambulatory (day) surgery facility;
2. A freestanding radiation therapy center; or
3. A freestanding birthing center.

Waiting Period means a period established by an Employer that must pass before an individual who is a potential enrollee in a Health Benefit Plan is eligible to be covered for benefits.

PRESCRIPTION DRUG PROGRAM

This portion of your Plan provides coverage for Medically Necessary Covered Drugs prescribed to treat a Participant for a condition, sickness, disease, injury, or bodily malfunction covered under the Plan if the drug:

1. Has been approved by the United States Food and Drug Administration (FDA) for at least one indication; and
2. Is recognized by the following for treatment of the indication for which the drug is prescribed
 - a. a prescription drug reference compendium, approved by the appropriate state agency, or
 - b. substantially accepted peer-reviewed medical literature.

As new drugs are approved by the Food and Drug Administration (FDA), such drugs, unless the intended use is specifically excluded under the Plan, are eligible for benefits. Benefits are available for Covered Drugs as indicated on your Schedule of Coverage.

How the Program Works

When you need a Prescription Order filled, you can elect to go to a Participating Pharmacy, a Non-Participating Pharmacy, or use the Mail Service Prescription Drug Program.

Participating Pharmacy

When you go to a Participating Pharmacy:

- present your Identification Card to the pharmacist along with your Prescription Order,
- provide the pharmacist with the birth date and relationship of the patient,
- pay the appropriate Copayment Amount for each Prescription Order filled or refilled and the pricing difference when it applies to the Covered Drug you receive.

Participating Pharmacies have agreed to accept as payment in full the least of:

- the billed charges, or
- the Allowable Amount as determined by the Claim Administrator, or
- other contractually determined payment amounts.

You are responsible for paying any Prescription Drug Deductibles, Copayment Amounts and any pricing differences, when applicable. You may be required to pay for limited or non-covered services. No claim forms are required.

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access our website at www.bcbstx.com or contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card.

Non-Participating Pharmacy

If you have a Prescription Order filled at a Non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill and submit a claim form to the Claim Administrator with itemized receipts verifying that the Prescription Order was filled. The Plan will reimburse you for Covered Drugs equal to:

- 80% of the Allowable Amount,
- less the Prescription Drug Deductible,
- less the appropriate Copayment Amount, and
- less any pricing differences that may apply to the Covered Drug you receive.

Mail Service Prescription Drug Program

Your Employer has chosen to provide a Mail Service Prescription Drug Program to you and your covered Dependents. The Copayment Amounts and Prescription Drug Deductible are indicated on your Schedule of Coverage.

When you mail your Prescription Orders to the address provided on the *Mail Service Prescription Drug Program Claim Form*, you must send in your payment. If you need assistance in determining the amount of your payment, you may either contact the Customer Service Helpline for assistance.

If you send an incorrect payment amount for the Covered Drug dispensed, you will: (a) receive a credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.

If you have any questions about the Program or need to obtain the *Mail Service Prescription Drug Program Claim Form*, you may access our website at www.myrxhealth.com or call the Customer Service Helpline at the telephone number shown in this Benefit Booklet or on your Identification Card.

Preferred Brand Name Drug List

A Preferred Brand Name Drug is subject to the Preferred Brand Name Drug Copayment Amount plus any pricing differences that may apply to the Covered Drug you receive. These drugs are identified on the *Preferred Brand Name Drug List* that is maintained by BCBSTX. This list is developed using monographs written by the American Medical Association, Academy of Managed Care Pharmacies, and other Pharmacy and medical related organizations, describing clinical outcomes, drug efficacy, and side effect profiles.

BCBSTX will routinely review the *Preferred Brand Name Drug List* and periodically adjust it. Changes to this list will be implemented on the Employer's Plan Anniversary Date. The *Preferred Brand Name Drug List* and any modifications will be made available to Participants. Participants may access our website at www.bcbstx.com or call the Customer Service Helpline at the telephone number shown in this Benefit Booklet or on your Identification Card to determine if a particular drug is on the *Preferred Brand Name Drug List*. Drugs that do not appear on the *Preferred Brand Name Drug List* may be subject to the Non-Preferred Brand Name Drug Copayment Amount plus any pricing differences that may apply to the Covered Drug you receive.

Injectable Drugs

Injectable drugs for subcutaneous self-administration are also covered under the Plan. You are responsible for any Prescription Drug Deductibles, Copayment Amounts, and pricing differences that may apply to the Covered Drug dispensed. Injectable drugs include, but are not limited to, insulin and Imitrex.

The day supply of disposable syringes and needles you will need for self-administered injections will be limited on each occasion dispensed to amounts appropriate to the dosage amounts of covered injectable drugs actually prescribed and dispensed, but cannot exceed 100 syringes and needles per Prescription Order in a 30-day period.

Prior Authorizations

To ensure that a drug is safe, effective, and part of a specific treatment plan, certain medications may require prior authorization and the evaluation of additional clinical information before dispensing. A list of the medications which require prior authorization is available to you on our website at www.myrxhealth.com.

When you present a Prescription Order to a Participating Pharmacy or through the Mail Service Prescription Drug Program for one of these designated medications, your Physician or authorized Professional Other Provider will be required to submit a *Prior Authorization Request* form on your behalf before the medication can be dispensed.

Non-Participating Pharmacies cannot access the criteria for prior authorizations online. It is important to contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card prior to using one of these Pharmacies since Prescription Orders obtained through a Non-Participating Pharmacy may be denied for reimbursement based upon this criteria.

Step Therapy

To ensure that a drug is Medically Necessary and part of a specific treatment plan, designated drugs may require the utilization of acceptable alternative medications prior to dispensing. A list of the medications which require alternative steps to be taken before the requested Prescription Order can be filled is available to you on our website at www.bcbstx.com/nabors.

When you submit a Prescription Order to a Participating Pharmacy or through the Mail Service Prescription Drug Program for one of these designated medications, the Pharmacist will review your online prescription history and determine if any acceptable alternatives are required before filling the Prescription Order. If so, he will direct you to contact your Physician or authorized Professional Other Provider to obtain an acceptable alternative Prescription Order or to discuss possible over the counter solutions. Acceptable alternatives can be Legend Drugs or over the counter medications which may or may not be in the same therapeutic category.

Non-Participating Pharmacies cannot access the criteria for step therapy online. It is important to contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card prior to using one of these Pharmacies since Prescription Orders obtained through a Non-Participating Pharmacy may be denied for reimbursement based upon this criteria.

Limitations on Quantities Dispensed-Day Supply

Benefits for Covered Drugs obtained from a Participating Pharmacy, a Non-Participating Pharmacy, or through the Mail Service Prescription Drug Program are provided up to the maximum day supply limit indicated on your Schedule of Coverage. The Copayment Amount applicable for the designated day supply of dispensed drugs for retail Pharmacies and the Mail Service Prescription Drug Program are also indicated on your Schedule of Coverage.

If you are leaving the country or need an extended supply of medication, call Customer Service at least two weeks before you intend to leave. (Extended supplies or vacation override are not available through the mail-order Pharmacy but may be approved through the retail Pharmacy only. In some cases, you may be asked to provide proof of continued enrollment eligibility under the Plan.)

Right of Appeal

In the event that a requested Prescription Order is still denied on the basis of prior authorization criteria, step therapy criteria, after your Physician or authorized Professional Other Provider has submitted clinical documentation, you have the right to appeal as indicated under the **Review of Claim Determinations** section of this Benefit Booklet.

Deductibles and Copayment Amounts

Prescription Drug Deductible

The Prescription Drug Deductible shown on your Schedule of Coverage is the dollar amount of Covered Drug expenses that must be satisfied by each Participant each Calendar Year before benefits under the Prescription Drug Program will be available. The Prescription Drug Deductible will apply to Covered Drugs obtained through retail Pharmacies and through the Mail Service Prescription Drug Program. After the Prescription Drug Deductible for a Participant is met, the Participant will pay the appropriate Copayment Amount and any pricing differences that may apply for each Prescription Order filled or refilled for the remainder of the Calendar Year..

Whether you use a Participating Pharmacy, a Non-Participating Pharmacy, or the Mail Service Prescription Drug Program the Allowable Amount of your Covered Drug expenses will be applied toward satisfaction of your Prescription Drug Deductible.

The pharmacist can tell you once the Prescription Drug Deductible has been satisfied or you may contact the Customer Service Helpline.

Copayment Amounts

Copayment Amounts for a Participating Pharmacy or a Non-Participating Pharmacy, or the Mail Service Prescription Drug Program are shown on your Schedule of Coverage. The amount you pay depends on the Covered Drug dispensed. If the Covered Drug dispensed is a:

1. Generic Drug - You pay the Generic Drug Copayment Amount
2. Preferred Brand Name Drug – You pay the Preferred Brand Name Drug Copayment Amount

3. Non-Preferred Brand Name Drug – You pay the Non-Preferred Brand Name Drug Copayment Amount

Drug Coupons, Rebates or Other Drug Discounts

Drug manufacturers may offer coupons, rebates or other drug discounts to Participants, which may impact the benefits provided under this Plan. The total benefits payable will not exceed the balance of the Allowable Amount remaining after all drug coupons, rebates or other drug discounts have been applied. The Participant agrees to reimburse BCBSTX any excess amounts for benefits that we have paid you and for which you are not eligible due to the applications of drug coupons, rebates or other drug discounts.

**Prescription Drug Program
Limitations and Exclusions**

The benefits of the Prescription Drug Program are not available for:

1. Drugs, supplies or devices which do not by law require a Prescription Order from a Provider (including insulin pens and other insulin auto-injectors and their needles, prescriptive and non-prescriptive oral agents for controlling blood sugar levels, control solutions, and alcohol swabs); and drugs or covered devices for which no valid Prescription Order is obtained. This limitation does not apply to insulin, insulin analogs, test strips, or lancets needed for covered injectable drugs.
2. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order,) such as, but not limited to, contraceptive devices, therapeutic devices, including support garments and other non-medical substances, artificial appliances, inhaler assist devices, lancet devices/kits, glucometers or similar devices (**except** disposable hypodermic needles and syringes for self-administered injections).
3. Administration or injection of any drugs.
4. Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is **no** non-prescription alternative). However, in no event will coverage be provided for prescription pre-natal vitamins.
5. Drugs dispensed in a Physician's or authorized Professional Other Provider's office or during confinement while a patient is in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
6. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
7. Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this section shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
8. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery.
9. Covered Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Participant's cost share determined under this Plan.
10. Contraceptive devices, non-prescription contraceptive materials, and prescription contraceptive drugs, except generic oral contraceptives and Brand Name oral contraceptives that are Medically Necessary.

11. Oral and injectable infertility and fertility medications.
12. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, topical oral solutions or preparations or pediatric fluoride vitamins.
13. Drugs required by law to be labeled: "Caution - Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.
14. Drugs dispensed in quantities in excess of the day supply amounts stipulated in your Schedule of Coverage, or refills of any prescriptions in excess of the number of refills specified by the Physician or authorized Professional Other Provider or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.
15. Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.
16. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, NOTE: This exclusion does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU).
17. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
18. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
19. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your Employer's group health care plan, or for which benefits have been exhausted.
20. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
21. Services and supplies for smoking cessation programs and the treatment of nicotine addiction.
22. Compounded drugs that do not meet the definition of Compound Medications in this portion of your Benefit Booklet.
23. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
24. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined by the Plan (except omeprazole).
25. Retin A or pharmacologically similar topical drugs after a Participant attains 30 years of age.
26. Athletic performance enhancement drugs.
27. Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), Cialis, Levitra, phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form.
28. Allergy serum and allergy testing materials.

29. Injectable drugs, except those self-administered subcutaneously.
30. Drugs to treat obesity.
31. Respiratory supplies.
32. Growth Hormones unless Prior Authorization is obtained.
33. Prescription Orders which do not meet the required Step Therapy criteria.
34. Prescription Orders which do not meet the required Prior Authorization criteria.
35. Some equivalent drugs manufactured under multiple brand names. BCBSTX may limit benefits to only one of the brand equivalents available. If you do not accept the brand that is covered under this Plan, the Brand Name Drug purchased will not be covered under any benefit level.
36. Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.
37. Shipping, handling or delivery charges.
38. Drugs that are repackaged by anyone other than the original manufacturer.
39. Prescription Orders written by a member of your immediate family, or a self-prescribed Prescription Order.

In addition, no benefit will be paid under the Mail Service Prescription Drug Program portion of this Plan for any Prescription Order or refill if the cost of a 60 day supply of such order or refill would exceed \$300. In such an event, the Prescription Order or refill must be filled at a Retail Pharmacy.

Definitions

*(In addition to the applicable terms provided in the **DEFINITIONS** Section of the Benefit Booklet, the following terms will apply specifically to this **PRESCRIPTION DRUG PROGRAM** section.)*

Allowable Amount means the maximum amount determined by the Claim Administrator to be eligible for consideration of payment for a particular Covered Drug.

1. As applied to Participating Pharmacies, the Mail-Order Program and Preferred Specialty Drug Providers, the Allowable Amount is based on the provisions of the contract between BCBSTX and the Participating Pharmacy or Pharmacy for the Mail-Order Program or the Preferred Specialty Drug Provider in effect on the date of service.
2. As applied to non-Participating Pharmacies, the Allowable Amount is based on the Participating Pharmacy contract rate.

Compound Medications mean those drugs that have been measured and mixed with U.S. Food and Drug Administration (FDA) approved pharmaceutical ingredients by a pharmacist to produce a unique formulation that is Medically Necessary because commercial products either do not exist or do not exist in the correct dosage, size, or form. The drugs used must meet the following requirements:

1. The drugs in the compounded product are Food and Drug Administration (FDA) approved;
2. The approved product has an assigned National Drug Code (NDC); and
3. The primary active ingredient is a Covered Drug under the Plan.

Copayment Amount, with respect to the Prescription Drug Program, means the amount paid by the Participant for each Prescription Order filled or refilled through a Participating Pharmacy, Non-Participating Pharmacy or through the Mail Service Prescription Drug Program.

Covered Drugs means any Legend Drug (including insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, with disposable syringes and needles needed for self-administration):

1. Which is Medically Necessary and is ordered by a Physician or authorized Professional Other Provider naming a Participant as the recipient;
2. For which a written or verbal Prescription Order is provided by a Physician or authorized Professional Other Provider;
3. For which a separate charge is customarily made;
4. Which is not entirely consumed at the time and place that the Prescription Order is written;
5. For which the U.S. Food and Drug Administration (FDA) has given approval for at least one indication; and
6. Which is dispensed by a Pharmacy and is received by the Participant while covered under the Plan, **except when** received from a Provider's office, or during confinement while a patient in a hospital or other acute care institution or facility (refer to **Limitations and Exclusions**).

Deductible means the dollar amount of Eligible Expenses that must be incurred by a Participant before benefits under the Plan will be available.

Generic Drug means a drug which is approved by the U.S. Food and Drug Administration (FDA) as pharmaceutically and therapeutically equivalent for a particular use or purpose to the brand name drug prescribed.

Legend Drugs means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution - Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose.

National Drug Code (NDC) means a national classification system for the identification of drugs.

Non-Participating Pharmacy means a retail Pharmacy which has not entered into an agreement to provide prescription drug services to Participants under the Prescription Drug Program.

Non-Preferred Brand Name Drug means a brand name drug which does not appear on the *Preferred Brand Name Drug List*.

Non-Preferred Brand Name Drug Copayment Amount means the Copayment Amount applicable if a Non-Preferred Brand Name Drug is dispensed.

Participant means an Employee or Dependent whose coverage has become effective under this Plan.

Participating Pharmacy means an independent retail Pharmacy or chain of retail Pharmacies which have entered into an agreement to provide prescription drug services to Participants under the Prescription Drug Program.

Pharmacy means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

Preferred Brand Name Drug means a brand name drug which appears on the *Preferred Brand Name Drug List*.

Preferred Brand Name Drug Copayment Amount means the Copayment Amount applicable if a Preferred Brand Name Drug is dispensed.

Prescription Order means a written or verbal order from a Physician or authorized Professional Other Provider to a pharmacist for a drug or device to be dispensed. Orders written by Physicians or authorized Professional Other Providers located outside the United States to be dispensed in the United States are not covered under the Plan.

GENERAL PROVISIONS

Agent

The Employer is not the agent of the Claim Administrator.

Amendments

The Plan may be amended or changed at any time by agreement between the Employer and the Claim Administrator. No notice to or consent by any Participant is necessary to amend or change the Plan.

If the Plan is changed, benefits for health care services received after the effective date of the change will be subject to the change, even if the Participant was receiving benefits before the change became effective.

Assignment and Payment of Benefits

Rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided.

In the absence of a written agreement with a Provider, the Claim Administrator reserves the right to make benefit payments to the Provider or the Employee, as the Claim Administrator elects. Payment to either party discharges the Plan's responsibility to the Employee or Dependents for benefits available under the Plan.

Claims Liability

BCBSTX, in its role as Claim Administrator, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any health care Provider, insurance carrier, or other entity to furnish the Claim Administrator all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

Medicare

Special rules apply when you are covered by this Plan and by Medicare. Generally, this Plan is a Primary Plan for you and your covered spouse. The special rules also affect the Primary status of this Plan in the event you or a covered Dependent of yours has end-stage renal disease. In that case, the Plan is Primary for the first 30 months and then Medicare becomes the Primary Plan. Whether this Plan or Medicare is Primary will be determined according to the requirements of Title XVIII of the Social Security Act of 1965, as amended.

Participant/Provider Relationship

The choice of a health care Provider should be made solely by you or your Dependents. The Claim Administrator does not furnish services or supplies (nor does the Plan or any Plan fiduciary) but only makes payment for Eligible Expenses incurred by Participants. Neither the Claim Administrator, the Plan or any Plan fiduciary will be liable for any act or omission by any health care Provider, nor will they have any responsibility for a health care Provider's failure or refusal to provide services or supplies to you or your Dependents. Care and treatment received are subject to the rules and regulations of the health care Provider selected and are available only for sickness or injury treatment acceptable to the health care Provider.

The Claim Administrator, Network Providers, and/or other contracting Providers are independent contractors with respect to each other. The Claim Administrator, the Plan or any Plan fiduciary will in no way control, influence, or participate in the health care treatment decisions entered into by said Providers, and they do not furnish medical, surgical, hospitalization, or similar services or supplies, or practice medicine or treat patients. The Providers, their employees, their agents, their ostensible agents, and/or their representatives do not act on behalf of BCBSTX, the Plan or any Plan fiduciary nor are they employees of BCBSTX.

Refund Of Benefit Payments

If the Claim Administrator pays benefits for Eligible Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, the Plan has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, the Claim Administrator may deduct any refund due it from any future benefit payment.

Subrogation and Reimbursement

The Plan is intended only to pay for expenses that are not payable by any other person or business entity. In many cases, another person or business entity may be required to pay. For example, if you are injured in a motor vehicle accident, the other driver may be required to pay your expenses or damages. In addition, your expenses and damages might be covered by one of your own automobile policies or other insurance you or some other person or business entity may have. Under the Plan, you are not allowed to collect double benefits. If another person or business entity (someone other than you or the Plan) is required to pay for expenses paid as a benefit under the Plan, the Plan may recover the amount of the benefit payment either from the other person or business entity (subrogation) or from you (reimbursement), as discussed more fully below.

Right of Subrogation

If the Plan pays or provides benefits for you or your Dependents, the Plan is subrogated to all rights of recovery which you or your Dependent have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits the Plan has paid or provided. That means the Plan may use your or your Dependents' rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer.

For the purposes of this provision, *subrogation* means the substitution of one person or entity (the Plan) in the place of another (you or your Dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

Right of Reimbursement

The Plan also has a right of reimbursement from you (or your Dependent) if another person or business entity (someone other than you or the Plan) is required to pay for expenses paid or provided as a benefit under the Plan. If you or your Dependent is entitled to recover money from any person, organization, or insurer for an injury or condition for which the Plan paid benefits, the Plan has the right to seek reimbursement for the amount of benefits paid or provided by the Plan plus the Plan's costs of collection, such as its attorneys' fees. That means your or your Dependent will pay to the Plan the amount of money recovered through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the Plan. The Plan may also take other actions to prevent double benefits, such as subtracting the amount owed the Plan from benefits to be paid or provided by the Plan on your or your Dependents' behalf in the future. The Plan's right of recovery applies to any money that you may be entitled to receive from any person or business entity for a covered condition or for the events leading to the covered conditions, such as an accident.

Right of Recovery by Subrogation or Reimbursement

By accepting coverage under the Plan, and in consideration for receiving such coverage, you agree that you are subject to the Plan's subrogation and reimbursement rights. You or your Dependent agree to furnish promptly to the Plan Administrator (or its designated representative) all information and legal documents that you have concerning your rights of recovery from any person, organization, or insurer and any such documents and information requested by the Plan Administrator (or its designated representative) for enforcing the Plan's subrogation and reimbursement rights. You or your Dependent also agree to fully assist and cooperate with the Plan in protecting and obtaining its reimbursement and subrogation rights. You or your Dependent must notify the Plan Administrator whenever it appears that another person or business entity may be liable for a condition covered by the Plan. You must also advise the other person or business entity and their attorney of the Plan's subrogation rights. You, your Dependent or your attorney must notify the Plan before settling any claim or suit so as to enable the Plan to enforce its rights by participating in the settlement of the claim or suit. Further, if you or your Dependent notifies any parties, including an attorney, of the intention to pursue or investigate a claim to recover damages from or obtain compensation against any person or business entity with respect to a condition covered by the Plan, the Plan's subrogation rights must be included as a part of such claim. Additionally, you must inform the Plan Administrator (or its designated representative) within 30 days of the date you provide such notice to any party. If you or your Dependent receives money as a result of such legal action, such money must be held in trust for the Plan to the extent of the Plan's subrogation and reimbursement rights. You or your Dependent must serve as constructive trustee over any such money. Failure to hold any such money in constructive trust for the Plan will be treated as a breach of your fiduciary duty to the Plan.

You or your Dependent further agree not to allow the reimbursement and subrogation rights of the Plan to be limited or harmed by any acts or failure to act on your part and also agree not to release any other person or business entity (even if the release purports to be a partial release or a release for the excess liability over Plan benefits) without the advance written consent of the Plan Administrator. The Plan's subrogation and reimbursement rights will not be affected by any release entered into without such consent. The Plan's subrogation and reimbursement rights apply to any recovery with respect to a condition that is subject to such rights, whether received through a settlement, judgment, arbitration or otherwise.

The amount that the Plan can recover includes the amount of benefits involved plus the Plan's cost of collection, such as its attorneys' fees. The amount recovered by the Plan is not reduced by the amount of your or your Dependent's attorneys' fees or by any other amount for any reason. The Plan will not attempt to recover more than you received or could receive from another person or business entity. However, when the Plan pays benefits for which any other person or business entity is liable or potentially liable, the Plan automatically has a first priority lien against any amounts you or your Dependent receive or may receive from the other person or business entity, before other expenses and damages are recovered and regardless of any label anyone may put on the payment (for example, "medical expenses," "pain and suffering," "property damage," "attorneys' fees," "costs of court," etc.). Further, the Plan's right to recover applies regardless of whether liability for payment is admitted by any potentially responsible party and regardless of whether any settlement or judgment received by you or your Dependent identifies the medical benefits the Plan provided.

These rules apply even if your losses are not completely paid by the other person or business entity. For example, if you have an automobile accident, the Plan may recover all benefits paid even if your insurance and the other driver's insurance do not make you "whole" or otherwise fully pay all of your expenses and damages related to the accident.

The Plan Administrator (or its designated representative) may take any actions that it determines are necessary to protect the Plan's subrogation and reimbursement rights, including (1) bringing a legal action in the name of the Plan or in your name or in the name of your Dependent; (2) joining in a legal action brought by you or your Dependent; (3) offsetting future Plan benefits by amounts which you or your Dependent has obtained (or could have obtained with reasonable diligence) from another person or business entity; (4) bringing a legal action to set aside any settlement agreement entered into without the consent of the Plan Administrator; or (5) without you or your Dependent's consent,

unless otherwise required by the privacy standards under the Health Insurance Portability and Accountability Act (HIPAA), releasing to or obtaining from any other person or business entity any information that the Plan Administrator or its designated representative deems necessary or advisable for the enforcement the Plan's subrogation and reimbursement rights. Further, if you or your Dependents fail to comply with the subrogation and reimbursement requirements described above, the Plan Administrator may, in its discretion, deny benefits under the Plan with respect to the condition subject to the Plan's subrogation and reimbursement rights, terminate your and/or your Dependent's participation in the Plan, and/or initiate legal action against you, your Dependent, or any party holding a payment for you or your Dependent's benefit to which the Plan's subrogation or reimbursement rights apply. The Plan Administrator, in its discretion, may waive or modify any or all of these subrogation and reimbursement provisions whenever, under the facts and circumstances of a particular case, it deems such waiver or modification necessary to prevent inequity with respect to you or your Dependent.

In the event that any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator will have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

You and your Dependent agree that any legal action or proceeding with respect to this subrogation and reimbursement rights provision may be brought in any court of competent jurisdiction as the Plan Administrator may elect. Upon receiving benefits under the Plan, you and your Dependent hereby submit to each such jurisdiction, waiving whatever rights may correspond to his or her present or future domicile.

Coordination of Benefits

The availability of benefits specified in This Plan is subject to Coordination of Benefits (COB) as described below. This COB provision applies to This Plan when a Participant has health care coverage under more than one Plan.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan shall not be reduced when This Plan determines its benefits before another Plan; but may be reduced when another Plan determines its benefits first.

Coordination of Benefits – Definitions

1. **Plan** means any group insurance or group-type coverage, whether insured or uninsured.

This includes:

- a. group or blanket insurance;
- b. franchise insurance that terminates upon cessation of employment;
- c. group hospital or medical service plans and other group prepayment coverage;
- d. any coverage under labor-management trustee arrangements, union welfare arrangements, or employer organization arrangements;
- e. governmental plans, or coverage required or provided by law.

Plan does *not* include:

- a. any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
- b. a policy of health insurance that is individually underwritten and individually issued;
- c. school accident type coverage; or
- d. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. **This Plan** means the part of this Benefit Booklet that provides benefits for health care expenses.

3. **Primary Plan/Secondary Plan**

The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the Participant. A *Primary Plan* is a Plan whose benefits are determined before those of the other Plan and without considering the other Plan's benefit. A *Secondary Plan* is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the Participant, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

4. **Allowable Expenses** means those necessary, reasonable, and customary items of expense for health care that are covered at least in part by this Plan.

5. **We or Us** means Blue Cross and Blue Shield of Texas.

Order of Benefit Determination Rules

1. **General Information**

a. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless (a) the other Plan has rules coordinating its benefits with those of This Plan, and (b) both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.

b. If this Benefit Booklet contains any dental or vision benefits, the benefits provided by the health portion of this document or Claim Administrative Document will be the Secondary Plan.

2. **Rules**

This Plan determines its order of benefits using the first of the following rules which applies:

a. **Non-Dependent/Dependent.** The benefits of the Plan which covers the Participant as an Employee, member or subscriber are determined before those of the Plan which covers the Participant as a Dependent. However, if the Participant is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(1) secondary to the Plan covering the Participant as a Dependent and

(2) primary to the Plan covering the Participant as other than a Dependent (e.g., a retired Employee), then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant other than a Dependent.

b. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in Paragraph c below, when This Plan and another Plan cover the same child as a Dependent of different parents:

(1) The benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but

(2) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in this Paragraph b, but instead has a rule based on gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

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

- (1) First, the Plan of the parent with custody of the child;
- (2) Then, the Plan of the spouse of the parent with custody, if applicable;
- (3) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- d. **Joint Custody.** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph b.
- e. **Active/Inactive Employee.** The benefits of a Plan which covers a Participant as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a Dependent of a person covered as a retired Employee and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Paragraph e does not apply.
- f. **Continuation Coverage.** If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:
 - (1) First, the benefits of a Plan covering the Participant as an Employee, member or subscriber (or as that Participant's Dependent);
 - (2) Second, the benefits under the continuation coverage.

If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits this Paragraph f does not apply.

- g. **Longer/Shorter Length of Coverage.** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Participant for the shorter period of time.

Effect on the Benefits of This Plan

1. When This Section Applies

This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

2. Reduction in this Plan's Benefits

The benefits of This Plan will first be calculated as if it were the Primary Plan and then This Plan will adjust its benefits so that:

- a. If the benefits payable by the Primary Plan for Allowable Expenses equals or exceeds the benefits that would have been payable by This Plan if it were the Primary Plan, no benefits will be paid by This Plan;
- b. The benefits paid by This Plan, when combined with the benefits paid for Allowable Expenses by the Primary Plan, will not exceed the benefits that would have been paid by This Plan had it been the Primary Plan.

NOTE: This Coordination of Benefits provision may result in unreimbursed patient out-of-pocket expenses despite coverage under two or more Plans.

Right to Receive and Release Needed Information

We assume no obligation to discover the existence of another Plan, or the benefits available under the other Plan, if discovered. We have the right to decide what information we need to apply these COB rules. We may get needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person claiming benefits under This Plan must give us any information concerning the existence of other Plans, the benefits thereof, and any other information needed to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again.

Right to Recovery

If the amount of the payments We make is more than We should have paid, We may recover the excess from one or more of:

1. the persons We have paid or for whom We have paid;
2. insurance companies; or
3. Hospitals, Physicians, or Other Providers; or
4. any other person or organization.

Termination of Coverage

The Claim Administrator for the Plan is not required to give you prior notice of termination of coverage. The Claim Administrator will not always know of the events causing termination until after the events have occurred.

Termination of Individual Coverage

Coverage under the Plan for you and/or your Dependents will end: on the last day of the pay period in which:

1. Your contribution for coverage under the Plan is not received timely by the Plan Administrator; or
2. You no longer satisfy the definition of an Employee as defined in this Benefit Booklet, including termination of employment; or
3. A Dependent ceases to be a Dependent as defined in the Plan.

Coverage under the Plan for you and/or your Dependents will also end on the date the Plan is terminated or the Plan is amended, at the direction of the Plan Administrator, to terminate the coverage of the class of Employees to which you belong.

However, when any of these events occur, you and/or your Dependents may be eligible for continued coverage. See **Continuation Privilege** in the **GENERAL PROVISIONS** section of this Benefit Booklet.

The Claim Administrator may terminate and refuse to renew the coverage of an eligible Employee or Dependent for fraud or intentional misrepresentation of a material fact by that individual.

Coverage for a child who is medically certified as *Disabled* and dependent on the parent will not terminate upon reaching the limiting age shown in the Schedule of Coverage if the child continues to be both:

1. *Disabled*, and
2. Dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin before the child attains the limiting age. You must submit satisfactory proof of the disability and dependency to your Plan Administrator within 30 days following the child's attainment of the limiting age. As a condition to the continued coverage of a child as a *Disabled* Dependent beyond the limiting age, the Claim Administrator may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Termination of the Group

The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan.

Notice of Creditable Coverage

A Certificate of Creditable Coverage will be issued to each person whose coverage under this Plan is terminated. A Certificate of Creditable Coverage may also be requested by or on behalf a terminated individual within 24 months following their termination of coverage.

Continuation Privilege

COBRA Continuation - Federal

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Participants may have the right to continue coverage after the date coverage ends. Participants will not be eligible for COBRA continuation if the Employer is exempt from the provisions of COBRA.

Minimum Size of Group

The Group must have normally employed more than twenty (20) employees on a typical business day during the preceding Calendar Year. This refers to the number of full-time and part-time employees employed, not the number of employees covered by a Health Benefit Plan.

Loss of Coverage

If coverage terminates as the result of termination (other than for gross misconduct) or reduction of employment hours, then the Participant may elect to continue coverage for eighteen (18) months from the date coverage would otherwise cease.

A covered Dependent may elect to continue coverage for thirty-six (36) months from the date coverage would otherwise cease if coverage terminates as the result of:

1. divorce from the covered Employee,
2. death of the covered Employee,
3. the covered Employee becomes eligible for Medicare, or
4. a covered Dependent child no longer meets the Dependent eligibility requirements.

COBRA continuation under the Plan ends at the earliest of the following events:

1. The last day of the eighteen (18) month period for events which have a maximum continuation period of eighteen (18) months.
2. The last day of the thirty-six (36) month period for events which have a maximum continuation period of thirty-six (36) months.
3. The first day for which timely payment of contribution is not made to the Plan with respect to the qualified beneficiary.

4. The Group Health Plan is canceled.
5. The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health plan.
6. The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

Extension of Coverage Period

The eighteen (18) month coverage period may be extended if an event which could otherwise qualify a Participant for the thirty-six (36) month coverage period occurs during the eighteen (18) month period, but in no event may coverage be longer than thirty-six (36) months from the initial qualifying event.

If a Participant is determined to be disabled as defined under the Social Security Act and the Participant notifies the Employer before the end of the initial eighteen (18) month period, coverage may be extended up to an additional eleven (11) months for a total of twenty-nine (29) months. This provision is limited to Participants who are disabled at any time during the first sixty (60) days of COBRA continuation and only if the qualifying event is termination of employment (other than for gross misconduct) or reduction of employment hours.

Notice of COBRA Continuation Rights

The Employer is responsible for providing the necessary notification to Participants as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

For additional information regarding your rights under COBRA continuation, refer to the Continuation Coverage Rights Notice in the **NOTICES** section of this Benefit Booklet.

Information Concerning Employee Retirement Income Security Act Of 1974 (ERISA)

If the Health Benefit Plan is part of an “employee welfare benefits plan” and “welfare plan” as those terms are defined in ERISA:

1. The Plan Administrator will furnish summary plan descriptions, annual reports, and summary annual reports to you and other plan participants and to the government as required by ERISA and its regulations.
2. The Claim Administrator will furnish the Plan Administrator with this Benefit Booklet as a description of benefits available under this Health Benefit Plan. Upon written request by the Plan Administrator, the Claim Administrator will send any information which the Claim Administrator has that will aid the Plan Administrator in making its annual reports.
3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions of this Health Benefit Plan. Claim filing and claim review health procedures are found in the **CLAIM FILING AND APPEALS PROCEDURES** section of this Benefit Booklet.
4. BCBSTX, as the Claim Administrator is not the ERISA “Plan Administrator” for benefits or activities pertaining to the Health Benefit Plan.
5. This Benefit Booklet, including the SCHEDULE OF COVERAGE is not, by itself, a Summary Plan Description. The Plan Administrator is providing you with additional important information about your Health Benefit Plan and other important notices required by ERISA as part of a separate section at the end of this document.
6. The Plan Administrator has given the Claim Administrator the final authority to interpret the Plan provisions and make benefit determinations. The Plan Administrator has full and complete authority and discretion to

make decisions regarding the Plan's provisions and determining questions of eligibility. Any decisions made by the Plan Administrator shall be final and conclusive.

AMENDMENTS

An Amendment

The effective date of this amendment is June 1, 2012.

Nabors Industries, Inc.

Account Number: 80189

To be attached to and made a part of your Managed Health Care, Traditional Benefits and Prescription Drug Program Benefit Booklet.

This is an amendment to your Blue Cross and Blue Shield of Texas, A Division of Health Care Service Corporation Benefit Booklet. It is to be attached to and become part of the Benefit Booklet.

What follows will apply on and after the effective date shown above. Anything in the Schedule of Coverage or in any provisions, definitions, limitations or exclusions currently in your Benefit Booklet that is contrary to what is described below, will not apply:

The first paragraph of the *Termination of Individual Coverage* provision under **Termination of Coverage** in the section entitled **GENERAL PROVISIONS** is deleted in its entirety and replaced with the following:

Termination of Individual Coverage

Coverage under the Plan for you and/or your Dependents will end on the day:

1. Your contribution for coverage under the Plan is not received timely by the Plan Administrator; or
2. You no longer satisfy the definition of an Employee as defined in this Benefit Booklet, including termination of employment; or
3. A Dependent ceases to be a Dependent as defined in the Plan.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Benefit Booklet to which this amendment is attached will remain in full force and effect.

Blue Cross and Blue Shield of Texas (BCBSTX)

By: 

President, Blue Cross and Blue Shield of Texas

NOTICES

NOTICE
Other Blue Cross and Blue Shield Plans Separate Financial Arrangements with Providers

BlueCard

Blue Cross and Blue Shield of Texas hereby informs you that other Blue Cross and Blue Shield Plans outside of Texas (“Host Blues”) may have contracts similar to the contracts described above with certain Providers (“Host Blue Providers”) in their service areas.

When you access health care services through BlueCard outside of Texas and from a Provider which does not have a contract with Blue Cross and Blue Shield of Texas, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your covered services, or
- The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield of Texas.

Often, this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that takes into consideration the actual price increased or reduced to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be charged as a billed charge reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, Blue Cross and Blue Shield of Texas would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

NOTICE

The Women's Health and Cancer Rights Act of 1998 requires this notice. This Act is effective for plan year anniversaries on or after October 21, 1998. This benefit may already be included as part of your coverage.

In the case of a covered person receiving benefits under their plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Deductibles, Co-Share and copayment amounts will be the same as those applied to other similarly covered medical services, such as surgery and prostheses.

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

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

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

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

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of

COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

Information Provided by your Employer

- **Important ERISA Information**
- **Information about Certificates of Creditable Coverage**
- **HIPAA Privacy Information**
- **Information about Prescription Drug Coverage for Medicare Participants**
- **Special Enrollment Notice**

EMPLOYEE RETIREMENT INCOME
SECURITY ACT OF 1974
PLAN ADMINISTRATION INFORMATION

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your benefit booklet/Certificate. Your Plan Administrator has determined that this information together with the information contained in your benefit booklet/Certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Blue Cross and Blue Shield is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan: NABORS INDUSTRIES, INC. GROUP
INSURANCE PLAN

Plan Sponsor: NABORS INDUSTRIES, INC.
515 WEST GREENS ROAD
HOUSTON, TX 77067-4525
281-874-0035

Employer Identification Number: 93-0711613

Plan Administrator: NABORS INDUSTRIES, INC.
515 WEST GREENS ROAD
HOUSTON, TX 77067-4525
281-874-0035

Plan Number: 501

Claim Administration: CLAIMS FOR BENEFITS SHOULD BE
DIRECTED TO: BLUE CROSS AND
BLUE SHIELD OF TEXAS
P.O. BOX 660044
DALLAS, TEXAS 75266-0044901

Type of Plan Administration: The Plan Sponsor provides certain administration services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network

Provider; claims processing services, including coordination of benefits and subrogation; utilization management and compliant resolution assistance. The external administrator is referred to as the Claims Administrator. The Plan Sponsor also has selected a provider network established by Blue Cross and Blue Shield of Texas. The named fiduciary of the Plan is Blue Cross and Blue Shield of Texas.

Agent For Service of Legal Process:

PLAN SPONSOR OR PLAN ADMINISTRATOR AT ADDRESS SHOWN ABOVE

Plan Fiduciary:

Blue Cross and Blue Shield of Texas

Plan Year: January 1

Open Enrollment: Dec 1 – Dec 31

Funding Arrangements:

THE HEALTH PROGRAM IS FUNDED THROUGH EMPLOYEE CONTRIBUTIONS MADE ON A PRE-TAX BASIS UNDER SECTION 125 AND THROUGH EMPLOYER CONTRIBUTIONS. THE AMOUNT OF EMPLOYEE CONTRIBUTIONS WILL BE ANNOUNCED ANNUALLY.

Type of Plan: PPO-ASO Standard

How To Get Your Benefits:

This information is explained in the section of the booklet entitled “**CLAIMS FILING PROCEDURES.**”

Claim Review Procedure:

This information is explained in the section of the booklet entitled “**REVIEW OF CLAIMS DETERMINATIONS**”

Participating Employers

Canrig Drilling Technology Ltd. (USA)

Epoch Well Services, inc.

Nabors Alaska Drilling, Inc.

Nabors Corporate Services, Inc.

Nabors Drilling USA, Inc.

Nabors Drilling International

Limited and Pool Arabia Company

Limited (excluding non-salaried) employees who are not U.S. citizens or U.S. residents)

Nabors Holding Limited

Nabors Industries Limited

Nabors International Limited

Nabors Management Ltd.

Nabors Offshore Corporation

Peak USA Energy Services, Ltd. (excluding drivers of trucks leased to Peak USA Energy, Ltd or commissioned drivers)

Nabors Well Services Co.

Nabors Well Services Ltd.

Ryan Energy Technologies, USA, Inc, Inc.

SWSI

Statement of ERISA Rights:

As a participant in this 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:

- a. 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 Employee Benefits Security Administration.
- b. 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 Plan Administrator may make a reasonable charge for the copies.
- c. 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.

Continue Group Health Plan Coverage:

- a. 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 booklet and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- b. 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 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 under the plan 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 the plan fiduciaries misuse the plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees.

If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your Claim is frivolous.

Assistance With Your Questions:

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

SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA):

Group health plans and health insurance issuers, under USERRA, must protect all persons who perform duty, voluntarily or involuntarily, in the “uniformed services”, which include the Army, Navy, Marine Corps, Air Force, Coast Guard and Public Health Service commissioned corps, as well as the reserve components of each of these services. If you are a pre-service member returning from a period of service in the uniformed services, you are entitled to reemployment from your Employer if you meet the following criteria:

- you held the job prior to service;
- you gave notice to your Employer that you were leaving your employment for service in the uniformed services, unless giving notice was precluded by military necessity or otherwise impossible or unreasonable;
- your cumulative period of service did not exceed five years;
- you were not released from service under dishonorable or other punitive conditions; and
- you reported back to the job in a timely manner or submitted a timely application for reemployment.

The time limits for returning to work are as follows:

- For less than 31 days of service – by the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight hour rest period. If this is impossible or unreasonable through no fault of your own, then as soon as possible;
- For 31 to 180 days of service – you must apply for reemployment no later than 14 days after completion of military service. If this is impossible or unreasonable through no fault of your own, then as soon as possible;
- For 181 days or more of service – you must apply for reemployment no later than 90 days after completion of military service;
- For service-connected injury or illness – reporting or application deadlines are extended for up to two years if you are hospitalized or convalescing.

Important Notice:

To obtain information or make a complaint you may call Blue Cross and Blue Shield of Texas's toll-free telephone number for information or to make a complaint at: 1-800-521-2227. You may also write to Blue Cross and Blue Shield of Texas at: P.O. Box 660044, Dallas, Texas 75266-0044

Aviso Importante:

Para obtener informacion o para someter una queja usted puede llamar al numero de telefono gratis de Blue Cross and Blue Shield of Texas para informacion o para someter una queja al: 1-800-521-2227. Usted tambien puede escribir a Blue Cross and Blue Shield of Texas al: P. O. Box 660044, Dallas, Texas 75266-0044.

INFORMATION ABOUT CERTIFICATES OF CREDITABLE COVERAGE

Certification

You have the right to obtain from a prior employer or insurance carriers a certification regarding any period of coverage which you or one of your dependents may have had which would be considered to be “creditable coverage” for purposes of reducing the Health Program’s “pre-existing condition exclusion period.” If you need assistance in how to obtain such certification, you should contact the NCS Benefits Department.

In the event that you or one of your dependents subsequently become eligible for group health plan coverage under another employer’s plan or otherwise is eligible for other health insurance coverage, “creditable coverage” for prior coverage under the Health Program should be applicable to reduce any “pre-existing condition exclusion period” under such other group health plan coverage or health insurance coverage. You can obtain further information regarding your right to documentation of health coverage under the Health Program from NCS Benefits Department.

HIPAA PRIVACY INFORMATION

Privacy of Protected Health Information

The Health Insurance Portability and Accountability Act of 1996, as amended, (“HIPAA”) requires that the Plan must comply with HIPAA’s Privacy Standards.

In order for the Plan to provide benefits, it may be necessary for health care professional, the Plan Administrator, personnel or individuals who perform Plan related functions under the guidance of the Plan Administrator, the Third Party Administrators, Insurance Companies and other service providers contracted to assist the Plan Administrator with the delivery of benefits, to have access to Protected health Information (“PHI”).

PHI is defined as individually identifiable health information about an employee or other covered person. Patient Records, which would include, but not limited to, all health records, physician, hospital and other medical professionals’ notes, health bills and claims filed for the employee or other covered person; Patient Information includes Patient Records and all oral or written information provided for an employee or other covered person. All other individually identifiable health information related to an employee or other covered person.

Any PHI received during the course of Plan administration the Plan Sponsor agrees:

- Not to use or disclose PHI other than as permitted or required by the Plan Document or as required by law (as defined in the Privacy Standards)
- To ensure that any agent, including subcontractors, that receives PHI from the Plan Sponsor agrees to the same restrictions and conditions that apply to the Plan Sponsor regarding PHI.
- Not to use or disclose any PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan, except those authorized by the Privacy Standards.
- To report any PHI use or disclosure that is inconsistent with the uses or disclosure allowed by the Privacy Standards.
- To make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524)
- To make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526)
- To make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528)
- To make internal practices, books, and records relating to the use and disclosure of PHI received available to the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority has been delegated, for purpose of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.528).
- If possible, to return or destroy all PHI when no longer needed; and if not possible to limit further use or disclosure of PHI for other than the purpose originally designated.

- To ensure that proper separation between the Plan and the Plan Sponsor, as required in Section 164.504 (f)(2)(iii) of the Privacy Standards (45 CFR 164.504 (f)(2)(iii)), is established as follows:
 - the following employee or class of employees, or other persons under the control of the Plan Sponsor, shall be given access to the PHI to be disclosed: Chief Benefits Officer, and Plan Auditor.
 - The access to and use of PHI by the employees described in the preceding sentence shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

In the event any of the employees indicated do not comply with the provisions of the Plan Document related to the use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (an oral warning, a written warning, suspension without pay and termination), if appropriate, and should be imposed based upon the severity of the violation.

Plan Administration activities are limited to activities that would meet the definition of payment or health care operations, but do not include the function to modify, amend or terminate the Plan or solicit bids from prospective issuers. Plan Administration functions include quality assurance, claims processing, auditing, monitoring and management of carve out plans, such as vision and dental. It does not include any employment related functions or functions in connection with any other benefit or benefits plans. The Plan shall disclose PHI to the Plan Sponsor only upon receipt of certification by the Plan Sponsor that the Plan has been amended to incorporate the above provisions and the Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504 (f)(1)(iii) of the Privacy Standards (45 CFR 164.504 (f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an employee or covered person is participating in a Program or is enrolled in or has terminated from a health or other coverage offered by the Plan.

Disclosure of PHI to Obtain Stop-Loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes the Plan, through the Plan Administrator, the Third Party Administrators, Insurance Companies and other service providers contracted to assist the Plan Administrator with the delivery of benefits, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to health claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

Important Notice from NCS Benefits Department 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 NCS Benefits Department and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- 2. NCS Benefits Department has determined that the prescription drug coverage offered by The Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.**

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individual's can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiary's leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

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.

If you do decide to enroll in a Medicare prescription drug plan and drop your NCS Benefits Department prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with NCS Benefits Department and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% 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 what many 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 our office for further information. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through NCS 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 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. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- 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 Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Name of Entity/Sender:	NCS Benefits Department
Contact--Position/Office:	Chief Benefits Officer
Address:	515 W. Greens Road, Suite 1200, Houston, TX 77067
Phone Number:	281-775-8016

SPECIAL ENROLLMENT NOTICE IF YOU ARE WAIVING GROUP HEALTH INSURANCE

Waiving Coverage Because of Other Health Insurance

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Also, effective April 1, 2009, Childrens Health Insurance Program Reauthorization Act (CHIPRA) adds two new special enrollment events to HIPAA's special enrollment period rules. Specifically, CHIPRA provides that a group health plan is required to permit an employee who is eligible, but not enrolled, for coverage under the group health plan (or a dependent of the employee if the dependent is eligible, but not enrolled, for coverage) to enroll for coverage under the plan in either of the following circumstances:

- (i) the employee or dependent is covered under Medicaid or a state's Childrens Health Insurance Program (CHIP) and coverage of the employee or dependent under the Medicaid or CHIP plan is terminated as a result of a loss of eligibility for such coverage, and the employee requests coverage under the group health plan within 60 days of the loss of coverage; or
- (ii) the employee or dependent becomes eligible for a premium assistance subsidy with respect to coverage under the group health plan, and the employee requests coverage under the group health plan within 60 days after the date the employee or dependent is determined to be eligible for the premium assistance subsidy.

Note that employees have a 60 day period to enroll for coverage under these two new special enrollment events, instead of the shorter 30 day period that group health plans are allowed to impose under HIPAA's existing special enrollment event rules.

Conditions of Special Enrollment

- A. If the other coverage was COBRA coverage, then the COBRA coverage must be exhausted for the special enrollment to apply.
- B. If the other coverage was not COBRA coverage, then the other coverage must terminate because of one of the following reasons:
 - 1. Employer Contributions Towards The Coverage Have Been Terminated, or
 - 2. Loss of Eligibility Under the Other Coverage (divorce, termination of employment, reduction in number of work hours, or death). Loss of

eligibility does not include: 1. Loss of coverage due to failure on the individuals part to pay premiums on a timely basis, or 2. Termination of coverage for cause, such as fraudulent claims and/or intentional misrepresentation of a material fact in connection with the plan

Waiving Coverage But No Other Health Insurance

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Plan Administrator.

**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 January 31, 2012. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	COLORADO – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	FLORIDA – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150

<p align="center">IDAHO – Medicaid and CHIP</p> <p>Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588</p>	<p align="center">MONTANA – Medicaid</p> <p>Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084</p>
<p align="center">INDIANA – Medicaid</p> <p>Website: http://www.in.gov/fssa Phone: 1-800-889-9948</p>	<p align="center">NEBRASKA – Medicaid</p> <p>Website: http://dhhs.ne.gov/medicaid/Pages/med_kidsconx.aspx Phone: 1-877-255-3092</p>
<p align="center">IOWA – Medicaid</p> <p>Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562</p>	<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900</p>
<p align="center">KANSAS – Medicaid</p> <p>Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884</p>	
<p align="center">KENTUCKY – Medicaid</p> <p>Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-5218</p>
<p align="center">LOUISIANA – Medicaid</p> <p>Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447</p>	<p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>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</p>
<p align="center">MAINE – Medicaid</p> <p>Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-572-3839</p>	
<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629</p>	<p align="center">NORTH CAROLINA – Medicaid and CHIP</p> <p>Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100</p>
<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604</p>

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	VERMONT – Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-877-314-5678	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	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
RHODE ISLAND – Medicaid	WASHINGTON – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethiptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2012, 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

OMB Control Number 1210-0137 (expires 09/30/2013)

Administered by:



BlueCross BlueShield of Texas

Experience. Wellness. Everywhere.SM

www.bcbstx.com/nabors

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Texas provides administrative services only and does not assume any financial risk or obligation with respect to claims.
44111.0108