Your Health Care Benefit Program

Nabors Industries, Inc.
Group #80189

Dental Benefits
Current Dental Terminology © American Dental Association
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Information Provided by Your Employer
# Dental Schedule of Coverage

## Deductibles
- **Calendar Year Deductible**: $100 – per individual

## Maximum Calendar Year Benefits
- $1,500 per Participant
- $3,000 per family

## I. Diagnostic & Preventive Care Services
- Calendar Year Deductible does not apply
- 100% of Allowable Amount

## II. Miscellaneous Services
- Calendar Year Deductible does not apply
- 100% of Allowable Amount

## III. Restorative Services
- 80% of Allowable Amount after Calendar Year Deductible

## IV. General Services
- 80% of Allowable Amount after Calendar Year Deductible

## V. Endodontic Services
- 80% of Allowable Amount after Calendar Year Deductible

## VI. Periodontal Services
- 80% of Allowable Amount after Calendar Year Deductible

## VII. Oral Surgery Services
- 80% of Allowable Amount after Calendar Year Deductible

## VIII. Crowns, Inlays/Onlays Services
- 50% of Allowable Amount after Calendar Year Deductible

## IX. Prosthodontic Services
- 50% of Allowable Amount after Calendar Year Deductible

## Predetermination Amount
- $200

## Dependent Child Age Limit
- Age 26

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### Waiting Period

The waiting period for hourly employees is 90 consecutive days of employment. The waiting period for salaried employees is 30 consecutive days of employment.

### Effective Date

The effective date is the first day of the appropriate pay period following the completion of the waiting period.
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 dental care expenses for Dentally Necessary services and supplies. There are provisions throughout this Benefit Booklet that affect your dental 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 the Group Health Plan (GHP) by Blue Cross and Blue Shield of Texas (BCBSTX) prevails.

The Claim Administrator for the Plan is Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX, as part of its duties as Claim Administrator, may subcontract portions of its responsibilities.

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.

Benefits available under the Plan are explained in the COVERED DENTAL SERVICES section. The benefits available to you are indicated on the Dental Schedule of Coverage in this Benefit Booklet.

You are covered only for those benefit categories selected by your Employer and shown on your Dental Schedule of Coverage.

The benefit percentage to be applied to each category of service is shown on your Dental Schedule of Coverage.

Important Contact Information

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<tr>
<th>Resource</th>
<th>Contact Information</th>
<th>Accessible Hours</th>
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<tr>
<td>Dental Customer Service Helpline</td>
<td>1-800-521-2227</td>
<td>Monday – Friday 8:00 a.m. – 6:00 p.m.</td>
</tr>
<tr>
<td>Website</td>
<td><a href="http://www.bcbstx.com/nabors">www.bcbstx.com/nabors</a></td>
<td>24 hours a day 7 days a week</td>
</tr>
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</table>

Dental Customer Service Helpline

Customer Service Representatives can:

- Give you information about Contracting Dentists
- Distribute claim forms
- Answer your questions on claims
- Assist you in identifying a Contracting Dentist (but will not recommend specific Dentists)
- Provide information on the features of the Plan

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.
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 Dental 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.

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 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 enrollment within 30 days of rehire. 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.

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 enrollment as if you are a new hire. Hourly Employees must complete a new enrollment between the 45th and 75th day of rehire, and Salaried Employees must complete a new 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 Enrollment Documentation 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 Enrollment Documentation is received timely by 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 Enrollment Documentation 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 Enrollment Documentation is received by 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.

Dependent Coverage

Coverage of your natural child born after your Effective Date, a child of a Participant for whom the Employer has received a court order requiring health coverage be provided, your adopted child or a child involved in a suit for adoption will automatically be in effect from the:

1. Date of birth for the newborn child,
2. Date the court order is received by the Employer, or
3. Date of the adoption or suit for adoption,

through the 30th day following such date. For coverage to continue, the Plan Administrator must receive Enrollment Documentation from you during the 30-day period to add the child as a Dependent. If you wait until after this 30-day period to add the child, the Dependent child’s coverage will become effective on the Plan Anniversary Date following your Employer’s next Open Enrollment Period.

Other Dependents: Enrollment Documentation must be received within 30 days of the date that a spouse or child first qualifies as a Dependent. If the Enrollment Documentation is received within 30 days, coverage will become effective on the date the child or spouse first becomes an eligible Dependent. If Enrollment Documentation is not received within 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.

Dental Enrollment Opportunities

During your Employer’s Open Enrollment Period, you may apply for coverage for yourself or for yourself and any eligible Dependents. Coverage will become effective on the Plan Anniversary Date, provided your Enrollment Documentation is received timely by the Plan Administrator.

If you are a Participant under the Plan, you may enroll your Dependent children who are less than 5 years of age at any time. In this event, coverage will become effective on the first day of the Plan Month following receipt of the Enrollment Documentation by the Plan Administrator.
Enrollment Documentation

You will be required to provide appropriate Enrollment 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 Enrollment 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 Enrollment 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 Eligible Dental Expenses you incur under the Plan. In determining the Allowable Amount, the Claim Administrator will consider such factors as your Dentist’s usual fee and fees charged by other Dentists in the area with similar training and experience and any special circumstances, and whether your Dentist is a Contracting Dentist. The portion of the charges by your Dentist that exceeds the Allowable Amount of the Claim Administrator will be your responsibility to pay to your Dentist, except when you have used a Contracting Dentist. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan and any applicable Deductibles.

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

Course of Treatment

Your Dentist may decide on a planned series of dental procedures which a dental exam shows you need. In cases where there is more than one professionally acceptable Course of Treatment, benefits will be covered for the most economical procedures.

Current Dental Terminology (CDT)

The most recent edition of the manual published by the American Dental Association (ADA) entitled “Current Dental Terminology and Procedure Codes (CDT)” is used when classifying dental services.

The Allowable Amount for an Eligible Dental Expense will be based on the most inclusive procedure codes.

Freedom of Choice

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<th>Each time you need dental care, you can choose to:</th>
<th>See a Contracting Dentist</th>
<th>See a Non-Contracting Dentist</th>
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<tbody>
<tr>
<td><strong>BlueCare Dentist</strong></td>
<td><strong>DentaBlue Dentist</strong></td>
<td><strong>Your out-of-pocket maximum may be greater because Non-Contracting Dentists have not entered into a contract with BCBSTX to accept any Allowable Amount determination as payment in full for Eligible Dental Expenses.</strong></td>
</tr>
<tr>
<td>• Your out-of-pocket maximum will generally be the least amount because BlueCare Dentists have contracted to accept a lower Allowable Amount as payment in full for Eligible Dental Expenses</td>
<td>• Your out-of-pocket maximum may be greater because DentaBlueSM Dentists have contracted to accept a higher Allowable Amount as payment in full for Eligible Dental Expenses</td>
<td>• You are required to file claim forms</td>
</tr>
<tr>
<td>• You are not required to file claim forms</td>
<td>• You are not required to file claim forms</td>
<td>• You are balance billed for costs exceeding the BCBSTX Allowable Amount</td>
</tr>
<tr>
<td>• You are not balance billed for costs exceeding the BCBSTX Allowable Amount for BlueCare Dentists</td>
<td>• You are not balance billed for costs exceeding the BCBSTX Allowable Amount for DentaBlue Dentists</td>
<td>• You are balance billed for costs exceeding the BCBSTX Allowable Amount</td>
</tr>
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</table>
In each event as described above, you will be responsible for the following:

- any applicable Deductibles;
- Co-Share Amounts;
- Services that are limited or not covered under the Plan.

If your Dentist is not a Contracting Dentist, you may be responsible for filing your claim, as described in the CLAIM FILING AND APPEALS PROCEDURES portion of this booklet. You may also be responsible for payment in full at the time services are rendered.

To find a Contracting Dentist, you may look up a dental provider in the DentaBlue or BlueCare Dental Directory, log on to the Blue Cross and Blue Shield of Texas website at www.bcbstx.com/nabors and search for a Dentist using Provider Finder, or call the Dental Customer Service Helpline number located in this booklet or on your Identification Card.

**How Benefits are Calculated**

Your benefits are based on a percentage of the Dentist’s Allowable Amount. To determine your benefits, subtract the Deductible (if not previously satisfied) from your Eligible Dental Expenses, then, multiply the difference by the Co-Share Amount percentage applicable to the benefit category of services shown on your Dental Schedule of Coverage. The resulting total is the amount of benefits available.

The remaining unpaid amounts, including any excess portion above the Allowable Amount, except when you have used a Contracting Dentist, any Deductible and your Co-Share Amount will be your responsibility to pay to your Dentist.

**Identification Card**

The Identification Card tells Providers that you are entitled to benefits under your Employer’s dental care plan with the Claim Administrator. 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 dental care plan with the Claim Administrator.
- **Important telephone numbers.**

Always remember to carry your Identification Card with you and present it to your Dentist when receiving dental 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.

**Predetermination of Benefits**

Your Dental Schedule of Coverage indicates a “Predetermination Amount.” If a Course of Treatment for non-emergency services can reasonably be expected to involve Eligible Dental Expenses in excess of this predetermined amount, a description of the procedures to be performed and an estimate of the Dentist’s charge should be filed with and predetermined by the Claim Administrator prior to the commencement of treatment.

The Claim Administrator may request copies of existing x-rays, photographs, models, and any other records used by the Dentist in developing the Course of Treatment. The Claim Administrator will review the reports and materials,
taking into consideration alternative Courses of Treatment. The Claim Administrator will notify you and the Dentist of the benefits to be provided under the Plan. Predetermination gives you and your Dentist the opportunity to know the extent of the benefits available. Benefit payments may be reduced based on any claims paid after a predetermination estimate is provided.
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, or to the Dentist, the dental claim forms that are usually furnished by it for filing Proof of Loss. Claim forms may also be obtained by accessing the BCBSTX website.

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

Provider-filed claims
Dentists that contract with the Claim Administrator (such as DentaBlueSM and BlueCare Dentists) will usually 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 Dentists in filing your claims, you should carry your Identification Card with you.

Participant-filed claims
If your Dentist does not submit your claims, you will need to submit them to the Claim Administrator using a Subscriber-filed claim form provided by the Claim Administrator. Your Employer should have a supply of dental 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 Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the Dentist printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

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

Where to Mail Completed Claim Forms

Blue Cross and Blue Shield of Texas
Dental Claims Division
P. O. Box 660247
Dallas, Texas 75266-0247

Who Receives Payment

Benefit payments will be made directly to the Dentists when they bill the Claim Administrator. Written agreements between the Claim Administrator and some Dentists may require payment directly to them. Any benefits payable to you, if unpaid at your death, will be paid to your beneficiary or to your estate, if no beneficiary is named.

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

An Explanation of Benefits (EOB) for Dental Care summary is sent to you so you will know what has been paid.

When to Submit Claims

All claims for benefits under the 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 Dentist for the additional information.

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 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.

After processing the claim, the Claim Administrator will notify the Participant by way of an EOB for Dental Care.

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. First, read the EOB for Dental Care 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. Include your full name, group and subscriber numbers with the request.

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 denial;
• A reference to the dental care plan provisions on which the denial is based;
• A description of additional information which may be necessary to complete the claim and an explanation of why such information is necessary; and
• An explanation of how you may have the claim reviewed by the Claim Administrator if you do not agree with the denial.

Right to Review Claim Determinations

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, write to the Administrative Office of the Claim Administrator. The Claim Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Blue Cross and Blue Shield of Texas
Dental Claim Review Section
P. O. Box 660247
Dallas, Texas 75266-0247

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.

You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical/dental information within 180 days after you receive notice of a denial or partial denial. The Claim Administrator will give you a written decision within 60 days after it receives your request for review.

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

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 dental care plan and the discretion to interpret and determine benefits in accordance with the dental care plan’s provisions.

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

Any 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.

Claims Dispute Resolution

You must exhaust all administrative remedies as described in the Review of Claims Determinations section prior to taking further action under your dental care plan.

After exhaustion of all remedies offered, you may exercise your right to appeal all adverse determinations with the Claim Administrator of your dental care plan. The Claim Administrator is the final interpreter of the dental care plan and may correct any defect, supply any omission, or reconcile any inconsistency or ambiguity in such manner as it deems advisable in regards to claims administration. All final determinations and actions concerning the dental care plan claims administration and interpretation of benefits shall be made by the Claim Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, and your dental care plan is governed by the Employee Retirement Income Security Act (ERISA), you may file suit under 502 (a) of ERISA.
ELIGIBLE DENTAL EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Dental Expenses

The Plan provides coverage for services and supplies that are considered Dentally Necessary. The benefit percentage to be applied to each category of service is shown on the Dental Schedule of Coverage.

For benefits available for Eligible Dental Expenses, please refer to the Dental 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.

Deductibles

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

Calendar Year Deductible: The individual Deductible amount shown under “Deductible” on your Dental 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 services, before benefits are available under the Plan.

Maximum Dental Benefits

Maximum Calendar Year Benefits
The total amount of benefits available to any one Participant for all combined categories of services for a Calendar Year shall not exceed the “per Participant” Maximum Calendar Year Benefits amount shown on your Dental Schedule of Coverage.

The total amount of benefits available to all covered members of an Employee’s family for all combined categories of services for a Calendar Year shall not exceed the “per family” Maximum Calendar Year Benefits amount shown on your Dental Schedule of Coverage.

The “per Participant” and “per family” Maximum Calendar Year Benefits amounts include:

1. All payments made by the Claim Administrator under the benefit provisions of the Plan Services.
2. Any benefits provided to a Participant under a dental care plan held by the Employer with the Claim Administrator immediately prior to the Participant’s Effective Date of coverage under this Plan.

Changes in Benefits

Benefits for Eligible Dental Expenses incurred during a Course of Treatment that begins before the change will be those benefits in effect on the day the Course of Treatment was started.
COVERED DENTAL SERVICES

The Plan will provide benefits for the following Eligible Dental Expenses, subject to the limitations and exclusions described in this booklet, only if the category of service is shown on your Dental Schedule of Coverage. The benefit percentage applicable to each category of service is also shown on your Dental Schedule of Coverage.

You are covered only for those categories of services shown on the Dental Schedule of Coverage issued with this booklet.

I. Diagnostic and Preventive Care Services

Benefits are available for Eligible Dental Expenses incurred for services that are used to prevent dental disease or to determine the nature or cause of a dental disease including:

a. Routine oral evaluations (limited to two per Calendar Year);

b. X-rays (dental radiographs):
   (1) full mouth or panorex x-ray limited to once every 36 months;
   (2) bitewing limited to 4 horizontal films or 8 vertical films twice per Calendar Year; and
   (3) other x-rays as necessary for diagnosis (except in connection with a program of orthodontics);

c. Professional cleaning, scaling, and polishing teeth (prophylaxis) limited to two per Calendar Year;

d. Fluoride treatment (topical application), limited to two per Calendar Year for Participants up to age 19.

II. Miscellaneous Services

Benefits are available for Eligible Dental Expenses incurred for:

a. Space maintainers for Participants up to age 19;

b. Pulp vitality test;

c. Palliative (emergency) treatment to relieve dental pain except when performed in conjunction with definitive dental treatment; and

d. Lab and tests.

III. Restorative Services

Benefits are available for Eligible Dental Expenses incurred for the process of replacing, by artificial means, a part of a tooth that has been damaged by disease (e.g. cavities). Tooth preparation, all adhesive (including amalgam bonding agents), liners and bases are included as part of the restoration. Eligible Dental Expenses include:

a. Amalgam restorations limited to once per surface per tooth in any Calendar Year;

b. Pin retention, per tooth, in conjunction with the restoration;

c. Composite restorations limited to once per surface per tooth per Calendar Year; and

d. Simple tooth extractions.

IV. General Services

Benefits are available for Eligible Dental Expenses incurred for:

a. Intravenous sedation, except in connection with the extraction of impacted wisdom teeth;

b. General anesthesia, except in connection with the extraction of impacted wisdom teeth;

c. House/extended care facility call;

d. Injection of antibiotic drugs;

e. Stainless steel crowns limited to one per tooth in a 60-month period and not to be used as a temporary crown;
f. Denture relines, denture rebases, denture recementations; and
g. Denture adjustments, Denture/Crown repairs.

V. Endodontic Services
Benefits are available for Eligible Dental Expenses incurred for services for prevention, diagnosis, and treatment of diseases and injuries affecting tooth and dental pulp. Eligible Dental Expenses include the following:

a. Root canal therapy including treatment plan, clinical procedures, pre- and post-operative radiographs and follow-up care;
b. Direct pulp cap;
c. Apicoectomy/periradicular services;
d. Apexification/recalcification;
e. Retrograde filling;
f. Root amputation/hemisection;
g. Therapeutic pulpotomy; and
h. Gross pulpal debridement.

VI. Periodontal Services
Benefits are available for Eligible Dental Expenses incurred for services that treat diseases of the tissues that surround and support the teeth (e.g. gums and supporting bone); limited to two exams per Calendar Year. Periodontal maintenance includes the following:

a. Periodontal scaling and root planing, limited to one time per quadrant per Calendar Year;
b. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to one time per Calendar Year;
c. Gingivectomy or gingivoplasty, limited to one time per quadrant per Calendar Year;
d. Gingival flap procedure (includes root planing), limited to one time per quadrant per Calendar Year;
e. Osseous surgery, including flap entry with closure, limited to one time per quadrant per Calendar Year;
f. Osseous grafts, limited to one time per site per Calendar Year; and
g. Soft tissue grafts (includes donor site).

VII. Oral Surgery Services
Benefits are available for Eligible Dental Expenses incurred for services for the treatment of certain dental conditions by operative or cutting procedures, such as:

a. Alveoloplasty;
b. Surgical tooth extractions, except extraction of impacted wisdom teeth (tooth’s 01, 16, 17 and 32);
c. Vestibuloplasty; and
d. Other Dentally Necessary surgical procedures.

VIII. Crowns, Inlays/Onlays Services
Benefits are available for Eligible Dental Expenses incurred for services resulting from extensive disease or fracture, limited to one per tooth in a 60-month period, such as:

a. Prefabricated post and cores;
b. Cast post and cores;
c. Repair of crowns, inlays/onlays; and
d. Recementation of inlays/onlays.

Services include the replacement of a lost or defective crown, whether placement was under this Plan or under any prior dental coverage, even if the original crown was stainless steel.
IX. **Prosthodontic Services**

Benefits are available for Eligible Dental Expenses incurred for services that restore and maintain the oral function, comfort and health of a patient by replacing missing teeth and surrounding tissue with artificial substitute including bridges, partial dentures, and complete dentures including:

a. Initial installation of bridgework (including inlays and crowns as abutments), limited to once per tooth in any 60-month period, whether placement was under this Plan or under any prior dental coverage:
   
   (1) Bridge repair;
   (2) Recementing a bridge; and
   (3) Post and core buildup.

b. Initial installation of removable complete, immediate, or partial dentures, limited to once in any 60-month period, whether placement was under this Plan or under any prior dental coverage.

Eligible Dental Expenses are available for the replacement of complete or partial dentures, but only if the appliance is 60 months old or older and cannot be made serviceable.

c. Bridge adjustments limited to 3 times per appliance in any Calendar Year;

d. Bridge repairs; and

e. Addition of tooth or clasp (unless additions are completed on the same date as replacement partials/dentures), limited to a lifetime maximum of once per tooth.
DENTAL LIMITATIONS AND EXCLUSIONS

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

1. Any services or supplies which are not Dentally Necessary.
2. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by the Claim Administrator.
3. 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.
4. 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 dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
5. 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.
6. Any services or supplies provided for injuries sustained:
   a. As a result of war, declared or undeclared, or any act of war; or
   b. While on active or reserve duty in the armed forces of any country or international authority.
7. Any charges:
   a. Resulting from the failure to keep a scheduled visit with a Dentist; or
   b. Completion of any insurance forms; or
   c. Telephone consultations; or
   d. Records or x-rays necessary for the Claim Administrator to make a benefit determination.
8. Any benefits in excess of any specified dollar, Calendar Year, or lifetime maximums.
9. 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 dental services, supplies, or drugs.
10. Any services primarily for cosmetic purposes, including but not limited to bleaching teeth and grafts to improve esthetics, except for:
   a. Services provided for correction of defects incurred through traumatic injuries sustained by the Participant while covered under the Plan.
11. Any services or supplies for which the American Dental Association has not approved a specific procedure code.
12. Any services provided or received for:
   a. Behavior management; or
   b. Consultation purposes.
13. Any replacement of dentures, crowns, inlays/onlays, removable or fixed prostheses, and dental restorations due to theft, misplacement, or loss; or for replacement of dentures, removable or fixed prostheses, and dental restorations for any other reason within 60 months after receiving such dentures, prostheses, or restorations.
14. Any full-mouth x-ray provided within 36 months from the date of the Participant’s last full-mouth x-ray. Any bitewing x-ray or prophylaxis provided within 6 months of the previous bitewing x-ray or prophylaxis.
15. Any benefits for an alternate Course of Treatment which exceeds the most economical procedures.
16. Any personalized complete or partial dentures, overdentures, and their related procedures, or other specialized techniques not normally taught in regular dental school classes.
17. 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.

18. Any administration or cost of drugs and/or gases used for sedation or as an analgesia including nitrous oxide. Any administration of any local anesthesia and necessary infection control as required by OSHA or state and federal mandates when billed separately.

19. Any services or supplies which are otherwise provided under inpatient hospital expense or medical-surgical expense coverage under the medical benefits of the Health Benefit Plan.

20. Any treatment by other than a Dentist, except that x-rays, scaling, cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist, if the treatment is provided under the supervision and guidance of the Dentist.

21. Any prosthetic devices (including bridges), crowns, inlays, onlays, and the fitting thereof, or duplication of such devices, which began before the Effective Date of the Participant’s coverage under this Plan with the Claim Administrator.

22. Any replacement or repair of an orthodontic appliance.

23. Sealants.

24. Surgical extraction of impacted wisdom teeth (tooth’s 01, 16, 17, and 32) including related anesthesia and IV sedations.

25. Any treatment provided through a medical department, clinic, or similar facility furnished or maintained by the Participant’s Employer.

26. Any services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are Experimental/Investigational in nature or not fully approved by a Council of the American Dental Association.

27. Any duplicate prosthetic device, other duplicate appliances, or duplicate dental restoration.

28. Any dietary instructions or plaque control programs.

29. A partial or full denture or fixed bridge which includes replacement of a tooth which was missing before the Participant was covered under this Plan with the Claim Administrator, except this exclusion will not apply:
   a. If such partial or full denture or fixed bridge also includes replacement of a missing tooth which was extracted after coverage becomes effective under the Plan for such Participant; or
   b. If the Participant has been continuously covered under a group dental care plan, which includes prosthetic benefits, held by the Employer with the Claim Administrator for a period of 24 consecutive months following the Participant’s Effective Date; or
   c. To Participants effective on the Effective Date of the Plan who were covered under a previous group dental care plan held by the Employer with another carrier immediately prior to the Effective Date of the Plan.

30. Splinting of teeth, including double abutments for prosthetic abutments.

31. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.

32. Any Accidental Injuries including tooth transplantation or tooth re-implantation.

33. Any pin retention not performed on the same date of service and in conjunction with a covered amalgam or composite restoration.

34. Any palliative (emergency) treatment performed in conjunction with definitive dental treatment.

35. Any indirect pulp capping.

36. Any athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.

37. Any bacteriological studies for determination of pathologic agents and soft tissue allograft.
38. Any biological materials, cytology sample collection, and histopathological examinations.

39. Any canal preparation and fitting of prefabricated dowel and post if billed separately.

40. Any caries susceptibility tests.

41. Any chemical treatments, localized delivery of chemotherapeutic agents without history of active periodontal therapy.

42. Any crowns to restore occlusion or incisal edges due to bruxism or harmful habits.

43. Any desensitizing medicaments and/or their application.

44. Any discing, enamel microabrasion, post removal, and provisional splinting.


46. Any guided tissue regeneration.

47. Any occlusal adjustment if not performed with active periodontal therapy or following active periodontal therapy and occlusal analysis.

48. Any oral hygiene instruction and/or tobacco use counseling.

49. Any office visit for observation and/or second professional opinions.

50. Any periodontal maintenance procedures not following active periodontal therapy.

51. Any prescription drugs.

52. Any osseous grafts if the following procedures have been performed on the affected tooth or site on the same date of service:
   a. apicoectomy;
   b. extraction;
   c. hemisection;
   d. retrograde filling;
   e. root amputation; or
   f. root canal therapy.

53. Any polishing of restorations.

54. Any pulpotomy on permanent teeth.

55. Any recontouring and restoration overhang removal.

56. Any replacement of:
   a. a prosthodontic appliance (fixed or removable) more often than once in any 60-month period (whether under this Plan or under any prior dental coverage); or
   b. restorations due to mercury or other possible allergies; or
   c. serviceable prosthodontics and upgrading of serviceable dentistry.

57. Any surgical repositioning of teeth and surgical revision procedure.

58. Any services or supplies not specifically defined as Eligible Dental Expenses in this Plan or not shown as a covered category of service on your Dental Schedule of Coverage.

59. Any temporary/interim prosthodontia or appliances (temporary crowns, bridges, partials, dentures, etc.).

60. Any appliances, materials, restorations, or special equipment used to increase vertical dimension, correct, or restore the occlusion.

61. Any services to correct Temporomandibular Joint (TMJ) dysfunction or pain syndromes.
62. Any services or supplies, including splinting, grafting, and preparation, for or associated with implants.
63. Any diagnostic photographs.
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 Dentist.

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

- **For certain Dentists contracting with the Claim Administrator** – The Allowable Amount is based on the terms of the Dentist’s contract and the Claim Administrator’s methodology in effect on the date of service. The methodology used may include relative value, global pricing, or a combination of methodologies.

- **For Dentists not contracting with the Claim Administrator** – The Allowable Amount is based on the amount the Claim Administrator would have paid for the same covered service, supply, or procedure if performed or provided by a Contracting Dentist.

Unless otherwise stipulated by a contract between the Dentist and the Claim Administrator:

- **For services performed in Texas** – The Allowable Amount is based upon the applicable methodology for Dentists with similar experience and/or skills.

- **For services performed outside of Texas** – The Allowable Amount will be established by identifying Dentists with similar experience or skills in order to establish the applicable amount for the procedure, services, or supplies.

- **For multiple surgical procedures performed in the same operative area** – 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 an additional Allowable Amount for covered supplies or services.

- **When a less expensive professionally acceptable service, supply, or procedure is available** – The Allowable Amount will be based upon the least expensive services. This is not a determination of Dental Necessity, but merely a contractual benefit allowance.

The Allowable Amount for all Eligible Dental Expenses also includes the administration of any local anesthesia and necessary infection control as required by state and federal mandates.

**BlueCare Dentist** means a Dentist who has entered into an agreement with the Claim Administrator to participate as a BlueCare Dental provider.

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

**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.

**Contracting Dentist** means a Dentist who has entered into a written agreement with the Claim Administrator to participate as a DentaBlue dental provider or a BlueCare dental provider.

**Co-Share Amount** means the dollar amount (expressed as a percentage) of Eligible Dental Expenses incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan.

**Course of Treatment** means any number of dental procedures or treatments performed by a Dentist in a planned series resulting from a dental examination concurrently revealing the need for such procedures or treatments.

**Deductible** means the dollar amount of Eligible Dental Expenses that must be incurred by a Participant before benefits under the Plan will be available.
DentaBlue Dentist means a Dentist who has entered into a written agreement with the Claim Administrator to participate as a DentaBlue dental provider.

Dentally Necessary or Dental Necessity means those services, supplies, or appliances covered under the Plan which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the dental condition or injury; and
2. Provided in accordance with and are consistent with generally accepted standards of dental practice in the United States; and
3. Not primarily for the convenience of the Participant or his Dentist; and
4. The most economical supplies, appliances, or levels of dental service that are appropriate for the safe and effective treatment of the Participant.

The Claim Administrator shall determine whether a service, supply, or appliance is Dentally Necessary and will consider the views of the state and national health communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Dentist may have prescribed treatment, such treatment may not be Dentally Necessary within this definition.

Dentist means a person, when acting within the scope of his license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree) and shall also include a person who is a Doctor of Medicine or a Doctor of Osteopathy.

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).

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

Eligible Dental Expenses means the professionally recognized dental services, supplies, or appliances for which a benefit is available to a Participant when provided by a Dentist on or after the Effective Date of coverage and for which the Participant has an obligation to pay.

Eligibility Date means the date the 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 the Benefit Booklet.

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.

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 in which they were performed; and
• the Dentist has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of the Claim Administrator 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 Dentist 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.

Group Health Plan (GHP), as applied 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.

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

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

Non-Contracting Dentist means a Dentist who is not a Contracting Dentist as defined herein.

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.

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

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 the 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 corresponding date in each year thereafter for as long as the 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.

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.

**Waiting Period** means the number of days of continuous employment required by the Employer that must pass before an individual who is a potential enrollee under the Plan is eligible to be covered for benefits.
GENERAL PROVISIONS

Amendments
The Plan may be amended or changed at any time by the Plan Administrator with prior written notice to the Claim Administrator. No notice to or consent by any Participant is necessary to amend or change the Plan.

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 Dentist, 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.

Participant/Dentist Relationship
The choice of a Dentist 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 Dental Expenses incurred by Participants. Neither the Claim Administrator, the Plan or any Plan fiduciary will be liable for any act or omission by any Dentist, nor will they have any responsibility for a Dentist’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 Dentist selected and are available only for treatment acceptable to the Dentist.

Refund of Benefit Payments
If the Plan pays benefits for Eligible Dental 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 Plan may deduct any refund due it from any future benefits 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/dental 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/dental 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, dental 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/dental 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 Expense** means a necessary, reasonable, and customary item of expense for health/dental care when the item of expense is covered at least in part by one or more Plans covering the Participant for whom claim is made.

5. **Claim Determination Period** means a Calendar Year. However, it does not include any part of a year during which a Participant has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

6. **We** or **Us** means the Claim Administrator (Blue Cross and Blue Shield of Texas).

**Order of Benefit Determination Rules**

1. **General Information**

   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.
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 as 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/dental 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/dental 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 be reduced when the sum of:
   
   a. The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
   
   b. The benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period.
   
   In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.
   
   When the benefits of This Plan are reduced as previously described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

**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 under this COB provision, 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 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
Upon termination of your coverage under this Plan, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your Dependent’s coverage under this Plan.

Continuation of Group Coverage - Federal
The following “events” may provide you or your Dependents an option to continue group coverage:

1. Your death, divorce, retirement, or eligibility for Medicare;
2. The termination of your status as an Employee (except for reason of gross misconduct) or retirement;
3. If you are covered as a retired Employee, the filing of a Title XI bankruptcy proceeding by the group; or
4. Your child’s marriage or reaching the “Dependent child age limit”.

If such an event occurs, you or your Dependents should immediately contact your Employer to determine your rights.

If the occurrence of the event requires coverage to terminate and if there is a right to continue the group coverage, the election to do so must be made within a prescribed time period. You or your Dependents may be required to pay your own contributions. Any continued coverage will be identical to that of similarly situated members of the group, including any changes (see your Dental Schedule of Coverage). Hence, changes in the group’s contribution or benefits will change the contributions or benefits for any continued coverage.
The continued coverage automatically terminates after a period of time (never to exceed three years) but will be terminated earlier upon the occurrence of certain circumstances. These circumstances include, but are not limited to, nonpayment of contributions, entitlement to or coverage under Medicare and coverage under any other group health coverage which does not contain a limitation with respect to a Preexisting Condition of the Participant (even if such coverage is less valuable than your current health plan). Your Employer will give you more detailed information upon your request.

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

If the 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 Plan. Upon written request by the Plan Administrator, the Claim Administrator will send any information which it 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 Plan. Claim filing and claim review 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 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 Dental Benefits Benefit and Prescription Drug Program Benefits 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
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 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
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 75266-004901

**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