Farm Bureau Health Plans
HDHP Family

fbhealthplans.com

CON-HDHPFAMN-013
Effective January 1, 2026

Important Member Notifications

Please read this Contract carefully and keep it in a safe place for future reference. If You have any questions about this Contract or any other matter related to Your membership in the Plan, please write or call:

Farm Bureau Health Plans
P.O. Box 313
Columbia, TN 38402-0313
(877) 874-8323

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Introduction

Farm Bureau Health Plans ("FBHP"), is a membership based organization, which promotes health care for the rural people of Tennessee and provides a program of health care benefits to its Members and Members of the Tennessee Farm Bureau Federation ("Farm Bureau").

Please read this Contract carefully. It describes Your rights and duties as a Subscriber/Member. It is important to read the entire Contract. Certain services are Non-Covered Services. Other Covered Services are limited. We will not pay for any service not specifically listed as a Covered Service, even if a Provider recommends that Non-Covered Service.

"Coverage" is used to refer to the benefits available to You under the terms of this Contract. "You" and "Your" mean the Subscriber. "Member" means the Subscriber and/or Eligible Dependent(s) enrolled under this Coverage.

This Contract replaces any Certificate, Evidence of Coverage ("EOC"), or Contract previously issued by FBHP in effect prior to the Effective Date of this Contract.

A Benefit Exclusion Rider, Member Exclusion Rider or rating classification attached to a previous Certificate, EOC, or Contract issued by FBHP may apply to this Contract also. Any remaining Pre-Existing Condition Waiting Period from a previous Certificate, EOC, or Contract issued by FBHP will apply to this Contract. This Coverage may be renewed by payment of the Premium.

Any dispute related to this. Coverage will be resolved in accordance with the Grievance Procedure section of this Contract.

Words defined in the "Definitions" section of this Contract are capitalized throughout.

If you are a new Subscriber, and You are not satisfied with this Coverage, You may return this Contract to FBHP within thirty (30) days of receipt. In this event, Your Coverage will terminate and any Premium paid for this Coverage will be refunded minus any benefits paid.

If You are transferring from another FBHP Coverage to this Coverage, and You are not satisfied with this Coverage, You may return this Contract to FBHP within thirty (30) days of receipt. In this event, Your Coverage will terminate and any Premium paid for this Coverage will be refunded minus any benefits paid. Your prior FBHP Coverage will not be reinstated.

If You have questions, please contact one of the customer service representatives at the number listed on Your Plan ID card or Your FBHP Representative at Your local Farm Bureau office.

RIGHT TO RECEIVE AND RELEASE INFORMATION

You authorize FBHP, its affiliate, or a third-party vendor to use and release the personal information for Yourself and all Eligible Dependents. This authorization includes any and all medical, vision and dental records obtained, used or released in connection with administration of this Coverage. Personal information will be maintained and released in accordance with applicable state and federal laws and the FBHP Notice of Privacy Practices. In the event information in this Coverage is inconsistent with the FBHP Notice of Privacy Practices, the terms of the FBHP Notice of Privacy Practices will prevail and this Coverage will be deemed to be modified to the extent necessary for consistency. Your authorization is deemed given by Your and Your Eligible Dependents' signatures on Your application and Your acceptance of Coverage. Additional authorization and/or consent may be required at the time Covered Services are obtained. This authorization remains in effect throughout the period You or Your Eligible Dependents are covered under this Coverage survives the termination of the Coverage to the extent that such information or records relate to services rendered while You or Your Eligible Dependents were covered under this Coverage.

You may also be required to separately authorize the release of personally identifiable health information in connection with the administration of this Coverage. Please consult the FBHP Notice of Privacy Practices for more information about Your rights regarding the use and release of Your personal information. You can find a copy of the FBHP Notice of Privacy Practices at fbhealthplans.com or You can call the toll-free number listed on the back of Your Plan ID card or contact the Farm Bureau Health Plans representative at Your local Farm Bureau office.

HOW YOUR PPO PLAN WORKS

You have a Preferred Provider Organization ("PPO") plan. FBHP, its affiliate, or a third party vendor contracts with a network of doctors, hospitals and other health care facilities and professionals. These Providers, called Network Providers, agree to special pricing arrangements.

Your PPO plan has two levels of benefits. By using Network Providers, You receive the highest level of benefits, and your out-of-pocket costs will generally be lower when you use Network Providers. However, You can choose to use Providers that are not Network Providers. These Providers are called Out-of-Network Providers. When You use Out-of-Network Providers, Your benefits will be reduced. You will be responsible for amounts that an Out-of-Network Provider bills above the Maximum Allowable Charge ("MAC"), which is called Balance Billing, and any amounts not covered under the terms of this Contract.

If Your doctor refers You to another doctor, hospital, or other health care Provider, or You see a covering physician in Your doctor's practice, please make sure this Provider is a Network Provider. By using Network Providers, You maximize Your benefits and avoid being billed the difference between what the Plan pays and what the Out-of-Network Provider charges. This amount can be substantial.

The reference to Providers as "Network Providers" or "Out-of-Network Providers" is not a statement about their abilities.

To find out which network a Provider belongs to, please refer to the Provider Directory accessible from www.fbhealthplans.com or call the toll-free number listed on the back of Your Plan ID card. The participation status of Providers may change from time to time.

AVAILABLE NETWORKS

The following primary and additional networks are available under Your Policy:

1) If a Provider belongs to the **UnitedHealthcare Choice Plus PPO** network, claims for Covered charges will normally be processed in accordance with the network benefit levels listed in the Schedule of Benefits.
2) If a Provider belongs to a secondary network, claims for Covered charges will normally be processed in accordance with the Out-of-Network benefit levels listed in the Schedule of Benefits. Secondary network providers have agreed to negotiate fees which may result in lower costs than other Out-of-Network claims and limit balance billing of members.
3) For services received from any other Provider, claims for Covered charges will normally be processed in accordance with the Out-of-Network benefit levels that are listed in the Schedule of Benefits. These Providers charge their normal rates for services, so You may need to pay more. You are responsible for paying the balance of these claims after the Plan pays its portion, if any.
4) The Program for Transplant Services at Centers of Excellence is **OptumHealth**.

FBHP reserves the right to modify available networks.

EXCEPTIONS TO THE PROVIDER NETWORK RATES

Some benefits may be processed at Network benefit levels when provided by an Out-of-Network Provider. When Out-of-Network charges are covered in accordance with Network benefits, the charges are subject to the usual and customary charge limitations. The following exceptions may apply:

A. Certain Out-of-Network Providers in Network Facilities - Covered Services provided by an Out-of-Network radiologist, anesthesiologist, or pathologist during an Inpatient stay will be payable at the Network level of benefits when provided in a Network facility.

B. Emergency Services – If a Member experiences an Emergency, charges from Out-of-Network Providers and facilities may be processed at the Network level of benefits as outlined in the Hospital Emergency Room Services benefit in the Member Benefit section of this Contract.

RELATIONSHIP WITH NETWORK PROVIDERS

Independent Contractors

Network Providers are not employees, agents or representatives of FBHP. Network Providers contract with FBHP, its affiliate, or a third party vendor which has agreed to pay them for rendering Covered Services to Members. Network Providers, in consultation with their patients, are responsible for making all medical treatment decisions. FBHP does not make medical treatment decisions under any circumstances.

Providers can dispute Coverage decisions with which they disagree. If Your Provider does not dispute a Coverage decision, You may request reconsideration of that decision as explained in the Grievance Procedure section of this Contract.

Termination of Providers' Participation

FBHP (or its affiliate or third party vendor on behalf of FBHP) or any Network Provider may end their relationship with each other at any time. A Network Provider may limit the number of Members that he, she or it will accept as patients. FBHP does not guarantee any specific Network Provider will be available to render services while the Member is covered.

CONTINUITY OF CARE

When a Network Provider no longer has an agreement with FBHP, its affiliate, or a third party vendor and becomes an Out-of-Network Provider, benefits may be available as if such Provider were still a Network Provider. If the Out-of-Network Provider agrees to continue to provide Covered Services on the same terms and conditions as applied under its former agreement with FBHP, or its affiliate or third party vendor, benefits will be available as if such Provider were still a Network Provider:

- For up to 90 days following notice that such agreement has been terminated, provided the Member was under active treatment for a particular illness or injury on the date such agreement was terminated and Covered Services are for the same illness or injury; or

- Until the completion of postpartum care, if the Member was in the second trimester of pregnancy on the date such agreement was terminated; or
- Until discharge, if the Member was under treatment at an inpatient facility on the date such agreement was terminated.

You need to complete a continuity of care request form and send it to FBHP. Contact FBHP at the telephone number on your Plan ID card for a copy of this form. If authorized by FBHP, Coverage will be provided for the services requested for the transitional period as designated above.

MEMBER/PROVIDER RELATIONSHIP

The choice of a Provider is solely the decision of the Member.

FBHP does not furnish Covered Services. FBHP is not liable for any act or omission of any Provider, bears no responsibility for a Provider's failure or refusal to provide Covered Services to a Member and cannot be held responsible for any injuries or damage caused by negligence or malpractice of a Provider.

Section II
Definitions

Accidental Injury – an unintentional traumatic bodily injury that, if not immediately diagnosed and treated, could reasonably be expected to result in serious physical impairment or loss.

Acute - an illness or injury that is both severe and of short duration.

Advanced Radiological Imaging – services such as MRIs, MRAs, CAT scans, CT scans, PET scans, nuclear medicine and similar technologies.

Ambulance - a specially designed and equipped vehicle used only to transport the sick and injured which meets all applicable legal and licensing requirements.

Behavioral Health Care - Any services or supplies that are Medically Necessary and Medically Appropriate to treat a mental or nervous condition, alcoholism, chemical dependence, drug abuse, or drug addiction.

Benefit Exclusion Rider - an attachment to this Contract excluding benefits for You or Your Eligible Dependents for the listed conditions. A Benefit Exclusion Rider will remain in effect until the Benefit Exclusion Rider termination date specified on Your underwriting decision letter. The underwriting decision letter will serve as the only notification regarding the removal of the Benefit Exclusion Rider. A Benefit Exclusion Rider will be applied independently from and in addition to the Pre-Existing Condition Waiting Period.

Billed Charges - the amount that a provider charges for services rendered. Billed Charges may be different from the amount that the Plan determines to be the Maximum Allowable Charge for services.

Calendar Year – The period of time beginning at 12:01 a.m. on January 1st and ending at 12:00 a.m. on the following January 1st.

Care Management – a program that promotes cost effective coordination of care for Members with complicated medical needs, complex conditions, and/or catastrophic illnesses or injuries. This process links individual Members and families with the appropriate medical services and community resources necessary to manage the Member's total care to promote optimum quality and optimum outcomes. Care management involves a systematic process of assessing, planning, service coordination and monitoring through which multiple health needs of patients are met.

Cell Therapy -Transfer of cells into a patient with the goal of treating a disease. The cells may be from the patient (autologous) or from a donor (allogenic). Cell therapy treatment includes, but is not limited to, the collection, processing, modification, or administration of autologous or allogeneic cells, stem cell therapy (including embryonic stem cells, induced pluripotent stem cells, nuclear transfer embryonic stem cells, parthenogenic embryonic stem cells, hematopoietic stem cells, mesenchymal stem cells, neural stem cells, epithelial stem cells, and immune cell therapy), chimeric antigen receptor (CAR) T-cell therapy, and any related laboratory testing, imaging, preparatory regimens, follow-up care, or management of complications.

Center of Excellence - A facility that has contracted to provide transplant services for specific organ and/or bone marrow transplant procedures covered under this Plan. For example, some Centers of Excellence might contract to perform heart transplants, but not liver transplants. Not all Network Providers are Centers of Excellence.

Child Health Supervision - routine visits to a pediatrician or other qualified provider to include Medically Necessary and Medically Appropriate periodic health screenings, immunizations and injections for children through the age of 6 years.

Chronic – lasting for a long period of time or recurring frequently.

Coinsurance - the amount of the Maximum Allowable Charge for a Covered Service that is the responsibility of the Member during the Calendar Year after any Deductible has been satisfied.

The Member will be responsible for the difference between Billed Charges and the Maximum

Allowable Charge for a Covered Service if an Out-of-Network Provider's Billed Charges are more than the Maximum Allowable Charge for Covered Services. In such case, the Member's total payment as a percentage of the Out-of-Network Provider's Billed Charges may exceed the Coinsurance.

Coinsurance Percentage - the percentage of the Maximum Allowable Charge that will be paid for a Covered Service during a Calendar Year after a Member satisfies Deductible. The Coinsurance Percentage is shown in the Schedule of Benefits.

Complex Diagnostic Services – non-routine services ordered by a provider to diagnose a specific condition or disease, billed to the Plan with procedure codes other than laboratory or office visit procedures pursuant to the American Medical Association ("AMA") code guidelines. Includes services performed by the provider in an office visit setting and services sent out for outside processing and review.

Complications of Pregnancy - Complications of Pregnancy, as defined by Tennessee state law, means conditions, requiring Hospital confinement when the pregnancy is not terminated, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as Acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also includes non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy or a live birth cesarean section.

Compound Drug - an outpatient prescription drug, which is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration ("FDA") and which contains at least one ingredient classified as a legend prescription drug.

Concurrent Review - the determination of whether continued inpatient or outpatient care, or a given level of service, is Medically Necessary and Medically Appropriate.

If, under such review, it is determined that continued care is not Medically Necessary and Medically Appropriate, the facility and Physician will be notified in writing of a specific date after which benefits will no longer be payable under this Plan. The Member or Physician can appeal the decision by contacting the Plan. The case will be reviewed and both the Physician and the Member will be notified of the results.

Cosmetic Services – services or supplies, including surgery and drugs, intended to alter or reshape the body for the purpose of improving appearance.

Covered Service, Coverage - Medically Necessary and Medically Appropriate services or supplies specified in this Contract for which benefits may be available. Covered Services are subject to all the terms, conditions, exclusions and limitations of this Contract.

Custodial Care - care provided primarily for maintenance designed to assist the patient in activities of daily living, such as convenience and hygiene services. It is not provided primarily for its therapeutic value in treatment of an illness or injury. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision of self-administration of medication not requiring constant attention of medical personnel.

Custodial Care includes services that the Medical Director determines are not effective or will not result in improvement in the Member's medical condition or long-term health.

Deductible - the dollar amount of Covered Services specified in the Schedule of Benefits that must be incurred and paid each Calendar Year before benefits are payable for all or part of the

remaining Covered Services. Any balance of charges (between Billed Charges and the Maximum Allowable Charge) required for services will not be considered when determining if the Family has satisfied a Deductible. There are two (2) separate Deductible amounts – one for Network Providers and one for Out-of-Network Providers. The Deductible is a Family Deductible; covered Eligible Dependents do not have a separate Deductible.

a. **Family Network Deductible** – the dollar amount of Covered Services from a Network Provider as specified in the Schedule of Benefits that must be incurred and paid by a Subscriber and Eligible Dependents each Calendar Year before benefits are payable for all or part of the remaining Network Provider Covered Services. Any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge for Covered Services) will not be considered when determining if a Deductible is satisfied. The full Family Deductible must be satisfied before benefits will be paid for the Subscriber or any Eligible Dependents. The Family Deductible can be satisfied by one or more Covered Members during a Calendar Year. Covered Members do not have separate Deductibles. The amount applied to the Family Network Deductible will apply to the Family Network Out-of-Pocket Maximum.

b. **Family Out-of-Network Deductible** – the dollar amount of Covered Services from an Out-of-Network Provider as specified in the Schedule of Benefits that must be incurred and paid by a Subscriber and Eligible Dependents each Calendar Year before benefits are payable for all or part of the remaining Out-of-Network Covered Services. Any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge for Covered Services) will not be considered when determining if a Deductible is satisfied. The full Family Out-of-Network Deductible must be satisfied before benefits will be paid for the Subscriber or any Eligible Dependents for Out-of-Network Provider services. The Family Out-of-Network Deductible can be satisfied by one or more Covered Members during a Calendar Year. Covered Members do not have separate Deductibles.

The Family Network Deductible and Family Out-of-Network Deductible are separate and do not combine. The Deductible amounts will be reviewed annually to ensure that the Deductible meets current IRS qualifications for Health Savings Accounts (HSA). If any adjustment in Deductible amount is necessary, You will be given 30 days advance notice.

Durable Medical Equipment - equipment which:

- can only be used to serve the medical purpose for which it is prescribed;
- is not useful to the patient or other person in the absence of illness, injury or disability;
- is able to withstand repeated use; and
- is appropriate for use within the home.

Such equipment will not be considered a Covered Service, even if it is prescribed by a Physician or Other Provider, simply because its use has an incidental health benefit.

Effective Date - is the date on which Coverage of a Member begins under this Plan.

Eligible Dependent - A spouse or child who has been approved for Coverage on this Plan. Refer to the Eligibility section of this Contract for complete details.

Eligible Provider – A person or entity that is engaged in the delivery of health services that is licensed, certified, or practicing in accordance with applicable state or federal laws. An Eligible Provider is a provider that has been approved by the Plan. Eligible Providers include:

Hospital – a licensed short-term, Acute care facility which provides inpatient services and is compensated by or on behalf of its patients. A Hospital must provide surgical and medical facilities primarily to diagnose, treat and care for the injured and sick; have a staff of Physicians licensed to practice; and provide 24-hour nursing care by registered nurses. A facility which serves, other than incidentally, as a nursing home, Custodial Care home, health

resort, rest home, rehabilitation facility, or place for the aged is not considered a Hospital.

Other Facility Providers – a facility that is licensed to perform Covered Services in the state where such services are provided. Other Facility Providers include, but are not limited to, the following:

– Behavioral Health Care Facility
– Ambulatory Surgical Facility
– Contracted Transplant Facility
– Licensed Birthing Center
– Freestanding Dialysis Facility
– Residential Treatment Facility
– Skilled Nursing Facility
– Substance Abuse Treatment Facility
– Other facilities approved by the Medical Director and licensed to provide Covered Services

Physician – a licensed practitioner legally entitled to practice medicine and perform surgery. Such practitioner must be licensed in Tennessee or in the state in which Covered Services are rendered and must provide services within the scope of his/her licensure. All services rendered must fall within the providers' specialty and be those normally rendered by a provider within this specialty or degree.

Other Professional Providers – Other Professional Providers may provide services covered by this Contract. To be eligible, a provider must be licensed or certified in Tennessee or in the state in which Covered Services are rendered; provide services within the scope of his/her licensure; practice in accordance with applicable state and federal laws; and be approved by Us. All services rendered must fall within the providers' specialty and be those normally rendered by a provider within this specialty or degree. All services and supplies must be rendered by the provider actually billing for them. Other Professional Providers include, but are not limited to, a nurse midwife, advance practice nurse, and Physician assistant.

Other Providers – other providers of Covered Services include, but are not limited to, the following:

– Durable Medical Equipment suppliers
– certified Ambulance service
– Hospice
– Pharmacy
– Home Health Care
– suppliers of oxygen

Emergency - the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention, could potentially result in:

- placing the person's health in serious jeopardy;
- serious impairments to bodily functions;
- serious dysfunction of any bodily organ or part; or
- other serious medical consequences.

Explanation of Benefits (EOB) - the form the Plan sends after a claim has been filed that tells the Subscriber which services were covered and which, if any, were not.

Family Coverage - Coverage for the Subscriber and Eligible Dependents. Refer to the Eligibility Section for a description of Eligible Dependents.

When the applicable Family Out-of-Pocket Maximum for services is reached, 100% of the Maximum Allowable Charge is payable for other Covered Services received from a Network Provider during the remainder of the Calendar Year.

Gene Therapy - Treatment that includes, but is not limited to, gene addition, gene correction, gene silencing, reprogramming, cell elimination, the administration of gene-modifying agents, genetic editing technologies (such as CRISPR), somatic or germline cell modification, and any related diagnostic testing, pre-treatment evaluations, follow-up care, or complications arising from such treatments.

Home Health Care Agency - an organization that provides health care services in a Member's home.

Hospice - a public agency or private organization that provides services for a terminally ill patient.

- **Approved Hospice** refers to a Hospice that:
  - is licensed by and, if legally required, has been issued a Certificate of Need from the state in which it is operating,
  - is certified as a Home Health Care Agency under Title XVIII and Title XIX of the Social Security Act,
  - is eligible for accreditation by the Joint Commission on Accreditation of Healthcare Organizations as a Hospice, and
  - provides in-home health care services which conform to the standards of a Hospice Program of Care as adopted by the Board of Directors of the National Hospice Organization.
- **Contracting Hospice** means an Approved Hospice licensed in Tennessee that has contracted with FBHP, its affiliate, or a third party vendor.

Hospice Care - Medically Necessary and Medically Appropriate medical services rendered to a terminally ill patient. Services must be provided by a Physician-supervised team of professionals and volunteers on twenty-four (24) hour call. Bereavement services to the family must be available.

Individual (Self-only) Coverage - Coverage for the Subscriber only. No maternity benefits are available under Individual Coverage.

Investigational Services - a drug, device, treatment, therapy, procedure, or other service or supply that does not meet the definition of Medical Necessity or:

- Cannot be lawfully marketed without approval of the Food and Drug Administration ("FDA") when such approval has not been granted at the time of its use or proposed use, or
- Is the subject of a current Investigational new drug or new device application on file with the FDA, or
- Is being provided according to Phase I or Phase II clinical trial or the experimental or research portion of a Phase III clinical trial (provided, however, that participation in a clinical trial shall not be the sole basis for denial), or
- Is being provided according to a written protocol which describes among its objectives, determining the safety, toxicity, efficacy or effectiveness of that service or supply in comparison with conventional alternatives, or
- Is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board ("IRB") as required and defined by Federal regulations, particularly those of the FDA or the Department of Health and Human Services ("HHS"), or

- The Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within HHS has determined that the service or supply is either experimental or Investigational or that there is insufficient data to determine if it is clinically acceptable, or
- In the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings, or
- In the predominant opinion of experts, as expressed in the published authoritative literature, further research is necessary in order to define safety, toxicity, efficacy, or effectiveness of that service compared with conventional alternatives, or
- The service or supply is required to treat a complication of an experimental or Investigational Service.

The Medical Director has discretionary authority to make a determination concerning whether a service or supply is an Investigational Service. If the Medical Director does not authorize the provision of a service or supply, it will not be a Covered Service. In making such determinations, the Medical Director shall rely upon any or all of the following, at his or her discretion:

- the Member's medical records, or
- the protocol(s) under which proposed service or supply is to be delivered, or
- any consent document that the Member has executed or will be asked to execute, in order to receive the proposed service or supply, or
- the published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses such as those experienced by the Member, or
- regulations and other official publications issued by the FDA and HHS, or
- the opinions of any entities that contract with FBHP, its affiliate, or a third party vendor to assess and coordinate the treatment of Members requiring non-Investigational Services.

The Medical Director's decision may be appealed to the Plan, which has final authority on any decision affecting the Plan.

Material Misrepresentation – Furnishing incorrect, incomplete, or misleading information, or failing to provide accurate information, whether intentionally or unintentionally, on Your application which, had accurate and complete information been known at the time of application, would have resulted in a different underwriting decision (higher rate tier, rider or exclusion applied, declined coverage, etc.).

Maximum Allowable Charge (MAC) - the amount the Plan has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the contract with a Network Provider or the amount payable based on the fee schedule for the Covered Services when rendered by Out-of-Network Providers.

Medical Director - a Physician designated by the Plan, or that Physician's designee, who is responsible for the administration of the medical management programs.

Medically Appropriate –services which have been determined by the Medical Director to be of value in the care of a specific Member. To be Medically Appropriate a service must:

- be Medically Necessary.
- be used to diagnose or treat a Member's condition caused by disease, injury or congenital malformation.
- be consistent with current standards of good medical practice for the Member's medical condition.

- be provided in the most appropriate site and at the most appropriate level of service for the Member's medical condition.
- on an ongoing basis, have a reasonable probability of:
  - correcting a significant congenital malformation or disfigurement caused by disease or injury.
  - preventing significant malformation or disease.
  - substantially improving a life sustaining bodily function impaired by disease or injury.
- not be provided solely to improve a Member's condition beyond normal variations in individual development and aging including:
  - comfort measures in the absence of disease or injury.
  - improving physical appearance that is within normal individual variation.
- not be for the sole convenience of the provider, Member or Member's family.

Medically Necessary or Medical Necessity – services which have been determined by the Plan to be of proven value for use in the general population. To be Medically Necessary a service must:

- have final approval from the appropriate government regulatory bodies.
- have scientific evidence permitting conclusions concerning the beneficial effect of the service on health outcomes.
- improve the net health outcome.
- be as beneficial as any established alternative.
- demonstrate the improvement outside the Investigational setting.

Member - a Subscriber or an Eligible Dependent.

Member Exclusion Rider - an attachment to this Contract excluding Coverage for listed Members. This rider will remain in effect for the life of this and any subsequent Contract.

Network Pharmacy - a pharmacy that has entered into a Network Pharmacy Agreement with FBHP, its affiliate, or a third party vendor to legally dispense prescription drugs to Members, either in person or through home delivery. This does not include the Specialty Pharmacy.

Network Provider – an Eligible Provider that has contracted with FBHP, its affiliate, or a third party vendor to furnish Covered Services to Members and to accept the Plan's payment, plus applicable Deductibles and Coinsurance as payment in full for Covered Services.

Non-Covered Service - a service or supply for which no benefits are available.

Out-of-Network Pharmacy – a pharmacy that has not contracted with FBHP, its affiliate, or a third party vendor to legally dispense prescription drugs to Members.

Out-of-Network Provider – an Eligible Provider that has not contracted with FBHP, its affiliate, or a third party vendor to furnish Covered Services to Members and to accept the Plan's payment, plus applicable Deductibles and Coinsurance as payment in full for Covered Services.

Out-of-Pocket Maximum -the dollar amount stated in the Schedule of Benefits which a Subscriber and covered Eligible Dependents must incur and pay for Covered Services during a Calendar Year. There are two Out-of-Pocket Maximums – one for services rendered by Network Providers, and one for services rendered by Out-of-Network Providers.

a. **Family Network Out-of-Pocket Maximum** – the amount stated in the Schedule of Benefits which a Subscriber and Eligible Dependents must incur and pay for Covered Services during a Calendar Year. This maximum can be satisfied by charges for Covered

Services provided by Network Providers. Services or charges which exceed the Maximum Allowable Charge, charges for Covered Services from an Out-of-Network Provider or any balance of charges (the difference between Billed Charges and the Maximum Allowable Charges for Covered Services) will not be considered when determining if the Out-of-Pocket Maximum has been satisfied.

When the Family Network Out-of-Pocket Maximum has been reached, benefits are payable at 100% of the Maximum Allowable Charge for other Covered Services from

Network Providers for all Covered Members during the remainder of that Calendar Year excluding any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge for Covered Services).

The Family Network Out-of-Pocket Maximum amount will be reviewed annually to ensure that the Out-of-Pocket Maximum meets current IRS qualifications for Health Savings Accounts (HSA). If any adjustment in Out-of-Pocket amount is required, You will be given 30 days advance notice.

b. **Family Out-of-Network Out-of-Pocket Maximum** - there is no limit to Out-of-Pocket expenses when Out-of-Network Providers are used.

When the applicable Out-of-Pocket Maximum for Covered Services is reached, 100% of the Maximum Allowable Charge is payable for other Covered Services received from a Network Provider during the remainder of the Calendar Year.

Pre-Existing Condition - an illness, injury, pregnancy or any other medical condition which existed at any time preceding the Effective Date of Coverage under this Contract for which:

- medical advice or treatment was recommended by, or received from a provider of health care services; or
- symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment.

Pre-Existing Condition Waiting Period - that period of time during which no benefits are available for a Pre-Existing Condition. It begins on the Effective Date of Coverage.

Premium – The amount paid by or on behalf of the Subscriber each billing cycle for Coverage provided under the terms of this Contract.

Prior Authorization – The purpose of Prior Authorization is solely to ensure that patients receive services at the appropriate time and in the appropriate setting. A Prior Authorization is not a guarantee of benefits. It is a review conducted prior to delivery of certain services, to determine if such services will be considered Covered Services. Benefits are based on all terms and conditions of the Coverage in force for the Member at the time Covered Services are provided.

Specialty Pharmacy Network Pharmacy - A pharmacy which has contracted with FBHP, its affiliate, or a third party vendor to provide Specialty Pharmacy Products to Members at specified rates.

Specialty Pharmacy Products - Injectable, infusion, and select oral medications that require complex care, including special handling, patient education and continuous monitoring. Specialty Pharmacy Products are categorized as provider-administered or self-administered.

Subscriber - an FBHP Member who has satisfied the eligibility requirements and has been enrolled for Coverage under this Plan.

Telemedicine – The use of Health Insurance Portability and Accessibility Act (HIPAA) (42 U.S.C. § 1320d et seq.) compliant real-time, interactive audio, video telecommunications, or electronic technology, or store-and-forward telemedicine services, used over the course of an interactive visit by a healthcare services provider to deliver healthcare services to a patient within the scope of practice of the healthcare services provider when:

- The healthcare services provider is at a qualified site other than the site where the patient is located and has access to the relevant medical record for that patient;
- The patient is located at a location the patient deems appropriate to receive the healthcare service that is equipped to engage in the telecommunication described herein; and
- The healthcare services provider makes use of HIPAA compliant, real-time, interactive audio, video telecommunications or electronic technology, or store-and-forward telemedicine services to deliver healthcare services to a patient within the scope of practice of the healthcare services provider as long as the healthcare services provider,

  the healthcare services provider's practice group, or the healthcare system has established a provider-patient relationship by submitting to Us evidence of an in-person encounter between the healthcare service provider, the healthcare services provider's practice group, or the healthcare system and the patient within sixteen (16) months prior to the interactive visit.

Telemedicine does not include:

- An audio-only conversation;
- An electronic mail message or phone text message;
- A facsimile transmission;
- Remote patient monitoring; or
- Healthcare services provided pursuant to a contractual relationship between Us and any entity that facilitates the delivery of provider-based telemedicine as the substantial portion of the entity's business.

Transplant Maximum Allowable Charge (TMAC) - The amount determined to be the maximum amount payable for Covered Services for organ transplants. Each type of organ transplant has a separate TMAC. That determination will be based upon the contract with a Center of Excellence.

We, Us, Our, and Plan – refers to Farm Bureau Health Plans ("FBHP")

TYPES OF COVERAGE AVAILABLE

Individual – Subscriber only **(No maternity benefits)**

Family – Subscriber and Eligible Dependents (**Maternity benefits available after a Member's FBHP Family Coverage has been in effect for nine (9) consecutive months) The nine (9) consecutive months of coverage may be under more than one Family Plan, as long as there is no lapse in coverage.**

SUBSCRIBER

To be eligible as a Subscriber, You must:

1. Be a member of Your local Tennessee Farm Bureau and Farm Bureau Health Plans;
2. Complete an application for You and any dependent you want to cover;
3. Meet FBHP medical underwriting requirements; and
4. Meet any additional requirements established.

TRH reserves the right to change these eligibility requirements at any time.

ELIGIBLE DEPENDENTS

The following will be eligible as Your Eligible Dependents:

1. Your current lawful spouse.
2. Your natural child until the age of twenty-six (26).
3. Your adopted child until the age of twenty-six (26).
4. A child who has been placed in the home of the Subscriber in anticipation of adoption by the Subscriber within six (6) months of the date of placement. Coverage under this Contract will terminate for a child placed with the Subscriber in anticipation of adoption on the date the child is removed from placement with the Subscriber if placement is disrupted prior to the final adoption.
5. Your stepchild until the age of twenty-six (26).
6. A child for whom You or Your spouse has been granted legal guardianship or custody until the age of twenty-six (26).

   To establish eligibility, a complete copy of any court documents establishing guardianship or custody, such as a final court order must be provided.

FBHP reserves the right to request proof of continuing eligibility at any time.

COVERAGE FOR DISABLED DEPENDENTS

Coverage for a child with a physical or intellectual disability may continue past age twenty-six (26) if he or she is incapable of self-support and mainly dependent upon You at that time. The disability must be certified by a physician. Coverage will continue as long as You continue to pay the required Premium for the Eligible Dependent's Coverage, Your own Coverage remains in effect, and You provide Us with required proof of the Eligible Dependent's incapacity and dependency. Initial proof of the Eligible Dependent's incapacity and dependency must be provided to FBHP within sixty (60) days of the Eligible Dependent's attainment of age twenty-six (26).

A child who has a physical or intellectual disability and has reached age twenty-six (26) at the time of application for Coverage is not eligible as a dependent on Your Contract. The child must

apply for his or her own Coverage.

ADDING DEPENDENTS

For newborns, adoption, guardianship, or placement of a child in anticipation of adoption, Coverage will be effective as of the date of the qualifying event (i.e., birth, adoption, guardianship or placement) if the application to enroll the dependent is furnished within thirty-one (31) days of the qualifying event.

Upon the birth of an Eligible Dependent, You must give notice to FBHP for processing of newborn claims. Once the Eligible Dependent has been enrolled in your Coverage, You will need to direct Providers to refile any relevant newborn claims with FBHP.

A biological child, for whom a newborn coverage waiver has not been signed, born after the Effective Date of an existing Family Contract will be added to the family contract effective the child's date of birth.

A biological child, for whom a newborn coverage waiver has been signed, born after the Effective Date of an existing family Contract will be subject to medical. If the application to add the child is approved, the child's Coverage will be effective on the next available Effective Date.

A biological child, for whom a newborn coverage waiver has not been signed, born after the Effective Date of the biological parent's individual Contract may be added to the biological parent's contract effective the child's date of birth. Application for Family Coverage and to add the newborn child must be made within 31 days of the child's date of birth.

A biological child, for whom a newborn coverage waiver has been signed, born after the Effective Date of the biological parent's individual Contract will be subject to medical underwriting. Application for Family Coverage and to add the child must be made. If the application to add the child is approved, the child's Coverage will be effective on the next available Effective Date.

FBHP reserves the right to request proof of continuing eligibility at any time. Dependent eligibility may be reviewed periodically beginning at age eighteen (18).

CHANGES IN ENROLLMENT STATUS

If any changes occur in the eligibility status of any Member, You must notify Us within sixty (60) days from the date of the event causing that change. Such events include, but are not limited to: (1) marriage, (2) divorce, (3) death, (4) dependency status, or (5) enrollment in Medicare. These are called qualifying events. You must also notify Us if You or an Eligible Dependent have a change of address.

Intentional failure to timely notify FBHP of a change in the eligibility status of any Member will be considered fraud.

Certain conditions may result in a change in Coverage as follows:

1. Upon the death of the Subscriber, surviving Eligible Dependents who are nineteen (19) years of age or older may continue Coverage by paying the Premium.
2. When a Member no longer meets the definition of an Eligible Dependent, the Member's Coverage will end at midnight on the day that loss of eligibility occurred. If the Member is nineteen (19) years of age or older, the Member may apply for a Subscriber Contract within sixty (60) days of the date the Member becomes ineligible. The Member will be issued the type of Contract then being issued to such Subscribers.
3. If Coverage terminates due to failure to pay the Premium and the Subscriber's spouse chooses to continue Coverage, the spouse and Eligible Dependents may apply for Coverage within sixty (60) days of the date of termination. The spouse and Eligible Dependents will be issued the type Contract then being issued to such Subscribers.

APPLICABLE LAW

The laws of the state of Tennessee govern this Coverage.

BENEFITS TO WHICH A MEMBER IS ENTITLED

Benefits are provided only for Covered Services received on or after the Member's Effective Date and prior to the termination date of the Member's Coverage. Benefits are provided for inpatient Covered Services only if the Member's admission occurs on or after his or her Effective Date.

THE PLAN IDENTIFICATION (ID) CARD

Your Plan ID Card is proof of Your right to receive the benefits of this Plan.

1. You should carry Your Plan ID Card at all times.
2. Only You or Your Covered Dependents may use Your Plan ID Card.
3. Be sure to show Your Plan ID Card each time You receive medical services. Inform Your physician that Prior Authorization may be required. The Plan ID Card contains special instructions on how to initiate the Prior Authorization process.

THE CONTRACT

This Contract explains the benefits available to Members. This Coverage cannot be transferred or assigned to another party. We may change the terms of Your Coverage by giving You at least thirty (30) days notice before the effective date of any change. Your continued payment of Premium indicates acceptance of the change. Notice of any change to the terms of Your Coverage will be mailed to You at the address shown in Our records.

BRINGING LEGAL ACTION

Any legal action taken with respect to Coverage under this Plan must begin within three (3) years following the period permitted for timely filing of a claim. Legal action may not be taken until:

- A properly completed notice of claim has been submitted, and
- Such claim has either been denied in writing or not followed by a written response within sixty (60) days after it is submitted, and
- The Member has exercised all of his or her review and appeal rights under this Contract, as defined under Grievance Procedure unless the period set forth in the Grievance Procedure has expired.

RIGHT TO REQUEST INFORMATION

We have the right to request any additional necessary information or records with respect to any Member covered or claiming benefits under the Policy.

ADMINISTRATIVE ERRORS

If We make an error in administering the benefits under this Policy, We may recover any overpayments from any person, insurance company, or plan. Any recovery must being within eighteen (18) months (or the time frame allowed by law) of the date the claim was paid. This

time limit does not apply if the Member did not provide complete information or if material misstatements or fraud have occurred.

No such error may be used to demand more benefits than those otherwise due under this Policy.

TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the Effective Date of this Coverage, no Material Misrepresentations of a material fact, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void this Coverage or to deny a claim for loss incurred after the expiration of such two-year period.

SUBROGATION AND RIGHT OF RECOVERY

You agree that the Plan shall be subrogated to and/or have the right to recover amounts paid to provide Covered Services to You and Your Covered Dependents for illnesses or injuries caused by third parties, including the right to recover the reasonable value of prepaid services rendered by Network Providers.

The Plan shall have first lien against any payment, judgment or settlement of any kind that You or Your Covered Dependents receive from or on behalf of such third parties for medical expenses, for the costs of Covered Services and any costs of recovering such amounts from those third parties. The Plan may notify those parties of its lien without notice to or consent from You or Your Covered Dependents.

Without limitation, the Plan may enforce its rights of subrogation and recovery against any tortfeasors, other responsible third parties or against available insurance Coverages, including underinsured or uninsured motorist coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

To enable the Plan to protect its rights under this section, You are required to notify the Plan promptly if an illness or injury is caused by a third party. You are also required to cooperate with the Plan and to execute any documents that the Plan deems necessary to protect its rights under this section. If You or Your Covered Dependents settle any claim or action against any third party without the Plan's consent, You shall be deemed to have been made whole by the settlement, and the Plan shall be entitled to immediately collect the present value of its rights as a first priority claim from the settlement fund. Any such proceeds of settlement or judgment shall be held in trust by You for the Plan's benefit. The Plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by You in such circumstances.

NOTICES

All notices required by this Contract should be in writing. Notices to Us should be addressed to:

Farm Bureau Health Plans

P.O. Box 313

Columbia, TN 38402-0313.

We will mail notices to You at the most recent address on file. It is Your responsibility to maintain Your and Your Covered Dependent's current address on file with Us.

Women's Health and Cancer Rights Act of 1998

Patients who undergo a mastectomy, and who elect breast reconstruction in connection with the mastectomy, are entitled to Coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient.

The Coverage may be subject to Coinsurance and Deductibles consistent with those established for other benefits.

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

Under federal law, health insurance issuers offering health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a shorter stay if the attending Provider (e.g., Your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, an issuer may not, under federal law, require that a physician or other health care Provider obtain Authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce Your Out of-Pocket costs, You may be required to obtain Prior Authorization. For information on Prior Authorization, contact Us.

Section V
Premium & Termination of Coverage

PREMIUM

We may change Your Premium by giving You at least thirty (30) days notice before the effective date of any Premium change. Your continued payment of Premium indicates acceptance of the change. Your Coverage is age rated. Your Premium will automatically change on the first billing date after You move to a different age bracket. Rates for Family Coverage are based on the age of the oldest family Member.

Your Coverage is also subject to separate and additional general rate increases.

YOUR PREMIUM

Your Premium must be submitted to FBHP. Your first Premium will be billed by paper invoice. Payment of Your first Premium indicates acceptance of Your Coverage offer. Monthly Premium payments will occur by the method designated during the application process until You submit a change request.

Should Your payment be dishonored (returned unpaid) by Your financial institution, You could forfeit Your Coverage. Your Coverage is subject to a ten (10)day grace period if Premium is paid on a monthly basis. If Your Premium is not paid within Your grace period, Your Coverage will terminate retroactively effective as of the Premium and You shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

FEE FOR DEFAULT OF PAYMENT

Should Your payment be dishonored by Your financial institution, You will be responsible for default fees in the amount of $25. This default fee will be waived if Your Coverage has not experienced a defaulted payment in the previous twelve (12) months. FBHP reserves the right to change the default fee amount at any time.

RESTORATION OF COVERAGE

If Your Coverage has been cancelled due to non-payment of Premium within Your grace period, Your Coverage may be restored by paying the total Premium due, including any applicable default fees and a restoration fee of $100, to Us within ten (10) days of the final day of Your grace period.

REFUNDS

In the event a refund of Premium is due, We will make the refund payable to the payor. In the event the Subscriber and payor are not the same person, We will mail a cover letter explaining the refund to the payor and You, as the Subscriber, will receive a copy of the refund explanation letter.

CHANGES TO COVERAGE

You can request a change to Your Coverage. Your request is subject to approval by us and must be made in writing and received by Us at least ten (10) days prior to the next Premium due date.

TERMINATION OF COVERAGE

This Coverage may be terminated if:

- The required Premium for Your Coverage is not received when it is due; or
- You fail to pay Your Tennessee Farm Bureau Federation or FBHP membership dues; or

- You fail to cooperate with FBHP as required by this Contract; or
- You act in such a disruptive manner as to prevent or adversely affect Our ability to administer Your Coverage; or
- You request that Your Coverage be cancelled for any reason by giving FBHP written notice which is received by Us at least ten (10) days prior to the next Premium due date, in which case Coverage will remain in effect until the paid-to date; or
- You have resided outside the United States for twenty-four (24) consecutive months; or
- This Plan is terminated; or
- You, or an Eligible Dependent, have made a Material Misrepresentation or committed fraud against Us. This provision includes, but is not limited to, furnishing incorrect, incomplete, or misleading information, failing to provide accurate information or permitting the improper use of Your Plan ID Card.

Material Misrepresentation or fraud could result in amended Coverage or termination of Coverage. This means, in instances of Material Misrepresentation or fraud, We reserve the right to re-underwrite and rate your Coverage considering the information left off the application due to Material Misrepresentation or fraud. This may result in a higher Premium, benefit riders or exclusions (where applicable), or termination of Coverage. If Your Coverage is terminated as a result of Material Misrepresentation or fraud, We will return Premium paid minus any claims paid. If the claims paid exceed Premium paid, We have the right to collect that amount from You. We will notify You thirty (30) days in advance of any rescission.

Your Eligible Dependent's Coverage will automatically terminate on the earliest of the following dates:

1) The date Your coverage terminates; or

2) The last day of the month for which You paid Your Eligible Dependent's Premium; or

3) The date Your Eligible Dependent is no longer eligible.

FBHP may cancel this Coverage for any of the reasons described herein by giving written notice to You thirty (30) days prior to the date of termination. Notice will be mailed to You at the most recent address on file. It is Your responsibility to maintain Your current address on file with us.

If Coverage terminates as a result of Your death and You have no Eligible Dependents, Your Coverage will be terminated on the date of Your death, and Your estate is entitled to a refund of any unused Premium.

If You are on a monthly bank draft, You have the option to stop payment at Your bank, provided You present Your bank with the proper account information and exact bank draft amount. FBHP is not responsible for any fees that may be charged by Your bank to exercise a stop payment option.

PAYMENT FOR SERVICES RENDERED AFTER TERMINATION OF COVERAGE

If You or Your Eligible Dependents receive and We pay for Covered Services after the termination of Coverage, We may recover the amount We pay for such Covered Services from You, plus any costs of recovering such charges, including Our attorney's fees.

In the event Your Coverage is terminated back to the original Effective Date, We may recoup the

amount of any benefits paid that exceed Premium paid. If such amounts cannot be recouped from providers, the Member will be responsible for reimbursement.

We may impose a finance charge of 1 ½ % per month to any amount not remitted to Us within thirty (30) days of the date of notification of the amount due.

BENEFITS AVAILABLE

A Member is entitled to benefits for Covered Services as specified in this Schedule of Benefits. Benefits shall be determined according to the Contract terms in effect when a service is received. Benefits may be amended at any time in accordance with applicable provisions of this Contract. Under no circumstance does a Member acquire a vested interest in continued receipt of a particular benefit or level of benefit.

CALCULATION OF COINSURANCE

As part of their efforts to contain health care costs, FBHP, its affiliate or a third party vendor has negotiated agreements with Hospitals under which the Plan receives a discount on Hospital bills. In addition to such discounts, FBHP, its affiliate or a third party vendor also have some agreements with Hospitals under which payment is based upon other methods of payment (such as flat rates, capitation or per diem amounts).

The Member's Coinsurance will be based upon the same dollar amount of payment used to calculate the Plan's portion of the claims payment to the Hospital, regardless of whether the Plan payment is based upon a discount or an alternative method of payment.

MEMBER'S RESPONSIBILITY

The purpose of Prior Authorization is solely to ensure that patients receive services at the appropriate time and in the appropriate setting. Prior Authorization is required for certain services, which are listed in the Cost Containment and Medical Management Section of this Contract. Please have the Member's Physician call the telephone number shown on Your Plan ID card before services are provided. Otherwise, the Member's benefits may be reduced or denied. A Prior Authorization is not a guarantee of benefits. Benefits are based on all terms and conditions of the Coverage in force for the Member at the time services are provided.

This section shows how much the Plan pays for Covered Services described in the Member Benefits section.

NOTE: Billed Charges from an Out-of-Network Provider which exceed the Maximum Allowable Charge will be the responsibility of the Member.

Coinsurance Percentages	Network Provider Services	Out-of-Network Provider Services
Covered Services	**80% of the Maximum Allowable Charge after Deductible**	**60% of the Maximum Allowable Charge after Deductible**
Covered Teladoc Services*	**100% of the Maximum Allowable Charge**	**Not Covered**
***Covered Teladoc Services subject to a consultation fee until Deductible is reached for Calendar Year.**		

BENEFITS FOR PRESCRIPTION DRUGS	
Network Pharmacies	**Out-of-Network Pharmacies**
80% of the Maximum Allowable Charge after Deductible	**60% of the Maximum Allowable Charge after Deductible**

SPECIALTY PHARMACY PRODUCTS*	
Network Pharmacy	**Out-of-Network Pharmacy**
80% of the Maximum Allowable Charge after Deductible	**60% of the Maximum Allowable Charge after Deductible**
Specialty Pharmacy Products are limited to a quantity of up to a 30-day fill.	

ORGAN TRANSPLANT SCHEDULE OF BENEFITS	
Organ Transplant Services	**Center of Excellence Benefits:** 80% of Transplant Maximum Allowable Charge (TMAC) after Deductible; Network Out-of-Pocket Maximum applies. Member is not responsible for amounts over TMAC.

All transplants require Prior Authorization. Benefits will be denied without Prior Authorization.

A Center of Excellence is a facility that has contracted to provide transplant services for specific organ and/or bone marrow transplant procedures covered under this Plan. For example, some Centers of Excellence might contract to perform heart transplants, but not liver transplants. Not all Network Providers are Centers of Excellence. Call customer service before any pre-transplant evaluation or other transplant service is performed to request Prior Authorization and to obtain information about Centers of Excellence.

WELL CARE SERVICES

Benefits are available, subject to Deductible and Coinsurance, for the following services only when provided by a Network Provider in the provider's office.

Child Health Supervision Services. Benefits are available for a Member under 7 years of age for physical examinations and appropriate immunizations/vaccinations rendered by a Network Provider. Services include history, physical exam, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards. No benefit is available for the examinations and immunizations if provided by an Out-of-Network Provider.

Benefits for physical examinations are subject to the following guidelines:

Under age one: 4 exams from birth to the child's first birthday

Age one: 2 exams from the child's first birthday to the child's second birthday

Age two through six: *1 exam per year

*The Member's birthday determines when a year begins and ends.

Exams not used during these time periods do not carry over to the next time period.

The initial examination of a newborn in the Hospital is covered subject to the Deductible and Coinsurance. This examination may be by a Network or Out-of-Network Provider and does not count toward the physical examination limitations above. Benefits will be allowed, subject to Deductible and Coinsurance, for the initial newborn hearing screening. Additional routine examinations and hearing screenings for a newborn in the Hospital will not be considered eligible services.

Immunizations, vaccinations and booster shots recognized as appropriate for Child Health Supervision are eligible and include:

Diphtheria, Tetanus, Pertussis (DPT)	Measles, Mumps, Rubella (MMR)
Haemophilus influenza type B (HIB)	Meningococcal
Hepatitis A	Pneumococcal
Hepatitis B	Rotavirus
Inactivated Poliovirus	Varicella
Influenza	

Annual OB/GYN Exam. Benefits will be available for one routine OB/GYN exam per Calendar Year. Services must be rendered by a Network Provider in the Physician's office and billed by the Network Provider. Related pathology, including pap smear, which is provided as a part of the routine OB/GYN exam, will be covered when the services are rendered by a Network Provider in the Physician's office and billed by the Network Provider. Related pathology that the Physician sends to an independent laboratory will be subject to Deductible and Coinsurance. No benefit is available for routine OB/GYN exams provided by an Out-of-Network Provider.

Benefits are available, for the following services when provided by a Network or Out-of-Network Provider as outlined in the Schedule of Benefits.

Annual routine PSA. Benefits will be provided, subject to Deductible and Coinsurance, for one routine PSA per Calendar Year when services are rendered by an independent laboratory or other outpatient setting.

Annual routine Pap Smear. Benefits will be provided, subject to Deductible and Coinsurance, for the interpretation of one routine pap smear per Calendar Year when services are rendered by an independent laboratory or other outpatient setting. Coinsurance.

Colorectal Cancer Screening. Benefits will be provided, subject to Deductible and Coinsurance, for colorectal cancer screening at age forty-five (45) and older as follows:

- High-sensitivity guaiac fecal occult blood test (HSgFOBT) or fecal immunochemical test (FIT) every year;
- Stool DNA-FIT every 1 to 3 years;
- Computed tomography colonography every 5 years;
- Flexible sigmoidoscopy every 5 years;
- Flexible sigmoidoscopy every 10 years + annual FIT; and
- Colonoscopy screening every 10 years

Mammograms. Benefits are available, subject to Deductible and Coinsurance for routine mammography screening, provided such examinations are conducted upon the recommendation of the Member's Physician. One baseline routine mammogram will be allowed for Members between the ages of 35 and 39. One routine mammogram will be allowed per Calendar Year for Members age 40 and above.

Section VIII
Member Benefits

This Coverage provides benefits for many medical services and supplies received by a Subscriber or Eligible Dependent. However, not all medical expenses are covered. It is important for the Members to understand which services are covered by this Contract. Members also need to remember how the Cost Containment and Medical Management features can affect their benefits as Prior Authorization is required for certain services.

Most health care Coverage contains specific benefit maximums, limitations and exclusions. The benefit maximums, limitations and exclusions that apply to this Coverage are outlined in the Limitations/Exclusions Section, in the Schedule of Benefits section and in this Member Benefits section**.**

Benefits will be provided under this Coverage only for services or supplies which are Medically Necessary and Medically Appropriate and performed and billed by an Eligible Provider. Services must be related to the diagnosis and/or treatment of the Member's illness, injury, or pregnancy.

Services provided during a Telemedicine encounter are covered consistent with what this Coverage provides for in-person encounters for the same service.

Benefits for each expense are subject to the Deductible. Coinsurance will be a percentage of the Maximum Allowable Charge as stated in the Schedule of Benefits. The portion of any charge for a service or supply which is more than the Maximum Allowable Charge amount will not be considered covered. Charges billed by an Out-of-Network Provider which exceed the Maximum Allowable Charge will be the responsibility of the Member.

Active&Fit Direct™ Program

The Active&Fit™ Direct Program allows Members eighteen (18) years of age and older the opportunity to participate in the Active&Fit™ Direct fitness center discount access program. Active&Fit™ Direct is a product provided by American Specialty Health Fitness, Incorporated ("ASH Fitness"). An enrollment fee, monthly fee, and applicable taxes give Members access to a fitness center from among the Active&Fit™ Direct network of over 9,000 participating fitness centers and select YMCAs nationwide. A minimum three-month enrollment is required.

For additional information or to enroll, visit www.fbhealthplans.com/activeandfit.

Allergy Testing

Benefits are available for Medically Necessary and Medically Appropriate allergy testing.

Ambulance

Benefits are available, subject to Deductible and Coinsurance, up to a maximum of $450, per occurrence, for a ground Ambulance to transport the Member:

- from the Member's home or the scene of an accident or Emergency to the nearest Hospital where appropriate medical or surgical services are available;
- between Hospitals; or
- between a Hospital and a Skilled Nursing Facility.

Benefits are available for air or sea Ambulance, subject to Deductible and Coinsurance, from one location to another where:

- the Member's medical condition requires immediate transport that could not be provided by local ground Ambulance; or
- the point of pick up is not accessible by land vehicle; or

- the Member's medical condition is such that the time needed to transport poses a threat to his or her health.

Benefits will not be available under this Coverage for:

- Charges for dispatch of an Ambulance that is not used by the Member;
- transport to a Physician's office, outpatient department of a Hospital for medical care, or the patient's home; or
- Charges for waiting time or extrication.

Anesthesia

Anesthesia administered by a Certified Registered Nurse Anesthetist (CRNA) or a Physician (other than the operating surgeon) provided the surgery is covered.

Assistant Surgeon

Services of an assistant surgeon who actively assists the operating surgeon in performing a covered surgical procedure, when:

- no intern, resident, or other staff doctor is available; and
- the surgical procedure requires the services of an assistant.

Behavioral Health Care Services

Benefits are available for Medically Necessary and Medically Appropriate Applied Behavioral Analysis (ABA) Therapy, inpatient/rehabilitative and outpatient treatment of mental health disorders and substance abuse disorders (behavioral health conditions) characterized by abnormal functioning of the mind or emotions and in which psychological, emotional or behavioral disturbances are the dominant features. Benefits are also available for outpatient medication management.

Other levels of care may be substituted for inpatient days.

Prior Authorization is required for inpatient and intensive outpatient Behavioral Health Care Services.

Breast Reconstruction

Benefits are available for reconstructive breast surgery as a result of a mastectomy as well as surgery on the non-diseased breast needed to establish symmetry between the two breasts. Benefits are not available for reconstructive breast surgery as a result of a lumpectomy.

Post-mastectomy benefits are also available for:

- Breast prosthesis, surgical bras, or bras with an integrated prosthesis (combined limit of 5 per Calendar Year);
- Gel inserts, if Medically Necessary and Medically Appropriate; and
- Breast implants, if Medically Necessary and Medically Appropriate.

Cardiac Rehabilitative Services

Benefits are available for Medically Necessary and Medically Appropriate cardiac rehabilitative services for the treatment of cardiovascular disease. Prior authorization is required for inpatient and outpatient services. Outpatient services are limited to 36 visits per Calendar Year.

Chiropractic Services

Benefits are available for Medically Necessary and Medically Appropriate chiropractic services. Deductible and Coinsurance will apply.

Complications of Pregnancy

Benefits are available for Complications of Pregnancy, as defined by Tennessee state law, subject to Deductible and Coinsurance. Complications of Pregnancy means conditions, requiring Hospital confinement when the pregnancy is not terminated, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as Acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also includes non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy or a live birth cesarean section.

Dental Services For Accidental Injury

Covered Services

Medically Necessary and Medically Appropriate services performed by a doctor of dental surgery (DDS), a doctor of medical dentistry (DMD) or any Practitioner licensed to perform dental related oral surgery as indicated below.

- Dental services and oral surgical care resulting from an Accidental Injury to the jaw, sound natural teeth, mouth, or face, due to external trauma. The surgery and services must be started within three (3) months and completed within twelve (12) months of the injury unless the initial Medically Necessary and Medically Appropriate plan of treatment cannot be completed within twelve (12) months of the injury (such initial Medically Necessary and Medically Appropriate plan of treatment must be determined within twelve (12) months of the injury). Services include:
  - Tooth extraction needed due to Accidental Injury of teeth caused by external trauma;
  - Excision of partially or completely impacted teeth, including wisdom teeth;
  - Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological exams;
  - Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
  - Reduction of fractures and dislocations of the jaw;
  - External incision and drainage of cellulitis;
  - Incision of accessory sinuses, salivary glands or ducts;
  - Excision of exostosis of jaws and hard palate;
  - Dental implants needed due to Accidental Injury of teeth caused by external trauma.
- For dental services not listed in the section above, general anesthesia, nursing and related hospital expenses in connection with an inpatient or outpatient dental procedure are Covered, only when one of the five (5) following conditions is met:
  - Complex oral surgical procedures that have a high probability of complications due to the nature of the surgery;

- Concomitant systemic disease for which the patient is under current medical management and that significantly increases the probability of complications;
- Mental illness or a behavioral condition that precludes dental surgery in the office;
- Use of general anesthesia and the Member's medical condition requires that such procedure be performed in a Hospital; or
- Dental treatment or surgery performed on a Member eight (8) years of age or younger, where such procedure cannot be safely provided in a dental office setting.

- Oral Appliances to treat obstructive sleep apnea, if Medically Necessary.

Exclusions

- Except as listed above, routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) tooth extraction; (8) periodontal surgery; (9) root canals; (10) preventative care (cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth.
- Treatment for correction of underbite, overbite, and misalignment of the teeth including but not limited to, braces for dental indications, orthognathic surgery except as otherwise specified in this Contract, and occlusal splints and occlusal appliances to treat malocclusion/ misalignment of teeth.

Dental Services - Anesthesia and Hospital

Benefits are available for anesthesia, as well as inpatient or outpatient Hospital expenses, in connection with a dental procedure if such procedure involves:

- dental surgery performed on a Member eight years of age or younger, where such procedure cannot safely be provided in a dental office setting; or
- mental illness or behavioral condition which precludes dental surgery in an office setting.

Dental Services – Impacted Teeth

Benefits will be available for services and supplies for the surgical removal of impacted teeth. A Member's Coverage must be in effect for 12 months before this benefit is available.

Diabetes Treatment

Benefits are available for treatment, medical equipment, supplies and outpatient self-management training and education, including nutritional counseling, for the treatment of diabetes. In order to be covered, such services must be:

- prescribed and certified by a Physician as Medically Necessary and Medically Appropriate; and
- provided by a Physician, Registered Nurse, Dietician, or Pharmacist who has completed a diabetes patient management program recognized by the American Council on Pharmaceutical Education and the Tennessee Board of Pharmacy.

Services and supplies included under this provision shall include:

- blood glucose monitors, including monitors for the legally blind;
- test strips for blood glucose monitors;
- visual reading and urine test strips;

- injection aids;
- syringes and lancets;
- insulin pumps, infusion devices, and Medically Necessary and Medically Appropriate accessories;
- podiatric appliances for prevention of complications associated with diabetes;
- glucagon emergency kits; and
- insulin and oral hypoglycemic agents.

Diagnostic Services

When Medically Necessary and Medically Appropriate and ordered by an Eligible Provider to determine a specific condition or disease the following non-routine diagnostic services are covered:

- X-ray and other radiology services;
- laboratory and pathology services;
- cardiographic, encephalographic, and radioisotope test;
- prostate specific antigen (PSA) test;
- transrectal ultrasound for prostate cancer;
- group B Streptococcus testing on pregnant or newborn Members as recommended by the American College of Obstetricians and Gynecologists and the Center for Disease Control;
- mammograms; and
- pap smear.

Certain diagnostic services require Prior Authorization before services are rendered. For a list of diagnostic services requiring Prior Authorization, refer to the Cost Containment and Medical Management Section of this Contract.

Durable Medical Equipment

Benefits are available for the rental and, where deemed appropriate by the Plan, the purchase of manually operated Durable Medical Equipment when Medically Necessary and Medically Appropriate and prescribed by a Physician. Benefits for rental should not exceed the purchase price of the equipment.

Benefits are also available to fit, adjust, repair, or replace Durable Medical Equipment, provided the need for this arises from normal wear or the Member's physical development -- and not as a result of improved technology, loss, theft, or damage.

Prior Authorization is required for DME rentals over $500 and DME purchases over $1,500.

Hearing Aids

Benefits are available for each Member under 18 years of age for hearing aids prescribed by an audiologist or Physician. For the purpose of this benefit, hearing aid means any wearable, nonexperimental, nondisposable instrument or device designed for the ear and used to aid or compensate for impaired human hearing, including ear molds and services necessary to select, fit and adjust the hearing aid, but excluding batteries, cords, accessories, assistive listening devices, or implantable devices.

This hearing aid benefit is limited to $1,000 per individual hearing aid per ear every three years, subject to Deductible. The Coinsurance Percentage will be 100% up to the $1,000 maximum. Charges more than $1,000 will be the responsibility of the Member.

Home Health Care

Benefits are available for Medically Necessary and Medically Appropriate services and supplies authorized by the Plan and provided in a Member's home by an agency who is primarily engaged in providing home health care services. Covered Services include: part-time, intermittent nursing care by a visiting R.N. or L.P.N.; home infusion (IV) therapy; and respiratory therapy by persons licensed to perform such services; and oxygen and its administration.

Benefits will be provided for Covered Services prescribed by the Member's Physician and considered Medically Necessary and Medically Appropriate.

No Home Health Care benefits will be provided for:

- transportation services;
- services rendered primarily for Custodial Care;
- dietician services;
- social case work or homemaker services;
- home health aide;
- maintenance therapy; or
- food, including home-delivered meals.

Prior Authorization is required before Home Health Care services are rendered. Home Health Care is limited to 45 visits per Calendar Year.

Hospice Care

Hospice Care is an alternative to lengthy inpatient treatment for terminally ill patients. The patient's Physician must establish a plan of treatment. An approved Hospice must provide the services.

In-home services are available, such as:

- prescription drugs;
- medical supplies;
- Durable Medical Equipment; and
- other essential medical services.

The Deductible and Coinsurance will not apply to expenses incurred for Hospice care. The Coinsurance Percentage will be 100% for this service.

Inpatient Hospice Care is subject to medical review by Care Management.

Hospital Emergency Room Services

Benefits will be provided subject to Deductible and Coinsurance for Emergency Services received in a Hospital Emergency department when symptoms have been recorded by the attending Physician that an Emergency Medical Condition could exist.

Outpatient Emergency Room Services (including emergency room physician charges) received in an Out-of-Network hospital Emergency Department will be covered at the Network Provider Coinsurance Percentage level, after applicable Deductibles have been met for true medical emergencies. Any inpatient treatment or services for a covered condition by an Out-of-Network

Provider will be subject to the Out-of-Network Deductible, Out-of-Network Coinsurance, and Out-of-Network Out-of-Pocket Maximum.

An “Emergency” or "Emergency Medical Condition" means the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention, could potentially result in:

1. placing the person’s health in serious jeopardy;
2. serious impairments to bodily functions;
3. serious dysfunction of any bodily organ or part; or
4. other serious medical consequences.

An “Emergency” does not include treatment of a Chronic condition in which subacute symptoms have existed over a period of time and would not be considered an Emergency unless symptoms suddenly became severe enough to require immediate medical assistance.

Hospital Inpatient Services

- Room, board, and general nursing care in a
  - semi-private room,
  - private room (limited to most common semi-private room rate, unless approved by the Plan),
  - special care unit as approved by the Plan;
- Use of operating, delivery and treatment rooms;
- Prescription drugs and medicines, including take home prescription drugs;
- Medical supplies, sterile dressings, casts, splints and crutches;
- Anesthetics;
- Diagnostic services (x-ray, laboratory and certain other tests);
- 23-Hour Observation stays; and
- Certain therapy services.

Prior Authorization is required for Hospital admission.

Hospital Outpatient Services

- Treatment of a sudden and serious illness or Accidental Injuries;
- Removal of sutures, anesthetics and their administration, and other surgical services provided by a Hospital employee other than the surgeon or assisting surgeon;
- Prescription drugs, crutches, and medical supplies;
- Pre-Admission Testing;
- Ambulatory surgery; and
- Kidney dialysis clinic.

Inpatient Rehabilitation Facility

An Inpatient Rehabilitation Facility is an inpatient facility which provides multi-disciplinary, structured, intensive therapy. Care is given by or under the supervision of Physicians and is monitored by Care Management.

Prior Authorization is required for this service. Inpatient Rehabilitation services are limited to 28 days per Calendar Year.

Maternity Services

Benefits are available for pregnancy and childbirth. Unless the mother and attending health care provider agree on an earlier date of discharge, benefits will be available for Hospital stays of not less than 48 hours following a conventional delivery or 96 hours following a cesarean delivery.

A Member must have FBHP Family Coverage for nine (9) consecutive months before the Member is eligible to receive maternity benefits. The nine (9) consecutive months of coverage may be under more than one Family Plan, as long as there is no lapse in coverage.

Eligible maternity services will be subject to Deductible and Coinsurance.

Multiple or Bilateral Surgical Procedures

When two or more covered surgical procedures are performed at the same time, or in one surgical setting, benefits will be based on:

- the amount of benefits for the procedure for which the highest dollar amount would be billed (if charges for the surgical procedures are different); and
- up to one-half of the benefits which are available with respect to the other covered surgical procedure(s), whether performed through the same or separate incisions.

Occupational Therapy

Occupational therapy is covered only for the treatment of major trauma to the hand. Benefits for Outpatient services are limited to 30 visits per Calendar Year.

Prior Authorization must be obtained prior to services being rendered.

Orthognathic Surgery For Treatment of Clinically Significant Obstructive Sleep Apnea

Benefits are available for orthognathic surgery for the treatment of clinically significant obstructive sleep apnea (OSA) only after all of the following requirements have been met. The Member must have:

- documented results of a full polysomnogram (sleep study) which confirms a diagnosis of obstructive sleep apnea due to type II obstruction (oropharynx/hypopharynx) or type III obstruction (hypopharynx); and
- failed to respond to or tolerate nasal continuous positive airway pressure (nCPAP); and
- been treated unsuccessfully by uvulopalatopharyngoplasty (UPPP), if OSA is due to type I obstruction (oropharynx); and
- been confirmed by fiberoptic pharyngoscopy and cephalometric radiographs with tracing that the site of obstruction is oropharynx (palate) and/or hypopharynx (base of tongue); and
- a pre-surgical physical evaluation supporting the need for orthognathic surgery.

Prior Authorization must be obtained prior to services being rendered. Medical records must be submitted to Us to substantiate the preceding requirements have been met.

Physical Therapy

Benefits are available for Medically Necessary and Medically Appropriate physical therapy services to relieve pain, restore bodily function, and prevent disability following illness, injury, or loss of a body part. Prior Authorization is required for services rendered at home. Outpatient

physical therapy is limited to 40 visits per Calendar Year.

Physicians' Services

- Services and supplies for the diagnosis and treatment of illness or injury, including surgery.
- A second and/or third surgical opinion received before surgery.
- Services of an attending Physician for inpatient or outpatient services, or consultation services when requested by the attending Physician.
- Services of a Physician for treatment by x-ray, radium, or other radioactive substances.

Private Duty Nursing

Benefits are available for Medically Necessary and Medically Appropriate private duty nursing in Your home.

Prior Authorization must be obtained prior to services being rendered.

Prosthetic Appliances

When approved by the Plan, the cost of prosthetic appliances needed to replace all or part of an absent or malfunctioning body part, including surrounding tissue, is a Covered Service. The Plan also pays benefits to fit, adjust, repair or replace the device, provided the need for this arises from normal wear or the Member's physical development--not as a result of improved technology, loss, or theft to the appliance or device. No benefit will be provided for an artificial heart, lung, liver, pancreas or any other artificial organ or any associated expense(s). This benefit does not include dental appliances or the replacement of cataract lenses.

Prior Authorization is required for prosthetic appliances over $1,000.

Radiation Therapy

Treatment of disease by x-ray, radium, or radioactive isotopes is a Covered Service.

Reconstructive Surgery

Surgery to restore bodily function or correct deformity that began on or after the Effective Date of this Coverage, subject to all terms and conditions of this Contract, is a Covered Service. Benefits are only for problems caused by disease, injury, birth or growth defects, or previous treatments.

Respiratory Therapy

Introduction of dry or moist gases into the lungs is a Covered Service.

Skilled Nursing Facility

Benefits are available for a Skilled Nursing Facility, a facility which mainly provides inpatient skilled nursing and related services to patients requiring convalescent and rehabilitative care. Such care is given by or under the supervision of Physicians. A skilled nursing facility is not, other than incidentally, a place that provides:

- minimal custodial, ambulatory, or part-time care, or
- treatment for mental illness, alcoholism, drug abuse or pulmonary tuberculosis.

Skilled Nursing is limited to 60 days per Calendar Year. Prior Authorization is required for this service.

Speech Therapy

Speech therapy is covered only for disorders of articulation and swallowing resulting from Acute illness, injury, stroke, autism in children under age 12 or cleft palate. Outpatient speech therapy is limited to 30 visits per Calendar Year.

Prior Authorization must be obtained prior to services being rendered.

Sterilization

Benefits are available for male or female sterilization after a Member's Coverage has been in effect for 6 consecutive months. Benefits are subject to Deductible and Coinsurance.

Teladoc

Benefits are available for telephone or web-based video consultations with health care providers through Teladoc for routine primary medical diagnoses. Covered Teladoc Services are available in the following situations:

- When You or an Eligible Dependent needs immediate care;
- When You or an Eligible Dependent is considering the ER or urgent care center for non-Emergency issues; or
- When You or an Eligible Dependent is on vacation or on a business trip.

Covered Teladoc Services include the following types of conditions:

- General medicine, including, but not limited to:
    - Sinusitis
    - Colds and flu
    - Sore throats
    - Ear infections
    - Allergies
    - Urinary tract infections
- A refill of a recurring prescription;
- Pediatric care;
- Non-Emergency medical assistance.

In order to obtain this benefit:

1. The Member must complete a medical history disclosure form that will serve as an electronic medical record for consulting Teladoc physicians. This form can be completed via the Teladoc website at teladoc.com, via the Teladoc call center at 1-800-TELADOC (1-800-835-2362), or via the Teladoc mobile app.
2. Once enrolled, a Member may phone 1-800-TELADOC (1-800-835-2362) and request a consultation with a Teladoc physician. A Teladoc physician will then return the Member's phone call. If a Member requests a web-based video consultation, the consultation will be scheduled and an appointment reminder notification will be sent prior to the appointed time.

3. If necessary, the Teladoc physician will write a prescription. The prescription will be called in to a pharmacy of the Member's choice.

Teladoc may not be used for:

1. Charges for telephone or online consultations with health care providers who are not contracted through Teladoc.
2. Drug Enforcement Agency-controlled Prescriptions.

Benefits for this service are shown in the Schedule of Benefits.

Please Note: Not all medical conditions can be appropriately treated through Teladoc consultations. The Teladoc physician will identify any condition for which in-person treatment with a health care provider is necessary. **Benefits for any health care services or supplies recommended by Teladoc, including prescriptions ordered or refilled by Teladoc physicians, are based on all terms and conditions of the Coverage in force for the Member at the time services are provided, including deductible, coinsurance, and copays as applicable.**

TMJ (Temporomandibular Joint Syndrome or Dysfunction)

Benefits are available for the diagnosis and treatment of temporomandibular joint syndrome or dysfunction (TMJ or TMD) and associated pain of the joint between the temporal bones and the mandible. Non-surgical treatment of TMJ includes history exam, office visit, x-rays, diagnostic study casts, medications and appliances to stabilize the jaw joint. Non-surgical treatment of TMJ is limited to $750 per Member per Calendar Year, subject to Deductible and Coinsurance. Surgical treatment of TMJ will be considered as any other illness subject to the terms and conditions of this Contract.

Treatment for correction of underbite, overbite, and misalignment of the teeth (including orthognathic surgery except as appropriate per medical policy), including braces for dental indications, is excluded.

Vision Services

Benefits are available for services and supplies which are Medically Necessary and Medically Appropriate for the diagnosis and treatment of diseases and injuries to the eye. One set of eyeglasses or contact lenses required as a result of intraocular surgery or ocular injury. Covered Services must be performed within 90 days of the surgery or injury. Eligible expenses are subject to the Deductible and Coinsurance specified in the Schedule of Benefits. The maximum benefit payable for this service is $100.

PRESCRIPTION DRUGS

Benefits are available for prescription drugs, subject to the Deductible and Coinsurance, for use by a Member outside of a Hospital or Other Facility. In order to be considered covered, such drug must be:

- prescribed by a licensed practitioner who is authorized by law to prescribe a drug on or after the Member's Effective Date of Coverage,
- approved for use by the Food and Drug Administration (FDA) for the prescribed indication,

  (However, benefits will be available for a prescription drug which is prescribed to treat a recognized indication which has not been approved by the FDA for such indication, provided such prescription drug is: (a) otherwise approved by the FDA; and, (b) approved by the Medical Director based on peer-reviewed medical literature or standard reference compendia.)
- dispensed by a licensed Pharmacist, either in person or through home delivery, and
- unavailable for purchase without a prescription.

Some prescription drugs may require Prior Authorization or may be subject to quantity limitations. Please contact the number listed on Your Plan ID card for details.

The Pharmacist may not be You or a member of Your immediate household.

No benefits are available for prescription drugs purchased outside the United States, unless approved by the Plan.

Over-the-counter drugs (not requiring a prescription), prescription devices, vitamins which, by Tennessee law do not require a prescription; and/or prescription drugs dispensed in a doctor's office are not covered except as otherwise specified in this Contract. However, benefits will be available for:

- drugs or formula required to treat Phenylketornuria, and
- injectable insulin, oral hypoglycemic agents, and syringes.

Your prescription drug claims are electronically submitted by the pharmacy for reimbursement at the time of service. You are responsible for the full cost of Your prescription drug claims at the time of service and will be reimbursed based on the Maximum Allowable Charge at the applicable Coinsurance Percentage after Your Deductible is met.

Any prescription drug claims not electronically submitted by the pharmacy must be submitted within 12 months of the date on which the prescriptions were filled. To obtain a prescription drug claim form, call the toll free number on Your Plan ID Card.

PRESCRIPTION DRUG BENEFIT - NETWORK

The network of pharmacies can offer savings through the preferential pricing. To qualify for the savings, the Member must go to a Network Pharmacy to obtain the Member’s medication. Failure to use a Network Pharmacy may cost the Member more money. The Member should verify that the pharmacy is an active Network Pharmacy for the Plan each time he or she visits the pharmacy to obtain a prescription.

PRESCRIPTION DRUG BENEFIT - OUT-OF-NETWORK

When You use an Out-of-Network Pharmacy, You will not receive preferential pricing. You must pay the pharmacy for the prescription at the time of service. You will be reimbursed at the Out-of-Network Coinsurance Percentage applied to the Maximum Allowable Charge after Your Deductible is met.

Charges billed by an Out-of-Network Pharmacy which exceed the Maximum Allowable Charge will be the responsibility of the Member.

PRESCRIPTION DRUG BENEFIT - SELF-ADMINISTERED SPECIALTY PHARMACY PRODUCTS

Benefits are available for certain Medically Necessary and Medically Appropriate self-administered Specialty Pharmacy Products. Certain Specialty Pharmacy Products require Prior Authorization. The prescribing Physician should contact the Plan for Prior Authorization.

PROVIDER-ADMINISTERED SPECIALTY PHARMACY PRODUCTS

Benefits are available for Medically Necessary and Medically Appropriate provider-administered Specialty Pharmacy Products. This benefit includes administration by a qualified provider. Prior Authorization may be required for certain Provider Administered Specialty Pharmacy Products.

PRESCRIPTION DRUG BENEFIT – COMPOUND DRUGS

A Compound Drug is an outpatient prescription drug, which is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration (FDA) and which contains at least one ingredient classified as a legend prescription drug. Compound Drugs, which require a Physician's prescription, are prepared by a Pharmacist who mixes and adjusts drug ingredients to customize a medication to meet a patient's individual needs.

Check to see if Your pharmacy is a Network Pharmacy provider each time You fill a Compound Drug. You may have to pay more if You have a Compound Drug filled at a pharmacy that is not a Network Pharmacy provider.

Benefits will be provided at the Network Coinsurance Percentage after the Member's Deductible has been met. If the Member uses a pharmacy that is not a Network Pharmacy provider, the Member will be responsible for the difference between Billed Charges and the Maximum Allowable Charge.

Section X
Transplant Benefits

Subject to Deductible and Coinsurance, benefits are available for Medically Necessary and Medically Appropriate services and supplies provided to a Member when the Member is the recipient of the following transplant procedures: (1) heart, (2) heart/lung, (3) bone marrow, (4) lung, (5) liver, (6) pancreas, (7) pancreas/kidney, (8) kidney, (9) small bowel, and (10) small bowel/liver.

Benefits may be available for other transplant procedures, which are not considered Experimental or Investigational and which are Medically Necessary and Medically Appropriate as determined by the Plan.

The Member has access to Centers of Excellence, which provide incentives to the Member and are required in order to receive benefits. A Center of Excellence is a facility that has contracted to provide transplant services for specific organ and/or bone marrow transplant procedures covered under this Plan. For example, some Centers of Excellence might contract to perform heart transplants, but not liver transplants. Not all Network Providers are Centers of Excellence. Transplant services or supplies, including pre-transplant evaluation, that have not received Prior Authorization will not be covered.

1. Definitions

The following terms are used for the purpose of this Section X Transplants.

a. **Approved Transplant Services** means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician's charges, organ and tissue procurement, tissue typing and Ancillary Services.

b. **Center of Excellence** means a facility that has contracted to provide transplant services for specific organ and/or bone marrow transplant procedures covered under this Plan. For example, some Centers of Excellence might contract to perform heart transplants, but not liver transplants. Not all Network Providers are Centers of Excellence.

c. **Organ and Tissue Acquisition / Procurement** means the harvesting, preparation, transportation and medical expenses of a living donor.

d. **Stem Cell Transplant** includes autologous, allogeneic and syngeneic transplant of bone marrow, peripheral and cord blood stem cells.

2. Prior Authorization

Prior Authorization should be obtained as soon as possible after the Member has been identified as a possible candidate for transplant services. To obtain Prior Authorization, the Member or the Member’s Physician must contact the Plan’s Transplant Case Management department before pre-transplant evaluation or transplant services are received.

Transplant Case Management is a mandatory program for those Members seeking Transplant Services.

3. Covered Services

Approved Transplant Services which have received Prior Authorization and are provided in connection with a covered organ transplant procedure are Covered Services. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be included on individual Plan exclusions.

a. Organ and Tissue Acquisition / Procurement and transplantation is covered if the Member is the recipient. If a Member requires a transplant, including bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition / Procurement from a living human or cadaver will be included as part of the Member's Covered Service when the donor's own Plan does not provide Coverage for Organ and Tissue Acquisition / Procurement. This includes the cost of donor testing, blood typing and evaluation to determine if the donor is a suitable match.

b. The Plan will provide donor services for donor related complications during the transplant period, as per the transplant contract, if the recipient is a Member under this Plan. Complications, side effects or Injuries are not covered unless the donor is a Member on the Plan.

c. Approved Transplant Services for each listed covered organ transplant procedure are covered upon approval by Transplant Case Management.

4. Travel Expenses

(Applies to a Member who is a recipient or to a covered or Non-Covered donor if the recipient is a Member under this Contract)

If the Member or Non-Covered living donor lives more than fifty (50) miles from the transplant facility, the Plan will pay for travel and housing, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Member and:

- One or two parents of the Member (if the Member is under the age of eighteen (18)); or
- An adult to accompany the Member.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility including:
  - Airfare.
  - Tolls and parking fees.
  - Gas/mileage.
- Lodging at or near the transplant facility including:
  - Apartment rental.
  - Hotel rental.
  - Applicable tax.

Lodging for purposes of this Plan does not include private residences.

Lodging reimbursement that is greater than $50 per person per day may be subject to IRS codes for taxable income.

Benefits shall be payable for up to one year from the date of the transplant while the Member is receiving services at the transplant facility.

Note: This Plan will only pay travel and housing benefits for a Non-Covered living donor after any other Coverage that the living donor has is exhausted.

5. Exclusions

In addition to the items listed in Section XIII Limitations/Exclusions, the following services, supplies and charges are not covered under this section:

a. Expenses if a Member donates an organ and/or tissue and the recipient is not a Member under this Plan.

b. Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells or bone marrow, unless the Member has been diagnosed with a condition for which there would be Approved Transplant Services.
c. Expenses for any post-transplant complications of the donor, if the donor is not a Member under this Plan.
d. Transplants considered Experimental, Investigational or Unproven unless covered under a Qualifying Clinical Trial.
e. Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell), for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.
f. Expenses related to, or for, the purchase of any organ.

WHAT YOU CAN DO TO CONTAIN COSTS

Before a Member receives health care services, check to be sure that the health care provider is a member of the Network. You may also obtain the current directory of Network Providers by calling the toll free number on Your Plan ID card.

PRIOR AUTHORIZATION

The purpose of Prior Authorization is solely to ensure that patients receive Covered Services at the appropriate time and in the appropriate setting.

Prior Authorization is required for certain Covered Services. The treating Physician must contact the Plan at the telephone number shown on Your Plan ID card before Covered Services are provided. Otherwise, benefits may be reduced or denied. Covered Services that require Prior Authorization include:

- Advanced Radiological Imaging;
- Certain Home Infusion Therapy Medications;
- Certain Retail Prescriptions;
- Certain Specialty Pharmacy Products;
- Dialysis;
- Durable Medical Equipment;
- Home Health Care;
- Inpatient Behavioral Health Care;
- Inpatient Hospital Stays;
- Nuclear Cardiology;
- Orthognathic Surgery;
- Private Duty Nursing;
- Skilled Nursing Facility;
- Specialty Injectables;
- Therapeutic/Rehabilitative/ Habilitative Therapy;
- Transplants; and
- Twenty-Three (23) Hour Observation (Network Providers);

A Prior Authorization is not a guarantee of benefits. Benefits are based on all terms and conditions of the Coverage in force for the Member at the time Covered Services are provided.

Be sure to ask the doctor to contact the Plan to obtain Prior Authorization 30 days before admitting a Member to a Hospital.

The Member's doctor must report Emergency admissions to the Plan within 24 hours or within one working day after admission. If the Physician determines that a Member needs to remain in the Hospital for a longer period of time, additional authorization must be requested.

Prior Authorization is not required for maternity admissions or when Medicare is the primary payor. However, a Member must be covered by a FBHP Family Coverage for nine consecutive months before benefits will be available for maternity services for that Member.

Prior Authorization will not be required for the following Advanced Radiological Imaging services when performed during an Emergency or during an inpatient Hospital stay: CT Scans, CTA Scans, PET Scans, MRA, MRI, MRS, and Nuclear Cardiology.

You may call customer service to determine whether Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced to 50% or denied for Network and Out-of-Network Providers. In some cases, a Network Provider cannot bill You for services that are denied for no Prior Authorization.

Network Providers are responsible for obtaining Prior Authorization for the Member before providing services. It is the Member's responsibility to obtain the Prior Authorization if the provider is an Out-of-Network Provider.

If the reduction to 50% results in liability to the Member that is in excess of $2,500 above what the Member would have paid had Prior Authorization been obtained, the Member may contact customer service to have the claim reviewed and adjusted. In this event, the reduction of the Member's liability will be limited to $2,500.

All organ transplant services require Prior Authorization. Benefits for organ transplant services will be denied if Prior Authorization is not obtained.

Member liability resulting from any reduction in benefits will not apply to the Out-of-Pocket Maximum.

CONCURRENT UTILIZATION REVIEW

The goal of Concurrent Utilization Review is to encourage the appropriate use of hospitalization.

If under such review it is determined that continued care is not Medically Necessary and Medically Appropriate, the facility and the Physician will be notified in writing of a specific date after which benefits will no longer be payable under this Plan. The Member or Physician can appeal the decision. The case will be reviewed and both the Physician and the Member will be notified of the results.

CARE MANAGEMENT

The Care Management program will identify Members with potentially complicated medical needs, complex conditions and/or catastrophic illnesses or injuries that may be suited for alternative treatment plans. After evaluation of the Member's condition, the Plan may determine that alternative treatment is Medically Necessary and Medically Appropriate. In that event, the Plan may elect to offer alternative benefits for services not otherwise specified as Covered Services in this Contract. Such benefits will be offered only in accordance with a plan of treatment with which the Member (or the Member's legal guardian) and the attending Physician concur.

Care Management services will be made available on a case-by-case basis to individual Members. Under no circumstances does the Member acquire a vested interest in continued receipt of a particular benefit or level of benefits. Offer or confirmation of alternative benefits or modes of care in one instance shall not obligate the Plan to provide the same or similar benefits for the Member in another instance. In addition, nothing herein shall be deemed a waiver of the Plan's right to enforce this Coverage in strict accordance with its express terms and conditions.

Section XII
Claims: How and When To File

WHEN TO APPLY FOR BENEFITS

You or the health care provider should file claims as soon as possible after the Member receives Covered Services. If Covered Services are received on a continuous basis, claims should be submitted at least every 30 days.

All claims must be submitted within 12 months of the date of service.

Within 30 days of receipt of a claim, the Plan will provide You with one of the following:

- an Explanation of Benefits. Benefits will be paid directly to providers.
- a notice of denial of a claim.
- a request for additional information.

Claims will be processed based on information available at the time the claim is received. The Plan will not be responsible for over or under payment of claims resulting from incomplete or inaccurate information, provided reasonable efforts are made to obtain and verify relevant facts when claims are submitted.

Because Deductible and maximum amounts are calculated separately for each Member, it is important that You keep separate records of the eligible medical expenses for Yourself and each of Your Eligible Dependents.

CLAIMS FOR NETWORK PROVIDER SERVICES

Usually, when You or an Eligible Dependent receives care, the Network Provider will ask You to assign Your benefits to the provider. A Network Provider will file the necessary claims. Available benefits will be paid directly to the provider, and You will receive an Explanation of Benefits (EOB) showing the payment and any balance that is Your responsibility.

CLAIMS FOR OUT-OF-NETWORK PROVIDER SERVICES

If an Out-of-Network Provider asks You to pay for treatment, ask the provider to give You a claim form and an itemized statement listing the services received and the charges for each service. You may then submit a claim to the Plan, and available benefits will be paid to You. Be sure to include: (1) the patient's name; (2) Your Plan identification and group numbers; (3) treatment date(s); (4) the patient's diagnosis; and (5) information about any other health insurance the patient may have.

Benefits for Covered Services are subject to the Deductible, Out-of-Network Coinsurance Percentage and the Out-of-Network Out-of-Pocket Maximum. Charges billed by an Out-of-Network Provider which exceed the Maximum Allowable Charge will be the responsibility of the Member.

CLAIMS FOR PRESCRIPTION DRUGS

Your prescription drug claims are electronically submitted by the pharmacy for reimbursement at the time of service. You are responsible for the full cost of Your prescription drug claims at the time of service and will be reimbursed based on the Maximum Allowable Charge at the applicable Coinsurance Percentage after Your Deductible is met.

Any prescription drug claims not electronically submitted by the pharmacy must be submitted to FBHP within twelve (12) months of the date on which the prescriptions were filled. To obtain a prescription drug claim form, call the toll free number on Your Plan ID Card or go to fbhealthplans.com.

GRIEVANCE PROCEDURE

- **Introduction**

The Plan's Grievance procedure (the "Procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all disputes with the Plan. Such disputes include: any matters that cause You to be dissatisfied with any aspect of Your relationship with the Plan; any Adverse Benefit Determination concerning a Claim; or any other claim, controversy, or potential cause of action You may have against the Plan. Please contact Your local FBHP Representative or the customer service department, at the number listed on Your Plan ID card: (1) to file a Claim; (2) if You have any questions about this Plan or other documents that You receive from the Plan (e.g. an explanation of benefits); or (3) to initiate a Grievance concerning a dispute.

1. The Procedure can only resolve disputes that are subject to the Plan's control.
2. You cannot use this Procedure to resolve a claim that a provider was negligent. Network Providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact the Plan; however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with providers.
3. An Adverse Benefit Determination is any denial, reduction, termination or failure to provide or make payment for what You believe should be a Covered Service. In addition, an Adverse Benefit Determination includes any rescission of Coverage or a denial of Coverage in an initial eligibility determination.
    a. If a provider does not render, or reduces or terminates a service that has been rendered, or requires You to pay for what You believe should be a Covered Service, You may submit a Claim to the Plan to obtain a determination concerning whether the Contract will cover that service. Providers may be required to hold You harmless for the cost of services in some circumstances.
    b. Providers may also appeal an Adverse Benefit Determination through the Plan's provider dispute resolution procedure.
    c. The Plan's determination will not be an Adverse Benefit Determination if: (1) a provider is required to hold You harmless for the cost of services rendered; or (2) until the Plan has rendered a final Adverse Benefit Determination in a matter being appealed through the provider dispute resolution procedure.
4. You may request a form from the Plan to authorize another person to act on Your behalf concerning a dispute.
5. You and the Plan may agree to skip one or more of the steps of this Procedure if it will not help to resolve the dispute.
6. Any dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, and this Contract.

B. Description of the Review Procedures

- Reconsideration

  A Reconsideration is an informal process that may answer questions or resolve a potential dispute. You should contact Your local FBHP Representative or a customer service representative if You have any questions about how to file a Claim or to attempt to resolve any dispute. Requesting a Reconsideration does not stop the time period for filing a Claim or beginning a dispute. You do not have to request a Reconsideration before filing a Grievance.

- Grievance

  You must submit a written request asking the Plan to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of dispute (Your "Grievance"). You must begin the dispute process within 180 days from the date The Plan issues notice of an Adverse Benefit Determination or from the date of the event that is otherwise causing You to be dissatisfied with the Plan. If You do not initiate a Grievance within 180 days of when an Adverse Benefit Determination is issued, You may give up the right to take any action related to that dispute.

  Contact Your local FBHP Representative or the customer service department at the number listed on Your Plan ID card for assistance in preparing and submitting Your Grievance. They can provide You with the appropriate form to use in submitting a Grievance. These forms are also available at fbhealthplans.com.

  This is the first level Grievance procedure and is mandatory.

- Grievance Hearing

  After the Plan has received and reviewed Your Grievance, the Plan or its representative will meet to consider Your Grievance and any additional information that You or others submit concerning that Grievance. In Grievances concerning urgent care or pre-service Claims, the Plan will appoint one or more qualified reviewer(s) to consider such Grievances. Individuals involved in making prior determinations concerning Your dispute are not eligible to be voting members of the first level Grievance committee or reviewer(s). The first level Grievance committee or reviewer(s) have full discretionary authority to make eligibility, benefit and/or claim determinations, pursuant to the Contract.

- Written Decision

  The first level Grievance committee or reviewer(s) will consider the information presented, and the written decision concerning Your Grievance will be mailed to You as follows:

  a. For a pre-service claim, within 30 days of receipt of Your request for review;
  b. For a post-service claim, within 60 days of receipt of Your request for review; and
  c. For a pre-service, urgent care claim, within 72 hours of receipt of Your request for review.

  The decision of the first level Grievance committee or reviewer(s) will:

  a. A statement of the first level Grievance committee or reviewer's understanding of Your Grievance;
  b. The basis of the first level Grievance committee or reviewer's decision; and
  c. Reference to the documentation or information upon which the first level Grievance committee or reviewer(s) based its decision. The Plan will send You a copy of such documentation or information, without charge, upon written request.

- Second Level Grievance Procedure

  If You are not satisfied You may file a written request for a second level Grievance within ninety (90) days after the first level Grievance committee's decision has been issued. Upon receipt of Your request for a second level Grievance, Your request along with all submitted information will be forwarded to FBHP for review.

  Your decision concerning whether to file a second level Grievance has no effect on Your rights to any other benefits under the Contract. Any person involved in making a decision

concerning Your dispute (e.g. first level Grievance committee members) will not be a voting member of the second level Grievance committee.

- Second Level Grievance Hearing

  You may present testimony to the second level Grievance committee. You may also request that the second level Grievance committee reconsider the decision of the first level Grievance committee, even if You do not want to present testimony concerning Your second level Grievance.

  In either case, the second level Grievance committee will meet and consider all relevant information presented about Your second level Grievance and any new, relevant information that You submit for consideration.

- Second Level Written Decision

  After the hearing, the second level Grievance committee will meet in closed session to make a decision concerning Your second level Grievance. That decision will be sent to You in writing. The written decision will contain:

  - A statement of the second level Grievance committee's understanding of Your second level Grievance;
  - The basis of the second level Grievance committee's decision; and
  - Reference to the documentation or information upon which the second level Grievance committee based its decision. Upon written request, the Plan will send You a copy of any such documentation or information, without charge.

C. Independent Review of Medical Necessity Determinations or Coverage Rescissions

If Your Grievance involves a Medical Necessity or a Coverage rescission determination, then either: (1) after completion of the first level Grievance; or (2) after completion of the first level Grievance immediately followed by completion of the second level Grievance, You may request that the Dispute be submitted to a neutral third party, selected by the Plan to independently review and resolve such Dispute(s). If You request an independent review following the first level Grievance, You waive Your right to a second level Grievance and Your right to present testimony during the Grievance Procedure. Your request for independent review must be submitted in writing within 180 days after the date You receive notice of the committee's decision. Receipt shall be deemed to have occurred no more than two days after the date of issuance of the committee's decision. Any person involved in making a decision concerning Your Dispute will not be a voting member of the independent review panel or committee.

Your decision concerning whether to request independent review has no effect on Your rights to any other benefits under the Plan. The Plan will pay the fee charged by the independent review organization and its reviewers if You request that the Plan submit a Dispute to independent review. You will be responsible for any other costs that You incur to participate in the independent review process, including attorney's fees.

The Plan will submit the necessary information to the independent review entity within 5 business days after receiving Your request for review. The Plan will provide copies of Your file, excluding any proprietary information, to You, upon written request. The reviewer may also request additional medical information from You. You must submit any requested information, or explain why that information is not being submitted, within 5 business days after receiving that request from the reviewer.

The Plan must submit a written determination to You within 45 days after receipt of the independent review request. In the case of a life threatening condition, the decision must be issued within 72 hours after receiving the review request. Except in cases involving a life-

threatening condition, the reviewer may request an extension of up to 5 business days to issue a determination to consider additional information submitted by the Plan or You.

The reviewer's decision must state the reasons for the determination based upon: (1) the terms of this Contract; (2) Your medical condition; and (3) information submitted to the reviewer. The reviewer's decision may not expand the terms of the Contract. If you chose to pursue Independent Review following the first level Grievance process, Your Grievance rights would be exhausted following the Independent Review.

COORDINATION OF BENEFITS

This Coverage includes the following Coordination of Benefits (COB) provision, which applies when a Member has Coverage under more than one group contract or health care "Plan". Rules of this Section determine whether the benefits available under this Contract are determined before or after those of another Plan. In no event, however, will benefits under this Contract be increased because of this provision.

Periodically the We will send You a form to update Your COB information. Please complete the form and return it to Us to ensure Your records are accurate. Failure to return Your COB information to Us shall entitle the Plan to withhold any and all benefits due the Member under the Plan until such information is received.

Definitions

The following terms apply to this provision:

a. "**Plan**" means any arrangement which provides benefits or services for, or because of, medical or dental care or treatment through:

- group, blanket, or franchise insurance (whether insured or uninsured) other than school accident-type coverage;
- group practice, individual practice, or other pre-paid insurance;
- coverage under labor management trust Plans or Employee benefit organization Plans;
- coverage under government programs to which an Employer contributes or makes payroll deductions;
- coverage under a governmental Plan or coverage required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time); and
- any other arrangement of health coverage for individuals in a group.

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

b. "**This Plan**" refers to the part of the Contract under which benefits for health care expenses are provided.

The term "**Other Plan**" applies to each arrangement for benefits or services, as well as any part of such an arrangement that considers the benefits and services of other contracts when benefits are determined.

c. The order of benefit determination rules state whether This Plan is a "**Primary Plan**" or "**Secondary Plan**" as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the Other Plan and without considering the Other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the Other Plan and may be reduced because of the Other Plan's benefits.

When there are more than two Plans covering the person, 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.

d. "**Allowable Expense**" means a necessary, reasonable and customary item of expense when the item of expense is covered in whole or in part by one or more Plans covering the Member for whom the claim is made.

   The reasonable cash value of a service is deemed to be both an Allowable Expense and a benefit paid when a Plan provides benefits in the form of services.

   The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition, unless the patient's stay in a private Hospital room is Medically Necessary and Medically Appropriate, either in terms of generally accepted medical practice, or as specifically defined in the Plan.

   We will determine only the benefits available under This Plan. You are responsible for supplying them with information about Other Plans so they can act on this provision.

e. "**Claim Determination Period**" means a Calendar Year. It does not, however, include any part of a year during which a person has no Coverage under This Plan or any part of a year prior to the date this COB provision or a similar provision takes effect.

Effect on Benefits

This provision applies where there is a basis for a claim under This Plan and the Other Plan and when benefits of This Plan are determined after the Other Plan(s).

a. Benefits of This Plan will be reduced when the sum of:
   - the benefits that would be payable for the Allowable Expenses under This Plan, in the absence of this COB provision; and
   - the benefits that would be payable for the Allowable Expenses under the Other Plan(s), in the absence of provisions with a purpose similar to that of this COB provision, whether or not a claim for benefits is made;
   - the benefits exceed 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 Plan(s) do not total more than Allowable Expenses.

b. When the benefits of This Plan are reduced as described in (a) above, each benefit is reduced proportionately and is then charged against any applicable benefit limit of This Plan.

c. We will not, however, consider the benefits of the Other Plan(s) in determining benefits under This Plan when:
   - the Other Plan has a rule coordinating its benefits with those of This Plan and such rule states that benefits of the Other Plan will be determined after those of This Plan; and
   - the order of benefit determination rules require This Plan to determine benefits before those of the Other Plan.

Order of Benefit Determination 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 person as an Employee, Member, or Subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent, except that:

- if the person is also a Medicare beneficiary and,
- if the rule established by the Social Security Act of 1965 as amended makes Medicare secondary to the Plan covering the person as a Dependent of an active Employee, then the order of benefit determination shall be:

  – benefits of the Plan of an active Employee covering the person as a Dependent;

  – Medicare;

  – benefits of the Plan covering the person as an Employee, Member, or Subscriber.

b. Dependent Child/Parents Not Separated or Divorced

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

- the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
- if both parents have the same birthday, the benefits of the Plan which has covered one parent longer are determined before those of the Plan which has covered the other parent for a shorter period of time.

However, if the Other Plan does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the Other Plan will determine the order of benefits.

c. Dependent Child/Separated or Divorced Parents

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

- first, the Plan of the parent with custody of the child;
- then, the Plan of the spouse of the parent with the custody of the child; and
- finally, the Plan of the parent not having custody of the child.

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

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in the first bullet under Paragraph b, Dependent Child/Parents Not Separated or Divorced.

d. Active/Inactive Employee

The benefits of a Plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired Employee. The same would hold true if a person is a Dependent of a person covered as a retiree 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 Rule is ignored.

e. Continuation Coverage

If a person whose Coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

- first, the benefits of a Plan covering the person as an Employee, Member, or Subscriber (or as that person's Dependent);
- second, the benefits under the continuation Coverage.

If the Other Plan does not have the Rule described above, and if, as a result, the Plans do not agree on the order of benefits, this Rule is ignored.

f. Longer/Shorter Length of Coverage

If none of the above Rules determines the order of benefits, the benefits of the Plan which has covered an Employee, Member, or Subscriber longer are determined before those of the Plan which has covered that person for the shorter term.

To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within twenty-four hours after the first ended.

The start of the new Plan does not include:

- a change in the amount or scope of a Plan's benefits;
- a change in the entity which pays, provides, or administers the Plan's benefits; or
- a change from one type of Plan to another (such as, from a single Employer Plan to that of a multiple Employer plan).

The claimant's length of time covered under a Plan is measured from the claimant's first date of Coverage under that Plan. If that date is not readily available, the date the claimant first became a Member of the group shall be used as the date from which to determine the length of time the claimant's Coverage under the present Plan has been in force.

If the Other Plan does not contain provisions establishing the Order of Benefit Determination Rules, the benefits under the Other Plan will be determined first. However, if the Other Plan does contain provisions establishing the Order of Benefit Determination Rules but the Other Plan does not apply these Rules to specific Member claims (for example, prescription drug claims), the benefits under the Other Plan relating to these specific Member claims will be determined first.

g. Plans with Excess and Other Non-conforming COB Provisions

Some Plans declare their Coverage "in excess" to all Other Plans, "always Secondary" or otherwise not governed by COB rules. These Plans are called "**Non-complying Plans**."

Rules. This Plan coordinates its benefits with a Non-complying Plan as follows:

- If This Plan is the Primary Plan, it will provide its benefits on a primary basis.
- If This Plan is the Secondary Plan, it will provide benefits first, but the amount of benefits and liability of This Plan will be limited to the benefits of a Secondary Plan.
- If the Non-complying Plan does not provide information needed to determine This Plan's benefits within a reasonable time after it is requested, This Plan will assume that the benefits of the Non-complying Plan are the same as the benefits of This Plan and provide benefits accordingly.
- If the Non-complying Plan reduces its benefits so that benefits received by You are less than those You would have received if the Non-complying Plan provided its benefits as the Primary Plan and This Plan provided its benefits as the Secondary Plan, then This Plan may advance the difference to You or on Your behalf. The benefits advanced shall not exceed the benefits This Plan would have provided if it had been the Primary Plan, less any benefits already provided as the Secondary Plan. In consideration of such advance, This Plan shall be subrogated to all of Your rights against the Non-complying Plan. Such advance shall also be without prejudice to any independent claims This Plan may have against the Non-complying Plan in the absence of such subrogation.

Section XIII
Limitations/Exclusions

The services and supplies described in this Contract are subject to Medical Necessity, Coverage provisions and the following limitations and exclusions. **When a service or supply is limited or excluded, all expenses related to and in connection with the service and/or supply will also be limited or excluded**. Read this section carefully before submitting a claim.

PRE-EXISTING CONDITION WAITING PERIOD

A Member will not be eligible to receive benefits for Pre-Existing Conditions (as defined in Definitions) until the Member has completed a waiting period of at least twelve (12) months beginning with the Effective Date of the Member's Coverage.

In addition to the above waiting period, a Member must have FBHP Family Coverage for nine consecutive months before the Member is eligible to receive maternity benefits. The nine (9) consecutive months of coverage may be under more than one Family Plan, as long as there is no lapse in coverage. Individual Coverage has no maternity benefits.

EXCLUSIONS

1. Services or supplies not prescribed or performed by an Eligible Provider (as defined in the Definitions).
2. Services or supplies which the Plan determines are not Medically Necessary and Medically Appropriate.
3. Services provided before the Member's Coverage begins or after this Coverage is terminated. Services for a Pre-Existing Condition during the Pre-Existing Condition Waiting Period.
4. A drug, device, or medical treatment or procedure which is Investigational (as defined in the Definitions).
5. Any work related illness or injury (unless resulting from self-employment not subject to Workers Compensation insurance requirements).
6. Services or supplies furnished without cost under the laws of any government except Medicaid (TennCare[SM]) coverage provided by the State of Tennessee.
7. Illness or injury resulting from war.
8. Services and supplies for which the Member is not required or legally obligated to pay.
9. Services, supplies or prosthetics for Cosmetic Services. Services, supplies, or prosthetics primarily to change or improve appearance or which are provided in order to correct or repair the results of a prior surgical procedure the primary purpose of which was to change or improve appearance, except as otherwise specified in this Contract.
10. Self-treatment or services provided by any person related to a Member by blood or marriage or any person who resides in the Member's immediate household. A Pharmacist may not be You or a member of Your immediate household.
11. Services paid under any other group, blanket or franchise insurance coverage; any other group contract, other health insurance plan, union welfare plan, or labor-management trust plan.
12. Personal, physical fitness, recreational or convenience items and services such as: diapers, disposable underpads, and incontinence pads; barber and beauty services; television; breast pumps; air conditioners; humidifiers; air filters; heaters; physical fitness equipment or programs except as otherwise specified in this Contract; recreational equipment; saunas; whirlpools; water purifiers; swimming pools; tanning beds; weight loss programs; home

modifications or improvements; motorized vehicles (except Medically Necessary and Medically Appropriate electric wheelchairs).

13. Telephone, fax, and e-mail consultations and other services delivered by electronic means except as otherwise specified in this Contract or approved by the Plan.
14. Charges incurred due to failure to keep a scheduled appointment.
15. Charges to complete forms or to provide requested medical information or records.
16. Charges for writing or calling in a prescription.
17. Charges for depositions, testimony, or court-related fees.
18. Charges for handling fees, postage, shipping, mail, or sales tax.
19. Charges for admitting orders unless billed with in-hospital medical visits.
20. Hospital admissions which are primarily for diagnostic studies.
21. Custodial Care, such as help in walking, getting in or out of bed, or any service that could be performed by non-professional personnel.
22. Routine foot care including, but not limited to, trimming of toe nails, except for diabetic patients. Foot orthotics, shoe inserts and custom made shoes except for diabetic patients or as part of a leg brace.
23. Routine physical examinations and screening examinations, except as otherwise specified in this Contract.
24. Immunizations and vaccinations, including but not limited to, flu shots, flu mist, Human Papilloma Virus (HPV) and shots for traveling outside of the United States, except as otherwise specified in this Contract. Administration charges for Non-Covered immunizations and vaccinations are not eligible.
25. Services or supplies for dental care, except as otherwise specified in this Contract. Dental services include routine, restorative, prosthetic and orthodontic services.
26. Routine vision screenings. Eyeglasses, contact lenses, and examinations for and the fitting of eyeglasses and contact lenses, except as otherwise specified in this Contract. Eye exercises and/or therapy and visual training.Routine hearing screenings. Hearing aids and examinations for prescribing or fitting of hearing aids, except as otherwise specified in this contract. For the purpose of this limitation/exclusion, “hearing aids” shall include any service, device or surgical procedure designed to restore or enhance the ability to hear, including but not limited to, assistive listening devices, audient bone conductor, electromagnetic, and/or surgically implanted devices (such as cochlear implant).
27. Hospital admissions primarily for physical therapy.
28. Habilitative services of any kind (services to achieve a level of functioning that the Member has never attained). Rehabilitative services including, but not limited to, aquatic therapy, hydrotherapy, educational therapy, occupational therapy, speech therapy, recreational therapy, massage therapy, fluidotherapy, craniosacral therapy, vision exercise therapy, neuromuscular reeducation, cognitive rehabilitation, nutrition therapy, dietary supplements (vitamins), and acupuncture, unless otherwise specified in this Contract.

    (If The Plan determines that services during a continuous Hospital confinement have developed into primarily rehabilitative services, that portion of the stay beginning on the day of such development shall not be covered under this Plan.)
29. Surgery to change sex and related services.

30. Services or supplies that are designed to medically enhance a Member's level of fertility in the absence of a disease state, create a pregnancy, or improve conception quality. Services include, but are not limited to: artificial insemination; in vitro fertilization; fallopian tube reconstruction; uterine reconstruction; assisted reproductive technology (ART) including, but not limited to, GIFT and ZIFT; fertility injections; fertility drugs; sperm preservation; services for follow up care related to infertility treatments.

    However, a service or supply may be covered if it is provided to treat an illness or underlying medical condition resulting in infertility, which include treatment to correct a previous tubal pregnancy and treatment by ovulatory drugs (such as clomid) or hormonal treatment used primarily to treat irregular menstrual periods.

31. Services covered under Medicare, except as required by applicable state or federal law.

32. Non-medical self-care or self-help training and any related diagnostic testing or medical social services.

33. Services, surgeries or supplies to detect or correct refractive errors of the eye.

34. Services or supplies incurred after a Concurrent Review determines the services and supplies are no longer Medically Necessary and Medically Appropriate.

35. Charges in excess of the Maximum Allowable Charge for a service or supply.

36. Services rendered for or in connection with physical therapy which consist primarily in the application, supervision, or direction in the use of exercise or physical fitness equipment--whether or not such services are rendered by an Eligible Provider.

37. Any treatment, service or supply including, but not limited to, surgical procedures for the treatment of obesity or morbid obesity. Any treatment, service or supply arising out of the rendering of, or failure to render, treatment for obesity or morbid obesity.

38. Services or expenses for treatment of illness or injury sustained in the commission of a crime or for treatment while confined in a prison, jail or other penal institution or while in the custody of any government or law enforcement entity.

39. Room, board, and general nursing care rendered on the date of discharge, unless both admission and discharge occur on the same day.

40. A second or third surgical opinion rendered by a Physician in the same medical group or practice as (a) the Physician who initially recommended the surgery, or (b) the Physician who rendered the second surgical opinion.

41. Staff consultations required by Hospital rules.

42. Prosthetic appliances or items of Durable Medical Equipment to replace those which were lost, damaged (self-inflicted), stolen or prescribed as a result of improved technology.

43. Dental appliances, including those used for correction of jaw malformations, except where prescribed as part of a surgical procedure necessary to restore a major bodily function or except as otherwise specified in this Contract.

44. Inpatient private duty nursing in an Acute care Hospital.

45. Over-the-counter drugs (not requiring a prescription), unless required by law or specifically designated as covered under this Plan; prescription devices, dietary supplements, nutritional supplements, vitamins, except those which by law require a prescription; and/or prescription drugs dispensed in a doctor's office. Medical supplies that can be obtained without a prescription (except for diabetic supplies) including, but not limited to, adhesive bandages,

dressing material for home use, antiseptics, medicated creams and ointments, cotton swabs, and eyewash.

46. Replacement of implanted cataract lenses.
47. Court-ordered treatment for a Member unless benefits are otherwise payable.
48. Medical treatment for which a Member has been reimbursed under a mass tort or class action lawsuit, settlement or judgment.
49. Any treatment, services or supplies required as a result of attempted suicide or an intentionally self-inflicted illness or injury whether sane or insane, including any treatment, services or supplies arising out of the rendering of, or failure to render, treatment of any such attempted suicide or self-inflicted illness or injury.
50. Cranial prostheses (Wigs).
51. Services or supplies for the reversal of sterilization.
52. Well child services, except as otherwise specified in this Contract.
53. An artificial heart or any other artificial organ, or any associated expense.
54. Treatment of sexual dysfunction, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido. Treatment includes prescription drugs (such as Viagra, Cialis, etc.) and prosthetic appliances.
55. Services or expenses in connection with a surrogate birth. Surrogate birth means:
56. The union of an egg and sperm then placed in another woman to carry to term; or
57. The insemination of a woman under contract, who carries to term and relinquishes the child to the biological father (and his wife) to parent.
58. Services or supplies for orthognathic surgery, a discipline to specifically treat malocclusion except as appropriate per medical policy and as otherwise specified in the Orthognathic Surgery For Treatment of Clinically Significant Obstructive Sleep Apnea benefit in the Member Benefits section of this Contract. This exclusion supersedes any other provision in this Contract that may be interpreted as offering Coverage for this type of surgery.
59. Orthotripsy (extracorporeal shock wave therapy for musculoskeletal conditions).
60. Speech devices and examinations for prescribing or fitting of speech devices, including but not limited to Dynavox.
61. Marriage counseling, pastoral counseling, conjoint therapy, sex therapy, assertiveness training, hypnosis and regressive hypnotic techniques.
62. Cranial orthosis, including helmet or headband, for the treatment of plagiocephaly.
63. Genetic testing and genetic counseling for preventive services.
64. Services and supplies related to complications of Non-Covered Services.
65. Nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches or prescription drugs.
66. Prescription drugs intended to terminate a pregnancy including, but not limited to, RU-486.
67. Ambulance charges for dispatch of an Ambulance that is not used by a Member; charges for transport to a Physician's office, outpatient department of a Hospital for medical care or the patient's home; or charges for waiting time and extrication.
68. Routine medical services or surgery received outside the United States not related to a medical emergency.
69. Services not listed in this Contract as a Covered Service.

70. Coverage is excluded for Cell Therapy services, treatments, or procedures involving chimeric antigen receptor (CAR) T-cell therapy. Additionally, any related laboratory testing, imaging, preparatory regimens, follow-up care, or management of complications related to CAR T-cell therapy is excluded. This exclusion applies regardless of the treatment's intended use, regulatory approval status, method of administration, or whether the therapy is provided as part of a clinical trial, expanded access program, or standard clinical care.
71. Coverage is excluded for all services, treatments, or procedures involving Gene Therapy. This exclusion applies regardless of the therapy’s purpose, method of delivery, FDA approval status, or whether the gene therapy is provided as part of a clinical trial, compassionate use program, or standard medical care.