fbhealthplans.com

Farm Bureau Health Plans
DentalVision

CON-DV-003
Effective January 1, 2022

Please read this Policy carefully and keep it in a safe place for future reference. It explains Your Coverage. If You have questions about Your Coverage, please write or call:

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

CON-DV-003
Effective January 1, 2022

Table of Contents

INTRODUCTION 1
- ACCEPTANCE AND POLICY 1
- YOUR COVERAGE 1
- ADMINISTRATORS 1
- RIGHT TO RECEIVE AND RELEASE INFORMATION 2

DENTAL BENEFITS 3
- DENTAL SCHEDULE OF BENEFITS 3

DENTAL SERVICES 8
- NETWORK 8
- DEDUCTIBLE AND BENEFIT MAXIMUM 9

COVERED SERVICES – DENTAL 10
- OPTIONAL SERVICES 13

DENTAL EXCLUSIONS 15

USING YOUR DENTAL BENEFITS 16
- CHOICE OF DENTIST 16
- PROFESSIONAL RELATIONSHIP 16
- CLINICAL EXAMINATION 16
- CLAIM FOR DENTAL BENEFITS 16
- PREDETERMINATION 16
- PROOF OF LOSS 17
- DENTAL COORDINATION OF BENEFITS 17
- FIRST AND SECOND LEVEL REVIEW OF DENTAL CLAIMS DENIAL 21
- TERMINATION OF DENTAL BENEFITS ON LOSS OF ELIGIBILITY 22
- TO WHOM DENTAL BENEFITS ARE PAID 22

VISION BENEFITS 23
- VISION SCHEDULE OF BENEFITS 23

VISION SERVICES 27
- NETWORK 27
- ACCESSING VISION BENEFITS 27
- BENEFIT AUTHORIZATION 27
- OUT OF NETWORK PROVIDER SERVICES 28

COVERED SERVICES – VISION 29
- KidsCare PROGRAM 31
- COPAYMENTS 32
- EMERGENCY CONDITIONS 32

VISION EXCLUSIONS 33
- EXCLUSIONS AND LIMITATIONS OF VISION BENEFITS 33
- SERVICES NOT COVERED 33

USING YOUR VISION BENEFITS 34
- OBTAINING SERVICES FROM NETWORK PROVIDERS 34
- OUT-OF-NETWORK PROVIDER SERVICES 34
- TERMINATION 35
- LIABILITY IN EVENT OF NON-PAYMENT 35
- COMPLAINTS AND GRIEVANCES 35

ELIGIBILITY AND ENROLLMENT 38
TYPE OF COVERAGE AVAILABLE 38
ELIGIBILITY 38
COVERED DEPENDENTS 38
ADDING DEPENDENTS 38
CHANGES IN ENROLLMENT STATUS 39
PAYMENT OF PREMIUM 40
PREMIUM 40
YOUR PREMIUM 40
GRACE PERIOD 40
FEE FOR DEFAULT OF PAYMENT 40
REFUNDS 40
CHANGES TO YOUR POLICY 40
TERMINATION 41
PAYMENT FOR SERVICES AFTER TERMINATION 41
GENERAL PROVISIONS 42
APPLICABLE LAW 42
BENEFITS TO WHICH A MEMBER IS ENTITLED 42
PLAN IDENTIFICATION (ID) CARD 42
THE POLICY 42
LEGAL ACTION 42
RIGHT TO REQUEST INFORMATION 42
ADMINISTRATIVE ERRORS 42
TIME LIMIT ON CERTAIN DEFENSES 43
SUBROGATION AND RIGHT OF RECOVERY 43
NOTICES 43
GLOSSARY 44

INTRODUCTION

ACCEPTANCE AND POLICY

The issuance of this signed Policy by Tennessee Rural Health Improvement Association ("Farm Bureau Health Plans" or "FBHP") acknowledges acceptance of Your application for Coverage. This Policy constitutes the contract between FBHP and You and is issued as of the Effective Date stated on the ID Card mailing. Coverage is based upon the terms and conditions set out in this Policy including the application, all schedules, and amendments.

The Coverage detailed in this Policy is extended to You at the rates shown on Your first invoice. Any changes to the terms or conditions of this Policy will only be effective when issued in writing by FBHP.

This Policy replaces any Policy previously issued to You by FBHP. This Policy may be renewed by payment of the Premium.

YOUR COVERAGE

Please read this Policy carefully. It describes Your rights and duties as a Subscriber/Member. It is important to read the entire Policy. 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.

You will notice that certain words and phrases are capitalized. A capitalized word may have a different meaning in the context of this Policy than it does in general usage. Please check the "Glossary" for the meanings of capitalized words.

The word 'Coverage' means the Benefits available to You under this Policy. "You", "Your", and "Yourself" mean the Subscriber. "Member" means the Subscriber or a Covered Dependent.

Any grievance or appeal related to this Policy will be resolved in accordance with the applicable grievance procedure section of this Policy.

If, after examination, You are not satisfied with this Policy, You may return it within thirty (30) days after You receive it. In this event, Your Policy will be void from its start and any Premium paid will be refunded less any Benefits paid.

If You have questions, please contact one of the customer service representatives at the number on the back of Your Plan ID Card or Your Farm Bureau Health Plans representative at Your local Farm Bureau office.

ADMINISTRATORS

FBHP has contracted with third-party vendors to administer the terms of this Policy. Covered Services under this Policy are administered by Delta Dental of Tennessee ("Dental Administrator" or "DDTN") and Vision Service Plan Insurance Company ("Vision Administrator" or "VSP") on behalf of FBHP. FBHP shall be solely responsible for interpreting the terms of and making final Coverage determinations under this Policy.

RIGHT TO RECEIVE AND RELEASE INFORMATION

You authorize FBHP, its affiliate, or a third-party vendor to use and release personal information for Yourself and all Covered Dependents. This authorization includes any and all medical, vision and dental records obtained, used or released in connection with administration of this Policy. 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 Policy is inconsistent with the FBHP Notice of Privacy Practices, the terms of the FBHP Notice of Privacy Practices will prevail and this Policy will be deemed to be modified to the extent necessary for consistency. Your authorization is deemed given by Your signature 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 are covered under this Policy and survives the termination of this Policy to the extent that such information or records relate to services rendered while You were covered under this Policy. You may also be required to separately authorize the release of personally identifiable health information in connection with the administration of this Policy. 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 contact the Farm Bureau Health Plans representative at Your local Farm Bureau office.

Ryan Brown
Corporate Secretary

DENTAL BENEFITS

The Dental Administrator, Delta Dental of Tennessee ("DDTN"), administers dental Benefits under this Policy on behalf of FBHP.

DENTAL SCHEDULE OF BENEFITS

A Member is entitled to dental Benefits for Covered Services as specified in this Dental Schedule of Benefits. Benefits shall be determined according to the Policy terms in effect on the date a service is rendered. Benefits may be amended in accordance with applicable provisions of this Policy. Under no circumstance shall a Member acquire a vested interest in continued receipt of a particular Benefit or level of Benefit.

As detailed below, a Member will be entitled to certain dental Benefits which increase during the time the Member's Coverage is in effect:

- From the Effective Date until twelve (12) full months enrolled;
- From thirteen (13) months of enrollment until twenty-four (24) full months enrolled; and
- After the Member's Coverage has been in effect for twenty-four (24) months.

Each Member's coverage will be based on his or her own Effective Date.

Please read this Policy in its entirety to fully understand all terms, conditions, exclusions, and limitations that apply.

Calendar Year Dental Deductible and Benefit Maximums			
Calendar Year Dental **Deductible** on All Covered Services*****	**Individual, Two-Person, Family - $50 Per Member (Family - Up to $150)**		
Number of Months Enrolled	**0 – 12 Months**	**13 – 24 Months**	**25 + Months**
Calendar Year Dental **Benefit Maximum** on All Covered Services**	**$500 per Member**	**$1,000 per Member**	**$1,500 per Member**
Orthodontic Lifetime Maximum	**N/A**	**$1,000 per Member**	**$1,000 per Member**

* Calendar Year Dental Deductible does not apply to Benefits listed under Diagnostic & Preventive or Orthodontic.

** Calendar Year Dental Benefit Maximum does not include Orthodontic Lifetime Maximum. Orthodontic Benefits apply to Orthodontic Lifetime Maximum only.

Dental Covered Services						
Number of Months Enrolled	**Month 0 – 12**		**Month 13 – 24**		**Month 25 +**	
	Plan Pays (Subject to Deductibles and Maximums)					
	Network Provider	*Out-of-Network Provider	Network Provider	*Out-of-Network Provider	Network Provider	*Out-of-Network Provider
No Calendar Year Deductible Applies						
Diagnostic & Preventive Services Exams; cleanings; X-rays; fluoride; space maintainers. • Oral exams are payable two (2) times per Calendar Year. • Prophylaxes (cleanings) are payable two (2) times per Calendar Year. • Members with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings). • Bite-wing X-rays are payable one (1) time per Calendar Year. Full mouth X-rays (which include bite-wing X-rays) are payable one (1) time in any three (3) year period. • Fluoride treatments are payable two (2) times per Calendar Year for Members age 18 and under. • Space maintainers are payable one (1) time per area per lifetime for missing posterior, primary teeth for Members age 14 and under. All other space maintainers are not a Benefit.	**100% of MAC**	**80% of MAC**	**100% of MAC**	**80% of MAC**	**100% of MAC**	**80% of MAC**
Calendar Year Deductible Applies To All Other Covered Services (Except Orthodontic)						

Dental Covered Services						
Number of Months Enrolled	**Month 0 – 12**		**Month 13 – 24**		**Month 25 +**	
	Plan Pays (Subject to Deductibles and Maximums)					
	Network Provider	*Out-of-Network Provider	Network Provider	*Out-of-Network Provider	Network Provider	*Out-of-Network Provider
Emergency Palliative Treatment To temporarily relieve pain.	**50% of MAC**	**40% of MAC**	**80% of MAC**	**60% of MAC**	**80% of MAC**	**60% of MAC**
Sealants To prevent decay of permanent teeth. • Sealants are payable for first and second permanent molars for Members age 15 and under, limited to one (1) time per tooth per lifetime.	**50% of MAC**	**40% of MAC**	**80% of MAC**	**60% of MAC**	**80% of MAC**	**60% of MAC**
Brush Biopsy To detect oral cancer.	**50% of MAC**	**40% of MAC**	**80% of MAC**	**60% of MAC**	**80% of MAC**	**60% of MAC**
Minor Restorative Services Fillings, stainless steel crowns, and crown repair.	**50% of MAC**	**40% of MAC**	**80% of MAC**	**60% of MAC**	**80% of MAC**	**60% of MAC**
Simple Extractions Non-surgical removal of teeth.	**50% of MAC**	**40% of MAC**	**80% of MAC**	**60% of MAC**	**80% of MAC**	**60% of MAC**
Other Basic Services Miscellaneous services.	**50% of MAC**	**40% of MAC**	**80% of MAC**	**60% of MAC**	**80% of MAC**	**60% of MAC**
Endodontic Services Includes root canals. • Root canal treatment is payable one (1) time per tooth in a twenty-four (24) month period by the same Dentist or dental office.	**25% of MAC**	**10% of MAC**	**25% of MAC**	**10% of MAC**	**50% of MAC**	**40% of MAC**

Dental Covered Services						
Number of Months Enrolled	**Month 0 – 12**		**Month 13 – 24**		**Month 25 +**	
	Plan Pays (Subject to Deductibles and Maximums)					
	Network Provider	*Out-of-Network Provider	Network Provider	*Out-of-Network Provider	Network Provider	*Out-of-Network Provider
Periodontic Services To treat gum disease.	**25% of MAC**	**10% of MAC**	**25% of MAC**	**10% of MAC**	**50% of MAC**	**40% of MAC**
Oral Surgery Services Surgical extractions and other surgical procedures.	**25% of MAC**	**10% of MAC**	**25% of MAC**	**10% of MAC**	**50% of MAC**	**40% of MAC**
Major Restorative Services Includes major crowns and cast restorations; veneers. • Laminate veneers for anterior teeth are payable one (1) time per tooth in any five (5) year period for Members age 12 and older.	**25% of MAC**	**10% of MAC**	**25% of MAC**	**10% of MAC**	**50% of MAC**	**40% of MAC**
Reline and Rebase Includes complete or partial denture reline and rebase procedures. • Reline or rebase of a partial or complete denture is payable one (1) time in any three (3) year period.	**25% of MAC**	**10% of MAC**	**25% of MAC**	**10% of MAC**	**50% of MAC**	**40% of MAC**
Prosthodontic Services Fixed bridges; partial or complete dentures; bridge repair.	**25% of MAC**	**10% of MAC**	**25% of MAC**	**10% of MAC**	**50% of MAC**	**40% of MAC**

Dental Covered Services						
Number of Months Enrolled	**Month 0 – 12**		**Month 13 – 24**		**Month 25 +**	
	Plan Pays (Subject to Deductibles and Maximums)					
	Network Provider	*Out-of-Network Provider	Network Provider	*Out-of-Network Provider	Network Provider	*Out-of-Network Provider
Implant Services Implants and implant-related services. • Implant crowns are payable one (1) time per tooth in any five (5) year period for Members age 12 and over. • Implant dentures are payable one (1) time per tooth in any five (5) year period for Members age 16 and over. • Implants and implant abutments are payable one (1) time per tooth in any five (5) year period for Members age 19 and over.	**25% of MAC**	**10% of MAC**	**25% of MAC**	**10% of MAC**	**50% of MAC**	**40% of MAC**
Bleaching/Whitening Services • External bleaching covered one (1) time per Calendar Year per arch. • Internal bleaching covered one (1) time per Calendar Year per tooth.	**25% of MAC**	**10% of MAC**	**25% of MAC**	**10% of MAC**	**50% of MAC**	**40% of MAC**
Orthodontic Services All ages; subject to lifetime maximum. Does not apply to Calendar Year dental Benefit Maximum.	**0%**	**0%**	**50% of MAC**	**40% of MAC**	**50% of MAC**	**40% of MAC**

* When services are received from an Out-of-Network Provider, the percentages in this column indicate the portion of Maximum Allowable Charge (MAC) based on Delta Dental's PPO Dentist Fee Schedule (or the Out-of-Network Providers Fee) that will be paid for those services. This amount may be less than what the Dentist charges or the Plan approves, and You are responsible for that difference.

DENTAL SERVICES

To obtain the greatest Benefits, You should receive Covered Services from a Network Provider. When You have dental work performed by a Network Provider You simply present Your Plan ID Card. The Network Provider will file the necessary paperwork. Payment will be made directly to the Network Provider. Network Providers have agreed not to bill patients for additional amounts so You will have a lesser out-of-pocket expense.

You are free to use the Dentist of Your choice; however, Your out-of-pocket expense may be greater when You use an Out-of-Network Provider. You may be responsible for the difference in the amount charged by an Out-of-Network Provider and the amount the Plan approves.

NETWORK. This Plan utilizes the following network for dental Benefits:

Dental Provider Network	
Primary Network:	**Delta Dental PPO**

The Delta Dental PPO will provide the greatest amount of savings for Members based on the Dental Administrator's negotiated fee schedule.

If You visit a Dentist who is not a Delta Dental PPO Provider but is a Delta Dental Premier Provider (Delta Dental "Safety Net"), the amount You may owe is reduced. Delta Dental Premier Providers are allowed to charge more than a Delta Dental PPO Provider, but cannot bill You for any charges over the Premier network Maximum Allowable Charge. This may be an additional savings to You.

To find out if Your Dentist is a Delta Dental PPO or Delta Dental Premier Provider, visit the Dental Administrator's website at www.DeltaDentalTN.com or call Your Dentist's office.

FBHP will only pay the Benefits stated for each type of dental Covered Service described in this Policy. Not all dental services are Benefits under this Policy. Benefits will only be provided for Members who are enrolled on the date of treatment. Benefits will be based on the date services were completed. Services must be provided by a Dentist or properly licensed employee of a Dentist. To be a paid Benefit, services must be necessary and must be provided by generally accepted dental practice standards as determined by the dental profession. FBHP will pay allowable Benefits based upon the percentages shown on the Dental Schedule of Benefits. Such percentages will be applied to the lesser of the Maximum Allowable Charge or the fees the Dentist charges for the service. The Maximum Allowable Charge for in-state Out-of-Network Providers is limited to the Prevailing Fee. Out-of-state Out-of-Network Providers are paid in accordance with each state's local business rules from information provided from the National Provider File.

This Policy will be governed by DDTN as a Delta USA program. A Delta USA program is a program where DDTN and other participating plans have agreed to provide to Members the Benefits set forth in this Policy. DDTN shall be the control plan for this Policy. DDTN may act for itself and on behalf of each participating plan, for the purposes herein cited.

DEDUCTIBLE AND BENEFIT MAXIMUM. Except as listed below, FBHP will not pay Benefits for a Member until that Member's Calendar Year Dental Deductible, shown in the Dental Schedule of Benefits, has been met. For Family Coverage, each Member must meet the individual Calendar Year Deductible until the family Calendar Year Deductible of $150 has been met.

The Deductible applies to all dental Benefit types except those listed under Diagnostic & Preventive and Orthodontic. The Deductible applies to services received from Network Providers and Out-of-Network Providers. Only fees a Member pays for services covered under the Dental Schedule of Benefits will count toward satisfying the Deductible.

FBHP will pay up to the dental Benefit Maximum amount shown on the Dental Schedule of Benefits for each Member in a Calendar Year, based upon the length of time the Member's Coverage has been in effect. However, Members will still receive the advantage of DDTN network discounts for any Covered Services performed by a Network Provider after the dental Benefit Maximum amount has been reached in a Calendar Year.

The Deductible and dental Benefit Maximum apply each Calendar Year. The orthodontic lifetime maximum applies for the Member's entire Coverage. Orthodontic Benefits applied toward a Member's orthodontic lifetime maximum will not apply to the Member's Calendar Year dental Benefit Maximum.

COVERED SERVICES – DENTAL

Benefit Maximums, limitations or exclusions that apply to this Policy are outlined in this Policy. All limitations and exclusions apply only to the Benefit section under which they are listed unless stated otherwise.

Benefits are subject to the Deductible as detailed in the Dental Schedule of Benefits. Coinsurance will be calculated based on the Maximum Allowable Charge. The portion of any billed charges that exceeds the Maximum Allowable Charge will not be covered. Charges billed by an Out-of-Network Provider which exceed the Maximum Allowable Charge will be Your responsibility.

Other general limitations and exclusions will apply as outlined in the Dental Exclusions section and elsewhere in this Policy.

1. Diagnostic & Preventive Benefits, Limitations & Exclusions.

A. Oral examinations and cleanings (prophylaxis).
   1) Oral exams and cleanings, to include periodontal maintenance procedures, are limited to two (2) times in any Calendar Year.
   2) Members with high risk health conditions may receive a total of four (4) cleanings, to include periodontal maintenance procedures, in any Calendar Year. Eligible Members include:
      a. Diabetics with periodontal disease
      b. Pregnant women with periodontal disease
      c. Individuals with renal failure/dialysis
      d. Individuals with suppressed immune systems (undergoing chemotherapy or radiation treatment, HIV positive, organ transplant patients, stem cell/bone marrow transplant patients)
      e. Individuals at high risk for infective endocarditis (such as those with a history of infective endocarditis, certain congenital heart defects, artificial heart valves, heart valve defects, hypertrophic cardiomyopathy, or mitral valve prolapse)
   3) Adult prophylaxis for Members under fourteen (14) years of age is not allowed.
   4) Comprehensive oral examinations or extensive oral examinations performed by the same Dentist are allowed one (1) time within a three (3) year period.

B. X-rays.
   1) One set of bite-wing X-rays are covered per Calendar Year.
   2) Full mouth X-rays are covered one (1) time within a three (3) year period, unless special need is shown.

C. Fluoride - topical application of fluoride is covered two (2) times per Calendar Year for Members eighteen (18) years of age and under.

D. Space maintainers - space maintainers are covered once per area in a lifetime for missing posterior, primary teeth for Members fourteen (14) years of age and under.

2. Sealant Benefits, Limitations & Exclusions.

A. Sealants – resin filling used to seal grooves and pits on the chewing surface of first and second permanent molar teeth.
   1) Sealants are payable for the occlusal surface of first and second permanent molars.

The surface must be free from decay and restorations.
2) Benefits are available only for Members fifteen (15) years of age and under.
3) Benefits are limited to one (1) time per tooth per lifetime.

3. Basic Benefits, Limitations & Exclusions.

A. Simple extractions.
B. General Anesthesia & I.V. - sedation is covered only when administered by a properly licensed Dentist in a dental office in conjunction with covered surgical procedures or when necessary due to concurrent medical conditions.
C. Minor Restorations – amalgams (silver fillings), composites (white fillings), and prefabricated stainless steel crowns and crown restorations for the treatment of decay.
   1) Restorative Benefits are allowed one (1) time per surface in a twenty-four (24) month period, regardless of the number or combinations of procedures requested or performed.
   2) The replacement, by the same Dentist or dental office, of amalgam or composite restorations within twenty-four (24) months is not allowed.
   3) The replacement, by the same Dentist or dental office, of a stainless steel crown within twenty-four (24) months of the initial placement is not allowed.
D. Gold foil restorations and porcelain, composite, and metal inlays are Optional Services.

4. Oral Surgery Benefits, Limitations & Exclusions.

A. Oral Surgery – complex extractions and other surgical procedures (including pre- and post-operative care).

5. Endodontic Benefits, Limitations & Exclusions.

A. Endodontia – treatment of the dental pulp (root canal procedures).
   1) Payment for root canal treatment includes charges for X-rays and temporary restorations.
   2) Root canal treatment is limited to once in a twenty-four (24) month period by the same Dentist or dental office.

6. Periodontic Benefits, Limitations & Exclusions.

A. Periodontia – treatment of the gums and bones that surround the tooth.
   1) Payment for periodontal surgery shall include charges for three (3) months post-operative care and any surgical re-entry for a three (3) year period.
   2) Root planing, curettage and osseous surgery are not a Benefit for Members under fourteen (14) years of age.
   3) Scaling and root planing procedures are allowed one (1) time within a twenty-four (24) month period.
   4) Localized delivery of antimicrobial agents is not a Benefit.

7. Major Restorative Benefits, Limitations & Exclusions.

A. Cast Restorations **–** major crowns and onlays are Benefits for the treatment of visible decay and fractures of hard tooth structure when teeth are so badly damaged that they cannot be restored with amalgam or composite restorations.
   1) Replacement of crowns or cast restorations received in the previous five (5) years is

not a Benefit. Payment for cast restorations shall include charges for preparations of tooth and gingiva, crown build-up, impression, temporary restoration and any re-cementation by the same Dentist within a twelve (12) month period.

2) A cast restoration on a tooth that can be restored with an amalgam or composite restoration is not a Benefit.
3) Procedures for purely cosmetic reasons are not Benefits.
4) Porcelain, gold or veneer crowns for Members eleven (11) years of age and under are not a Benefit.
5) Veneers. Laminate veneers are covered for Members twelve (12) years of age and older for anterior teeth. Limited to one (1) per tooth in a five (5) year period.

8. Prosthodontic Benefits, Limitations & Exclusions.

A. Prosthodontics - procedures for construction of fixed bridges, partial or complete dentures and repair of fixed bridges.
   1) Replacement of any fixed bridges or partial or complete dentures that the Member received in the previous five (5) years is not a Benefit.
   2) Payment for a complete or partial denture shall include charges for any necessary adjustment within a six (6) month period.
   3) Payment for standard dentures is limited to the Maximum Allowable Charge for a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth. A standard denture is made by conventional means from acceptable materials. If a denture is constructed by specialized techniques and the fee is higher than the fee allowable for a standard denture, the Member is responsible for the difference.
   4) Payment for fixed bridges or cast partials for Members fifteen (15) years of age and under is not a Benefit.
   5) A posterior bridge where a partial denture is constructed in the same arch is not a Benefit.
   6) Temporary partial dentures are a Benefit only when upper anterior teeth are missing.
   7) Denture Repairs – services to repair complete or partial dentures.

B. Complete or Partial Denture Reline and Rebase Procedures - payment for a reline or rebase of a partial or complete denture is limited to once in a three (3) year period and includes all adjustments required for six (6) months after delivery.

9. Implant Benefits, Limitation and Exclusions.

A. Implants - the surgical placement of an endosteal (in the bone) implant and the connecting abutment are covered Benefits.
   1) Implant crowns are payable one (1) time per tooth in any five (5) year period for Members twelve (12) years of age and over.
      a. No Benefits are available for Members eleven (11) years of age and under.
   2) Implant dentures one (1) time per tooth in any five (5) year period for Members sixteen (16) years of age and over.
      a. No Benefits are available for Members fifteen (15) years of age and under.
   3) Implants and implant abutments are payable one (1) time per tooth in any five (5) year period for Members nineteen (19) years of age and over.
      a. No Benefits are available for Members eighteen (18) years of age and under.

b. Replacement of implants or abutments received in the previous five (5) years is not a Benefit.

4) The removal of an implant is allowed one (1) time per lifetime.
5) Specialized techniques are not Benefits (ex: bone grafts, guided tissue regeneration, precision attachments, etc.)
6) Implant maintenance procedures are allowed one (1) time in a twelve (12) month period.

10. Teeth Whitening and Bleaching Benefits, Limitations and Exclusions

A. Application of whitening agents or bleaching products are a Benefit.
   1) External bleaching procedures are covered one (1) time per Calendar Year per arch.
   2) Internal bleaching procedures are covered one (1) time per Calendar Year per tooth.

11. Orthodontic Benefits, Limitation and Exclusions.

A. Orthodontics – procedures using appliances to treat poor alignment of teeth and/or jaws. Such poor alignment must significantly interfere with function to be a Benefit. Includes cephalometric X-rays, photos, and diagnostic casts.
   1) Orthodontic Benefits are limited to Members enrolled in Coverage at the time of service. The Plan shall make regular payments for orthodontic Benefits.
   2) If orthodontic treatment began prior to enrolling in this Policy, the Plan will begin Benefits with the first payment due the Dentist after You or Your Covered Dependent becomes eligible.
   3) Benefits end with the next payment due the Dentist after loss of eligibility or immediately if treatment stops.
   4) Benefits are not paid to repair or replace any orthodontic appliance received.
   5) Orthodontic Benefits do not pay for extractions or other surgical procedures. However, these additional services may be covered under other Benefits of this Policy.
   6) The initial payment (initial banding fee) made by the Plan for comprehensive treatment will be 33% of the total fee for treatment subject to Your Copayment percentage and orthodontic lifetime maximum.
   7) Subsequent payments will be issued on a regular basis for continuing active orthodontic treatment. Payments will begin in the month following the appliance placement date and are subject to Your Copayment percentage and orthodontic lifetime maximum.
   8) Orthodontic Benefits do not count against a Member's Calendar Year dental Benefit Maximum.

OPTIONAL SERVICES. In cases where alternate or optional methods of treatment exist, Benefits are provided for the least costly professionally accepted treatment. This determination is not intended to reflect negatively on the Dentist's Treatment Plan or to recommend which treatment should be provided. It is solely a determination of Benefits under terms of the Member's Coverage. The Dentist and Member should decide the course of treatment. If the treatment rendered is other than the covered Benefit, the difference between the Maximum Allowable Charge and the Dentist's fee, up to the approved amount, for the actual treatment rendered is due from the Member.

Payment made by the Plan for any surgical service will include charges for routine post-operative exams or visits.

In the event a Member transfers from one Dentist to another during the course of care, the Plan may limit Benefits. The Plan will limit Benefits to the amount that would have been paid had only one Dentist rendered the service.

DENTAL EXCLUSIONS

General Limitations and Exclusions. In addition to limitations and exclusions listed elsewhere in this Policy, the Plan does not pay Benefits for:

1. Treatment of injury or illness covered by Workers' Compensation or Employer's Liability Laws.
2. Services received without cost from any federal, state or local agency. This exclusion will not apply if prohibited by law.
3. Cosmetic surgery or procedures for purely cosmetic reasons.
4. Services for congenital (hereditary) or developmental malformations. Such malformations include, but are not limited to, cleft palate, upper and lower jaw malformations. This does not exclude those services provided under Orthodontic Benefits.
5. Treatment to restore tooth structure lost from wear.
6. Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. For example: equilibration, periodontal splinting and double abutments on bridges.
7. Oral hygiene and dietary instructions, treatment for desensitizing teeth, prescribed drugs or other medication, experimental procedures, conscious sedation, and extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
8. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
9. Diagnosis or treatment for any disturbance of the temporomandibular joints (jaw joints) or myofacial pain dysfunction.
10. Services by a Dentist beyond the scope of his or her license.
11. Dental services for which the Member incurs no charge.
12. Dental services where charges for such care exceed the charge that would have been made and actually collected if no Coverage existed.
13. General anesthesia or I.V. sedation is a Benefit only when administered by a properly licensed medical provider. It must take place in a dental office in conjunction with covered surgical procedures or when necessary due to concurrent medical conditions.
14. Routine services or surgery received outside the United States not related to a medical emergency.

USING YOUR DENTAL BENEFITS

CHOICE OF DENTIST. The Plan does not furnish Covered Services directly. The Plan pays for licensed Dentists to provide these services. You may choose any Dentist. You should decide for Yourself the professional qualification of the Dentist You select. In Tennessee, participation in the Dental Administrator's Provider network is open to all Dentists who are licensed in Tennessee. Dentists may not have previously had their participation in Dental Administrator's Provider network terminated for cause. Whether a Dentist is a Network Provider or an Out-of-Network Provider should not be viewed as a statement about that Dentist's ability.

The Plan shares the public and professional concern about the possible spread of HIV and other infectious diseases in the dental office. However, the Plan cannot ensure Your Dentist's use of precautions against the spread of such diseases. The Plan cannot compel Your Dentist to be tested for HIV or to disclose test results to the Plan or to You. Dental Administrator's Provider network informs its Network Providers about the need for clinical safety measures as recommended by health authorities on this issue. If You have questions about Your Dentist's health status or use of recommended clinical safety measures, You should discuss them with Your Dentist.

The Plan is not liable for any injuries or damages suffered due to the actions of any Provider. The Plan is not liable for a Dentist's refusal or failure to provide services.

PROFESSIONAL RELATIONSHIP. You and the Plan agree to permit and encourage the professional relationship between Dentist and patient to be maintained without interference.

CLINICAL EXAMINATION. Before approving a claim, the Dental Administrator may obtain from any Dentist or hospital such information and records the Plan may require to administer the Benefits. The Dental Administrator may require a Member to be examined by a dental consultant, retained by the Plan, in or near his or her community or residence. Such information and records will be kept confidential.

CLAIM FOR DENTAL BENEFITS. To make a claim for dental Benefits, the dental Claim Form must be properly completed and submitted to the Dental Administrator or FBHP. Electronic claims may be accepted. The Dentist must maintain the supporting documentation. To obtain a dental Claim Form or receive information regarding the process of filing a claim, You may call **1-800-223-3104.**

Dental Claim Forms should be sent to:

Delta Dental
240 Venture Circle
Nashville, TN 37228

PREDETERMINATION. A Dentist may file a dental Claim Form showing the services he or she recommends. The Dental Administrator will then predetermine the Benefits payable under this Policy. Payment will only be made for predetermined services if the Member remains eligible and has not exceeded his or her Benefit Maximum. A dental Claim Form requesting a predetermination may be submitted electronically.

PROOF OF LOSS. Proof of loss must be furnished to the Dental Administrator within fifteen (15) months after completion of treatment for which dental Benefits are payable. Any dental claim filed after this period will be denied.

DENTAL COORDINATION OF BENEFITS.

This Policy 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". Coordination of Benefits rules determine whether the Benefits available under this Contract are determined before or after those of another plan. In no event will Benefits under this Contract be increased because of this provision.

Periodically 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 Us to withhold any and all Benefits due the Member until all requested 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.

   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;

   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 Noncomplying Plan in the absence of such subrogation.

FIRST AND SECOND LEVEL REVIEW OF DENTAL CLAIMS DENIAL. After a dental claim is processed, the Dental Administrator will send an Explanation of Benefits (EOB) to You. If any payment for services was denied, the EOB will give the reason why. You have one hundred eighty (180) days after receiving an EOB to request a first level review. All requests for review must be submitted to the Dental Administrator in writing to:

Delta Dental
240 Venture Circle
Nashville, TN 37228

All requests for review must give reasons the dental denial was wrong. You may also ask to look at any records to aid Your review. The Dental Administrator will make a review and may ask for more documents if needed. Unless unusual circumstances arise, a decision will be sent to the Subscriber within thirty (30) days after the Dental Administrator receives the request for review.

If You do not agree with the first level review decision, You may refer the request for review to the Professional Relations Advisory Committee of Dental Administrator. This second level

review must be in writing and received by the Dental Administrator within a reasonable time after You receive the first level review decision. Unless unusual circumstances arise, a decision will be sent to You within thirty (30) days after the Dental Administrator receives the request for second level review.

If You do not agree with the second level review decision, You may file civil action in court pursuant to the time lines set forth in the General Provisions section.

TERMINATION OF DENTAL BENEFITS ON LOSS OF ELIGIBILITY. This Policy will not pay dental Benefits for any services received by an individual who is not an eligible and enrolled Member at the time of treatment. You must repay FBHP for any payments made because of errors or delays in reporting required of You.

TO WHOM DENTAL BENEFITS ARE PAID. Dental Benefits provided under this Policy will be paid as follows:

- For dental services provided by a Network Provider, payment will be made to the Provider.
- For dental services provided by an Out-of-Network Provider, payment will be made to You. Payment may be assigned to the Provider.

VISION BENEFITS

The Vision Administrator, VSP, administers vision Benefits under this Policy on behalf of FBHP.

VISION SCHEDULE OF BENEFITS

The Vision Schedule of Benefits lists the vision care services and vision care materials to which Members are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Network Providers or Out-of-Network Providers.

Network Providers are those doctors who have agreed to participate in VSP's Choice Network.

- Covered Services received from Network Providers are subject to any Copayment(s) as stated below, to be paid at the time services are rendered.
  - If materials for prescription glasses are provided, the additional Copayment for prescription glasses will be payable at the time materials are ordered.
  - If contact lenses are provided, the Copayment for contact lenses will be payable at the time contact lenses are ordered.
- For Covered Services received from Out-of-Network Providers You will pay the Out-of-Network Provider his or her full fee and submit Your claims to the Vision Administrator for reimbursement as stated in this Vision Schedule of Benefits.

Vision Covered Services	Network Provider Benefit (Copayments Per Benefit)	Out-of-Network Provider Benefit Reimbursement
Vision Care Services		
Vision Examination • Limit one (1) per Calendar Year for Members nineteen (19) years of age and older • KidsCare: Two (2) vision exams payable per Calendar Year for Members eighteen (18) years of age and under, if needed	$15 Copayment	Up to $45

<table>
<tr><th colspan="3">Vision Care Materials – Prescription Glasses</th></tr>
<tr><td>Frames
Limit one (1) pair every two (2) Calendar Years for Members nineteen (19) years of age and older
KidsCare: Limit one (1) pair every Calendar Year for Members eighteen (18) years of age and under.
Maximum allowance of $150 for frames / $170 for featured frame brands</td><td>$35 Copayment for prescription glasses

Combined Copayment includes frames, lenses, and lens enhancements</td><td>Up to $70</td></tr>
<tr><td colspan="3">Lenses
Limit one (1) set of lenses per Calendar Year for Members nineteen (19) years of age and older.
KidsCare: Additional lenses for Members eighteen (18) years of age and under are Covered when needed. Minimum prescription change required.</td></tr>
<tr><td>Single Vision</td><td>Included in Copayment for prescription glasses</td><td>Up to $30</td></tr>
<tr><td>Lined Bifocal</td><td>Included in Copayment for prescription glasses</td><td>Up to $50</td></tr>
<tr><td>Lined Trifocal</td><td>Included in Copayment for prescription glasses</td><td>Up to $65</td></tr>
<tr><td colspan="3">Lens Enhancements or Options
Progressive Lenses
Limit one (1) per Calendar Year</td></tr>
<tr><td>Standard Progressive Lenses</td><td>Included in Copayment for prescription glasses</td><td rowspan="3">Up to $50</td></tr>
<tr><td>Premium Progressive Lenses</td><td>$95 - $105</td></tr>
<tr><td>Custom Progressive Lenses</td><td>$150 - $175</td></tr>
</table>

Contact Lenses		
Note: Instead of Glasses Includes contact lens fitting and evaluation. • Limit one (1) set per Calendar Year • Maximum allowance of $150 for contacts, Copayment does not apply	Up to $60 Copayment	Up to $105 (Professional Fees and Materials)
Diabetic Eyecare Plus Program		
Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Includes retinal screening for eligible Members with diabetes as needed. Limitations and coordination with medical coverage may apply. Ask Your VSP doctor for details.	$20	
Low Vision Services		
Professional services for severe visual problems not corrected with regular lenses. • Benefit Maximum for all Low Vision Benefits of $1000 every two (2) Calendar Years.		
Supplemental Testing Includes evaluation, diagnosis, and prescription of vision aids where indicated	Covered in Full	Up to $125

Supplemental Aids	75% of cost	75% of cost
Extra Services		
Glasses and Sunglasses	• Extra $20 to spend on featured frame brands – go to vsp.com/special offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any Network Provider within twelve (12) months of Your last vision examination.	
Retinal Screening	• No more than a $39 copay on routine retinal screening as an enhancement to a vision examination.	
Laser Vision Correction	• Average 15% off the regular price or 5% off the promotional price for laser vision correction services; discounts only available from contracted facilities.	

VISION SERVICES

NETWORK. This Plan utilizes the following network for vision Benefits:

Vision Provider Network
VSP Choice

To obtain a copy of the latest VSP Choice Network Provider list:

1. Visit VSP's website at www.vsp.com
2. By contacting VSP's Customer Service Department via the toll-free Customer Service telephone number at 1-800-877-7195
3. By submitting a written request to:
   Customer Service
   VSP
   P.O. Box 997100
   Sacramento, CA 95899-7100

If You supply Your email address to FBHP, VSP may use the email address to communicate information to You about Your vision Benefits.

ACCESSING VISION BENEFITS

IMPORTANT: Your vision Coverage under this Policy is associated with a unique Member identification (ID) number.
Please have Your Member ID number or Plan ID Card available when scheduling or receiving services from a Provider participating in the VSP Choice network, or Network Provider. Please note that some Network Providers are accustomed to use of an individual's social security number (SSN) as an account number. Please confirm Your Member ID number with the Network Provider if there are any questions about Your Coverage.

BENEFIT AUTHORIZATION. Benefit Authorization must be obtained before You can use Plan Benefits from a Network Provider. When You seek Plan Benefits from a Network Provider, You must schedule an appointment and identify Yourself as a Member so the Network Provider can obtain Benefit Authorization from Vision Administrator. Vision Administrator shall provide the Benefit Authorization to the Network Provider to authorize the administration of Plan Benefits to You. Each Benefit Authorization will contain an expiration date and must be used by You prior to the expiration date to obtain Plan Benefits. Vision Administrator shall issue Benefit Authorizations in accordance with the latest eligibility information furnished by the Plan and Your past service utilization, if any. Any Benefit Authorization so issued by Vision Administrator shall constitute a certification to the Network Provider that payment will be made to Network Provider, irrespective of a later loss of eligibility of the Member, as long as Plan Benefits are utilized prior to the Benefit Authorization expiration date.

OUT-OF-NETWORK PROVIDER SERVICES. If You elect to receive vision care services from a Network Provider, Plan Benefits are provided subject only to Your payment of any applicable Copayment. If You choose to obtain Plan Benefits from an Out-of-Network Provider, You should pay the Out-of-Network Provider his or her full fee. The Plan will reimburse You in accordance with the reimbursement schedule shown on the Schedule of Benefits, less any applicable Copayment. There is no assurance that the reimbursement will be sufficient to pay for the examination or the materials. Availability of services under the Out-of-Network Provider reimbursement schedule is subject to the same time limits and Copayments as those described for Network Provider services. Services obtained from an Out-of-Network Provider are in lieu of obtaining services from a Network Provider and count toward Plan Benefit frequencies.

When You elect to utilize the services of an Out-of-Network Provider, benefit payments for services from such Out-of-Network Provider will be determined according to the Vision Administrator Out-of-Network Provider Benefit fee schedule. YOU MAY BE LIABLE FOR MORE THAN THE COPAYMENT. The Out-of-Network Provider may bill You for that Provider's standard rates, regardless of the amount of Covered Services. If You are eligible for and obtain Covered Services from an Out-of-Network Provider, You remain liable for the Provider's full fee. You will be reimbursed by the Plan in accordance with the Out-of-Network Provider reimbursement schedule shown on the Schedule of Benefits, less any applicable Copayments.

Please Note: Certain Providers such as Walmart, which do not participate in Vision Administrator's vision Provider network, may choose to file a claim on Your behalf and accept assignment of Benefits for reimbursement from the Plan directly. Such Providers are Out-of-Network Provider, and You remain liable for the Provider's full fee.

COVERED SERVICES - VISION

Through Network Providers, the Plan provides Plan Benefits to Members, subject to the limitations, exclusions, and Copayment(s) described in this section and the Vision Schedule of Benefits. When You wish to obtain Plan Benefits from a Network Provider, You should contact the Network Provider of Your choice, identify Yourself as a Member, provide Your Member ID number, and schedule an appointment. If You are eligible for Plan Benefits, the Vision Administrator will provide Benefit Authorization for You directly to the Network Provider prior to Your Appointment.

1. **Eye Examination:** A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.
   A. Limit one (1) per Calendar Year after Copayment for Members nineteen (19) years of age and older.
   B. KidsCare: Limit two (2) per Calendar Year after Copayment for Members eighteen (18) years of age and under, if needed.
2. **Lenses:** The Network Provider will order the proper lenses necessary for Your visual welfare. The doctor shall verify the accuracy of the finished lenses.
   A. Benefits include single vision, lined bifocal, and lined trifocal lenses.
   B. Limit one (1) set of lenses per Calendar Year after Copayment for Members nineteen (19) years of age and older.
   C. KidsCare: Additional lenses for Members eighteen (18) years of age and under are Covered when needed. Minimum prescription change required.
   D. Polycarbonate lenses are covered in full for Covered Dependent children twenty-five (25) years of age and under.
3. **Frames:** The Network Provider will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency.
   A. Limit one (1) pair of frames every two (2) Calendar Years after Copayment for Members nineteen (19) years of age and older.
   B. KidsCare: Limit one (1) pair every Calendar Year after Copayment for Members eighteen (18) years of age and under.
   C. When frames are obtained from a Network Provider, the Plan will provide an allowance for materials of $150 (or $170 for featured frame brands).
   D. Discount of 20% on all amounts in excess of the frame allowance.
4. **Contact lenses:** Contact lenses are available under this Plan in lieu of all other lens and frame Benefits described herein for the current eligibility period. Includes elective contact fitting and evaluation services.
   A. Limit one (1) per Calendar Year after Copayment.

B. When elective contact lenses are obtained from a Network Provider, the Plan will provide an allowance of $150 toward the cost of professional fees and materials. Copayment does not apply.

C. A 15% discount shall also be applied to the Network Provider's usual and customary professional fees for contact lens evaluation and fitting.

D. Contact lens materials are provided at the Network Provider's usual and customary charges.

E. When contact lenses are obtained, the Member shall not be eligible for lenses and frames again for one (1) Calendar Year.

5. **Diabetic Eyecare Plus Program:** Services are available under this Plan related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD), including retinal screening for eligible Members with diabetes, as detailed below.

   A. **Program Description.** The Diabetic Eyecare Plus Program ("DEP Plus") is intended to be a supplement to a Member's medical coverage. Providers will first submit a claim to a Member's medical insurance plan, and then to the Vision Administrator under this Policy. Any amounts not paid by the medical plan will be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB".) If the Member does not have a medical insurance plan, providers will submit claims directly to the Vision Administrator under this Policy.

      1) Examples of symptoms which may result in a Member seeking services under DEP Plus may include, but are not limited to: blurry vision, transient loss of vision, tunnel vision, trouble focusing, "floating" spots, and visual distortion.

      2) Examples of conditions which may require management under DEP Plus may include but are not limited to: diabetic retinopathy, rubeosis, diabetic macular edema, age-related macular degeneration, and glaucoma.

   B. **Procedures for Obtaining Diabetic Eyecare Plus Services.**

      1) Member has a medical insurance plan – The DEP Plus Program provides coverage for certain vision-related medical services as a supplement to a Member's medical insurance plan. Members should refer to their medical insurance contract or Evidence of Coverage to determine how to obtain medical insurance plan benefits.

         a. The Provider should first submit a claim to the Member's medical insurance plan.

         b. Any amounts not paid by the medical insurance plan may then be considered for payment under this Policy.

      2) Member does not have a medical insurance plan – When a Member does not have a medical insurance plan, the DEP Plus Program provides Benefits as follows:

         a. Member contacts a VSP Network Provider and makes an appointment.

         b. Member pays the applicable Copayment at the time of each DEP Plus Program visit and amounts for any additional services not covered by this Policy.

   C. **Referrals**. If a Member's Network Provider cannot provide Covered Services, the Provider will refer the Member to another Network Provider or to a physician whose

offices provide the necessary services.

1) If the Member requires services beyond the scope of DEP Plus, the Network Provider will refer the Member to a physician.

2) Referrals are intended to ensure that Members receive the appropriate level of care for their presenting condition. Members do not require a referral from a Network Provider in order to obtain Benefits.

6. **Low Vision Services and Materials:** The Low Vision Benefit provides special aid for Members who have acuity or visual field loss that cannot be corrected with regular lenses. If You fall within this category, You will be entitled to professional services as well as ophthalmic materials, including but not limited to: supplemental testing, evaluations, visual training, low vision prescription services, plus optical and non-optical aids, subject to the frequency and Benefit Maximum limitations as outlined in the Vision Schedule of Benefits. Consult Your Network Provider for details.

   A. Benefit Maximum for all Low Vision Benefits of $1000 every two (2) Calendar Years.

7. **Extra Services:**

   A. Glasses and sunglasses

      1) Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details.

      2) Receive 20% savings on additional glasses and sunglasses, including lens enhancements, from any Network Provider within twelve (12) months of the last vision examination.

   B. Retinal screening

      1) No more than a $39 Copayment on routine retinal screening as an enhancement to a vision examination.

   C. Laser vision correction
      1) Receive an average 15% off the regular price or 5% off the promotional price for laser vision correction services.
      2) Discounts only available from contracted facilities.

KidsCare PROGRAM. Members who are Covered Dependents eighteen (18) years of age and under are entitled to an exam, frame, and additional pair of lenses or necessary contact lenses, or elective contact lenses.

- Plan Benefits – The Plan may authorize payment under the KidsCare Program for services and/or materials for Members more frequently than twelve (12) months if:
  - The new prescription differs from the original by at least a .50 diopter sphere or cylinder.
  - There is a change in the axis of 15 degrees or more.
  - There is a .5 prism diopter change in at least one eye.
- Services are subject to Copayments listed in the Vision Schedule of Benefits and all other terms of this Policy.
- Eligibility in the KidsCare program ends at the end of the month in which the Member attains the age of nineteen (19).

COPAYMENTS. The Benefits described herein are available to You subject only to Your payment of any applicable Copayments as described in this Policy. Copayments will be Your personal responsibility and must be paid at the time services/materials are ordered. Amounts which exceed Covered Services allowances, Benefit Maximum or any other limitations stated herein are not considered Copayments but are also Your responsibility. ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS POLICY MAY BE ARRANGED BETWEEN YOU AND THE DOCTOR.

EMERGENCY CONDITIONS. Medical services, even in emergency conditions, are not Plan Benefits under this Policy. You should contact a physician under Your medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, You should contact the Vision Administrator's Customer Service Department at 1-800-877-7195 for assistance. Emergency vision care is subject to the same Benefit frequencies, Plan allowances, Copayments and exclusions stated herein. Reimbursement to Network Providers will be made in accordance with their agreement with the Vision Administrator.

VISION EXCLUSIONS

EXCLUSION AND LIMITATION OF VISION BENEFITS. Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Members may obtain details regarding frame brand availability from their Network Provider or by calling VSP's Customer Care Division at (800) 877-7195.

This Policy is designed to cover visual needs rather than cosmetic materials. If You select any of the following vision options, the Plan will pay the basic cost of the allowed lenses or frames, and You will be responsible for the option's extra cost, unless it is defined as a Plan Benefit in the Schedule of Benefits:

1. Optional cosmetic processes.
2. Anti-reflective coating.
3. Color coating.
4. Mirror coating.
5. Scratch coating.
6. Blended lenses.
7. Cosmetic lenses.
8. Laminated lenses.
9. Oversize lenses.
10. Polycarbonate lenses.
11. Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
12. UV (ultraviolet) protected lenses.
13. Certain limitations on low vision care.

SERVICES NOT COVERED. There is no vision Benefit for professional services or materials connected with:

1. Services/materials not indicated as covered Plan Benefits in this Policy.
2. Plano lenses (lenses with refractive correction of less than ±.50 diopter power).
3. Two pair of glasses in lieu of bifocals.
4. Replacement of lenses and frames furnished under this Plan, which are lost or broken except at the normal intervals when services are otherwise available.
5. Orthoptics or vision training and any associated supplemental testing.
6. Medical or surgical treatment of the eyes.
7. Treatment for emergency conditions, defined as the need for immediate vision care of a medical nature such as for bodily trauma or disease.
8. Corrective vision treatment of an Experimental Nature.
9. Costs for services and/or materials above Plan Benefit allowances indicated in this Policy.
10. Contact lens modification, polishing, or cleaning.
11. Local, state and/or federal taxes, except where the Plan is required by law to pay.
12. Refitting of contact lenses after the initial (90-day) fitting period.
13. Routine services or surgery received outside the United States not related to a medical emergency.

USING YOUR VISION BENEFITS.

OBTAINING SERVICES FROM NETWORK PROVIDERS.

When You seek to obtain Covered Services, You must select a Network Provider, schedule an appointment and inform the doctor's office that You are a Member to enable the Network Provider to obtain a Benefit Authorization from VSP. A Benefit Authorization must be obtained before You obtain Covered Services from a Network Provider. If You receive Covered Services from a Network Provider without a Benefit Authorization, the Network Provider will be considered an Out-of-Network Provider and services may be limited to those for an Out-of-Network Provider.

When You desire to receive Plan Benefits from a Network Provider, contact the Vision Administrator or a Network Provider. A list of the names, addresses, and phone numbers of Network Providers in Your geographic location can be obtained from VSP at www.vsp.com. If this list does not cover the geographic area in which You desire to seek services, You may call VSP at 1-800-877-7195 to obtain one that does.

If You are eligible for Plan Benefits, the Vision Administrator will provide Benefit Authorization directly to the Network Provider. If You contact a Network Provider directly, You must identify Yourself as a Member so the Network Provider knows to obtain Benefit Authorization from Vision Administrator. Your account is associated with Your unique Member ID number. Please present Your Plan ID Card at the time of service or share Your Member ID number with the Network Provider prior to receiving services. This will allow a Network Provider to identify Your account.

When such a Benefit Authorization is provided by the Vision Administrator, and services are performed prior to the expiration date of the Benefit Authorization, this will constitute a claim against the Policy in spite of Your termination of Coverage or the termination of this Policy. **Should You receive services from a Network Provider without such Benefit Authorization or obtain services from an Out-of-Network Provider, You are responsible for payment in full to the Provider**.

You pay only the applicable Copayment to a Network Provider for services covered by the Policy. The Plan will pay the Network Provider directly according to the Vision Administrator's agreement with the doctor.

OUT-OF-NETWORK PROVIDER SERVICES. If You obtain Plan Benefits from an Out-of-Network Provider, You should pay the Provider his or her full fee. You will be reimbursed by the Plan in accordance with the Out-of-Network Provider reimbursement schedule shown, less any applicable Copayments. For more information about submitting a claim from an Out-of-Network Provider, visit vsp.com or contact VSP member services at 1-800-877-7195. Such claims should be submitted to Vision Administrator at the following address:

Vision Service Plan
Attention: Claims Services
P.O. Box 385018
Birmingham, AL 35238-5018

You or the Out-of-Network Provider may submit requests for reimbursement to the Plan. The

Plan will pay available Covered Services to You or directly to Out-of-Network Providers when claims include a valid Assignment of Benefits, except where the ability to assign benefits has been revoked as to a particular Out-of-Network Provider, when such revocation is allowed. The Plan may deny any claims received more than twelve (12) calendar months from the date services are rendered and/or materials provided, except in the case of legal incapacity, in which case there is no time limit.

TERMINATION. In the event of termination of a Network Provider's membership in Vision Administrator's Provider network, the Plan will remain liable to the Network Provider for services rendered to You at the time of termination and permit the Network Provider to continue to provide You with Plan Benefits until the services are completed or until Vision Administrator makes reasonable and appropriate arrangements for the provision of such services by another authorized doctor.

LIABILITY IN EVENT OF NON-PAYMENT. In the event the Plan fails to pay the Provider, You shall not be liable to the Provider for any sums owed by the Plan other than those not covered by this Policy.

COORDINATION OF VISION BENEFITS. Members who are covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). The Vision Administrator will combine other insurance plans' claim payments or reimbursements, if any, with Benefits available under this Policy, which may reduce or eliminate the Member's out of pocket expense. Members covered under more than one plan administered by the Vision Administrator may also be able to take advantage of COB. In order to process claims involving COB, the Vision Administrator may need to share personal information regarding Members with other parties (such as another insurance company). When this is necessary, information will be shared only with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

COMPLAINTS AND GRIEVANCES. For questions or problems regarding vision Benefits, call Vision Administrator's Customer Service Department at 1-800-877-7195. The Vision Administrator Customer Service Department will make every effort to answer Your question and/or resolve the matter informally. If a matter is not initially resolved to Your satisfaction, You may communicate a complaint or grievance to the Vision Administrator orally or in writing by using the complaint form that may be obtained upon request from the VSP Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment, or service. You also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in the Vision Administrator's review. The Vision Administrator will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after Vision Administrator's receipt of the complaint or grievance. If Vision Administrator determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to You to indicate the Vision Administrator's expected resolution date. Upon final resolution, You will be notified of the outcome in writing.

Vision Claim Payments and Denials.

A. Initial Determination: The Vision Administrator will pay or deny vision claims within thirty (30) calendar days of the receipt of the clean claim from You or Your authorized representative. In the event that a vision claim cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

B. Request for Appeals: If Your vision claim for vision Benefits is denied by the Vision Administrator in whole or in part, the Vision Administrator will notify You in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, You may make a request to the Vision Administrator for a full review of such denial.

This request may be made:

a. In writing, to the address listed below;
b. Verbally, by calling VSP's Customer Service Department at 1-800-877-7195;
c. Online, by completing a Member Grievance Form on www.vsp.com; or
d. In person, through Your Network Provider.

The request should contain sufficient information to identify the Member for whom a claim for vision Benefits was denied, including Your name, Member identification number, and date of birth; the name of the Provider of services and the claim number. You may state the reasons You believe that the claim denial was in error. You may also provide any pertinent documents to be reviewed. The Vision Administrator will review the claim and give You the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. You or Your authorized representative should submit all requests for appeals to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

The Vision Administrator's determination, including specific reasons for the decision, shall be provided and communicated to You within thirty (30) calendar days after receipt of a request for appeal from You or Your authorized representative.

C. Request for Second Level Appeals: If You disagree with the Vision Administrator's determination, You may request a second level appeal within sixty (60) calendar days from the date of the determination. The Vision Administrator shall communicate its final determination to You in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for this determination.

ELIGIBILITY AND ENROLLMENT

TYPES OF COVERAGE AVAILABLE

Individual – Subscriber only

Two-Person – Subscriber and one Covered Dependent

Family – Subscriber and all Covered Dependents

ELIGIBILITY

To be eligible as a Subscriber You must:

1. Be a resident of the state of Tennessee;
2. Be a Member of the Tennessee Farm Bureau Federation and Tennessee Rural Health Improvement Association;
3. Complete an application for You and any dependent You want to cover; and
4. Meet any additional requirements established.

Farm Bureau Health Plans reserves the right to change these eligibility requirements at any time.

COVERED DEPENDENTS

The following will be eligible as Your Covered Dependents:

1. Your lawful spouse.
2. Your or Your spouse's natural child who is under the age of twenty-six (26).
3. Your or Your spouse's legally adopted child who is under the age of twenty-six (26).
   To establish eligibility, a complete copy of the Final Order of Adoption must be provided.
4. Your or Your spouse's stepchild who is under the age of twenty-six (26).
5. A child who has been placed in Your home in anticipation of adoption by You or Your spouse within 6 months of the date of placement. Coverage will terminate for a Covered Dependent placed with You in anticipation of adoption on the date the child is removed from placement with You if placement is disrupted prior to the final adoption.
   To establish eligibility, documentation demonstrating the child has been placed with You in anticipation of adoption by You or Your spouse must be provided.
6. A child for whom You or Your spouse are legal guardian. The child must be under the age of twenty-six (26).
   To establish eligibility, a complete copy of the court order must be provided.

Coverage for a child with a physical or mental 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. Coverage will continue as long as You continue to pay the required Premium for the Covered Dependent's Coverage, Your own Coverage remains in effect and You provide Us with required proof of the Covered Dependent's incapacity and dependency. Initial proof of the Covered Dependent's incapacity and dependency must be provided within sixty (60) days of the Covered Dependent's attainment of age twenty-six (26).

A dependent who has a physical or mental disability and has reached age twenty-six (26) at the time of application for Coverage is not eligible as a Covered Dependent on Your Contract. The dependent must apply for his or her own Coverage.

Members covered on an individual child-only Plan upon attaining nineteen (19) years of age are required to submit additional information to maintain this Coverage.

We reserve the right to request proof of continuing eligibility at any time.

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 received within thirty-one (31) days of the qualifying event.

In the event of marriage, if the application is received within sixty (60) days of the marriage and the application is approved, Coverage for eligible dependents for whom application is made will be effective as of the first (1st) day of the month following the date of the marriage.

CHANGES IN ENROLLMENT STATUS

You must notify Us if any changes occur in Your status, or the status of a Covered Dependent, 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 a Covered Dependent have a change of address. This is not a qualifying event unless You move outside of Tennessee.

Please note:

1. Upon the death of the Subscriber, surviving Covered 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 a Covered Dependent, the Member's Coverage will end. 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 Premium and the Subscriber's spouse chooses to continue Coverage, the spouse and Covered Dependents may apply for Coverage within sixty (60) days of the date of termination. The spouse and Covered Dependents will be issued the type contract then being issued to such Subscribers.

PAYMENT OF PREMIUM

PREMIUM

The rates for Coverage provided in this Policy may be changed by providing written notice of the change at least thirty (30) days before the Effective Date of any Premium change. Your continued payment of Premium indicates acceptance of the change.

YOUR PREMIUM

Your first Premium will be a paper-billed invoice and payment must be submitted to FBHP. Payment of Your first Premium indicates acceptance of Your Coverage. All subsequent monthly Premium payments will occur on the first (1st) business day of each month by the method designated during the application process until You submit a change request. Should Your payment be dishonored by Your financial institution, You could forfeit Your Policy.

GRACE PERIOD

Your Policy is subject to a ten (10) day grace period, during which time Coverage under this Policy shall continue in force. If Your Premium is not paid within Your grace period, Your Policy will terminate retroactively effective as of the Premium due date 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 YOUR POLICY

You, as a Subscriber, may request a change to Your coverage. Your request for change 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. Changes to Your Policy may affect Your Premium.

TERMINATION

Your Policy may be terminated if:

- The required Premium for Your Policy is not received when it is due; or
- You fail to pay Your Tennessee Farm Bureau Federation membership dues: or
- You request that Your Policy 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
- This Plan is terminated; or
- You have made an intentional material misrepresentation of a material fact or committed fraud against Us. This provision includes, but is not limited to, furnishing incorrect or misleading information, failing to provide accurate information or permitting the improper use of Your Plan ID Card. If You make an intentional misrepresentation of a material fact or commit fraud against Us, We may rescind Your Policy back to the date of the act. This means We will return Premium paid minus any claims paid. If the claims paid exceed Premium paid, We have the right to collect the balance from You. We will notify You thirty (30) days in advance of any rescission.

Your Covered 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 Covered Dependent's Premium; or
3. The date Your Covered Dependent is no longer eligible.

FBHP may cancel this Policy for any of the reasons described herein by providing 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 Covered Dependents, Your Policy will terminate on the date of Your death and Your estate is entitled to a refund of any unused Premium.

PAYMENT FOR SERVICES RENDERED AFTER TERMINATION OF YOUR POLICY

Except as otherwise noted in this Policy, if You receive and We pay for Covered Services after the termination of the Policy, We may recover the amount We pay for such Covered Services from You plus any costs of recovering such charges, including Our attorneys' fees.

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

GENERAL PROVISIONS

APPLICABLE LAW

The laws of the state of Tennessee govern this Policy.

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 Policy, except as otherwise noted in this Policy.

IDENTIFICATION (ID) CARD

- Your Plan ID Card is proof of Your right to receive the Benefits of this Plan.
- You should carry Your Plan ID Card at all times.
- Only You may use Your Plan ID Card.
- Be sure to show Your Plan ID Card each time You receive services. Inform Your Provider that Benefit Authorization may be required.

THE POLICY

This Policy explains the Benefits available to Members. This Policy cannot be transferred or assigned to another party. The terms of this Policy can only be changed in writing. Such writing must be signed by an officer of FBHP. Notice of any change to the terms of Your Policy will be mailed to You at the address shown in Our records.

LEGAL ACTION

You cannot bring legal action under this Plan until sixty (60) days after proof of loss has been furnished. You cannot bring legal action after three (3) years after the time proof of loss is required.

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 begin 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 Policy, no intentional misrepresentations of a

material fact, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void this Policy or to deny a claim for loss incurred after the expiration of such two (2) 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 dental 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 tort feasors, 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 Policy must be in writing. To provide notice to FBHP for matters referenced in this section, please contact:

Farm Bureau Health Plans
P.O. Box 313
Columbia, Tennessee 38402-0313

We will mail notices to You at the most recent address on file. **It is Your responsibility to maintain Your current address on file with Us.**

GLOSSARY

When defined terms are used in this Policy, they have the meaning set forth in this section.

Assignment of Benefits – An arrangement by which a Member requests that his or her Benefit payments be made directly to a designated person or facility such as a Provider or hospital.

Benefit Authorization - Authorization issued by the Dental or Vision Administrator identifying the individual named as a Member of the Plan, and identifying those Plan Benefits to which a Member is entitled.

Benefits - The amounts that the Plan will pay for dental or vision services under this Policy.

Benefit Maximum – The total amount of Benefits available for services under Your Coverage during the Calendar Year.

Calendar Year or **Plan 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.

Claim Form - The standard form used to file a claim or request predetermination of Benefits. Claim Form also includes claims filed with the Dental or Vision Administrator electronically.

Copayment - The dollar amount of Covered Services that must be incurred and paid by a Member before Benefits are payable for all or part of the remaining Covered Services.

Coverage – The Benefits available to You and Your Covered Dependents under this Policy.

Covered Dependent – A Subscriber's dependent who meets the eligibility requirements of this Coverage and has been enrolled in the Policy.

Covered Service – A service or supply for which Benefits are available. Covered Services must be provided by a Provider, must be medically necessary and must be provided in accordance with professionally accepted standards of care.

Deductible - The amount You or a Covered Dependent must pay for services in any Calendar Year before Benefits will be paid by the Plan.

Dental Administrator or **DDTN** - Delta Dental of Tennessee, the third-party administration for dental benefits under this Policy on behalf of FBHP. As used in this Policy, DDTN may refer to Delta Dental of Tennessee acting on its own behalf or acting on behalf of or in conjunction with a member or members of the Delta Dental Plans Association.

Dentist - A doctor of dentistry duly licensed and qualified under applicable laws to practice dentistry at the time and place Covered Services are performed. Dentist may also apply to auxiliary personnel legally authorized to perform services under the supervision of a person licensed to practice dentistry.

Effective Date - The date a Member's Coverage under this Policy begins.

Emergency Condition - A condition, with sudden onset and acute symptoms, that requires the Member to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical action.

Experimental Nature - Procedure or material that is not used universally or accepted by the dental or vision care profession, as determined by the Dental or Vision Administrator.

Family Coverage – Coverage of a Subscriber and more than one Covered Dependents.

Farm Bureau Health Plans, FBHP, We, Us, Our or the Plan– Tennessee Rural Health Improvement Association.

Individual Coverage - Coverage for the Subscriber only.

Maximum Allowable Charge (MAC) - The amount Farm Bureau Health Plans has determined to be the maximum amount payable for a Covered Service. Maximum Allowable Charge will be based upon Farm Bureau Health Plans, or its affiliate or third-party vendor's, contract with a Network Provider or the amount payable based on Farm Bureau Health Plans, or its affiliate or third-party vendor's, fee schedule for the Covered Services when rendered by Out-of-Network Providers.

Member– Any person enrolled under this Coverage as a Subscriber or a Covered Dependent.

Necessary Dental Services – Dental care or treatment recognized by Us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Network Provider – A Provider who has contracted with Farm Bureau Health Plans, its affiliate, or a third-party vendor to provide Covered Services to Members at specified rates. Network Providers include: (a) An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to provide vision care services and/or vision care materials on behalf of Members of the Plan. (b) A licensed Dentist who is a member of DDTN or any other organization that is a member of Delta Dental Plans Association, and who has agreed to abide by their rules and regulations.

Non-Covered Service - A service, drug, or supply for which no Benefits are available.

Out-of-Network Provider – A Provider who has not contracted with Farm Bureau Health Plans, its affiliate, or a third-party vendor to provide Covered Services to Members at specified rates.

Plan Benefits - The vision care services and vision care materials which a Member is entitled to receive by virtue of Coverage under this Policy.

Plan ID Card – The card provided to You demonstrating Your right to receive Benefits under this Policy.

Policy - The document describing the terms and conditions of Your Coverage, including the application, all schedules, and all amendments as issued by FBHP.

Premium - The monthly amount paid by You to FBHP to provide Coverage under this Policy.

Prevailing Fee - The fee for a single procedure which satisfies the fee of most Network Providers.

Provider – A person or entity that is engaged in the delivery of dental or vision services that is licensed, certified or practicing in accordance with applicable state or federal laws.

Subscriber, You, Your – The individual who has met all applicable eligibility requirements, has applied for Coverage, and to whom We have issued the Policy.

Termination Date – The date Coverage ends.

Treatment Plan - A Provider's written report showing the recommended treatment of any dental or ocular disease, defect or injury for a member whose Coverage under this Policy is in effect.

Two-Person Coverage – Coverage of a Subscriber and one Covered Dependent.

Vision Administrator or **VSP** – Vision Service Plan Insurance Company, the third party administration for vision Benefits under this Policy on behalf of FBHP.