Farm Bureau Health Plans
Dental Care 3 Year Plan

fbhealthplans.com

CON-DEN-3YR-002
Effective January 1, 2019

Important Member Notifications

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

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

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Introduction

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

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

"Coverage" means the benefits available to You under this Contract. "You" and "Your" mean the Subscriber. "Member" means the Subscriber or a Covered Dependent.

This Contract replaces any Certificate, Evidence of Coverage ("EOC"), or Contract previously issued by Farm Bureau Health Plans ("FBHP") in effect prior to the Effective Date of this Contract. This Coverage may be renewed by payment of the Premium.

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

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

If You 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.

A Member is entitled to benefits for Coverage A as of the Member's Effective Date. After the Member's Coverage has been in effect for twelve (12) months, the Member will be entitled to benefits under Coverages A and B. After the Member's Coverage has been in effect for twenty-four (24) months, the Member will be entitled to benefits under Coverages A, B, and C. Each Member's coverage will be based on his or her own Effective Date. Any unexhausted Waiting Periods from a previous certificate or EOC will apply to this Coverage.

RIGHT TO RECEIVE AND RELEASE INFORMATION

You authorize Farm Bureau Health Plans, its affiliate, or a third party vendor to use and release the personal information for Yourself and all Eligible Dependents. This authorization includes any and all medical, vision and dental records obtained, used or released in connection with administration of this Coverage. Personal information will be maintained and released in accordance with applicable state and federal laws and the Farm Bureau Health Plans Notice of Privacy Practices. In the event that information in this Coverage is inconsistent with the Farm Bureau Health Plans Notice of Privacy Practices, the terms of the Farm Bureau Health Plans Notice of Privacy Practices will prevail and this Coverage will be deemed to be modified to the extent necessary for consistency. Your authorization is deemed given by Your and Your Eligible Dependents' 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 or Your Eligible Dependents are covered under this Coverage and survives the termination of this Coverage to the extent that such information or records relate to services rendered while You or Your Eligible Dependents were covered under this Coverage. Please consult the Farm Bureau Health Plans 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 Farm Bureau Health Plans Notice of Privacy Practices at www.fbhealthplans.com or You can call the toll-free number on the back of Your Plan ID card or contact the Farm Bureau Health Plans representative at Your local Farm Bureau office.

You may also be required to separately authorize the release of personally identifiable health information in connection with the administration of this Coverage.

Ryan Brown
Corporate Secretary

Section I
Definitions

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

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

Contract - The document describing the terms and conditions of Your Coverage.

Coverage – The benefits available to You and Your Covered Dependents under this Contract.

Covered Dependent –A Subscriber's dependent who meets the eligibility requirements of this Coverage and has been enrolled in the Plan. Refer to the Eligibility section of this Contract for complete details.

Covered Service – A service or supply for which benefits are available. Covered Services must be provided by a dental Provider, must be Necessary Dental Service and must be provided in accordance with professionally-accepted standards of care.

Deductible - The dollar amount You must incur and pay for Covered Services during a Calendar Year before We provide benefits. Any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge) will not be considered when determining whether Your Deductible has been met.

Dentist - A doctor of dentistry duly licensed and qualified under applicable laws to practice dentistry at the time and place Covered Services are performed.

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

Family Coverage - Coverage of a Subscriber and one or more Covered Dependents.

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.

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.

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

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

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

Termination Date – The date benefits end.

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

We, Us, Our, and Plan – refers to Tennessee Rural Health Improvement Association ("TRH"), also known as, Farm Bureau Health Plans ("FBHP").

Waiting Period - The period of time which must be exhausted before benefits are available.

Section II
Eligibility and Enrollment

TYPES OF COVERAGE AVAILABLE

Individual – Subscriber only

Family – Subscriber and Eligible Dependents

SUBSCRIBER

To be eligible as a Subscriber You must:

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

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

ELIGIBLE DEPENDENTS

The following will be eligible as Your Eligible Dependents:

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

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

Coverage for Disabled Dependents

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

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

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 furnished 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 day of the month following the date of the marriage.

CHANGES IN ENROLLMENT STATUS

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

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

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

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

Section III
General Provisions

APPLICABLE LAW

The laws of the state of Tennessee govern this Coverage.

BENEFITS TO WHICH A MEMBER IS ENTITLED

Benefits are provided only for Covered Services received on or after the Member's Effective Date and prior to the Member's termination date of the Member's Coverage. A Member is entitled to benefits for Covered Services after satisfying the appropriate Waiting Periods.

THE PLAN IDENTIFICATION (ID) CARD

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

THE CONTRACT

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

SCHEDULE OF CHARGES

The rates for Coverage provided in this Contract may be changed by providing notice of the changes at least 30 days prior to the Effective Date of such change.

A 10-day grace period is allowed if charges are paid on a monthly basis. This means that each charge will be accepted within 10 days after its due date. If it is not paid within 10 days, coverage ends on the due date. Coverage will automatically cancel if You fail to pay the charges within the grace period.

If Your Coverage is paid by monthly bank draft and the draft is dishonored (returned unpaid) by Your bank of record for any reason, such dishonor could result in forfeiture of Coverage.

TERMINATION OF COVERAGE

Your Coverage may be terminated if:

1. The required Premium for Your Coverage is not received when it is due; or
2. You fail to pay Your Tennessee Farm Bureau Federation or Farm Bureau Health Plans membership dues; or
3. You fail to cooperate with Us as required by this Contract; or

4. You act in such a disruptive manner as to prevent or adversely affect Our ability to administer Your Coverage; or
5. You request that We cancel Your Coverage at least 10 days prior to the next Premium due date; or
6. You have resided outside of the United States for 24 consecutive months; or
7. This Plan is terminated; or
8. You, or a Covered Dependent, 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 Coverage. This means We will return Premium paid minus any claims paid. If the claims paid exceed Premium paid, We have the right to collect that amount from You. We will notify You 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.

Farm Bureau Health Plans may cancel this Coverage for any of the reasons described herein by providing written notice to You 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 and Your Covered Dependents' current address on file with Us.

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

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 10 days of the final day of Your grace period.

BRINGING LEGAL ACTION

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

A properly completed notice of claim has been submitted, and

Such claim has either been denied in writing or not followed by a written response within sixty (60) days after it is submitted, and

The Member has exercised all of his or her review and appeal rights under this Contract, as defined under Grievance Procedure unless the period set forth in the Grievance Procedure has expired.

RIGHT TO REQUEST INFORMATION

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

ADMINISTRATIVE ERRORS

If We make an error in administering the benefits under this Policy, We may recover any overpayments from any person, insurance company, or plan. Any recovery must being within eighteen (18) months (or the time frame allowed by law) of the date the claim was paid. This time limit does not apply if the Member did not provide complete information or if material misstatements or fraud have occurred.

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

TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the Effective Date of this Coverage, no 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 Coverage or to deny a claim for loss incurred after the expiration of such two-year period.

SUBROGATION AND RIGHT OF RECOVERY

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

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

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

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

NOTICES

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

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

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

Section IV
How the Dental Program Works

NETWORK PROVIDERS

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.

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. Network Providers have agreed to the Plan's Maximum Allowable Charge (MAC). They have agreed not to bill patients for additional amounts so You will have a lesser out-of-pocket expense.

PAYMENT FOR AN OUT-OF-NETWORK PROVIDER

If You select a Dentist who is not a Network Provider, You may have to file the claim Yourself. In this event, payment for Covered Services will be made directly to You according to the MAC. This means that You are responsible for the difference between the billed charges and the MAC for a Covered Service.

PRE-TREATMENT ESTIMATE

A pre-treatment estimate lets You and Your Dentist know in advance approximately how much of the dental services expenses will be considered for payment. A pre-treatment estimate is not an agreement to pay for dental services.

If the charge for a dental service is expected to exceed $200, You or Your Dentist may request a pre-treatment estimate. You or Your Dentist should send the request via a claim form to Us prior to the dental service being rendered. We may request Your Dentist provide dental x-rays or other necessary information to evaluate the treatment plan.

Section V
Schedule of Benefits

Members are entitled to benefits during a Calendar Year, in the amounts specified below, subject to applicable exclusions, limitations, and Deductibles, if any.

A Member is entitled to benefits for Coverage A as of the Member's Effective Date. After the Member's Coverage has been in effect for 12 months, the Member will be entitled to benefits under Coverages A and B. After the Member's Coverage has been in effect for 24 months, the Member will be entitled to benefits under Coverages A, B, and C. Each Member's coverage will be based on his or her own Effective Date. Any unexhausted Waiting Periods from a previous certificate or EOC will apply to this Coverage.

Deductible

Coverage B	
Individual Deductible maximum per Calendar Year	$50
Family Deductible maximum per Calendar Year	$150
Coverage C	
Individual Deductible maximum per Calendar Year	$50
Family Deductible maximum per Calendar Year	$150

Covered Services	**Benefit Percentages**
Coverage A	80%
Diagnostic and Preventive Services	
Coverage B Restorative Services	80%
Coverage C	50%
Prosthetic and Complex Restorative Services	

Benefit Maximums

Coverages A, B, and C	$1,000 per Calendar Year, per Member

Section VI
Covered Services

COVERAGE A (Benefits for Preventive and Diagnostic Dentistry)

- One routine periodic examination every 6 months.
- Bitewing radiographs once per Calendar Year.
- Full mouth or panoramic radiographs once in any 36-month period.
- Topical fluoride application for dependent children under age 19, once per Calendar Year.
- Prophylaxis and periodontal maintenance, not to exceed two per Calendar Year.
- Any combination of exams – problem focused, comprehensive periodontal evaluations or emergency treatment for pain (palliative treatment) - limited to 3 times per Calendar Year.

COVERAGE B (Benefits for Restorative Dentistry)

12 MONTH WAITING PERIOD FROM MEMBER'S EFFECTIVE DATE.

- Emergency treatment for relief of pain (palliative treatment).
- Restorative services: filling material such as amalgam, synthetic porcelain and composite restorations--limited to one restoration per surface per tooth per year.
  Benefits will not be provided for replacement within 12 months of a restoration.
- Oral surgery:
  – Routine, non-impacted extractions, including pre- and post-operative care.
  – Surgical extractions of impacted teeth, including pre- and post-operative care.

  General anesthesia or intravenous sedation is covered only in connection with covered oral surgical procedures when administered by a Dentist licensed to administer anesthesia or intravenous sedation.
- Surgical extractions (impactions).
- Endodontics: root canal treatment.

  Benefits will be provided for one standard root canal treatment for an individual tooth in a single five-year period.

  Benefits will not be provided for X-rays and sedative filling which is part of a root canal treatment or a temporary when a casting is being prepared.
- Periodontics: treatment for diseases of the gums and bones supporting teeth.

  Benefits will be provided for root planning once in a single two-year- period, but will not be provided when performed on the same day as a prophylaxis or periodontal maintenance procedure.

  Benefits for periodontal surgical procedures shall be provided for up to three months post-operative care and any surgical re-entry for a three-year-period.

Benefits for periodontal maintenance will not be provided unless performed 91 days or more after completion of active periodontal treatment.

Benefits for scaling in the presence of gingival inflammation will be limited to one such procedure for Members age 19 years or older.

- Repair of full and partial dentures after 12 month initial placement.
- Space maintainers for Members up to age 14.
- Stainless steel crowns.

  Benefits will not be provided for replacement of a stainless steel crown within 36 months following initial placement of such crown.
- Sealants, only for occlusal biting surface of first and second permanent molar teeth on dependents under 16 years of age. Only one sealant benefit will be allowed on each tooth per lifetime of coverage.

COVERAGE C (Crown and Prosthetic Care)
24 MONTHS WAITING PERIOD FROM MEMBER'S EFFECTIVE DATE

- Full and partial upper and lower dentures.

  Benefits will be provided for any necessary adjustments for a six-month period. Benefits will not be provided for cast partial dentures for Members under age 16.
- Initial placement of fixed and removable bridges by standard procedure. Bridge repair after 6 month initial placement.

  Benefits will not be provided for fixed bridges for Members under age 16.

  Benefits will not be provided for recementation of a bridge if performed within 6 months of placement of the bridge where both procedures are performed by the same dentist.
- Cast crowns for treatment of severe carious lesions or severe fracture when the tooth cannot be restored with amalgam, synthetic porcelain or composite restorations. Crown repair after
  6-month initial placement.

  Benefits will not be provided for porcelain, gold or veneer crowns for Members under age 12. Benefits will not be provided for reseating of a crown within 12 months of its initial placement or for prefabricated crowns when used as a permanent restoration on an adult tooth.
- Cast inlays/onlays for treatment of severe carious lesions and severe fracture when the tooth cannot be restored with amalgam, synthetic porcelain or composite restorations.
- Laminate veneers for severe carious lesions and severely fractured teeth when the tooth cannot be restored with amalgam synthetic porcelain of composite restorations.
- Relining and rebasing of full and partial dentures. Limited to one upper and one lower every 3 years.

Benefits will be provided on behalf of an individual member for cast onlays, crowns, labial veneer (laminate), fixed bridges and prosthetic appliances once in any single five-year period. Benefits for post and core, and core buildup, will be limited to five-year replacement.

Section VII
Limitations/Exclusions

GENERAL EXCLUSIONS

Your Coverage does not provide benefits for:

1. Dental services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trustee or similar person or group.
2. Dental services which are free or for which You are not required or legally obligated to pay, or for which no charge would be made if You had no dental coverage.
3. Any work related illness or injury (unless resulting from self-employment not subject to Workers Compensation insurance requirements).
4. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes.
5. Services or supplies furnished without cost under the laws of any government except Medicaid or TennCare[SM] coverage provided by the State of Tennessee.
6. Diagnosis for or fabrication of appliances or restorations necessary to correct bite problems or restore the occlusion or correct temporomandibular joint dysfunction (TMJ) or associated muscles.
7. Replacement of tooth structure lost from wear or attrition.
8. Services rendered by a Dentist beyond the scope of his or her license.
9. Dental services to the extent charges for such services exceed the charge that would have been made and collected if You had no dental Coverage.
10. Non-Covered Services.
11. Dental services resulting from loss or theft of a denture, crown, or bridge.
12. Provisional splinting or double (multiple) abutments for fixed bridges.
13. Courses of treatment undertaken before a Member becomes covered under this program.
14. Services and supplies provided by anesthetists or anesthesiologists.
15. Services provided before the Member's Coverage begins, during the Waiting Periods, or after this Coverage is terminated.
16. Services rendered for oral hygiene or dietary instructions.
17. Prescription drugs or other medications.
18. Treatment for desensitizing teeth.
19. Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.

20. Implants (or any synthetic material implanted into or on bone or gums), or their removal. (Alternative benefits may be provided for a full or partial denture in connection with the restoration of fixed prosthesis to implanted artificial teeth.)

21. A posterior bridge in conjunction with an allowance for a partial denture in the same arch.

22. Temporary partial dentures, except those immediately following extraction of anterior teeth.

23. Gold foil restorations.

24. Orthodontic services and appliances.

25. This Coverage does not cover the following, except as specified in Section VI Covered Services:

    a. Crowns
    b. Prosthetics, including bridges, full and partial dentures and relining and duplication of full and partial dentures
    c. Restorative services or oral surgery
    d. Endodontics
    e. Periodontics
    f. Space Maintainers
    g. Sealants
    h. Denture Repairs.

26. Any court-ordered treatment of a Member unless benefits are otherwise payable.

27. Any treatment or service that the Plan determines: (1) is not Necessary Dental Care, (2) does not offer a favorable prognosis, (3) does not meet generally accepted standards of professional dental care, or (4) is experimental in nature.

28. Self-treatment or services performed by any person related to a Member by blood or marriage or any person who resides in the Member's immediate household.

29. Services paid under any other group, blanket or franchise insurance coverage; any other group contract, other health insurance plan, union welfare plan, or labor-management trust plan.

SPECIAL EXCLUSIONS

1. If a Member transfers from the care of one Dentist to another during a course of treatment, or more than one Dentist renders services for one dental procedure, The Plan will not pay more than the amount The Plan would have paid had one Dentist rendered the service.

2. If there are alternative procedures that meet the accepted standard of professional dental care for a Member's condition, The Plan will pay for the lowest cost alternative.

Section VIII
Claims: How and When To File

WHEN TO APPLY FOR BENEFITS

You or Your Provider should file claims as soon as possible after You receive Covered Services. If Covered Services are received on a continuous basis, claims should be submitted no less than every 30 days.

All claims must be submitted within 12 months of the date on which Covered Services were performed. Within 30 days of receipt of a claim, You will be provided with one of the following:

a. an Explanation of Benefits.

b. a notice of denial of a claim.

c. a request for additional information.

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

CLAIMS FOR NETWORK PROVIDER SERVICES

When You or a Covered Dependent receive care, the Network Provider will ask You to assign Your benefits to the Dentist. A Network Provider will file the necessary claims. Available benefits will be paid directly to the Dentist and You will receive an Explanation of Benefits (EOB) showing the Plan's payment and any balance that is Your responsibility.

CLAIMS FOR OUT-OF-NETWORK PROVIDER SERVICES

An Out-of-Network Provider may not file the necessary claims on Your behalf. If the Out-of-Network Provider does not, ask the Dentist to give You a claim form and an itemized statement listing the services received and the charges for each service. You may then submit a claim to Us, and available benefits will be paid directly to You. Be sure to include: (1) the patient's name; (2) Your Plan ID and group numbers; (3) treatment date(s); (4) the patient's diagnosis; and (5) information about any other health insurance the patient may have.

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

COORDINATION OF BENEFITS

This Coverage includes the following Coordination of Benefits (COB) provision, which applies when a Member has Coverage under more than one group contract or health care "plan". 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;
- the benefits exceed Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plan(s) do not total more than Allowable Expenses.

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

c. We will not, however, consider the benefits of the Other Plan(s) in determining benefits under This Plan when:

- the Other Plan has a rule coordinating its benefits with those of This Plan and such rule states that benefits of the Other Plan will be determined after those of This Plan; and
- the order of benefit determination rules require This Plan to determine benefits before those of the Other Plan.

Order of Benefit Determination Rules

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

a. Non-Dependent/Dependent

The benefits of the Plan which covers the person as an Employee, Member, or Subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent, except that:

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

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

  – Medicare;

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

b. Dependent Child/Parents Not Separated or Divorced

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

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

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

c. Dependent Child/Separated or Divorced Parents

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

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

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

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

d. Active/Inactive Employee

The benefits of a Plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired Employee. The same would hold true if a person is a dependent of a person covered as a retiree and an Employee. If the Other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule is ignored.

e. Continuation Coverage

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

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

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

f. Longer/Shorter Length of Coverage

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

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

The start of the new Plan does not include:

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

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

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

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

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

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

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