Farm Bureau Health Plans
Core Choice

fbhealthplans.com

CON-COREN-009
Effective January 1, 2025

Important Member Notifications

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

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

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Introduction

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

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

"Coverage" 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.

A rating classification attached to a previous Certificate, EOC, or Contract may apply to this Contract also. This Coverage may be renewed by payment of the Premium.

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

Words defined in the Glossary 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.

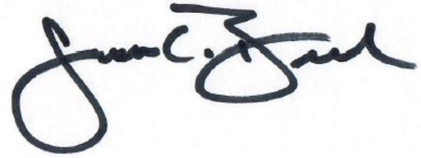
If You are transferring from another FBHP Coverage to this Coverage, and You are not satisfied with this Coverage, You may return this Contract to FBHP within thirty (30) days of receipt. In this event, Your Coverage will terminate and any Premium paid for this Coverage will be refunded minus any benefits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

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

RIGHT TO RECEIVE AND RELEASE INFORMATION

You authorize FBHP, its affiliate, or a third party vendor to use and release the personal information for Yourself and all Eligible Dependents. This authorization includes any and all medical, vision and dental records obtained, used or released in connection with administration of this Coverage. Personal information will be maintained and released in accordance with applicable state and federal laws and the FBHP Notice of Privacy Practices. In the event that information in this Coverage is inconsistent with the FBHP Notice of Privacy Practices, the terms of the FBHP Notice of Privacy Practices will prevail and this Coverage will be deemed to be modified to the extent necessary for consistency. Your authorization is deemed given by Your and Your Eligible Dependents' 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 the Coverage to the extent that such information or records relate to services rendered while You or Your Eligible Dependents were covered under this Coverage. You may also be required to separately authorize the release of personally identifiable health information in connection with the administration of this Coverage. Please consult the FBHP Notice of Privacy Practices for more information about Your rights regarding the use and release of Your personal information. You can find a copy of

the FBHP Notice of Privacy Practices at fbhealthplans.com or You can call the toll-free number listed on the back of Your Plan ID card or contact the Farm Bureau Health Plans representative at Your local Farm Bureau office.



Jason C. Beard
Corporate Secretary

Section I
Network Providers

HOW A PPO PLAN WORKS

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

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

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

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

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

AVAILABLE NETWORKS

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

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

FBHP reserves the right to modify available networks.

EXCEPTIONS TO THE PROVIDER NETWORK RATES

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

- Certain Out-of-Network Providers in Network Facilities - Covered Services provided by an Out-of-Network radiologist, anesthesiologist, or pathologist during an Inpatient stay will be payable at the Network level of benefits when provided in a Network facility.
- Gap Exception - If there is not a Network provider, or no Network Provider is willing or able to provide the necessary service(s) to a Member within a 50 mile radius of the Member's residence, then the Out-of-Network charges will be processed as Network charges so long as the Member provides appropriate documentation.
- Emergency Services – If a Member experiences an Emergency, charges from Out-of-Network Providers and facilities may be processed at the Network level of benefits as outlined in the Hospital Emergency Room Services benefit in the Member Benefit section of this Contract.

RELATIONSHIP WITH NETWORK PROVIDERS

1. Independent Contractors

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

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

2. Termination of Providers' Participation

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

CONTINUITY OF CARE

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

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

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

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

MEMBER/PROVIDER RELATIONSHIP

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

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

Section II
Definitions

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

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

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

Advanced Radiological Imaging – Services such as Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT scan), Positron Emission Tomography (PET scan), nuclear medicine and other similar technologies.

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

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

Billed Charges - The amount a Provider charges for services rendered. Billed Charges may be different from the Maximum Allowable Charge for a Covered Service.

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

Care Management – A program that promotes cost effective coordination of care for Members with complicated medical needs, complex conditions, and/or catastrophic illnesses or injuries.

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

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

Coinsurance – The share of the cost of Covered Services by Farm Bureau Health Plans and You, after Your Deductible has been satisfied. For certain Covered Services specifically designated within this Contract, including any Attachments, Your Deductible is not required to be satisfied before Your Coinsurance applies. Your Coinsurance is calculated at 100% minus Our Coinsurance. In addition to Your Coinsurance, You are responsible for the difference between Billed Charges and the Maximum Allowable Charge for Covered Services if the Billed Charges of an Out-of-Network Provider exceed the Maximum Allowable Charge for such services.

Coinsurance Percentage - The percentage of the Maximum Allowable Charge that will be paid by Farm Bureau Health Plans for a Covered Service during a Calendar Year after, and in some cases before, a Member satisfies his or her Deductible.

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

Complications of Pregnancy - Conditions requiring hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as Acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, non-elective cesarean section, ectopic pregnancy that is terminated, fetus is not viable, and spontaneous

termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor; occasional spotting; physician prescribed rest during the period of pregnancy; morning sickness; hyperemesis gravidarum or similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct Complication of Pregnancy.

Compound Drug - An outpatient prescription drug, which is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration and that contains at least one ingredient classified as a Legend Drug.

Concurrent Review - The process of evaluating care during the period when Covered Services are being rendered.

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

Copayment - The dollar amount You are required to pay directly to a Network Provider for certain Covered Services. You must pay such Copayments at the time You receive services.

Copayments do not apply to the following services: Advanced Radiological Imaging, allergy testing and injections, biopsy interpretations, bone density testing, cardiac diagnostic testing, chemotherapy services, chiropractic services, complex diagnostic services, dental services except preventative and restorative for all Members, diagnostic services sent out, Durable Medical Equipment, growth hormone injections, IV therapy, Lupron injections, mammography, maternity services, nerve conduction studies, neuropsychological or neurological tests, nuclear cardiology, nuclear medicine, orthotics, preventative services as indicated, prosthetics, Provider Administered Specialty Pharmacy Products, sleep studies, surgery performed in a physician's office and related surgical supplies, Synagis injections, therapeutic/rehabilitative services, ultrasounds, and Vision Services.

Deductible and Coinsurance will apply to these Covered Services except where otherwise indicated.

Copayments do not apply toward satisfying Deductibles or Out-of-Pocket Maximums. Once the Deductible and Out-of-Pocket Maximums are met, Copayments continue to apply.

Cosmetic Services – Any surgical or non-surgical treatments, drugs or devices intended to alter or reshape the body for the purpose of improving appearance or self-esteem.

Coverage - The benefits available to Members under this Contract.

Covered Charge – The amount of Billed Charges eligible for payment.

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 - Medically Necessary and Medically Appropriate services, drugs or supplies subject to all terms, conditions, exclusions and limitations set forth in this Contract.

Custodial Care – Any services or supplies provided to assist an individual in the activities of daily living. This includes, but is not limited to, eating, bathing, dressing, walking or other self-care services and supervision of self-administration of medications not requiring constant attention of medical personnel.

Deductible - The dollar amount You must incur and pay for Covered Services during a Calendar Year before We provide benefits. Any Copayment or 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.

Amounts paid toward Your Deductible will be applied to Your Out-of-Pocket Maximum.

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

Durable Medical Equipment - Medically Necessary and Medically Appropriate medical equipment or items that: (1) in the absence of illness or injury, are of no medical or other value to You; (2) can withstand repeated use in an ambulatory or home setting; (3) require the prescription of a Practitioner for purchase; (4) are approved by the FDA for the illness or injury for which it is prescribed; and (5) are not solely for Your convenience. Durable Medical Equipment may be purchased or rented.

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

Eligible Providers – All Covered Services must be rendered by a Practitioner or Provider within the Practitioner or Provider's specialty, degree, licensure or accreditation.

Emergency - A sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to result in:

- Placing a Member's health in serious jeopardy; or
- Serious impairments to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Room Deductible - A Deductible applied to each visit to an Emergency room. Your Emergency Room Deductible does not count toward Your Calendar Year Deductible or Your Out-of-Pocket Maximum.

Explanation of Benefits (EOB) - The form provided to the Subscriber after a claim has been filed notifying the Subscriber which services were covered and which, if any, were not.

Family Coverage - Coverage for the Subscriber and Covered Dependents. Please refer to the Eligibility section of this Contract for complete details.

Hospice - A public agency or private organization that provides services for terminally ill patients and that:

- is licensed by and, if legally required, has been issued a Certificate of Need from the state in which it is operating,
- is certified as a home health care agency under Title XVIII and Title XIX of the Social Security Act,
- is eligible for accreditation by the Joint Commission on Accreditation of Healthcare Organizations as a Hospice, and
- provides in-home health care services which conform to the standards of a Hospice program of care as adopted by the board of directors of the National Hospice Organization.

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

Investigational Services - The definition of "Investigational" is based on Our technology evaluation criteria. Any technology that fails to meet **ALL** of the following four criteria is considered to be Investigational.

a. The technology must have final approval from the appropriate governmental regulatory bodies, as demonstrated by:

i. This criterion applies to drugs, biological products, devices and any other product or procedure that must have final approval to market from the U.S. Food and Drug Administration or any other federal governmental body with authority to regulate the use of the technology.

ii. Any approval that is granted as an interim step in the U.S. Food and Drug Administration's or any other federal governmental body's regulatory process is not sufficient.

b. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes, as demonstrated by:

i. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

ii. The evidence should demonstrate that the technology could measure or alter the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence or a convincing argument based on established medical facts that such measurement or alteration affects health outcomes.

c. The technology must improve the net health outcome, as demonstrated by:

1. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.

d. The improvement must be attainable outside Investigational settings, as demonstrated by:

i. In reviewing the criteria above, the medical policy panel will consider physician specialty society recommendations, the view of prudent medical Practitioners practicing in relevant clinical areas and any other relevant factors.

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

- Your medical records, or
- the protocol(s) under which proposed service, drug or supply is to be delivered, or
- any consent document that You have executed or will be asked to execute, in order to receive the proposed service, drug or supply, or
- the published authoritative medical or scientific literature regarding the proposed service, drug or supply in connection with the treatment of injuries or illnesses such as those experienced by You, or
- regulations or other official publications issued by the U.S. Food and Drug Administration and Health and Human Services, or
- the opinions of any entities that contract with the Plan to assess and coordinate the treatment of Members requiring non-experimental or Investigational Services, or
- the findings of Our contracted Technology Evaluation Center or other similar qualified evaluation entities

Legend Drugs – A drug that, by law, can be obtained only by prescription and bears the label, "Caution: Federal law prohibits dispensing without a prescription."

Mandated Diabetes Supply List – In accordance with Tenn. Code Ann. § 56-7-2605, the following equipment and supplies for the treatment of diabetes must be included in the Coverage provided pursuant to subsection (b), when prescribed by a physician as Medically Necessary for the care of an individual patient with diabetes:

a. Blood glucose monitors and blood glucose monitors for the legally blind;

b. Test strips for blood glucose monitors;

c. Visual reading and urine test strips;

d. Insulin;

e. Injection aids;

f. Syringes;

g. Lancets;

h. Insulin pumps, infusion devices, and appurtenances thereto;

i. Oral hypoglycemic agents;

j. Podiatric appliances for prevention of complications associated with diabetes; and

k. Glucagon emergency kits.

Maximum Allowable Charge - 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.

Medical Director - A physician designated by Farm Bureau Health Plans, or that physician's designee, who is responsible for the administration of the medical management programs.

Medically Appropriate – Services which have been determined by the Medical Director, in his or her discretion, to be of value in the care of a specific Member. To be Medically Appropriate a service must:

a. be Medically Necessary;

b. be consistent with generally accepted standards of medical practice;

c. be provided in the most appropriate site and at the most appropriate level of service for the Member's medical condition;

d. not be provided solely to improve a Member's condition beyond normal variation in individual development, appearance and aging;

e. not be for the sole convenience of the Provider, Member or Member's family.

Medically Necessary or Medical Necessity – Services, procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical Practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

a. in accordance with generally accepted standards of medical practice; and
b. clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
c. not primarily for the convenience of the patient, physician or other health care Provider; and
d. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.

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

Monthly Claims Statement – The statement provided to the Subscriber each month showing claims processed during the preceding month. This statement notifies the Subscriber which services were covered and which, if any, were not.

Network Pharmacy - A Pharmacy that has contracted with Farm Bureau Health Plans, its affiliate, or a third party vendor to legally dispense prescription drugs to Members, either in person or through home delivery at specified rates.

Network Provider – An Eligible 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 Pharmacy – A Pharmacy that has not contracted with Farm Bureau Health Plans, its affiliate, or a third party vendor to legally dispense prescription drugs to Members, either in person or through home delivery at specified rates.

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

Out-of-Pocket Maximum - The maximum dollar amount You could incur and pay for Covered Services during a Calendar Year, including Deductible and Coinsurance.

Charges paid for Covered Services rendered by Out-of-Network Providers and any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge for Covered Services) will not be considered when determining if Your Out-of-Pocket Maximum has been met.

When Your Out-of-Pocket Maximum is met, benefits are payable at 100% for other Covered Services from Network Providers incurred by You or Your Covered Dependents during the remainder of that Calendar Year, excluding any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge).

Copayments and the Emergency Room Deductible do not apply to the Out-of-Pocket Maximum.

Pharmacy - A state or federally licensed establishment that is physically separate and apart from the office of a physician or authorized Practitioner, and where Legend Drugs are dispensed by prescription by a pharmacist licensed to dispense such drugs and products under the laws of the state in which he or she practices.

Plan Identification (ID) Card – The card provided to You demonstrating Your right to receive benefits under this Contract.

Practitioner – A person licensed by a state to provide medical services.

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

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

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

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

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

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

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

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

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

- The healthcare services provider is at a qualified site other than the site where the patient is located and has access to the relevant medical record for that patient;
- The patient is located at a location the patient deems appropriate to receive the healthcare service that is equipped to engage in the telecommunication described herein; and
- The healthcare services provider makes use of HIPAA compliant, real-time, interactive audio, video telecommunications or electronic technology, or store-and-forward telemedicine services to deliver healthcare services to a patient within the scope of practice of the healthcare services provider as long as the healthcare services provider, the healthcare services provider’s practice group, or the healthcare system has established a provider-patient relationship by submitting to Us evidence of an in-person encounter between the healthcare service provider, the healthcare services provider’s practice group, or the healthcare system and the patient within sixteen (16) months prior to the interactive visit.

Telemedicine does not include:

- An audio-only conversation;
- An electronic mail message or phone text message;

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

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

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

Vision Examination – Comprehensive ophthalmologic service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmologic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated, biomicroscopy, examination with cyclopedia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Section III
Eligibility and Enrollment

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;
3. Meet FBHP medical underwriting requirements; and
4. Meet any additional requirements established;

FBHP 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).

    A child for whom You or Your spouse has been granted legal guardianship or custody until the age of twenty-six (26).To establish eligibility, a complete copy of any court documents establishing guardianship or custody, such as a final court order must be provided.

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

Coverage for Disabled Dependents

Coverage for a child with a physical or intellectual disability may continue past age twenty-six (26) if he or she is incapable of self-support and mainly dependent upon You at that time. 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 to FBHP within Sixty (60) days of the Eligible Dependent's attainment of age twenty-six (26).

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

ADDING DEPENDENTS

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

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

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 the Premium and the Subscriber's spouse chooses to continue Coverage, the spouse and Eligible Dependents may apply for Coverage within sixty (60) days of the date of termination. The spouse and Eligible Dependents will be issued the type Contract then being issued to such Subscribers.

APPLICABLE LAW

The laws of the state of Tennessee govern this Coverage.

BENEFITS TO WHICH A MEMBER IS ENTITLED

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

THE PLAN IDENTIFICATION (ID) CARD

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 thirty (30) days notice before the effective date of any change. Your continued payment of Premium indicates acceptance of the change. Notice of any change to the terms of Your Coverage will be mailed to You at the address shown in Our records.

BRINGING LEGAL ACTION

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

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

RIGHT TO REQUEST INFORMATION

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

ADMINISTRATIVE ERRORS

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

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

TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the Effective Date of this Coverage, no 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, TN 38402-0313.

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

Women's Health and Cancer Rights Act of 1998

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

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient.

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

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

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

Section V
Premium & Termination of Coverage

PREMIUM

We may change Your Premium by giving You at least thirty (30) days notice before the effective date of any Premium change. Your continued payment of Premium indicates acceptance of the change.

Your Coverage is age rated based on Your age as of January 1 of the Calendar Year. Your Premium will automatically change on the first billing date of the following Calendar Year after You move to a different age bracket. Rates for Family Coverage are based on the age of the oldest family Member.

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

YOUR PREMIUM

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

Should Your payment be dishonored (returned unpaid) by Your financial institution, You could forfeit Your Coverage. Your Coverage is subject to a ten (10)-day grace period if Premium is paid on a monthly basis. If Your Premium is not paid within Your grace period, Your Coverage will terminate retroactively effective as of the Premium 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. FBHP reserves the right to change the default fee amount at any time.

RESTORATION OF COVERAGE

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

REFUNDS

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

CHANGES TO COVERAGE

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

TERMINATION OF COVERAGE

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 FBHP 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 Your Coverage be cancelled for any reason by giving FBHP written notice which is received by Us at least ten (10) days prior to the next Premium due date in which case Coverage will remain in effect until the paid to date; or
6. You have resided outside of the United States for twenty-four (24) consecutive months; or
7. This Plan is terminated; or
8. You, or an Eligible Dependent, have made an intentional 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 thirty (30) days in advance of any rescission.

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

a. The date Your Coverage terminates; or
b. The last day of the month for which You paid Your Covered Dependent's Premium; or
c. The date Your Eligible Dependent is no longer eligible.

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

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

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

PAYMENT FOR SERVICES RENDERED AFTER TERMINATION OF COVERAGE

If You or Your Eligible Dependents receive and We pay for Covered Services after the termination of Coverage, We may recover the amount We pay for such Covered Services from You, plus any costs of recovering such charges, including Our attorney's fees. In the event Your coverage is terminated back to the original Effective Date, We may recoup the amount of any benefits paid that exceed Premium paid. If such amount cannot be recouped from providers, the member will be responsible for reimbursement.

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

Section VI
Schedule of Benefits

BENEFITS

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

Coinsurance Percentages	Network Benefit	Out-of-Network Benefit
Covered Preventative Services	**100% of the Maximum Allowable Charge**	**60% of the Maximum Allowable Charge after Deductible**
All Other Covered Services	**80% of the Maximum Allowable Charge after Deductible**	**60% of the Maximum Allowable Charge after Deductible**
Covered Teladoc Services	**100% of the Maximum Allowable Charge**	**Not Covered**

COPAYMENTS

A Copayment will be applied to each office visit for the Covered Services performed in the office and provided and billed by a physician who is a Network Provider. The remaining charges for Covered Services rendered during the office visit will be paid at 100% of the Maximum Allowable Charge. If a physician who is an Out-of-Network Provider is utilized for Covered Services, benefits will be determined on the basis of the Out-of-Network Coinsurance Percentage after Deductible is met.

The network Plan benefits are based on negotiated fees. If the Member uses an Out-of-Network Provider, the Copayment will not apply and the Member's liability will increase significantly.

Copayments do not apply to the following services:

- Advanced Radiological Imaging
- Allergy testing and injections
- Biopsy interpretation
- Bone density testing
- Cardiac diagnostic testing
- Chemotherapy services
- Chiropractic services
- Complex Diagnostic Services
- Dental services except preventative and restorative for all Members
- Diagnostic services sent out
- Durable Medical Equipment
- Growth hormone injections
- IV therapy
- Mammography
- Maternity services
- Nerve conduction studies
- Lupron injections
- Neuropsychological or neurological tests
- Nuclear Cardiology
- Nuclear medicine
- Orthotics
- Preventative services as indicated in Contract
- Prosthetics
- Provider Administered Specialty Pharmacy products
- Sleep studies
- Surgery performed in a physician's office and related surgical supplies
- Synagis injections
- Therapeutic/Rehabilitative services
- Ultrasounds
- Vision Services

These services are subject to the terms and conditions of this Contract and Deductibles and Coinsurance will apply except where otherwise indicated.

Copayments will not be applied toward Deductibles or Out-of-Pocket Maximums.

PRESCRIPTION DRUGS*		
	Network Pharmacies	**Out-of-Network Pharmacies**
Generic Drugs	**100% of the Maximum Allowable Charge after Deductible**	**60% of the Maximum Allowable Charge after Deductible**
Brand Name Drugs	**75% of the Maximum Allowable Charge after Deductible**	**60% of the Maximum Allowable Charge after Deductible**

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

***PRESCRIPTION DRUG CALENDAR YEAR MAXIMUM PER MEMBER - $7,500**

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

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

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

Section VII
Member Benefits

This Coverage provides benefits for many medical services and supplies received by Members. However, not all healthcare services are Covered Services. It is important for Members to understand which services are covered by this Contract. Prior Authorization is required for certain Covered Services.

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

Benefits will only be provided for Covered Services performed and billed by an Eligible Provider. Services must be related to the diagnosis and/or treatment of the Member's illness, injury, or pregnancy.

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

Benefits are subject to the applicable Copayment or Deductible. Coinsurance will be calculated based on the Maximum Allowable Charge. The portion of any Billed charges that exceed the Maximum Allowable Charge will not be covered. Charges billed by an Out-of-Network Provider which exceed the Maximum Allowable Charge will be the responsibility of the Member.

A Member will not be eligible to receive benefits for Pre-Existing Conditions (as defined in Definitions) until the Member has completed a waiting period of six months beginning with the Effective Date of the Member's Coverage. Additional waiting periods will apply as otherwise specified in this Contract.

Other general exclusions will apply as described in Section XIII Limitations/Exclusions.

Active&Fit Direct™ Program

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

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

1. Ambulance

A. Covered Services

1) Land Ambulance

Benefits are available up to a Maximum Allowable Charge of $450, per occurrence, for Medically Necessary and Medically Appropriate land transportation services, supplies and medications provided by a licensed Ambulance service when time or technical expertise of the transportation is essential to reduce the probability of harm to the Member. Benefits are available for transport:

a. from the scene of an accident or Emergency to the nearest appropriate hospital;

b. between hospitals; or

c. between a hospital and a skilled nursing facility.

2) Air or Sea Ambulance

Benefits are available for Medically Necessary and Medically Appropriate air or sea transportation services, supplies and medications provided by a licensed Ambulance service when time or technical expertise of the transportation is essential to reduce the probability of harm to the Member if:

a. the Member's medical condition requires immediate transport that could not be provided by local land Ambulance; or

b. the point of pick up is not accessible by land vehicle; or

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

B. Exclusions

1) charges for dispatch of an Ambulance that is not used by the Member;

2) transport to a physician's office, outpatient department of a hospital for medical care, or the patient's home;

3) transportation for the Member's convenience or that is not essential to reduce the probability of harm to the Member;

4) services when the Member is not transferred to a hospital or skilled nursing facility; or

5) charges for waiting time or extrication.

2. Anesthesia

Benefits are available for Medically Necessary and Medically Appropriate anesthesia administered by a Certified Registered Nurse Anesthetist (CRNA) or a physician (other than the operating surgeon) provided the surgery is a Covered Service.

3. Behavioral Health Care Services

A. Covered Services

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

Other levels of care may be substituted for inpatient days.

Prior Authorization is required for inpatient Behavioral Health Care Services.

B. Exclusions

1) Pastoral counseling.

2) Marriage and family counseling.

3) Vocational and educational training and/or services.

4) Custodial or domiciliary care.

5) Conditions without recognizable ICD-9 /ICD-10 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs.

6) Sleep disorders.
7) Services related to intellectual disability.
8) Court ordered examinations and treatment, unless Medically Necessary.
9) Pain management.
10) Hypnosis or regressive hypnotic techniques.
11) Sex therapy.
12) Assertiveness training.
13) Habilitative as opposed to rehabilitative services, i.e., services to achieve a level of functioning the individual has never attained.
14) Charges for telephone consultations, missed appointments, completion of forms, or other administrative services.

4. Dental Services - All Members

A. Covered Services

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

1) Dental services and oral surgical care resulting from an Accidental Injury to the jaw, sound natural teeth, mouth, or face, due to external trauma. The surgery and services must be started within 3 months and completed within 12 months of the injury unless the initial Medically Necessary and Medically Appropriate plan of treatment cannot be completed within 12 months of the injury (such initial Medically Necessary and Medically Appropriate plan of treatment must be determined within 12 months of the injury). Services include:
   a. Tooth extraction needed due to Accidental Injury of teeth caused by external trauma;
   b. Excision of partially or completely impacted teeth, including wisdom teeth;
   c. Excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological exams;
   d. Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
   e. Reduction of fractures and dislocations of the jaw;
   f. External incision and drainage of cellulitis;
   g. Incision of accessory sinuses, salivary glands or ducts;
   h. Excision of exostosis of jaws and hard palate;
   i. Dental implants needed due to Accidental Injury of teeth caused by external trauma.
2) For dental services not listed in Section 1 above, general anesthesia, nursing and related hospital expenses in connection with an inpatient or outpatient dental procedure are Covered, only when one of the 5 following conditions is met:
   a. Complex oral surgical procedures that have a high probability of complications due to the nature of the surgery;

b. Concomitant systemic disease for which the patient is under current medical management and that significantly increases the probability of complications;

c. Mental illness or a behavioral condition that precludes dental surgery in the office;

d. Use of general anesthesia and the Member's medical condition requires that such procedure be performed in a Hospital; or

e. Dental treatment or surgery performed on a Member 8 years of age or younger, where such procedure cannot be safely provided in a dental office setting.

3) Oral Appliances to treat obstructive sleep apnea, if Medically Necessary;

B. Exclusions

1) Except as listed above, routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) tooth extraction; (8) periodontal surgery; (9) root canals; (10) preventative care (cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth.

2) Treatment for correction of underbite, overbite, and misalignment of the teeth including but not limited to, braces for dental indications, orthognathic surgery except as otherwise specified in this Contract, and occlusal splints and occlusal appliances to treat malocclusion/ misalignment of teeth.

5. Dental Services – Preventive and Restorative for All Members

After a six (6) month waiting period from the Member's Effective Date of Coverage, benefits are available for necessary dental services rendered by a doctor of dental surgery (DDS), a doctor of medical dentistry (DMD) or any physician licensed to perform dental procedures.

Routine Dental Services are subject to a Copayment per visit and a $500 Calendar Year maximum per Member. The $500 Calendar Year maximum per Member applies only to this section.

A. Covered Services

1) Periodic oral evaluations limited to two in any 12 month period.

2) Bitewing x-rays limited to one in any 12 month period.

3) Full mouth x-rays limited to one in any 36 month period.

4) Prophylaxis and periodontal maintenance limited to two in any 12 month period.

5) Sealants, only for occlusal (biting) surface of the first and second permanent molar teeth on Members under 16 years of age. Coverage limited to one sealant per tooth per lifetime.

6) 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.

7) Emergency treatment for relief of pain.

8) Extraction of non-impacted teeth.

The total number of examinations (initial, periodic or Emergency) may not exceed 3 in any 12 month period. Copayments for these services do not apply to the Out-of-Pocket Maximums.

Member will be responsible for all Network and Out-of-Network charges for dental services in excess of the $500 Calendar Year maximum.

6. Dental Services – Preventative for Pediatric Only

Benefits are available to Members under age 19 for the following Covered Preventative Services:

a. Routine oral health risk assessments, two in any 12-month period.

b. Topical fluoride application, once in any 12-month period.

c. As otherwise outlined in the guidelines and recommendations by the United States Preventive Task Force and the Health Resources and Services Administration.

7. Diabetes Treatment

A. Covered Services

Medically Necessary and Medically Appropriate diagnosis and treatment of diabetes. Such services must be prescribed and certified by a Practitioner as Medically Necessary. The treatment of diabetes consists of medical equipment, supplies, and outpatient self-management training and education, including nutritional counseling. Covered Services for diabetes treatment also include:

1) Blood glucose monitors including monitors designed for the legally blind;
2) Test strips for blood glucose monitors;
3) Visual reading and urine test strips;
4) Insulin;
5) Injection aids;
6) Syringes;
7) Lancets;
8) Injectable incretien mimetics (e.g., Exenatide/Byetta) when used in conjuction with selected Prescription Drugs for the treatment of diabetes;
9) Insulin pumps, infusion devices, and appurtenances;
10) Oral hypoglycemic agents;
11) Podiatric appliances for prevention of complications associated with diabetes; and
12) Glucagon emergency kits.

B. Exclusions

1) Treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary;
2) Supplies not required by state statute; or
3) Items not defined in the Mandated Diabetes Supply List.

8. Diagnostic Services

A. Covered Services

Medically Necessary and Medically Appropriate diagnostic radiology services and laboratory tests including;

1) Imaging services ordered by a Practitioner, including x-ray, ultrasound, bone density test, and Advanced Radiological Imaging Services.
2) Diagnostic laboratory services ordered by a Practitioner.

Prior Authorization for Advanced Radiological Imaging is required.

B. Exclusions

1) Diagnostic Services that are not Medically Necessary and Medically Appropriate.
2) Diagnostic Services not ordered by a Practitioner.

9. Durable Medical Equipment (DME)

A. Covered Services

Medically Necessary and Medically Appropriate medical equipment or items that: (1) in the absence of illness or injury, are of no medical or other value to You; (2) can withstand repeated use in an ambulatory or home setting; (3) require the prescription of a Practitioner for purchase; (4) are approved by the FDA for the illness or injury for which it is prescribed; and (5) are not solely for Your convenience. Durable Medical Equipment may be purchased or rented as determined by the Plan.

1) The maximum allowable rental charge shall not exceed the total Maximum Allowable Charge for purchase. If You rent the same type of equipment from multiple DME Providers, and the total rental charges from the multiple Providers exceed the purchase price of a single piece of equipment, You will be responsible for the amount in excess of the Maximum Allowable Charge for purchase.
2) Benefits are available for the repair, adjustment or replacement of components and accessories necessary for the effective functioning of covered equipment; and
3) Benefits are available for supplies and accessories necessary for the effective functioning of Covered Durable Medical Equipment. Insulin pump replacement is covered only for pumps older than 48 months and only if the pump cannot be repaired.
4) The replacement of items needed as the result of normal wear and tear, defects or obsolescence and aging.

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

B. Exclusions

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

1) Charges exceeding the total cost of the Maximum Allowable Charge to purchase the equipment;
2) Unnecessary repair, adjustment or replacement or duplicates of any such equipment;

3) Supplies and accessories that are not necessary for the effective functioning of the covered equipment;
4) Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology;
5) Items that require or are dependent on alteration of home, workplace or transportation vehicle;
6) Motorized scooters, exercise equipment, hot tubs, pool or saunas;
7) "Deluxe" or "enhanced" equipment. The most basic equipment that will provide the needed medical care will determine the benefit;
8) Computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, and seat lifts of any kind;

Patient lifts, auto tilt chairs, air fluidized beds, or air flotation beds, unless approved by Case Management for a Member who is in Case Management.

10. Emergency Care Services

A. Covered Services

Medically Necessary and Medically Appropriate health care services, supplies and medications furnished in a hospital Emergency department that are required to determine, evaluate and/or treat an Emergency until such condition is stabilized, as directed or ordered by the Practitioner or hospital protocol.

Medically Necessary and Appropriate Practitioner services and Emergency services, supplies and medications necessary for the diagnosis and stabilization of Your Emergency condition.

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

Prior Authorization is required for continuing inpatient care or transfer to another facility.

B. Exclusions

1) Treatment of a Chronic, non-Emergency condition, where the symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an Emergency.
2) Services received for inpatient care or transfer to another facility once Your medical condition has stabilized.

11. Family Planning and Reproductive Services

A. Covered Services

Medically Necessary and Medically Appropriate family planning services and those services to diagnose and treat diseases that may adversely affect fertility including benefits for:

1) (1) physical examination; and (2) diagnostic testing.
2) After a six (6) month waiting period from the Member's Effective Date of Coverage, benefits are available for male sterilization procedures. Female sterilizations – See **Practitioner Office Services**.

3) Medically Necessary and Medically Appropriate termination of a pregnancy.

4) Injectable and implantable hormonal contraceptives and vaginal barrier methods including initial fitting, insertion and removal.

B. Exclusions

1) Services or supplies for the evaluation of infertility.

2) Services or supplies that are designed to medically enhance a Member's level of fertility in the absence of a disease state, create a pregnancy, or improve the conception quality. Services include, but are not limited to: (1) artificial insemination; (2) in vitro fertilization; (3) fallopian tube reconstruction; (4) uterine reconstruction; (5) assisted reproductive technology (ART) including but not limited to GIFT and ZIFT; (6) fertility injections; (7) fertility drugs; (8) sperm preservation; (9) services for follow-up care related to infertility treatments. (A service, drug or supply may be covered if it is provided to treat an illness or underlying medical condition resulting in infertility, which include treatment to correct a previous tubal pregnancy and treatment by ovulatory drugs (such as Clomid) or hormonal treatment used primarily to treat irregular menstrual periods.)

3) Genetic testing and genetic counseling for preventive services.

4) Services or supplies for the reversals of sterilizations.

5) Induced abortion unless Complication of Pregnancy, which includes (1) non-elective cesarean section, (2) ectopic pregnancy which is terminated and (3) spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

6) Services or expenses in connection with a surrogate birth. Surrogate birth means: (1) The union of an egg and sperm then placed in another woman to carry to term; or (2) The insemination of a woman under Contract, who carries to term and relinquishes the child to the biological father (and his wife) to parent.

12. Hearing Aids

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

This hearing aid benefit is limited to $1,000 per individual hearing aid per ear every three (3) years, subject to Deductible. The Coinsurance Percentage will be 100% up to the $1,000 maximum. Charges more than $1,000 will be the responsibility of the Member.

This benefit may be accessed under the Plan by calling the number on the back of Your Plan ID Card. Once contacted, a hearing professional will coordinate care and direct You to the nearest appropriate Provider.

13. Home Health Care

A. Covered Services

Medically Necessary and Medically Appropriate services and supplies provided in Your home by a Practitioner who is primarily engaged in providing home health care services. Physical therapy provided in the home applies to the Therapy Services visit limits. Covered home health care services include:

1) Part-time, intermittent health services, supplies, and medications, by or under the supervision of a registered nurse;
2) Home infusion therapy;
3) Rehabilitative therapies such as physical therapy, etc. (subject to the limitations of the therapeutic /rehabilitative benefit.);

Prior Authorization is required. Rehabilitative therapies such as physical therapy provided in the home do not require Prior Authorization but do apply to the therapy services visit limits.

B. Limitations

Home Health Care is limited to 45 visits per Calendar Year.

C. Exclusions

Items such as non-treatment services or: (1) routine transportation; (2) homemaker or housekeeping services; (3) behavioral counseling; (4) supportive environmental equipment; (5) Maintenance Care or Custodial Care; (6) social casework; (7) meal delivery; (8) personal hygiene; (9) convenience items; (10) Medical social services; and Dietary guidance.

14. Hospice Care

A. Covered Services

Medically Necessary and Medically Appropriate services and supplies for supportive care. Benefits will be provided for: (1) part-time intermittent nursing care; (2) medical social services; (3) bereavement counseling; (4) medications for the control or palliation of the illness; (5) home health aide services; and (6) physical or pulmonary therapy for symptom control.

B. Exclusions

1) Inpatient Hospice services, unless approved by Care Management.
2) Services such as: (1) homemaker or housekeeping services; (2) meals; (3) convenience or comfort items not related to the illness; (4) supportive environmental equipment; (5) private duty nursing; (6) routine transportation; and (7) funeral or financial counseling.

The Coinsurance Percentage will be 100% for this service.

Hospice Care is subject to medical review by Care Management.

15. Inpatient Hospital Services

A. Covered Services

Medically Necessary and Medically Appropriate services and supplies in a hospital that: (1) is a licensed Acute care institution; (2) provides Inpatient services; (3) has surgical and medical facilities primarily for the diagnosis and treatment of disease and injury; and (4) has a staff of physicians licensed to practice medicine and provides 24 hour nursing care by graduate registered nurses. Psychiatric hospitals are not required to have a surgical facility.

1) Room, board, and general nursing care in a:
    a. semi-private room,
    b. private room (limited to most common semi-private room rate, unless approved by Us),
    c. special care unit as approved by Us;
2) Use of operating, delivery and treatment rooms;
3) Prescription drugs and medicines, including take home prescription drugs;
4) Medical supplies, sterile dressings, casts, splints and crutches;
5) Anesthetics;
6) Diagnostic services (x-ray, laboratory and certain other tests);
7) 23-Hour Observation stays; and
8) Certain therapy services.

Prior Authorization is required.

B. Exclusions
1) Inpatient stays primarily for therapy (such as physical therapy).
2) Services that could be provided in a less intensive setting.
3) Private room when not authorized by the Plan and room and board charges are in excess of semi-private room.
4) Blood or plasma provided at no charge to the patient.

16. Inpatient Rehabilitation Facility

A. Covered Services

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

Prior Authorization is required.

B. Limitations

Inpatient Rehabilitation services are limited to 28 days per Calendar Year.

C. Exclusions
1) Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care;
2) Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state;
3) Complementary and alternative therapeutic services;
4) Modalities that do not require the attendance or supervision of a licensed therapist;
5) Behavioral therapy, play therapy, communication therapy, and therapy for self-correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs;
6) Duplicate therapy.

17. Maternity Services

Medically Necessary and Medically Appropriate services for delivery and all inpatient services for maternity care (including routine nursery care and Complications of Pregnancy).

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

Maternity benefits are available only for a Member covered under FBHP Family Coverage which has been in effect for nine consecutive months.

Copayments do not apply to maternity services, including pre-natal ultrasounds.

18. Multiple or Bilateral Surgical Procedures

Benefits are available when two or more Medically Necessary and Medically Appropriate covered surgical procedures are performed at the same time, or in one surgical setting. Benefits will be based on:

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

19. Non-Emergency Care Outside the United States

A. Covered Services

Benefits are available for diagnosis or treatment of illness; injury; injections/medications administered in the office except specialty drugs; second surgical opinions; well child care and preventative/well care services.

B. Exclusions

1) Office visits, physical exams and related immunization and tests, when required solely for: (1) sports; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings;

2) Routine foot care or the treatment of: (1) flat feet; (2) corns; (3) bunions; (4) calluses; (5) toenails; (6) fallen arches; and (7) weak feet of Chronic foot strain;

3) Foot orthotics, shoe inserts and custom made shoes, except as required by law for diabetic patients or as part of a leg brace;

4) Rehabilitative therapies in excess of the limitations of the therapeutic/rehabilitative benefit;

5) Dental procedures not related to medical emergencies.

20. Orthognathic Surgery For Treatment of Clinically Significant Obstructive Sleep Apnea

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

The Member must have:

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

Prior Authorization is required. Medical records must be submitted to Us to substantiate the preceding requirements have been met.

21. Outpatient Facility Services

A. Covered Services

Medically Necessary and Medically Appropriate diagnostics, therapies and surgery occurring in the following types of outpatient facilities: (1) outpatient surgery centers; (2) the outpatient center of a hospital; (3) outpatient diagnostic centers; and (4) certain surgical suites in a Practitioner's office.

1) Practitioner services.
2) Outpatient diagnostics (such as x-rays and laboratory services).
3) Outpatient treatments (such as medications and injections or kidney dialysis clinic).
4) Outpatient surgery and supplies.
5) Observation stays less than 24 hours.

B. Exclusions

1) Rehabilitative therapies in excess of the terms of the therapeutic/ rehabilitative benefit.
2) Services that could be provided in a less intensive setting.
3) Surgery to change sex and related services

22. Physicians' Services

Benefits are available for Medically Necessary and Medically Appropriate physician services:

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

23. Practitioner Office Services

Medically Necessary and Medically Appropriate services in a Practitioner's office.

A. Covered Services

1) Diagnosis and treatment of illness or injury. [Note that allergy skin testing is covered only in the Practitioner office setting. Medically Necessary RAST (radioallergosorbent test), FAST (fluorescent allergosorbent test), or MAST (multiple radioallergosorbent test) is covered in the Practitioner office setting and in a licensed laboratory.]

2) Injections and medications administered in a Practitioner's office, except Specialty Drugs. (See Provider-Administered Specialty Drugs section for information on Coverage).

3) Second surgical opinions given by a Practitioner who is not in the same medical group as the Practitioner who initially recommended surgery.

4) Preventative/Well Care Services.

   Preventative health exam for adults and children and related services as outlined below and performed by the physician during the preventative health exam or referred by the physician as appropriate, including:

   a. Screenings and counseling services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)

   b. Bright Futures recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA)

   c. Preventative care and screening for women as provided in the guidelines supported by HRSA, and

   d. Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC).

   The frequency of visits and services are based on information from the agency responsible for the guideline or recommendation, or the application of medical management. These services include but are not limited to:

   a. Routine physical exams.

   b. Annual well woman exam – a routine well woman preventative exam office visit, including Pap smears and bone density measurement screening for the diagnostic and evaluation of osteoporosis or low bone mass, in accordance with the recommendations by the Health Resources and Services Administration. A routine well woman preventative exam is a medical exam given by a Physician for a reason other than to diagnose or treat a suspected or identified illness or injury. Well woman exam includes:

      i. Cervical cancer screening;

      ii. Screening mammography at age 40 and older, with one baseline mammogram between the ages of 35 and 39; and

      iii. Other USPSTF screenings with an A or B rating.

   c. Colorectal cancer screening at age forty-five (45) and older as follows:

      i. High-sensitivity guaiac fecal occult blood test (HSgFOBT) or fecal immunochemical test (FIT) every year;

      ii. Stool DNA-FIT every 1 to 3 years;

iii. Computed tomography colonography every 5 years;

iv. Flexible sigmoidoscopy every 5 years;

v. Flexible sigmoidoscopy every 10 years + annual FIT; and

vi. Colonoscopy screening every 10 years.

d. Prostate cancer and PSA screening for men age 50 and older.

e. Screening and counseling in the primary care setting for alcohol misuse and tobacco use.

f. Obesity and healthy diet counseling. Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:

    i. Preventive counseling visits and/or risk factor reduction intervention

    ii. Medical nutrition therapy

    iii. Nutritional counseling

    iv. Healthy diet counseling visits provided in connection with hyperlipidemia, hypertension, Type 2 diabetes, obesity, coronary artery disease and congestive heart failure.

g. FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity. Note that prescription contraceptive products are covered under the Pharmacy Prescription Drug Program section.

h. HPV testing once every 3 years for women age 30 and older.

i. Lactation counseling by a trained Provider during pregnancy or in the post-partum period, and manual breast pump.

B. Limitations

1) Screening and counseling in the primary care setting for alcohol misuse and tobacco use is limited to 8 visits each per Calendar Year.

2) Obesity and healthy diet counseling, including screening, for adults is limited to 6 visits per Calendar Year.

C. Exclusions

1) Office visits, physical exams and related immunizations and tests, when required solely for: (1) sports; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings.

2) Routine foot care for the treatment of: (1) flat feet; (2) corns; (3) bunions; (4) calluses; (5) toenails; (6) fallen arches; and (7) weak feet or Chronic foot strain.

3) Foot orthotics, shoe inserts and custom made shoes, except as required by law for diabetic patients or as a part of a leg brace.

4) Rehabilitative therapies in excess of the limitations of the therapeutic/ rehabilitative benefit.

5) Dental procedures not related to medical Emergencies.

6) Services covered to any extent under any other part of this Plan.

7) Services which are for diagnosis or treatment of a suspected or identified illness

or injury.

8) Exams given during Your stay for medical care.
9) Services not given by a Physician or under his or her direction.
10) Psychiatric, psychological, personality, or emotional testing or exams.
11) Nicotine replacement therapy except as otherwise specified in this Contract. Aids to smoking cessation including, but not limited to, patches and prescription drugs.

24. Private Duty Nursing

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

Prior Authorization is required.

B. Exclusions

Inpatient private duty nursing in an Acute care Hospital.

25. Prosthetic Appliances

A. Covered Services

Medically Necessary and Medically Appropriate devices used to correct or replace all or part of a body organ or limb that may be malfunctioning or missing due to: (1) birth defect; (2) accident; (3) illness; or (4) surgery.

1) The initial purchase of surgically implanted prosthetic or orthotic devices;
2) The repair, adjustment or replacement of components and accessories necessary for the effective functioning of covered equipment;
3) Splints and braces that are custom made or molded, and are incidental to a Practitioner's services or on a Practitioner's order;
4) The replacement of covered items required as a result of normal wear and tear, defects or obsolescence and aging;
5) The initial purchase of artificial limbs or eyes;
6) The first set of eyeglasses or contact lenses required to adjust for vision changes due to cataract surgery and obtained within 6 months following the surgery.

Post-mastectomy benefits are available for:

1) Breast prosthesis, surgical bras, or bras with an integrated prosthesis (combined limit of five per Calendar Year);
2) Medically Necessary and Medically Appropriate gel inserts.

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

B. Exclusions

1) Hearing aids for Members age 18 or older;
2) Prosthetics primarily for cosmetic purposes, including but not limited to wigs, or other hair prosthesis or transplants;
3) Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology;
4) The replacements of contact lenses after the initial pair have been provided following cataract surgery;
5) Foot orthotics, shoe inserts and custom made shoes except as required by law for

diabetic patients or as a part of a leg brace.

26. Radiation Therapy

Benefits are available for Medically Necessary and Medically Appropriate treatment of disease by x-ray, radium, or radioactive isotopes.

27. Reconstructive Surgery

Medically Necessary and Medically Appropriate Surgical Procedures intended to restore normal form or function.

1) Surgery to correct significant defects from congenital causes, (except where specifically excluded), accidents or disfigurement from a disease state;
2) Reconstructive breast surgery as a result of a mastectomy or partial mastectomy (other than lumpectomy) including surgery on the non-diseased breast needed to establish symmetry between the two breasts

B. Exclusions

1) Services, supplies or prosthetics primarily to improve appearance;
2) Surgeries to correct or repair the results of a prior Surgical Procedure, the primary purpose of which was to improve appearance, and surgeries to improve appearance following a prior Surgical Procedure, even if that prior procedure was a Covered Service;
3) Surgery to change sex and related services.

28. Routine Foot Care

A. Covered Services

Medically Necessary and Medically Appropriate routine foot care for Members with diabetes.

B. Exclusions

1) Foot orthotics, shoe inserts and custom made shoes except approved by law for diabetic patients or as part of a leg brace; or
2) Routine foot care for the treatment of: (1) flat feet; (2) corns; (3) bunions; (4) calluses; (5) toenails; (6) fallen arches; (7) weak feet or Chronic foot strain.

29. Skilled Nursing Facility

A. Covered Services

Medically Necessary and Medically Appropriate inpatient care provided to Members requiring medical, rehabilitative or nursing care in a restorative setting. Services shall be considered separate and distinct from the levels of Acute care rendered in a hospital setting, or custodial or functional care rendered in a nursing home.

1) Room and board in a semi-private room, general nursing care, medications, diagnostics and special care units;
2) The attending Practitioner's services for professional care.

Prior Authorization is required.

B. Limitations

Skilled nursing is limited to 60 days per Calendar Year.

C. Exclusions

1) Custodial, domiciliary or private duty nursing services.

2) Skilled nursing services not received in a Medicare certified skilled nursing facility.

3) Services for cognitive rehabilitation.

30. Teladoc

Benefits are available, as shown in the Schedule of Benefits, for telephone or web-based video consultations with health care providers through Teladoc for routine primary medical diagnoses in the following situations:

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

A. Covered Services

Covered Teladoc Services include the following types of conditions:

1) General medicine, including, but not limited to:

a. Sinusitis

b. Colds and flu

c. Sore throats

d. Ear infections

e. Allergies

f. Urinary tract infections

2) A refill of a recurring prescription;

3) Pediatric care;

4) Non-Emergency medical assistance.

In order to obtain this benefit:

1) The Member must complete a medical history disclosure form that will serve as an electronic medical record for consulting Teladoc physicians. This form can be completed via the Teladoc website at teladoc.com, via the Teladoc call center at 1-800-TELADOC (1-800-835-2362), or via the Teladoc mobile app.

2) Once enrolled, a Member may phone 1-800-TELADOC (1-800-835-2362) and request a consultation with a Teladoc physician. A Teladoc physician will then return the Member's phone call. If a Member requests a web-based video consultation, the consultation will be scheduled and an appointment reminder notification will be sent prior to the appointed time.

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

B. Exclusions

1) Charges for telephone or online consultations with health care providers who are not contracted through Teladoc.

2) Drug Enforcement Agency-controlled Prescriptions.

Please Note: Not all medical conditions can be appropriately treated through Teladoc consultations. The Teladoc physician will identify any condition for which in-person treatment

with a health care provider is necessary.

Benefits for any health care services or supplies recommended by Teladoc, including prescriptions ordered or refilled by Teladoc physicians, are based on all terms and conditions of the Coverage in force for the Member at the time services are provided, including deductible, coinsurance, and copays as applicable.

31. .TMJ (Temporomandibular Joint Syndrome or Dysfunction)

A. Covered Services

Includes Medically Necessary and Medically Appropriate services to diagnose and treat temporomandibular joint syndrome or dysfunction (TMJ or TMD).

1) Diagnosis and management of TMJ or TMD;
2) Surgical treatment of TMJ or TMD, if performed by a qualified oral surgeon or maxillofacial surgeon;
3) Non-surgical TMJ includes: (1) history and exam; (2) office visit; (3) x-rays; (4) diagnostic study casts; (5) medications; and (6) Oral Appliances to stabilize jaw joint.

B. Limitations

Non-surgical treatment of TMJ is limited to $750 per Member per Calendar Year.

C. Exclusions

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

32. Therapeutic/Rehabilitative Services

A. Covered Services

Medically Necessary and Medically Appropriate outpatient, home health or office therapeutic and rehabilitative services that are expected to result in significant and measurable improvement in Your condition resulting from an Acute disease, injury, autism in children under age 12, or cleft palate. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Practitioner;

1) Therapeutic/rehabilitative Services include: (1) physical therapy; (2) manipulative therapy (including chiropractic therapy); (3) cardiac rehabilitative services; and (4) pulmonary (or respiratory) rehabilitative services.
   a. The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner’s office, outpatient facility or home health setting.
   b. Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are covered as shown in the inpatient hospital,

skilled nursing and rehabilitative facility section, and are not subject to the therapy visit limits.

Prior Authorization is required.

B. Limitations

1) Physical therapy is limited to 40 visits per Calendar Year.
2) Manipulative therapy is limited to 40 visits per Calendar Year.
3) Cardiac rehabilitative therapy is limited to 36 visits per Calendar Year.
4) Pulmonary rehabilitative therapy is limited to 36 visits per Calendar Year.

C. Exclusions

1) Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care;
2) Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state;
3) Complementary and alternative therapeutic services;
4) Modalities that do not require the attendance or supervision of a licensed therapist;
5) Rehabilitative services including, but not limited to, hydrotherapy, educational therapy, occupational therapy, speech therapy, recreational therapy, massage therapy, fluidotherapy, craniosacral therapy, vision exercise therapy, neuromuscular reeducation, cognitive rehabilitation, nutrition therapy, dietary supplements (vitamins) and acupuncture, unless otherwise specified in this Contract.
6) Behavioral therapy, play therapy, communication therapy, and therapy for self-correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs;
7) Duplicate therapy;
8) Services during a continuous Hospital confinement have developed into primarily rehabilitative services, that portion of the stay beginning on the day of such development.

33. Vision Services – All Members

A. Covered Services

Medically Necessary and Medically Appropriate diagnosis and treatment of diseases and injuries that impair vision.

1) Services and supplies for the diagnosis and treatment of diseases and injuries to the eye;
2) The first set of eyeglasses or contact lens required to adjust for vision changes due to intraocular surgery and obtained within 6 months following the surgery, subject to a $100 maximum.

B. Exclusions

1) Routine vision services, including examinations, services, surgeries and supplies to detect or correct refractive errors of the eyes;
2) Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses;

3) Eye exercises and/or therapy;
4) Visual training.

34. Vision Services – Pediatric Vision

Vision services designated as Preventative by the United States Preventive Task Force and the Health Resources and Services Administration will be paid as Covered Preventative Services.

All other vision services will be subject to Deductible and Coinsurance as all other Covered Services except where otherwise listed.

A. Covered Services
   1) Routine Vision Examinations, including dilation, of Members under age 19 will be paid as a Covered Preventative Service.
   2) Eyeglass frames, eyeglass lenses or contact lenses.

B. Limitations
   1) Vision Examinations are covered once every Calendar Year.
   2) Eyeglass frames, eyeglass lenses or contact lenses are covered once every Calendar Year at 100% up to a maximum of $100 per Member not subject to Deductible and Coinsurance.
   3) Prescription sunglasses will be handled as any other lens.

C. Exclusions:
   1) Medical and/or surgical treatment of the eye, eyes, or supporting structure, including surgeries to detect or correct refractive errors of the eyes.
   2) Eye exercises and/or therapy.
   3) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses.
   4) Charges for non-prescription sunglasses, photosensitive, anti-reflective or other optional charges when the charge exceeds the amount allowable for regular lenses.
   5) Charges filed for procedures determined by the Plan to be special or unusual, (i.e. orthoptics, vision training, subnormal vision aids, aniseikonic lenses, tonography, corneal refractive therapy, etc.)
   6) Charges for lenses that do not meet the Z80.1 or Z80.2 standards of the American National Standards Institute.
   7) Oversized Lenses.
   8) Corrected eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the Plan.
   9) Non-prescription lenses and frames, and non-prescription sunglasses.
   10) Two (2) pairs of glasses in lieu of bifocals.
   11) Charges for replacement of broken, lost, or stolen lenses, contact lenses, or frames.
   12) Charges for any additional service required outside basic vision analyses for contact lenses, except fitting fees.

35. Vision Services – Routine for Members 19 Years of Age and Older

A. Covered Services

After a six (6) month waiting period from the Member's Effective Date of Coverage, benefits are available for routine Vision Examinations, eyeglass lenses and contact lenses.

B. Limitations

1) Vision Examinations are limited to $40 per Member per Calendar Year.
2) Eyeglasses or contact lenses are limited to $100 per Member per Calendar Year.
3) Prescription sunglasses will be handled as any other lens.

Benefits are available for Network and Out-of-Network Providers.

Section VIII
Prescription Drug Benefits

PRESCRIPTION DRUGS

Benefits are available for prescription drugs, subject to Deductible and Coinsurance, for use by a Member outside of a hospital or other facility. To be a Covered Service, a prescription drug must be:

1. prescribed on or after the Member's Effective Date by a licensed Practitioner who is authorized by law to prescribe the drug.
2. approved by the Food and Drug Administration (FDA) for the prescribed indication. Benefits will be available for a prescription drug which is prescribed to treat a recognized indication which has not been approved by the FDA for such indication, provided such prescription drug is: (a) otherwise approved by the FDA; and, (b) approved by the Medical Director based on peer-reviewed medical literature or standard reference compendia.
3. dispensed by a pharmacist, either in person or through home delivery, and
4. unavailable for purchase without a prescription.

Some prescription drugs, including but not limited to prescription drugs purchased outside the United States, may require Prior Authorization or may be subject to quantity limitations. Please call the number listed on Your Plan ID Card for details.

Over-the-counter drugs (not requiring a prescription), prescription devices, vitamins which, by Tennessee law do not require a prescription; and/or prescription drugs dispensed in a physician's office are not Covered Services except as specified in this Contract. Benefits are available for:

1. drugs or formula required to treat Phenylketornuria,
2. injectable insulin, oral hypoglycemic agents, and syringes, and
3. over-the-counter drugs designated as preventative under: screenings and counseling services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF); Bright Futures recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA); preventative care and screening for women as provided in the guidelines supported by HRSA; and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC). Coverage of such over-the-counter drugs requires a prescription.

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

Any prescription drug claims not electronically submitted by the Pharmacy must be submitted within 12 months of the date on which the prescriptions were purchased. If Your Coverage is terminated, claims for prescription drugs purchased before termination but not electronically submitted by the Pharmacy for reimbursement at the time of service must be received within nine months following the termination date. To obtain a prescription drug claim form, call the toll free number on Your Plan ID Card.

NETWORK PHARMACY

Network Pharmacies can offer savings through negotiated preferential pricing. To qualify for savings, the Member must utilize a Network Pharmacy. The Member should verify that the Pharmacy is an active Network Pharmacy for the Plan each time he or she visits the Pharmacy to obtain a prescription.

OUT-OF-NETWORK PHARMACY

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

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

SELF-ADMINISTERED SPECIALTY PHARMACY PRODUCTS

Benefits are available for certain Medically Necessary and Medically Appropriate self-administered Specialty Pharmacy Products. Prior Authorization may be required for certain self-administered Specialty Pharmacy Products.

PROVIDER-ADMINISTERED SPECIALTY PHARMACY PRODUCTS

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

COMPOUND DRUGS

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

All ingredients within the Compound Drug must be submitted on the claim. Only prescription drug ingredients covered under the Plan will be included in the payment for the Compound Drug. Non-prescription or over-the-counter drugs will not be paid. Compound Drugs are processed at brand or preferred brand copay.

Prior authorization is required for Compound Drugs over $400.

Check to see if Your Pharmacy is a Network Pharmacy each time You fill a Compound Drug.

When purchasing a Compound Drug from a Network Pharmacy, You will be reimbursed based on the Maximum Allowable Charge at the Network Coinsurance Percentage after Your Deductible is met.

When purchasing a Compound Drug from an Out-of-Network Pharmacy, You will be reimbursed, based on the Maximum Allowable Charge, at the Out-of-Network Coinsurance Percentage after Your Deductible is met. Charges billed by an Out-of-Network Pharmacy which exceed the Maximum Allowable Charge are the responsibility of the Member.

Section IX
Transplants

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

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

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

d. Definitions

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

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

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

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

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

2. Prior Authorization

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

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

3. Covered Services

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

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

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

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

4. Travel Expenses

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

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

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

Covered travel and housing expenses include the following:

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

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

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

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

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

5. Exclusions

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

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

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

Section X
Cost Containment & Medical Management

PRIOR AUTHORIZATION

Farm Bureau Health Plans does not make medical treatment decisions under any circumstances. The purpose of Prior Authorization is solely to ensure that patients receive Covered Services at the appropriate time and in the appropriate setting.

Prior Authorization is required for certain Covered Services to be paid at the Maximum Allowable Charge. The treating physician must contact Us at the telephone number shown on Your Plan ID Card before Covered Services are provided. Otherwise, benefits may be reduced or denied. Covered Services that require Prior Authorization include, but are not limited to:

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

Prior Authorization is not a guarantee of benefits.

Be sure to ask the doctor to contact Us to obtain Prior Authorization at least 30 days before admitting a Member to a hospital.

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

Prior Authorization is not required for maternity admissions or when Medicare is the primary payor.

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

You may call customer service to determine whether Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced to 50% or denied for Out-of-Network Providers and Network Providers.

Network Providers are responsible for obtaining Prior Authorization for the Member before providing services. It is the Member's responsibility to obtain the Prior Authorization if the Provider is an Out-of-Network Provider. If the reduction to 50% results in liability to the Member that is in excess of $2500 above what the Member would have paid had Prior Authorization been obtained, the Member may contact customer service to have the claim

reviewed and adjusted. In this event, the reduction of the Member's liability will be limited to $2500.

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

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

CONCURRENT UTILIZATION REVIEW

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

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

CARE MANAGEMENT

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

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

Section XI
Claims: How and When To File

WHEN TO APPLY FOR BENEFITS

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

All claims must be submitted within 12 months of the date of service. If Coverage is terminated, notice of Your claim must be received within nine months following the termination date.

Within 30 days of receipt of a claim, You will be provided with one of the following:

a. a Monthly Claims Statement or 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 Provider. A Network Provider will file the necessary claims. Available benefits will be paid directly to the Provider and You will receive a Monthly Claims Statement or an Explanation of Benefits (EOB) showing the payment and any balance that is Your responsibility.

CLAIMS FOR OUT-OF-NETWORK PROVIDER SERVICES

An Out-of-Network Provider will file the necessary claims on Your behalf. If the Out-of-Network Provider does not, ask the Provider to give You a claim form and an itemized statement listing the services received and the charges for each service. You may then submit a claim to 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.

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

CLAIMS FOR PRESCRIPTION DRUGS

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

Any prescription drug claims not electronically submitted by the Pharmacy must be submitted within twelve (12) months of the date on which the prescriptions were purchased. If Your Coverage is terminated, claims for prescription drugs purchased before termination but not electronically submitted by the Pharmacy for reimbursement at the time of service must be

received within 9 months following the termination date. To obtain a prescription drug claim form, call the toll free number on Your Plan ID Card or go to fbhealthplans.com.

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.

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

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

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

Effect on Benefits

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

a. Benefits of This Plan will be reduced when the sum of:
   - the benefits that would be payable for the Allowable Expenses under This Plan, in the absence of this COB provision; and
   - the benefits that would be payable for the Allowable Expenses under the Other Plan(s), in the absence of provisions with a purpose similar to that of this COB provision, whether or not a claim for benefits is made;
   - the benefits exceed Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plan(s) do not total more than Allowable Expenses.
b. When the benefits of This Plan are reduced as described in (a) above, each benefit is reduced proportionately and is then charged against any applicable benefit limit of This Plan.
c. We will not, however, consider the benefits of the Other Plan(s) in determining benefits under This Plan when:
   - the Other Plan has a rule coordinating its benefits with those of This Plan and such rule states that benefits of the Other Plan will be determined after those of This Plan; and
   - the order of benefit determination rules require This Plan to determine benefits before those of the Other Plan.

Order of Benefit Determination Rules

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

a. Non-Dependent/Dependent

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

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

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

  – Medicare;

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

b. Dependent Child/Parents Not Separated or Divorced

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

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

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

c. Dependent Child/Separated or Divorced Parents

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

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

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

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

d. Active/Inactive Employee

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

e. Continuation Coverage

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

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

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

f. Longer/Shorter Length of Coverage

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

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

The start of the new Plan does not include:

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

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

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

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

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

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

- If This Plan is the Primary Plan, it will provide its benefits on a primary basis.
- If This Plan is the Secondary Plan, it will provide benefits first, but the amount of benefits and liability of This Plan will be limited to the benefits of a Secondary Plan.
- If the Non-complying Plan does not provide information needed to determine This Plan's benefits within a reasonable time after it is requested, This Plan will assume that the benefits of the Non-complying Plan are the same as the benefits of This Plan and provide benefits accordingly.

- If the Non-complying Plan reduces its benefits so that benefits received by You are less than those You would have received if the Non-complying Plan provided its benefits as the Primary Plan and This Plan provided its benefits as the Secondary Plan, then This Plan may advance the difference to You or on Your behalf. The benefits advanced shall not exceed the benefits This Plan would have provided if it had been the Primary Plan, less any benefits already provided as the Secondary Plan. In consideration of such advance, This Plan shall be subrogated to all of Your rights against the Non-complying Plan. Such advance shall also be without prejudice to any independent claims This Plan may have against the Non-complying Plan in the absence of such subrogation.

Section XII
Grievance Procedure

Introduction

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

Adverse Benefit Determination means:

A. A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for Medical Necessity, appropriateness, healthcare setting, level of care or effectiveness and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;
B. The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier of a covered person's eligibility to participate in the health carrier's health benefit plan; or
C. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment for, in whole or in part, a benefit.

1. The Procedure can only resolve disputes that are subject to Our control.
2. You cannot use this Procedure to resolve a claim that a Provider was negligent. Network Providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact Us; however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Providers.
3. Under this Procedure:

    A. If a Provider does not render, or reduces or terminates a service that has been rendered, or requires You to pay for what You believe should be a Covered Service, You may submit a claim to Us to obtain a determination concerning whether the Contract will cover that service. Providers may be required to hold You harmless for the cost of services in some circumstances.
    B. Providers may also appeal an Adverse Benefit Determination through Our Provider dispute resolution procedure.
    C. Our determination will not be an Adverse Benefit Determination if: (1) a Provider is required to hold You harmless for the cost of services rendered; or (2) until We have rendered a final Adverse Benefit Determination in a matter being appealed through the Provider dispute resolution procedure.

4. You may request a form from Us to authorize another person to act on Your behalf concerning a dispute.
5. The Plan and You may agree to skip one or more of the steps of this Procedure if it will not help to resolve Our dispute.

6. Any dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, and this Contract.

B. Description of the Review Procedures

1. Reconsideration

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

2. Grievance

   You must submit a written request asking Us to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of dispute (Your "Grievance"). You must begin the dispute process within 180 days from the date We issue notice of an Adverse Benefit Determination or from the date of the event that is otherwise causing You to be dissatisfied with Us. If You do not initiate a Grievance within 180 days of when We issue an Adverse Benefit Determination, You may give up the right to take any action related to that dispute. The Grievance process that was in effect on the date(s) of service for which You received an Adverse Benefit Determination will apply.

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

   This is the first level Grievance procedure and is mandatory.

3. Grievance Hearing

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

4. Written Decision

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

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

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

   a. A statement of the first level Grievance committee or reviewer’s understanding of Your Grievance;

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

5. Second Level Grievance Procedure

   You may file a written request for a second level Grievance within 90 days after We issue the first level Grievance committee's decision. Information on how to submit a second level Grievance will be provided to You in the decision letter following the first level Grievance review. Your request along with all submitted information will be forwarded to Farm Bureau Health Plans for review.

   Your decision concerning whether to file a second level Grievance has no effect on Your rights to any other benefits under the Contract. Any person involved in making a decision concerning Your dispute (e.g. first level Grievance committee members) will not be a voting member of the second level Grievance committee.

6. Second Level Grievance Hearing

   You may request an in-person or telephonic hearing before the second level Grievance committee. You may also request that the second level Grievance committee reconsider the decision of the first level Grievance committee, even if You do not want to participate in a hearing concerning Your second level Grievance. If You wish to participate, Our representatives will contact You to explain the hearing process and schedule the time, date and place for that hearing.

   In either case, the second level Grievance committee will meet and consider all relevant information presented about Your second level Grievance, including:

   1. Any new, relevant information that You submit for consideration; and
   2. Information presented during the hearing. Second level Grievance committee members may ask You questions during the hearing. You may make a closing statement to the committee at the end of the hearing.
   3. If You wish to bring a personal representative with You to the hearing. You must notify Us at least 5 days in advance and provide the name, address and telephone number of Your personal representative.

7. Second Level Written Decision

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

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

C. Independent Review of Medical Necessity Determinations or Coverage Rescissions

If Your Grievance involves a Medical Necessity or a Coverage rescission determination, then either: (1) after completion of the first level Grievance; or (2) after completion of the first level Grievance immediately followed by completion of the second level Grievance, You

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

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

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

The reviewer must submit a written determination to You and Us within 45 days after receipt of the independent review request. In the case of a life threatening condition, the decision must be issued within 72 hours after receiving the review request. Except in cases involving a life-threatening condition, the reviewer may request an extension of up to 5 business days to issue a determination to consider additional information submitted by You or Us.

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

Section XIII
Limitations/Exclusions

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

EXCLUSIONS

1. Services or supplies not prescribed or performed by an Eligible Provider.
2. Services or supplies which We determine are not Medically Necessary and Medically Appropriate.
3. Services provided before the Member's Coverage begins or after the Member's Coverage is terminated. Services for a Pre-Existing Condition during the Pre-Existing Condition Waiting Period.
4. A drug, device, services, medical treatment or procedure which is Investigational.
5. Any work related illness or injury (unless resulting from self-employment not subject to workers compensation insurance requirements).
6. Services or supplies furnished without cost under the laws of any government except Medicaid (TennCare℠) coverage provided by the State of Tennessee.
7. Illness or injury resulting from war.
8. Services and supplies for which the Member is not required or legally obligated to pay.
9. Self-treatment or services provided by any person related to a Member by blood or marriage or any person who resides in the Member's immediate household.
10. Services paid under any other group, blanket or franchise insurance coverage; other health insurance plan, union welfare plan, or labor-management trust plan.
11. Personal, physical fitness, recreational or convenience items and services such as: diapers, disposable underpads, and incontinence pads; barber and beauty services; television; air conditioners; humidifiers; air filters; heaters; physical fitness equipment or programs except as otherwise specified in the Contract; recreational equipment; saunas; whirlpools; water purifiers; swimming pools; tanning beds; weight loss programs; home modifications or improvements; or motorized vehicles (except Medically Necessary and Medically Appropriate electric wheelchairs).
12. Charges incurred: (1) due to failure to keep a scheduled appointment; (2) to complete forms or to provide requested medical information or records; (3) for writing or calling in a prescription; (4) for depositions, testimony or court related fees; (5) for handling fees, postage, shipping, mail charges or sales tax; (6) for admitting orders unless billed with in-hospital medical visits.
13. Immunizations and vaccinations, including but not limited to, shots for traveling outside of the United States and except as otherwise specified in this Contract. Administration charges for Non-Covered immunizations and vaccinations are not eligible.
14. Services or supplies for dental care, except as otherwise specified in this Contract. Dental services include routine, restorative, prosthetic and orthodontic services.
15. Routine hearing screenings except as otherwise specified in this Contract.

16. Habilitative services of any kind.
17. Services covered under Medicare, except as required by applicable state or federal law.
18. Non-medical self-care or self-help training and any related diagnostic testing or medical social services.
19. Services or supplies incurred after a Concurrent Review determines the services and supplies are no longer Medically Necessary and Medically Appropriate.
20. Charges in excess of the Maximum Allowable Charge for a service, drug or supply.
21. Any treatment, service, drug or supply including, but not limited to, surgical procedures for the treatment of obesity or morbid obesity. Any treatment, service, drug or supply arising out of the rendering of, or failure to render, treatment for obesity or morbid obesity, except as otherwise specified in this Contract.
22. Services or expenses for treatment of illness or injury sustained in the commission of a crime or for treatment while confined in a prison, jail or other penal institution or while in the custody of any government or law enforcement entity.
23. Room, board, and general nursing care rendered on the date of discharge, unless both admission and discharge occur on the same day.
24. A second or third surgical opinion rendered by a physician in the same medical group or practice as (1) the physician who initially recommended the surgery, or (2) the physician who rendered the second surgical opinion.
25. Staff consultations required by hospital rules.
26. Dental appliances, including those used for correction of jaw malformations, except where prescribed as part of a surgical procedure necessary to restore a major bodily function or except as otherwise specified in this Contract.
27. Over-the-counter drugs (not requiring a prescription), unless required by law or specifically designated as covered under this Plan; prescription devices, dietary supplements, nutritional supplements, vitamins, except those which by law require a prescription, except as otherwise specified in this Contract; and/or prescription drugs dispensed in a doctor's office. Medical supplies that can be obtained without a prescription (except for diabetic supplies) including, but not limited to, adhesive bandages, dressing material for home use, antiseptics, medicated creams and ointments, cotton swabs, and eyewash.
28. Court-ordered treatment for a Member unless benefits are otherwise payable.
29. Medical treatment for which a Member has been reimbursed under a mass tort or class action lawsuit, settlement or judgment.
30. Well child services, except as otherwise specified in this Contract.
31. Treatment of sexual dysfunction, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido including prescription drugs (such as Viagra, Cialis, etc.) and prosthetic appliances.
32. Services or supplies for orthognathic surgery, a discipline to specifically treat malocclusion except as appropriate per medical policy and as otherwise specified in the Orthognathic surgery For Treatment of Clinically Significant Obstructive Sleep Apnea benefit in the Member Benefits section of this Contract. This exclusion supersedes any other provision in this Contract that may be interpreted as offering Coverage for this type of surgery.

33. Orthotripsy (extracorporeal shock wave therapy for musculoskeletal conditions).
34. Speech devices and examinations for prescribing or fitting of speech devices, including but not limited to DynaVox.
35. Cranial orthosis, including helmet or headband, for the treatment of plagiocephaly.
36. Services and supplies related to complications of Non-Covered Services.
37. Services not listed in this Contract as a Covered Service.
38. Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection.
39. Charges for copies of Your records, charts or x-rays, or any costs associated with forwarding/mailing copies of Your records, charts or x-rays.
40. Services, supplies or prosthetics for Cosmetic Services, except as otherwise specified in this Contract.
41. Telephone, fax, and e-mail consultations and other services delivered by electronic means except as otherwise specified in this Contract or approved by the Plan.
42. Charges incurred due to failure to keep a scheduled appointment.
43. Charges to complete forms or to provide requested medical information or records.
44. Charges for writing or calling in a prescription.
45. Charges for depositions, testimony, or court-related fees.
46. Charges for handling fees, postage, shipping, mail, or sales tax.
47. Charges for admitting orders unless billed with in-hospital medical visits.