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GRIEVANCE PROCEDURE

A. 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 Farm Bureau Health Plans 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 Farm Bureau Health Plans 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 Farm Bureau Health Plans 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. This is the first level Grievance procedure and is mandatory.

3. Grievance Hearing
   After We have received and reviewed Your Grievance, Our first level Grievance committee 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 reviewers. 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 reviewers will consider the information presented, and You will receive a written decision concerning Your Grievance 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 will be sent to You in writing and will contain:
   a. A statement of the first level Grievance committee's understanding of Your Grievance;
   b. The basis of the first level Grievance committee's decision; and
   c. Reference to the documentation or information upon which the first level Grievance committee 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 mandatory first level Grievance; or (2) after completion of the mandatory 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 mandatory 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.