

## TENNESSEE MEMBER GRIEVANCE PROCESS

**Grievance** means a written complaint submitted by You or on Your behalf regarding the availability or delivery of healthcare services, claims payment or reimbursement for healthcare services, matters pertaining to this Certificate of Coverage or the agreement between the Employer and the Plan. This process includes Grievances submitted regarding Adverse Determinations and Coverage Denials, further defined below.

Please note that this Grievance procedure can only resolve complaints that We have control over.

**Adverse Determination** means a determination by an insurer or its designee that the healthcare services furnished or proposed to be furnished to a Covered Person are:

- A. Not Medically Necessary, as determined by the insurer, or its designee or Experimental or Investigational, as determined by the insurer, or its designee; and
- B. Benefit coverage is therefore denied, reduced, or terminated.

**Coverage Denial** means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the Covered Person's health benefit plan.

### The Grievance Process

A Member, the Member's Authorized Representative, or a Physician acting on behalf of the Member may initiate filing a Grievance with Us. You must file Your Grievance within sixty (60) days of Your receipt of an Adverse Determination or Coverage Denial from Us or from the date of the event that causes You to be dissatisfied with the Plan. Within ten (10) days of receiving a Grievance request, BFH will acknowledge receipt of the Grievance in writing. If You do not file Your Grievance within that time, You may have given up the right to take any action regarding Your complaint.

### Expedited Grievance

In the event of an Emergency or a situation where, in the opinion of a treating Physician, failure to provide health services promptly is likely to cause substantial harm, You may use what is called an "expedited Grievance" process by verbally requesting an expedited Grievance. The Grievance Review Committee will make a decision not later than three (3) working days after the receipt of this verbal request.

### First Level Grievance Process

To file a Grievance, contact the Grievance/Appeals Coordinator at (859) 269-4475 or (800)787-2680 for assistance. This person can provide You with an outline of the procedure and assist You during the Grievance process. This is the first level Grievance procedure.

### Grievance Hearing

After the Plan has received and reviewed Your Grievance, the Plan's First Level Grievance Review Committee will meet to consider Your Grievance. The Grievance Review Committee will not include a person whose decision is being appealed or who made the initial determination denying a claim or handling a Grievance. You may submit additional written information to the Grievance Review Committee. You may personally appear before the Grievance Review Committee. You may request a board eligible or certified Physician in the appropriate specialty or subspecialty area to participate on the Grievance Review Committee when the Grievance is regarding an Adverse Determination. Pursuant to the Group Agreement, the Grievance Review Committee shall have the authority to make eligibility, benefit and/or claims determinations.

## **Written Decision**

The Grievance Review Committee will send You a written decision concerning Your Grievance within five (5) working days from the date of its review. This written decision will contain:

- A. A statement of the Grievance Review Committee's understanding of the Grievance;
- B. The Grievance Review Committee's decision in clear terms including the basis or medical rationale for the decision; and
- C. A reference to the documentation and information used as the basis for the decision.

## **Second Level Grievance Procedure**

If You are not satisfied with the First Level Grievance Review Committee's decision, You may file a written request for reconsideration within thirty (30) days after You receive the First Level Grievance Review Committee's decision. The Plan's Grievance/Appeals Coordinator can provide You with an outline of the procedure and assist You during the Grievance process. This is called the Second Level Grievance procedure.

## **Grievance Hearing**

The Grievance Review Committee shall meet and reconsider the Grievance and all relevant information presented about it. You may personally appear before the Grievance Review Committee. You may submit new written information pertinent to the Grievance for consideration by the Grievance Review Committee.

## **Written Decision**

As with the First Level Grievance Review Committee, the Second Level Grievance Review Committee will send You a written decision concerning Your Grievance within five (5) working days from the date of its review. This written decision will contain:

- A. A statement of the Grievance Review Committee's understanding of the Grievance;
- B. The Grievance Review Committee's decision in clear terms including the basis or medical rationale for the decision; and
- C. A reference to the documentation and information used as the basis for the decision.

## **Review by Commissioner or Designee**

After either the First Level Grievance Review Committee or the Second Level Review Grievance Committee decision has been made, if You are still not satisfied, You may request that the Commissioner of the Tennessee Department of Commerce and Insurance or a designee of the Commissioner (the "Commissioner") review Your Grievance. You must start this review by submitting to the Commissioner and to the Plan a written request for review within thirty (30) days of the date of either the decision by the First Level Grievance Review Committee or the Second Level Grievance Review Committee. The Commissioner may consult with medical personnel in the Tennessee Department of Health for a Grievance that involves primarily questions of Medical Necessity or medical appropriateness. The Commissioner will review the file of the Plan and any other information submitted by either the Plan or by You.

The Commissioner shall provide You the results of this review. Review by the Commissioner does not prevent You or the Plan from filing a lawsuit regarding the Grievance. You may contact the Commission at:

Tennessee Department of Commerce and Insurance  
Attn: HMO Grievance Coordinator  
500 James Robertson Parkway  
Davy Crockett Tower, 4<sup>th</sup> Floor  
Nashville, TN 37243-1130  
(800) 861-1270

## Independent Review

If You are still not satisfied, You may request an independent review of the Plan's Grievance Review Committee decisions or other Plan decision by an Independent Review Entity ("IRE") selected by the Plan as follows:

- A. You have received an Adverse Determination;
- B. You were covered under this Certificate on the date of service or, if a prospective denial, You were enrolled and eligible to receive Covered Services under this Certificate on the date the proposed service was requested;
- C. You complied with the Grievance procedures outlined above; and
- D. The proposed service or treatment would require the Plan to incur five hundred dollars (\$500) or more of expenditures to cover such service or treatment.

The Plan will notify You in writing of the opportunity to request this independent review at the time of the final decision to deny coverage. You may file a request for this independent review with the Plan no later than sixty (60) days after receiving such notification. At the time You file Your request, You will provide written consent authorizing the IRE to obtain all medical records from Us and any Provider You used. All medical records involved in the independent review will be deemed confidential.

You will be responsible for paying a one-time fee of fifty dollars (\$50) for the cost of the independent review at the time of Your request.

Within five (5) business days of the Plan's receipt of a request from You for an independent review, the Plan will provide the IRE all information You submitted or Your Provider submitted in support of Your request for coverage, a copy of the contract provisions upon which the denial of coverage was based and any other relevant documents used by the Plan in determining whether the proposed service or treatment should be covered, and any statement by the Plan explaining the reasons for the Plan's decision not to provide coverage for the proposed service or treatment. You may request a copy of these documents from the Plan, which the Plan will provide You and Your Provider except for any legally privileged information.

The IRE will notify You and Your Provider of any additional medical information required to conduct the review within five (5) business days of receipt of the information from the Plan. You and Your Provider shall submit the requested additional information, or a reason why the information is not being submitted, to the IRE and the Plan within five (5) business days of the receipt of this request. The Plan may, in its discretion, decide at this time to reconsider its Coverage Denial and if the Plan then grants coverage the independent review shall be terminated. You will then be entitled to any refund of the fifty dollars (\$50) You paid.

Within thirty (30) days of its receipt of the request for review, the IRE shall submit its determination to the Plan and to You and Your Provider, except that for life-threatening conditions, as determined by Your Provider, determinations shall be submitted with five (5) days of the receipt of the request for review. The IRE may extend its decision at its request by five (5) business days for the consideration of additional information.

The IRE's determination shall be in writing and will state the reasons the requested service or treatment should or should not be covered under the terms and conditions set forth in this Certificate. The IRE's determination shall specifically cite the relevant provisions in this Certificate, Your specific medical condition and the relevant documents provided. The determinations shall be binding upon You and the Plan. Nothing in this section shall be construed to require the Plan to pay for services rendered by a Non-Participating Provider, that are not otherwise covered pursuant to the Evidence of Coverage under the Plan.