[184] [MEDICAL EXPENSE INSURANCE

[185] UTILIZATION MANAGEMENT PROGRAM

In order to monitor the use of inpatient health care services, services within specialized facilities, and other kinds of medical treatment, this plan has a Utilization Management program which will promote efficiency and cost containment. Utilization Review procedures are used to evaluate the necessity and appropriateness of services while maintaining quality of care.

- **Utilization Management Requirements [- Applicable to medical care received from a [PPO Provider or a] Non-PPO Provider]**

[185a] Benefits payable for Hospital Inpatient Confinement Charges and confinement charges for services provided in an inpatient confinement facility will be reduced by **[**30%**]** unless:

- For Hospital Inpatient Confinement Charges and charges for services provided in an inpatient confinement facility, a Precertification is requested from the Company by the Insured Person or a designated patient representative as soon as a Hospital Inpatient Confinement or confinement in an inpatient confinement facility is scheduled, but no later than **[**two business days before**] [**the day of**]** a Hospital Inpatient Confinement or confinement in an inpatient confinement facility, for other than Emergency Services.

[185a] If a Precertification is not requested in a timely manner as specified above, the **[**30%**]** reduction in benefits payable will be applied to all non-emergency Hospital Inpatient Confinement Charges and charges in an inpatient confinement facility.

For the purpose of these requirements, "Precertification" means notification to the Company by the Insured Person or his or her designated representative prior to a non-emergency Hospital Inpatient Confinement or confinement in an inpatient confinement facility.

Benefits will be payable only for that part of the Hospital Inpatient Confinement Charges or inpatient confinement facility charges that the Company determines to be a Covered Charge.

An inpatient confinement facility includes:

- Hospital;
- Skilled Nursing Facility;
- Rehabilitation hospital;
- Hospice;
- Long term acute care facility;
- Psychiatric Hospital or psychiatric unit of a general Hospital for Mental Health and Behavioral Treatment Services;

- Inpatient Alcohol or Drug Abuse Treatment Facility or drug or alcohol unit of a general Hospital or any other facility required by state law to be recognized as a treatment facility under the Group Policy for Alcohol and Drug Abuse Treatment Services;
- Residential treatment center or facility.

Certain exceptions apply to Hospital Inpatient Confinement for childbirth as described below.

- For Emergency Services, the Insured Person or a designated patient representative must contact the Company within two business days of a Hospital Inpatient Confinement or of a confinement in an inpatient confinement facility.

[185a] The **[**30%**]** reduction in Benefits Payable is a penalty for failure to comply with the Utilization Management Requirements listed. The reduction:

- will not count toward satisfaction of the Out-of-Pocket Expense limits described in the Summary of Benefits section on page NBM 5102 **[**PPO**] [**HDHP**]**; and

[185b]
- will not exceed **[**$10,000**]** per individual each **[**Calendar Year**] [**Plan Year**]**.

[186] - [Precertification [- Applicable to medical care received from [PPO Providers or] Non-Preferred Providers]

A Precertification by the Company is required for all Hospital Inpatient Confinements or inpatient facility confinements.

[Precertification requires a review by the Company of a Physician's report of the need for a Hospital Inpatient Confinement or confinement in an inpatient confinement facility, (unless it is for an automatically approved Hospital Inpatient Confinement for childbirth).**]**

The report (verbal or Written) must include the:

- reason(s) for the Hospital Inpatient Confinement or confinement in an inpatient confinement facility; and
- significant symptoms, physical findings, and treatment plan; and
- procedures performed or to be performed during the Hospital Inpatient Confinement or confinement in an inpatient confinement facility; and
- estimated length of the Hospital Inpatient Confinement or confinement in an inpatient confinement facility.

If a Hospital Inpatient Confinement or confinement in an inpatient confinement facility will exceed the approved number of days, the Company will initiate a Continued Stay Review. For the purpose of these requirements, **Continued Stay Review** means a review by the Company of a Physician's report of the need for continued Hospital Inpatient Confinement or confinement in an inpatient confinement facility.

The report (verbal or Written) must include the:

- reason(s) for requesting continued Hospital Inpatient Confinement or confinement in an inpatient confinement facility; and
- significant symptoms, physical findings, and treatment plan; and
- procedures performed or to be performed during the Hospital Inpatient Confinement or confinement in an inpatient confinement facility; and
- estimated length of the continued Hospital Inpatient Confinement or confinement in an inpatient confinement facility.

Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by the Company for Inpatient Hospital Confinement or confinement in an inpatient confinement facility will not be considered Covered Charges.**]**

[186a] **[**The following exception applies to Hospital Inpatient Confinement for childbirth.

Covered Charge requirements are waived and a Precertification is not required for mother and baby, for:

- A 48-hour Hospital Inpatient Confinement following vaginal delivery; or
- A 96-hour Hospital Inpatient Confinement following cesarean section.

A request for review by the Company of the need for continued Hospital Inpatient Confinement for mother or baby beyond the automatically approved time period stated above must be made by the Insured Person or a designated patient representative before the end of that time period.

If the Insured Person or a designated patient representative fails to request a review as specified in this section, **benefits will be reduced as described above**.

Exception: For all Hospital Inpatient Confinement Charges incurred beyond the 48-hour or 96-hour automatically approved Hospital Inpatient Confinement for childbirth, the penalty will be applied beginning the day after the automatically approved time period ends. **Except as waived above, no benefits will be payable for any Treatment or Service that is not a Covered Charge.]**

- **Definitions Applicable to the Utilization Management Program**

Concurrent Review

Utilization Review conducted during an Insured Person's Hospital stay or course of treatment.

Continued Stay Review

A review by the Company of a Physician's report of the need for continued Hospital Inpatient Confinement or confinement in an inpatient confinement facility to determine if the continued stay is a Covered Charge.

Health Professional

An individual who:

- has undergone formal training in a health care field;
- holds an associate or higher degree in a health care field, or holds a state license or state certificate in a health care field; and
- has professional experience in providing direct patient care.

Initial Clinical Review(er)

Clinical review conducted by appropriate licensed or certified Health Professionals. Initial Clinical Review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to a Peer Clinical Reviewer for certification or Adverse Benefit Determination.

Notification of Utilization Review Services

Receipt of necessary information to initiate review of a request for Utilization Review services to include the Insured Person's name and the Member's name (if different from Insured Person's name), attending Physician's name, treatment facility's name, diagnosis, and date of service.

Ordering Provider

The Physician or other provider who specifically prescribes the health care service being reviewed.

Peer Clinical Review(er)

Clinical review conducted by a Physician or other Health Professional when a request for an admission, procedure, or service was not approved during the Initial Clinical Review.

In the case of an appeal review, the Peer Clinical Reviewer is a Physician or other Health Professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the Ordering Provider.

Precertification

A review by the Company of a Physician's report of the need for a Hospital Inpatient Confinement or a confinement in an inpatient confinement facility (unless it is for an automatically approved Hospital Inpatient Confinement for childbirth).

Prospective Review

Utilization Review conducted prior to an Insured Person's stay in a Hospital or other health care facility or course of treatment, including any required preauthorization or

Precertification.

Retrospective Review

Utilization Review conducted after the Insured Person is discharged from a Hospital or other health care facility or has completed a course of treatment.

Urgent Review

Utilization Review that must be completed sooner than a Prospective Review in order to prevent serious jeopardy to an Insured Person's life or health or the ability to regain maximum function, or in the opinion of a Physician with knowledge of the Insured Person's medical condition, would subject the Insured Person to severe pain that cannot be adequately managed without treatment. Whether or not there is a need for an Urgent Review is based upon the Company's determination using the judgment of a prudent layperson who possesses an average knowledge of health and medicine. An Insured Person's provider should not request an Urgent Review for a situation in which the provider or Insured Person has had adequate time to request standard Precertification.

Utilization Management

The administration of Utilization Review procedures, such as Precertification of hospital admissions and inpatient confinements, monitoring services during a course of treatment, discharge planning, peer reviews, case management and appeals.

Utilization Review

The evaluation of the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities according to a set of formal techniques and guidelines.

- **Utilization Review Program**

  - **Prospective Review**

    For an initial Prospective Review, a decision and notification of the decision will be made within 15 calendar days of the date the Company receives Notification of Utilization Review Services. If a decision cannot be made due to insufficient information, the Company will either issue an Adverse Benefit Determination or send an explanation of the information needed to complete the review prior to expiration of the 15 calendar days. If the Company does not issue an Adverse Benefit Determination and requests additional information to complete the review, the Insured Person, the attending Physician or other Ordering Provider, or the facility rendering the service is permitted up to 45 calendar days to provide the necessary information. The Company will render a decision within 15 calendar days

of either receiving the necessary information or the expiration of 45 calendar days, if no additional information is received. For certifications, the Company will provide notification to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person. Upon request, the Company will provide Written notification of the certification. Adverse Benefit Determinations will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person.

- **Urgent Prospective Review**

For Urgent Review of a Prospective Review, a decision and notification of the decision will be made as soon as possible but no later than 72 hours of the date the Company receives Notification of Utilization Review Services. If a decision cannot be made due to insufficient information, the Company will either issue an Adverse Benefit Determination or send an explanation of the information needed to complete the review within 24 hours of receipt of Notification of Utilization Review Services. If the Company does not issue an Adverse Benefit Determination and requests additional information to complete the review, the Insured Person, the attending Physician or other Ordering Provider, or the facility rendering the service is permitted up to 48 hours to provide the necessary information. The Company will render a decision within 48 hours of either receiving the necessary information or if no additional information is received, the expiration of the 48 hours to provide the specified additional information. For certifications, the Company will provide notification to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person. Upon request, the Company will provide Written notification of the certification. Adverse Benefit Determinations will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person.

- **Concurrent Review**

For a Concurrent Review that does not involve an Urgent Review, a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the Company will be decided within the timeframes and according to the requirements for Prospective Review.

- **Urgent Concurrent Review**

For an Urgent Review of a Concurrent Review, a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the Company will be decided and notification of the decision will be made within 24 hours of receipt of the Notification of Utilization Review Services if the request is made at least 24 hours prior to the expiration of the previously approved period or number of treatments. If a request is made less than 24 hours prior to the

expiration of the previously approved period or number of treatments, a decision and notification of the decision will be made within 72 hours of receipt of the Notification of Utilization Review Services. For an ongoing course of treatment involving urgent care, the Company will allow concurrent internal appeals and external reviews.

- **Retrospective Review**

  For a Retrospective Review, a decision and notification of the decision will be made within 30 calendar days after the Company receives Notification of Utilization Review Services. If a decision cannot be made due to insufficient information, the Company will either issue an Adverse Benefit Determination or send an explanation of the information needed to complete the review prior to the expiration of the 30 calendar days. If the Company does not issue an Adverse Benefit Determination and requests additional information to complete the review, the Insured Person, the attending Physician or other Ordering Provider, or the facility rendering the service is permitted up to 45 calendar days to provide the necessary information. The Company will render a decision within 15 calendar days of either receiving the necessary information or the expiration of 45 calendar days, if no additional information is received. For certifications, the Company will provide notification to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person. Upon request, the Company will provide Written notification of the certification. Adverse Benefit Determinations will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person.

  Upon Written request, the Company will permit a Retrospective Review for a claim that is submitted for a Treatment or Service where Precertification was required but not obtained if the Treatment or Service meets all of the following:
  - The Treatment or Service is directly related to another Treatment or Service for which certification was obtained and the Treatment or Service has already been performed.
  - The Treatment or Service was not known to be needed at the time the original approved Treatment or Service was performed.
  - The need for the Treatment or Service was revealed at the time the original approved Treatment or Service was performed.

  Once the Written request and all necessary information is received, the Company will review the claim for medical necessity. The Company will not deny a claim for a Treatment or Service based solely on the fact that Precertification was not received for the Treatment or Service.

- **Request for Reconsideration**

When an initial decision is made not to certify an admission or other service and no peer-to-peer conversation has occurred, the Peer Clinical Reviewer that made the initial decision will be made available within one (1) business day to discuss the Adverse Benefit Determination decision with the attending Physician or other Ordering Provider upon their request. If the original Peer Clinical Reviewer is not available, another Peer Clinical Reviewer will be made available to discuss the review.

At the time of the conversation, if the reconsideration process is unable to resolve the difference of opinion regarding a decision not to certify, the attending Physician or other Ordering Provider will be informed of the right to initiate an appeal and the procedure to do so. For certifications, the Company will provide notification to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person. Upon request, the Company will provide Written notification of the certification. Adverse Benefit Determinations will be made in Writing to the attending Physician or other Ordering Provider, the facility rendering service and the Insured Person.

- **Appeal of Adverse Benefit Determinations**

The Insured Person, a designated patient representative, Physician, or other health care provider has the right to request an appeal review of any Utilization Management decision by fax or in Writing. The Company will make a full and fair review of the Adverse Benefit Determination.

The Company will allow a claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeal process.

The Company will provide the claimant, free of any charge, with any new or additional evidence considered, relied upon, or generated by the Company in connection with the claim. The evidence will be provided in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided. If it is impossible to provide the new or additional evidence in time for the Insured Person to have a reasonable opportunity to respond, the timing for appeal determinations will be tolled until the earlier of:

- the date the claimant responds to the new or additional evidence; or
- three weeks from the date the new or additional evidence was mailed to the claimant.

Before the Company issues a final internal Adverse Benefit Determination based on a new or additional rationale, the claimant will be provided, free of charge, with the rationale. The rationale will be provided in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided. If it is

impossible to provide the new or additional rationale in time for the Insured Person to have a reasonable opportunity to respond, the timing for appeal determinations will be tolled until the earlier of:

- the date the claimant responds to the new or additional rationale; or
- three weeks from the date the new or additional or rationale was mailed to the claimant.

- **Expedited Appeal Review [and Voluntary Appeal Review]**

An expedited appeal review is a request, usually by telephone but can be Written, for a review of a decision not to certify an Urgent Review. An expedited appeal review must be requested within 180 calendar days of the receipt of an Adverse Benefit Determination.

An Insured Person in the process of an expedited internal appeal review may request an expedited external review be conducted simultaneously if:

- the Insured Person's treating Physician certifies in Writing that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function if treated after the time frame of an expedited internal appeal review; or
- in the case of experimental or investigational treatment, the Insured Person's treating Physician certifies in Writing that the recommended Health Care Service or treatment would be significantly less effective if not initiated promptly.

A decision and notification of the decision on the expedited appeal of an Urgent Review decision will be made within 72 hours from request of an expedited appeal review. Written or electronic notification of the appeal review outcome will be made to the attending Physician or other Ordering Provider and the Insured Person.

[186a] **[**If the Adverse Benefit Determination is affirmed on the appeal review, the Insured Person, attending Physician, or other Ordering Provider can request an external review or a voluntary appeal review. The voluntary appeal review may be requested by telephone, fax or in Writing within 60 calendar days of the receipt of the appeal review Adverse Benefit Determination. The Insured Person, attending Physician or other Ordering Provider may submit Written comments, documents, records and other information relating to the request for the voluntary appeal review. The Company will make a decision within 72 hours of request for a voluntary appeal review.

Election of a second appeal is voluntary and does not negate the Insured Person's right to an external review, nor does it have any effect on the Member or the Insured Person's rights to any other benefit under the Group Policy. The Company

offers the voluntary appeal review process in an effort that the claim may be resolved in good faith without legal intervention. At any time during the second appeal process, the Insured Person may request an external review.**]**

Note: The expedited appeal process does not apply to Retrospective Reviews.

- **Standard Appeal Review [and Voluntary Appeal Review]**

A standard appeal may be requested in Writing. It must be requested within 180 calendar days of the receipt of an Adverse Benefit Determination. A final decision will be made in Writing to the Insured Person, the attending Physician or other Ordering Provider within 30 calendar days of receiving the request for an appeal for post-service claims and 15 calendar days for pre-service claims.

[186a] **[**If the Adverse Benefit Determination is affirmed on the appeal review, the Insured Person, attending Physician, or other Ordering Provider can request an external review or a voluntary appeal review. The voluntary appeal review may be requested by fax or in Writing within 60 calendar days of the receipt of the appeal review Adverse Benefit Determination. The Insured Person, attending Physician or other Ordering Provider may submit Written comments, documents, records and other information relating to the request for voluntary appeal review. The Company will make a decision within 30 calendar days of request for a voluntary appeal review for post-service claims and 15 calendar days for pre-service claims.

Election of a second appeal is voluntary and does not negate the Insured Person's right to an external review, nor does it have any effect on the Member or the Insured Person's rights to any other benefit under the Group Policy. The Company offers the voluntary appeal review process in an effort that the claim may be resolved in good faith without legal intervention. At any time during the second appeal process, the Insured Person may request an external review.**]**

- **Notice of Utilization Review**

For purposes of satisfying the claims processing requirements, receipt of claim will be considered to be met when the Company receives Notification of Utilization Review Services.

Upon request, the Company must provide copies of all documents considered, relied upon or generated by the Company regarding the claim as well as any new or additional rationale for an Adverse Benefit Determination of an appeal. This documentation will be provided free of charge to the Insured Person. The Insured Person may provide the Company with any additional information the Insured Person deems relevant.

The Company will provide continuation of coverage pending the outcome of appeals.

If an Insured Person or designated patient representative fails to follow the Company's procedures for filing a claim for a Precertification, a Prospective Review, or an Urgent Review, the Company will notify the Insured Person or designated patient representative of the failure and the proper procedures to be followed.

If the Company determines that the Treatment or Service is not covered under the Group Policy and does not involve medical necessity, the Insured Person may contact:

The Ohio Department of Insurance Office of Consumer Affairs
Ohio Department of Insurance
50 West Town Street - Suite 300
Columbus, OH 43215

Phone: 1-800-686-1526
Website: www.ohioinsurance.gov

The Insured Person has the right to an external review if the Company fails to meet all the requirements of the internal appeal process unless the failure:

- was de minimis;
- does not cause or is not likely to cause prejudice or harm to the Insured Person;
- was for good cause and beyond the control of the Company; or
- is not reflective of a pattern or practice of non-compliance.

SEE CLAIM PROCEDURES IN PAGE NBM 5146 FOR IMPORTANT CLAIM PROCEDURES INFORMATION ON FILING MEDICAL CLAIMS.]