

MONUMENTAL LIFE INSURANCE COMPANY (MLIC) UTILIZATION REVIEW POLICIES AND PROCEDURES

I. Executive Summary

Monumental Life Insurance Company's ("Company" or "Our" or "Us" or "We") Utilization Review Program consists of retrospective review of claims to determine that the services, supplies, and treatments ("Services") received by the Covered Person were Medically Necessary. The Company does not require its Covered Persons to participate in a utilization review program that includes pre-authorization or concurrent review. The underlying program will not deny care; adjudication is used to determine amounts payable under the program.

II. Responsibilities

Responsibilities for the program are managed by:

1. The Senior Vice President of Claims Administration of Company or its designated Claims Administrator ("Claims Administrator") is responsible for coordinating the Company's Utilization Review Program.
2. As described below, the Company delegates certain utilization review functions that must be performed by a Physician specialist to Coventry/First Health, a URAC accredited independent case review organization. The Company relies on the experience and qualifications of such Physician specialists to make recommendations regarding the medical necessity of Services received by Covered Persons.
3. The Company also delegates certain functions to Coventry/First Health, an outside, independent Utilization Review Organization, as described below, and relies on the experience and qualifications their personnel to provide the Company with final utilization review determinations.

III. Covered Person Rights and Responsibilities

Covered Person Rights:

A Covered Person has the right to:

1. choose their own physician;
2. make the own medical decisions;
3. request copies of their medical records
4. file a complaint or an appeal without being subject to disenrollment or otherwise penalized.

Covered Person Responsibilities:

A Covered Person has the responsibility to:

1. provide accurate information;
2. provide physician with information regarding medical changes

IV. Confidentiality

In the course of administering the program, personnel responsible for Utilization Review may have access to highly sensitive clinical, personal and confidential information on individuals. Clinical, personal and confidential information is to be safeguarded by such personnel and maintained in accordance with state, federal, and external accreditation agency regulations and standards. This

information is to be used only to administer MLIC's Utilization Review Procedures and for the claims payment process as delegated to designated Claims Administrator by MLIC.

V. Reporting Requirements

Utilization Review Organizations must provide MLIC, on a quarterly basis, quality assurance reporting including accuracy of documentation, clinical decision making and adherence to Utilization Review procedures. MLIC will audit compliance with these procedures as a part of MLIC's quarterly Quality Management and Utilization Review Committee meeting.

VI. Components of the Utilization Review Process

This Policy provides benefits for expenses or Medically Necessary charges incurred by a Covered Person for loss due to a covered Injury or Sickness. Benefits will be paid up to the Maximum Benefit for each service as listed in the schedule of benefits.

VII. Claim Review Process

During the claims process the following services are available to covered members:

- The Claims Administrator is available 8 hours per day regarding claims inquires and the utilization management process.
- Customer service representatives identify themselves by name, title, and organization when initiating or returning telephone calls.
- A toll free number is provided for members and facilities/providers to contact the Claims Administrator.
- All messages (telephone or e-mail) and return calls are completed within 48 hours; all telephone calls are returned during normal business hours only, unless requested.

The following workflow procedures have been established to implement the Utilization Review Program:

- 1) All claims information including claim forms, bills, medical records, and all other documentation received is opened, date stamped, and sorted by clerical personnel in the Claims Office. The claims information is then delivered to the appropriate examiner for processing (each account is handled by a dedicated claims examiner).
- 2) Claims data, including treatment information and codes are entered into the claims system for processing. At this point, some treatment codes result in a claim being denied for payment because the Services provided are not within the plan design and are therefore not considered covered benefits. In these situations a denial letter is sent to the Covered Person detailing this as the reason for denial.

It is also at this point that other claims are denied because the benefits provided per the policy terms have been exhausted. In these situations a denial letter is sent to the Covered Person detailing this as the reason for denial and referring them back to the school's student health center and local social services agency so that the Covered Member can attempt to transition to other sources of care.

- 3) The Company relies initially on the experience and training of its Claims Administrator's examiners to identify claims for Services (such as procedures commonly performed as cosmetic surgery, e.g. breast implants, rhinoplasty, septoplasty, etc.) that may not be Medically Necessary as defined by the plan. The Company's plans typically define Medically Necessary as care which has determined to be certifiably essential for the diagnosis or treatment of a Sickness or Injury and does not include experimental or investigational treatments and technologies. The initial claim determination is made by the claims examiner after he/she has reviewed all of the medical, billing and other information presented. A claims examiner, claims manager, the Senior Vice President for Claims Administration,

the Medical Director, a Physician reviewer from Coventry/First Health, or anyone else reviewing the file for medical necessity may at any time contact the treating Physician or Physicians to request any additional information, documentation, or clarification on the information in the claim file to substantiate the medical necessity of the Services. Information on how to contact the Company Medical Director or reviewing Coventry/First Health specialist can be provided to or arranged by the Claim Administrator for the treating Physician at that time.

- 4) If the claims examiner initially determines that a claim is payable after reviewing all of the evidence presented, the claim is processed for payment and paid. If the claims examiner initially determines that a claim is not payable because the Services were not Medically Necessary, then a claims manager will review the file to determine medical necessity.
- 5) If the claims manager determines that the Services were Medically Necessary the claim is processed for payment and paid. If the claims manager determines that the Services were not Medically Necessary the claims examiner shall refer the file to the Company Medical Director for a determination.
- 6) All medical and clinical information is subsequently forwarded to the Company's Medical Director and a determination as to whether the Services provided were Medically Necessary is either made, or the Medical Director determines that a Coventry/First Health Physician of the appropriate medical specialty should review the claim and make a medical necessity recommendation. If a specialist's review is needed the file is shipped to the Coventry/First Health Physician.
- 7) The Coventry/First Health Physician specialist's review shall include a review of all presented information including the Covered Person's presenting symptoms, conditions, and diagnosis and treatment interventions within the appropriate clinical practice guideline and review criteria. For specialist reviews, each Coventry/First Health specialist reviewer uses clinical support tools guide the Health Services Department in evaluating medical necessity and in recommending certification for medical services. Internally developed clinical support tools are reviewed annually and updated as necessary by Health Services staff based on (but not limited to) literature searches, national practice standards and recommendations in the field. Externally developed clinical support tools are nationally recognized guidelines used by Coventry Health Care to supplement internally developed clinical support tools (e.g., InterQual criteria, etc.). Externally developed criteria are updated annually by licensed contract and informational system updates. Any materials associated with the national vendor are distributed to the staff when the annual updates are received. Additionally, on an annual basis the Quality Improvement and the Utilization Management Committee reviews and endorses the continued use of criteria. These criteria and guidelines are clinically valid and applied nationally; they are not subject to regional practice patterns that are not evidenced-based.

The decisions and actions of the Health Services team are based on professionally developed medical practice standards and guidelines, employer and government contracts/agreements, and state/federal law and regulations. These guidelines are available upon request. In instances where the question of medical necessity involves an experimental or investigational treatment or technology, the Coventry/First Health reviewer will include this as part of the analysis.

- 8) If based on the Medical Director or Coventry/First Health Physician specialists' recommendation, it is determined by the Company that the claim is payable, the claim is approved, processed for payment and then paid. The Explanation of Benefits (EOB) attached to the check gives the claimant an explanation of what benefits were paid.
- 9) If based on the Medical Director or Coventry/First Health Physician specialists' recommendation it is determined by the Company that the Services were not Medically Necessary, the Coventry/First Health will send out a denial letter to the Covered Person specifically stating the reason or reasons why no benefits were payable and the specific clinical guidelines used in arriving at that determination. The denial letter shall advise the Covered Person of the right to appeal to the Company or the State agency which handles such appeals, how to access appropriate information on

how to file such an appeal including an explanation of the appeals process, and shall have enclosed an Explanation of Benefits (EOB) to the Covered Person and, if applicable, to the treating provider.

VIII. Post Claim Denial Procedures

A post claim denial communication from a Covered Person shall be handled depending on how that communication is defined. These factors shall be utilized to determine if the communication is by definition: 1) an **Inquiry**; 2) a **Grievance involving an Adverse Determination**; or 3) a **Grievance involving a plan benefit denial**. Inquiry policies and procedures are stated below. Policies and procedures for each specific type of Grievance, are also stated below.

The following definitions apply:

Adverse Determination means a determination, based upon a review of information provided, by the Company or our designated utilization review organization, to deny or reduce the availability of any health care services or payment for health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

Grievance means any oral or written complaint submitted to the Company which has been initiated by a Covered Person, or on behalf of a Covered Person with his consent, concerning any aspect or action of the Company relative to the Covered Person.

Inquiry means any communication by or on behalf of a Covered Person to the Company or its administrator or utilization review organization that has not been the subject of an adverse determination and that requests redress of an action, omission, or policy of the Company.

Medically Necessary means health care services that are consistent with generally accepted principles of professional medical practice as determined by whether: (a) the service is the most appropriate available supply or level of services for the Covered Person in question considering potential benefits and harms to the individual; (b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (c) for services and interventions not in widespread use, is based on scientific evidence.

A. The Inquiry Process

After receiving the notice of an adverse determination a Covered Person may call the Claims Administrator with questions or concerns. The Claims Administrator shall attempt to answer questions and resolve the concerns to the Covered Person's satisfaction. The Claims Administrator shall do so within three business days.

A copy of the following internal inquiry process shall be provided to the Covered Person who has inquired:

"A Covered Person is encouraged to submit its specific question or concern and any applicable thoughts or reasoning to the Claims Administrator at Bollinger, Inc. either by telephone to {866-267-0092; or by mail to 101 JFK Parkway, Short Hills, NJ 07078}. The Claims Administrator shall acknowledge the inquiry with a response via the mode received. This inquiry will be reviewed and if necessary investigated by an individual who is appropriate for the question or concern conveyed by the Covered Person. The Covered Person's inquiry will be addressed in writing within three business days. That written communication will, 1) convey the results of the Company's efforts to address the inquiry, 2) ask the Covered Person to consider whether the Company has responded the inquiry to his/her satisfaction, and 3) if that answer is negative, advise the Covered Person of his/her rights to utilize the Company's internal Grievance process, and 4) have any oral inquiry and the

Company's subsequent actions and response reduced to writing. The Claims Administrator shall keep records of each inquiry for at least two years."

However, if a Covered Person contacts the Claims Administrator after an adverse determination concluding that Services provided were not Medically Necessary and the purpose of that contact is to appeal or object to the Company's adverse determination, the Claims Administrator shall begin to treat this as part of the Grievance process.

B. Grievances Involving a Plan Benefit Denial – 1st Level

(All reviews are retrospective so expedited appeal procedures are not applicable).

If the claim is denied payment because: 1) the benefit claimed is not a covered one under the plan; 2) the benefit claimed is excluded under the plan; 3) plan benefits have been exhausted; or 4) any other reason not related to medical necessity, the Covered Person may appeal the decision within 45 days of receipt of the claim denial and the file will be reviewed by an individual or individuals who are knowledgeable about the matters at issue in the Grievance. Grievances shall be reviewed with the participation of an individual(s) who did not participate in any of Our prior decisions on the Grievance.

A Covered Person shall submit an appeal request or Grievance to the Claims Administrator at Bollinger, Inc. This may be presented by telephone to {866-267-0092; or by mail to 101 JFK Parkway, Short Hills, NJ 07078}.

If the appeal or Grievance is made orally via the telephone, it shall be reduced to writing by the Claims Administrator who shall forward a copy of that writing, including an acknowledgement of the Grievance and an authorization form, within 48 hours to the Covered Person and the Company. Otherwise, a written acknowledgement of the Grievance and if necessary, an authorization form allowing the release of medical records and information shall be sent to the Covered Person for his/her signature within fifteen (15) days of receipt of notice of the Grievance. (If additional medical records still need to be obtained the 30-day period will not begin until the Covered Person (or his authorized representative) submits a signed authorization for release of medical records and treatment information. In the event the signed authorization is not provided by the Covered Person within 30 days of receipt of the Grievance, the Company may, at Our discretion, issue a resolution of the Grievance without review of some or all of the medical records.)

In addition, the Covered Person should submit with the Grievance any additional information or evidence he or she wants considered regarding the claim denial. The Claims Administrator shall notify the Company of the Grievance and acknowledge it in writing by sending a letter back to the Covered Person.

All necessary information and documentation and the request for review will be considered by the Company. Written notification of the decision by the Company will be sent to the Covered Person within 30 days of the Grievance receipt date.

If the Company determines the claim is payable under the terms and conditions of the policy the claim is processed according to the terms of the plan and a payment is processed and issued. An Explanation of Benefits (EOB) which is attached to the payment gives the claimant an explanation of what benefits were paid. In addition, a written notification which includes identification of the specific information considered and an explanation of the basis for the decision will also be sent to the Covered Person.

If the Company determines the claim is not payable because of the plan benefit provisions, benefits have been exhausted, or some other non-Medically Necessary related reason the denial is upheld. A written resolution shall be issued to the Covered Person and include identification of the specific information considered and an explanation of the basis for the decision will also be sent to the Covered Person.

The written resolution shall also notify the Covered Person (or an authorized representative) of the procedures for requesting a review with the State Office of Patient Protection and a copy of the appropriate form used by the OPP to request and external review if denial of the claim medical necessity is upheld.

Failure To Meet Time Limits - A Grievance not properly acted on by us within the time limits required by 105 CMR 128.300 - 128.310 shall be deemed resolved in favor of the Covered Person. Time limits include any extensions made by mutual written agreement of the Covered Person or the Covered Person's authorized representative, if any, and us.

C. Grievances Based on an Adverse Determination – 1st Level

(All reviews are retrospective so expedited appeal procedures are not applicable).

If the claim is denied payment due to lack of Medical Necessity, the Covered Person may appeal the decision within 45 days of receipt of the Adverse Determination and the file will be reviewed by Coventry/First Health an independent third party review organization not involved in the initial Adverse Determination. If the appeal or Grievance issue is a clinical one, at least one of participating individual shall be an actively participating Physician in the same or similar specialty who typically treat the medical condition, perform the procedure, or provide the treatment that is the subject of the Grievance.

The Covered Person shall submit an appeal request or Grievance to the Claims Administrator at Bollinger, Inc. This may be presented by telephone to {866-267-0092; or by mail to 101 JFK Parkway, Short Hills, NJ 07078}.

If the appeal or Grievance is made orally via the telephone, it shall be reduced to writing by the Claims Administrator who shall forward a copy of that writing, including an acknowledgement of the Grievance and an authorization form, within 48 hours to the Covered Person, the Company, and Coventry/First Health. Otherwise, a written acknowledgement of the Grievance including a statement advising the Covered Person of his/her right to appear before Coventry/First Health Utilization Review Organization's appeals panel or have his Physician do so on his behalf, and an authorization form allowing the release of medical records and information shall be sent to the Covered Person for his/her signature within fifteen (15) days of receipt of notice of the Grievance or appeal. The 30-day period will not begin until the Covered Person (or his authorized representative) submits a signed authorization for release of medical records and treatment information. In the event the signed authorization is not provided by the Covered Person within 30 days of receipt of the Grievance, the Company may, at Our discretion, issue a resolution of the Grievance without review of some or all of the medical records.

In addition, the Covered Person should submit with the written appeal or Grievance any additional information or evidence the Covered Person wants considered regarding the adverse claim determination. The Claims Administrator shall notify the Company of the appeal, acknowledge the appeal in writing by sending a letter back to the Covered Person.

All necessary information and documentation and the request for review due to the appeal will be sent to Coventry/First Health, the independent Utilization Review Organization, currently, for a medical necessity determination. All decisions and determinations will be made by an appropriately licensed Physician and will be honored by the Company.

Written notification of the decision by Coventry/First Health will be sent to the Covered Person within 30 days of the appeal receipt date. If a review of medical records is required the 30 day period does not begin until a signed authorization is received.

If Coventry/First Health determines the Services were Medically Necessary the claim is processed according to the terms of the plan and a payment is processed and issued. The Explanation of Benefits (EOB) attached to the payment gives the claimant an explanation of what benefits were paid.

If Coventry/First Health determines the Services were not Medically Necessary the denial is upheld. The written resolution is issued to the Covered Person and shall include a clear description of the substantive clinical justification for the adverse medical necessity determination, and shall at a minimum: (1) identify the specific information upon which the adverse determination was based; (2) discuss the Covered Person's presenting symptoms or conditions, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria; and (3) reference and include applicable clinical practice guidelines and review criteria.

The written resolution shall also notify the Covered Person (or an authorized representative) of the procedures for requesting a review with the State Office of Patient Protection and a copy of the appropriate form used by the OPP to request and external review if denial of the claim medical necessity is upheld.

D. 2nd LEVEL Grievance or Appeal to the MA Office of Patient Protection

Office of Patient Protection of the Massachusetts Department of Public Health

The Office of Patient Protection is available to assist the Covered Person with Grievances and may also answer questions concerning new legislation or regulations under the authority of such office. The Covered Person may contact the Office of Patient Protection at the following toll-free telephone number, facsimile number, or web-site address:

Toll-Free: 1-800-436-7757
Facsimile: (617) 624-5046
Web-site: www.state.ma.us/dph/opp

The Covered Person may at any time file an appeal with the Office of Patient Protection. If the Covered Person files an appeal with the Office of Patient Protection the ruling or decision of the Office of Patient Protection will govern.

If the Covered Person chooses to first appeal through the company's appeal procedures and the appeal is denied, an additional appeal may be submitted to the Office of Patient Protection within 45 days of the Covered Person's receipt of the written decision. The procedures for filing the appeal are those of Office of Patient Protection. The written request by the Covered Person (or an authorized representative) shall: (1) be on a form prescribed by the Division; (2) include the signature of the Covered Person (or an authorized representative) consenting to the release of medical information; (3) include a copy of the written final Adverse Determination issued by Us; and (4) include the \$25.00 fee required. The fee may be waived by the Office of Patient Protection if it determines that the payment of the fee would result in an extreme financial hardship to the Covered Person. All new information or evidence regarding the Medical Necessity of the claim should be submitted to the Office of Patient Protection for review. The medical necessity determination made by the Office of Patient Protection will govern.

The Office of Patient Protections requires carriers to file Grievance and external appeals information annually. You can obtain a copy of this information by contacting the Office of Patient Protection.

IX. Utilization review criteria

Coventry/First Health Independent Review Criteria

Each Coventry/First Health specialist reviewer uses clinical guidelines for medical appropriateness specific to his or her medical specialty. The Company Medical Director will review a random sample of the Coventry/First Health reviews and the independent guidelines used to ensure the quality and sufficiency of the standards used, and to ensure that the guidelines are consistently ones which are based on scientific evidence, are explicit, can be validated, and are objectively standards which are accepted in the managed care industry. The Medical Director shall report the results of his survey to the

Utilization Management and the Quality Improvement Committee so that any issues or problems may be communicated to and addressed by Coventry/First Health and followed up on by the UM Committee.

X. Complaint Tracking Process/Oversight

The Company will require an annual report of the medical necessity denials and the reviews that have been completed by the Claims Administrator, and the outcomes (including any appeals or action) of the reviews. The annual report will be reviewed by the Quality Improvement Committee to determine if any concerns exist regarding decisions made by the Claims Administrator or the Utilization Review Organization (for example, patterns of adverse determinations reversed upon appeal).