WMI MUTUAL INSURANCE COMPANY (WMI)
MONTANA UTILIZATION REVIEW PLAN

Types of claims

A claim is any request for a plan benefit made by an insured individual, or that individual's representative. There are two types of claims as defined in the plan: pre-service and post-service. A pre-service claim is one that involves the cost of medical care that has not yet been rendered and that requires pre-certification before benefits will be received. Pre-service claims that require pre-certification are ones that involve an inpatient facility confinement. A post-service claim is one that involves the cost of medical care that has been rendered.

Process for utilization review

In the event that the medical necessity and appropriateness of services and treatment must be determined upon receipt of a request for benefits in order to establish the eligibility of benefits, the following processes will apply.

The following policy definitions will be used in utilization reviews.

> **"Medically Necessary (Medical Necessity)"** means health care services that a health care Provider who exercises prudent clinical judgment would provide to a patient. Such services must be provided to prevent, to evaluate, to diagnose, to treat, to cure, or to relieve a health condition, an Illness, an Injury, or a disease or its symptoms. Such services must be all of the following.
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> They are in accordance with the generally accepted standards of practice.
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> They are clinically appropriate in terms of the type, the frequency, the extent, the site, and the duration. They are considered effective for the Illness, the Injury or the disease of the patient.
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> They are not primarily for the convenience of the patient or the health care Provider. They are not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Illness, the Injury, or the disease of the patient.
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> **"Experimental** or **Investigational Treatment or Procedures"** means medical treatment, services, supplies, medications, drugs, or other methods of therapy or medical practices which have not been accepted as a valid course of treatment for at least three years by the U.S. Food and Drug Administration, the American Medical Association, the Surgeon General, or any other medical society recognized by the Company, and any services, supplies, or accommodations provided in connection with such procedures.

Pre-service claims:

1) A pre-service claim that involves an inpatient confinement must be pre-certified to determine whether the length of stay is medically necessary and appropriate. (**Note**: Pre-certification is not required for treatment for mental illness/substance abuse, reconstructive breast surgery, or maternity delivery services that are within the federally allowed time limits, although it is still

recommended.) As stated on the insured's insurance ID card, MedWatch is the company that WMI uses for pre-certification, and they have been URAC accredited since 1997. Requests for pre-certification must be submitted directly to MedWatch, via written form, telephonic, or through their website at www.urmedwatch.com. Pre-certification is not required for a pre-service claim that involves urgent care, however, if pre-certification is requested, it may be requested orally.

2) Upon receipt of a pre-certification request, clinical information, including appropriate medical records, will be obtained from the treating physician, hospital or other medical staff. This information will be reviewed by medical personnel at MedWatch to compare the reason for admission against medical criteria using the most current edition of the Milliman Care Guidelines and URAC standards. Review decisions shall be made in accordance with currently accepted medical practice guidelines or health care practices, and will take into account special circumstances for each patient. If the nurse reviewer is unable to make a decision based on the information provided, the case is forwarded to the Medical Director and/or a physician advisor of the same or similar specialty as the ordering physician for review.

3) The case will be followed up concurrently up to the day prior to the last certified day to determine if an extension of stay is required. If additional days are needed, the review process as outlined above starts again with obtaining the clinical rationale and treatment plan to validate additional days.

4) Notification of the benefit determination for a pre-service claim will be made within seven (7) business days after the receipt of the request, or within forty-eight (48) hours for a pre-service claim that involves urgent care. Pre-certification determination letters will be sent via fax to the treating provider and facility. A pre-certification letter will be sent to the patient if the case does not meet criteria for pre-certification. All denials of "not medically necessary" will be made by the Medical Director and/or a Physician Advisor. The right to appeal will be explained to all parties involved.

Post-service claims:

1) A post-service claim must be submitted electronically or in writing directly to WMI.

2) Upon receipt of a claim, claims processing personnel will determine if the service needs to be reviewed in order to determine if treatment is medically necessary or is experimental/investigational. Medical records will be requested from the treating provider and any other applicable providers who are involved with the claim(s) being reviewed. All relevant information related to the case will then be sent to Medical Review Institute of America ("MRIoA"), an external independent review organization that is accredited by URAC. MRIoA will assign the case to an active, practicing board-certified physician or professional in the same or similar specialty as the treating physician for review. Reviewers will use evidence-based guidelines, in addition to any state/federal laws and regulations.

3) Once the review is completed, the complete analysis, including resources used in the review, as well as the reviewing provider's credentials, will be sent to WMI, and the claim will either be paid or denied based on the determination. The Insured will receive a notification of the benefit determination within thirty (30) days after the receipt of the request. If denied, the explanation of denial as well as the right to appeal will be set forth in the explanation of benefits sent to the provider and the insured.

Appeals:

The Plan provides two levels of internal appeal review. If an adverse benefit determination is received regarding an issue of whether services were medically necessary or experimental/investigational, such determination may be appealed in writing within 180 days from the receipt of the adverse benefit determination. Comments, documents, records and other information relating to the claim may be submitted for the review. The plan will consult with a health care professional who is part of an independent review organization, who is not affiliated with the Company, who was not involved in the initial benefit determination, and who has appropriate training and expertise in the field of medicine involved in the medical judgment. If the decision on the first appeal is adverse, a second level of review may be submitted within sixty (60) days of receipt of the first level decision, along with any additional applicable information.

In the case of a pre-service claim, each level of appeal will be responded to within fifteen (15) days after the receipt of the appeal, unless the appeal is for a pre-service urgent care claim, which will be responded to within seventy-two (72) hours. In the case of a post-service claim, each level of appeal will be responded to within thirty (30) days after the receipt of the appeal. The decision upon review will be communicated in writing.

A third appeal level known as an external review level is also available. This level is available once the internal appeals process is exhausted. This appeal level must be submitted within four (4) months from the date of the final adverse benefit determination. An insured individual has the right to contact the Montana Commissioner of Insurance and Securities for help at any time at 840 Helena Avenue, Helena, MT 59601 or by telephone at (800) 332-6148 or (406) 444-2040. The external review level can only be used for adverse benefit determinations that are based on medical necessity, appropriateness of care, health care setting, level of care, or effectiveness of care or for adverse benefit determinations for services that are experimental or that are investigational.

The complete appeals procedure language is contained in the certificate booklet that is given to each insured upon enrollment, and is available upon request.

Privacy:

All employees of WMI are trained on the privacy procedures implemented by the company, and WMI maintains signed Business Associate Agreements with all business associates. All protected health information, including medical records, is kept in the strictest confidence in accordance with state law and with federal privacy requirements. Access to information is limited to only those employees or business associates that need the information and is limited to the minimum necessary information that is needed. Information is only disclosed for those purposes as allowed by law, and is not disclosed otherwise unless a written authorization is first obtained from the insured.