Notice of Oxford Benefits Review and Utilization Review Determination Procedures

We are providing this notice in accordance with state regulatory requirements. Your right to medical benefits is limited to the Covered Services outlined in your benefit plan documents, such as the Certificate of Coverage (COC), Schedule of Benefits, and any Riders and/or amendments. Benefit coverage is subject to the terms, conditions, exclusions and limitations of the policy, as agreed upon between Oxford[1] and the group offering you your benefit plan. We have several procedures in place for determining benefit coverage as outlined below.

Precertification

Before you are admitted to a health care facility or receive certain diagnostic tests and therapeutic procedures, we must review and approve the admission, test or procedure. We call this process precertification. Your provider initiates precertification by contacting our Medical Management Department to request a review of the proposed admission to a health care facility, test or procedure. We will collect all necessary information, look at the available benefits under your plan, and review applicable policies and criteria. We may request additional information from you or your provider to evaluate the request. We will make a decision on the requested service within all required federal and state decision time frames. You and your provider will be informed of our decision in writing by mail or electronic means. There are two different types of review that could be performed as part of the precertification process: benefits review and utilization review determinations.

Benefits Review

Benefits Review, or Administrative Review, is the process we perform to determine whether your benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. We conduct the review process according to the coverage terms, benefits, limitations and exclusions of your benefit plan documents. Benefits Review includes, but is not limited to, assessing whether the requested service is a covered benefit under your plan, whether benefit limitations have been exhausted or whether your plan offers coverage for services provided by nonparticipating providers.

Utilization Review

We make Utilization Review determinations based on whether a service is medically necessary. We also take into consideration whether a treatment or service is experimental or investigational. Although many Utilization Review determinations are made before services are administered, medical necessity determinations may be made while services are occurring or after they have been provided. Medical

---

Note: Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

necessity means health care services that a physician, using careful clinical judgment, would provide to you, a patient, for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms.

The health care services must be:

- provided according to generally accepted standards of medical practice;
- clinically appropriate (in terms of type, frequency, extent, site and length of time); and
- considered effective for your illness, injury or disease.

The health care services may not be:

- primarily for your convenience or the convenience of your physician or other health care provider; and
- more costly than an alternative service or sequence of services that are at least as likely to produce equivalent results (therapeutic or diagnostic) as to the diagnosis or treatment of your illness, injury or disease.

[1]Oxford HMO products are underwritten by Oxford Health Plans (CT), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc.