Mental Health Parity and Addiction Equity Act
Non-Quantitative Treatment Limitations – Answers to Key Questions

Oxford Health Insurance, Inc.
Medical Necessity Model

This summary is applicable to fully insured Oxford Health Insurance, Inc. plans using the Medical Necessity Model as administered through the services of UnitedHealthcare Life Insurance Company or its designee. If a grid is needed for another UnitedHealth Group entity or plan type (including a Care Coordination Model), please refer to the appropriate grid for that other entity or plan type.

The information provided below is based, where applicable, on standard Oxford Health Insurance, Inc. policies.
Date: June 30, 2016

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Non-Quantitative Treatment Limitations	General Medical/Surgical	Mental Health/Substance Use
Are services subject to a medical necessity standard?	Yes, services received from both Network and non-Network providers must meet the following definition of medical necessity: ***Medically Necessary*** – means a health care service, supply, or drug provided for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, condition, disease, or its symptoms, that is determined by us or in consultation with an appropriate medical professional to be: • In accordance with generally accepted standards of medical practice; • Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the covered person's illness, injury, condition, disease, or its symptoms; • Not provided mainly for the covered person's convenience or that of the covered person's doctor or other health care provider; • Not furnished solely to promote athletic achievement, a desired lifestyle, or to improve the covered person's environmental or personal comfort; and; • As cost effective as any established alternative service, supply, or drug(s) that is as likely to produce equivalent therapeutic or diagnostic results as the diagnosis or treatment of the covered person's illness, injury, condition, disease, or its symptoms. A health care service, supply, or drug will not meet this definition based solely on the fact that a doctor or health care provider of a covered person performs, provides, prescribes, orders, recommends, or approves that service, supply, or drug. A final decision to provide medical services can only be made between the covered person and the health care provider; however, the Plan will not pay benefits if it is not satisfied that a medical service meets all of the above requirements.	Yes, services received from both Network and non-Network providers meet the following definition of medical necessity: ***Medically Necessary*** - means a health care service, supply, or drug provided for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, condition, disease, or its symptoms, that is determined by us or in consultation with an appropriate medical professional to be: • In accordance with generally accepted standards of medical practice; • Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person's illness, injury, condition, disease, or its symptoms; • Not provided mainly for the covered person's convenience or that of the covered person's doctor or other health care provider; • Not furnished solely to promote athletic achievement, a desired lifestyle, or to improve the covered person's environmental or personal comfort; and • As cost effective as any established alternative service, supply, or drug(s) that is as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the covered person's illness, injury, condition, disease, or its symptoms. A health care service, supply, or drug will not meet this definition based solely on the fact that a doctor or health care provider of a covered person performs, provides, prescribes, orders, recommends, or approves that service, supply, or drug. A final decision to provide medical services can only be made between the covered person and the health care provider; however, the Plan will not pay benefits if it is not satisfied that a medical service meets all of the above requirements.

Non-Quantitative Treatment Limitations	General Medical/Surgical	Mental Health/Substance Use
How Does the Plan Detect Fraud, Waste and Abuse?	The Plan utilizes a comprehensive program for the detection, investigation and remediation of potential fraud, waste and abuse. The processes utilized are claims algorithms and a reporting hotline for detection, pre-payment and post-payment review for investigation and recovery is conducted via claims offsets and invoicing for collection of overpaid amounts. The Fraud, Waste and Abuse processes that investigate and identify fraud though pre-payment and post-payment reviews are non-quantitative limits that may impact the scope or duration of treatment by affecting the payment of benefits to a provider or member. This limitation may occur through the denial of claims (pre-payment review) and recovery of overpaid claims (post- payment review). Pre-payment review may be applied to the claims or a provider or member for whom there is a basis to suggest irregular or inappropriate services based on the claims submitted, referral tips from the fraud hotline or other means. A pre-payment review entails review of each claim, requests for additional information to support and/or validate the claim and, if necessary, may result in denial of the claim if not substantiated. This process may be applied to any provider or member's claims without regard to the payer, the amount of claim, type of service etc. Post-payment review is conducted when an algorithm, routine claims audit, referral tips from the fraud hotline or other information suggests the need for review of a provider's billing practices and patterns after claims have previously been processed and paid. A post-payment review will involve an audit for a period that may span from six months to six years using a sampling and extrapolation methodology and may involve any amount of claims with no specified minimum amount involved or potential recovery probability. The audit and investigation will involve review of contemporaneous treatment records as well as member and provider interviews.	The Plan utilizes a comprehensive program for the detection, investigation and remediation of potential fraud, waste and abuse. The processes utilized are claims algorithms and a reporting hotline for detection, pre-payment and post-payment review for investigation and recovery is conducted via claims offsets and invoicing for collection of overpaid amounts. The Fraud, Waste and Abuse processes that investigate and identify fraud though pre-payment and post-payment reviews are non-quantitative limits that may impact the scope or duration of treatment by affecting the payment of benefits to a provider or member. This limitation may occur through the denial of claims (pre-payment review) and recovery of overpaid claims (post- payment review). Pre-payment review may be applied to the claims or a provider or member for whom there is a basis to suggest irregular or inappropriate services based on the claims submitted, referral tips from the fraud hotline or other means. A pre-payment review entails review of each claim, requests for additional information to support and/or validate the claim and, if necessary, may result in denial of the claim if not substantiated. This process may be applied to any provider or member's claims without regard to the payer, the amount of claim, type of service etc. Post-payment review is conducted when an algorithm, routine claims audit, referral tips from the fraud hotline or other information suggests the need for review of a provider's billing practices and patterns after claims have previously been processed and paid. A post-payment review will involve an audit for a period that may span from six months to six years using a sampling and extrapolation methodology and may involve any amount of claims with no specified minimum amount involved or potential recovery probability. The audit and investigation will involve review of contemporaneous treatment records as well as member and provider interviews.

Non-Quantitative Treatment Limitations	General Medical/Surgical	Mental Health/Substance Use
Are there Exclusions for Experimental, Investigational and Unproven Services?	Yes, services received from both Network and non-Network providers are subject to the following exclusions and Definitions: *Experimental or investigational treatment(s)* or *unproven services* and all services related to *Experimental or Investigational treatment(s)* or *unproven services* are excluded. The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition. *Experimental or investigational treatment* means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that after consultation with a medical professional, we determine to be: A. Under study in an ongoing phase I or phase II clinical trial as set forth in the United States Food and Drug Administration ("USFDA") regulation, regardless of whether the trial is subject to USFDA oversight. B. An *unproven service*. C. Subject to USFDA approval, and: 1. It does not have USFDA approval; 2. It has USFDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or 3. It has USFDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use of a USFDA-approved drug is a use that is determined by us to be: a. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services; b. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or c. Not an *unproven services*; or	Yes, services received from both Network and non-Network providers are subject to the following exclusions and Definitions: *Experimental or investigational treatment(s)* or *unproven services* and all services related to *Experimental or Investigational treatment(s)* or *unproven services* are excluded. The fact that an *experimental or investigational treatment* or *unproven service* is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an *experimental or investigational treatment* or *unproven service* for the treatment of that particular condition. *Experimental or investigational treatment* means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that after consultation with a medical professional, we determine to be: A. Under study in an ongoing phase I or phase II clinical trial as set forth in the United States Food and Drug Administration ("USFDA") regulation, regardless of whether the trial is subject to USFDA oversight. B. An *unproven service*. C. Subject to USFDA approval, and: 1. It does not have USFDA approval; 2. It has USFDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or 3. It has USFDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use of a USFDA-approved drug is a use that is determined by us to be: a. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services; b. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or c. Not an *unproven services;* or

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	4. It has USFDA approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the USFDA or has been determined through peer-reviewed medical literature to treat the medical condition of the covered person. D. Experimental or investigational according to the provider's research protocols. Items C and D above do not apply to phase II or IV USFDA clinical trials. *Unproven services* are service(s), including medications, which are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature. • Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.) • Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)	4. It has USFDA approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the USFDA or has been determined through peer-reviewed medical literature to treat the medical condition of the covered person. D. Experimental or investigational according to the provider's research protocols. Items C and D above do not apply to phase II or IV USFDA clinical trials. *Unproven services* are service(s), including medications, which are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes, due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature. • Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.) • Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

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Network Admission Criteria	**In Network** Providers must meet all credentialing criteria outlined in the UnitedHealthcare Credentialing Plan to remain eligible for network participation. The Credentialing Plan is available online at www.unitedhealthcareonline.com. Go to Quick Links > Policies, Protocols and Administrative Guides. Participation criteria for practitioners include: 1. Education • M.D.s and O.D.s: graduation from allopathic or osteopathic medical school and successful completion of either a residency program or other clinical training and experience for their specialty and scope of practice. • Chiropractors: graduation from chiropractic college • Dentists: graduation from dental school • Podiatrists: graduation from podiatry school and successful completion of a hospital residency program • Mid-level practitioners: graduation from an accredited professional school and successful completion of a training program. Any board certification claimed by an applicant shall be verified by the credentialing committee. 2. Licensing Applicants must maintain current, valid licensure or certification, without material restrictions, conditions or other disciplinary actions in all states where the applicant practices. 3. Admitting privileges Must have full hospital admitting privileges without material restrictions, conditions or other disciplinary actions with at least one network hospital or arrangements with a network physician to admit and provide hospital coverage to members at a network hospital. 4. Valid DEA or Controlled Substance Certificate or acceptable substitute in each state where the Applicant practices (unless such Certificate is not required for the Applicant's practice).	**In Network** Providers must meet all credentialing criteria outlined in the Credentialing Policies to remain eligible for network participation. The Credentialing Plan is available online at www.providerexpress.com. Participation criteria for providers include: 1. Education • Psychiatrists must be board certified by the American Board of Psychiatry and Neurology (ABPN) or the American Osteopathic Association (AOA). If not board certified by ABPN or AOA, a physician who has completed an American College of Graduate Medical Education approved residency in psychiatry or an ABPN or AOA approved program for combined pediatrics/child and adolescent residency may be acceptable. • Physicians without a residency in psychiatry may be accepted if they are board certified by the America Society of Addictions Medicine (ASAM) • Physician addictionologists must be board certified by ASAM or have added qualifications in Addiction Psychiatry through the ABPN. • Developmental Behavioral Pediatricians (DBP) must provide evidence of passing the National Certification Exam. Non-physician providers must be: • A doctoral and/or master's level psychologist, social worker behavioral health care specialist or a Master's level psychiatric clinical nurse, must be licensed to practice independently by the state in which they practice and must have at least 2 years of post-licensure direct patient care experience in a mental health/substance use disorder setting. Any board certification claimed by an applicant shall be verified by the credentialing committee. 2. Licensing Applicants must maintain current, valid licensure or certification, without material restrictions, conditions or other disciplinary actions in all states where the applicant practices.

Non-Quantitative Treatment Limitations	General Medical/Surgical	Mental Health/Substance Use
	5. Medicare/Medicaid Program Participation Eligibility Must not be ineligible, excluded or debarred from participation in Medicare, Medicaid or other related state and federal programs, or terminated for cause from same, and must be without any sanctions levied by the Office of the Inspector General or General Services Administration or other disciplinary action by any federal or state entities identified by CMS. 6. Work History Must provide a 5 year employment history. Gaps longer than 6 months must be explained by the applicant and found acceptable by the credentialing committee. 7. Insurance or state approved alternative Must maintain malpractice insurance coverage or show similar financial commitments made through an appropriate State-approved alternative in the required amounts, and provide a 5 year professional liability claims history showing any settlements or judgments paid by or on behalf of the Applicant and a history of liability insurance coverage, including any refusals or denials to cover the Applicant or cancellations of coverage. 8. Site visit If required by the credentialing committee must agree to a site visit and obtain a passing score.	3. Admitting privileges If the applicant's practice requires hospital staff privileges, those privileges must be in good standing at a network hospital. Privileges at any hospital must not have been suspended during the past 12 months due to inappropriate, inadequate or tardy completion of medical records or for quality of care issues. 4. Current and unrestricted DEA or Controlled Substance Certificate or acceptable substitute in each state where the Applicant practices (unless such Certificate is not required for the Applicant's practice). 5. Medicare/Medicaid Program Participation Eligibility Must not be ineligible, excluded or debarred from participation in Medicare, Medicaid or other related state and federal programs, or terminated for cause from same, and must be without any sanctions levied by the Office of the Inspector General or General Services Administration or other disciplinary action by any federal or state entities identified by CMS. 6. Work History Must provide a 5 year employment history. Gaps longer than 6 months (or earlier if required by state regulations) must be explained by the applicant and found acceptable by the credentialing committee.

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	9. Network participation At the credentialing committee's discretion, Applicant must not have been denied initial network participation or had prior network participation terminated (for reasons other than network need) within the preceding 24 months. Participation criteria for facilities includes: 1. Current required licenses 2. Must maintain general/comprehensive liability coverage and malpractice insurance for at least the "per occurrence" and aggregate limits required by UnitedHealthcare, or show similar financial commitments made through an appropriate state approved alternative. 3. Medicare/Medicaid Program Participation Eligibility Must not be ineligible, excluded or debarred from participation in Medicare, Medicaid or other related state and federal programs, or terminated for cause from same, and must be without any sanctions levied by the Office of the Inspector General or General Services Administration or other disciplinary action by any federal or state entities identified by CMS. 4. Appropriate accreditation or satisfactory alternative by a recognized accreditation entity (e.g. JC, AOA, CARF, AFAP, etc.) and must provide copy of the accreditation report.	7. Insurance or state approved alternative Must have current malpractice insurance coverage or Federal Tort Coverage in the required amounts. Records must show an absence of history of malpractice lawsuits, judgments, settlements or other incidents that indicate a competency or quality of care issue. 8. Site visit Applicants practicing in a home office setting must agree to a site visit and obtain a passing site visit score. 9. Network participation Applicant must not have been denied initial network participation or had prior network participation terminated (for reasons other than network need), within the preceding 24 months. Participation criteria for facilities includes: 1. Current required licenses 2. Must maintain general/comprehensive liability coverage and malpractice insurance that satisfies UBN's standards or as required by state law.

Non-Quantitative Treatment Limitations	General Medical/Surgical	Mental Health/Substance Use
	5. Compliance with participation agreement (for re-credentialing) Providers and facilities are re-credentialed every 36 months, unless earlier re-credentialing is required under an applicable state or federal law/ regulation. The information provided to the Credentialing Committee is forwarded without reference to clinician's race, gender, age, sexual orientation or the types of procedures so decisions are made in a nondiscriminatory manner. **Accessibility Standards** The health plan maintains standards for the numeric and geographic availability of participating medical/surgical practitioners and providers based on the following strategies, processes, evidentiary standards and other factors: 1. Geographic factors 2. Provider/facility availability 3. Supply/demand factors Based on these strategies, processes, evidentiary standards and other factors the plan analyzes the network against the following established standards at least annually:	3. Medicare/Medicaid Program Participation Eligibility Must not be ineligible, excluded or debarred from participation in Medicare, Medicaid or other related state and federal programs, or terminated for cause from same, and must be without any sanctions levied by the Office of the Inspector General or General Services Administration or other disciplinary action by any federal or state entities identified by CMS. 4. Appropriate accreditation or satisfactory alternative by a recognized accreditation entity (e.g. JCAHO, AOA, CARF, ACAP, etc.) and must provide copy of the accreditation report. If a facility is not accredited or certified by an agency recognized by UBN, a site visit is required and a passing site visit score is required. 5. Completion of a malpractice history review may be required. Facilities are credentialed prior to inclusion in the network and are re-credentialed every three (3) years to assure that they remain in good standing with regulatory and accrediting bodies, continue to maintain the appropriate level of malpractice insurance, and are free from sanctions or ethical violations which indicate a problem with the quality of service delivery.

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<tr><th>Non-Quantitative Treatment Limitations</th><th>General Medical/Surgical</th><th>Mental Health/Substance Use</th></tr>
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Standards for the Geographic Distribution of Participating Practitioners and Providers

<table>
<tr><th rowspan="2">Practitioner/Provider Type</th><th>Large Metro</th><th>Metro</th><th>Micro</th><th>Rural</th><th>CEAC</th><th rowspan="2">Goal-All Categories</th></tr>
<tr><th>Miles</th><th>Miles</th><th>Miles</th><th>Miles</th><th>Miles</th></tr>
<tr><td>Primary Care 1 within
• Family Practice
• General Practice
• Internal Medicine
• Gerontology
• Pediatrics
• OB/GYN (in states where applicable)</td><td>5</td><td>10</td><td>20</td><td>30</td><td>60</td><td>90%</td></tr>
<tr><td>Specialty Care Physician 1 within
• Cardiology
• General Surgery
• Ophthalmology
• Orthopedics</td><td>10</td><td>20</td><td>35</td><td>60</td><td>85</td><td>90%</td></tr>
<tr><td>• Dermatology
• Gastroenterology
• Endocrinology
• Neurology
• Oncology
• Pulmonology
• Rheumatology
• Urology</td><td>10</td><td>30</td><td>45</td><td>60</td><td>100</td><td>90%</td></tr>
<tr><td>• Allergy/Immunology
• ENT
• OB/GYN</td><td>15</td><td>30</td><td>60</td><td>75</td><td>110</td><td>90%</td></tr>
</table>

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UnitedHealthcare Life Insurance Company or its Designee/Subcontractor applies the criteria to those clinicians who apply for participation in the UnitedHealthcare Life Insurance Company, its Designee/Subcontractor network without discrimination due to the clinician's race, ethnic/national identity, religion, gender, age, sexual orientation or the types of procedures or patients in which the practitioner specializes.

Accessibility Standards

UnitedHealthcare Life Insurance Company or its Designee/Subcontractor maintains standards for the numeric and geographic availability of participating medical/surgical practitioners and providers based on the following strategies, processes, evidentiary standards and other factors:

1. Geographic factors
2. Provider/facility availability
3. Supply/demand factors

Based on these strategies, processes, evidentiary standards and other factors the plan analyzes the network against the following established standards at least annually:

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</table>

Non-Quantitative Treatment Limitations

General Medical/Surgical

Practitioner/Provider Type	Large Metro	Metro	Micro	Rural	CEAC	Goal-All Categories
	Miles	Miles	Miles	Miles	Miles	
Hosptial 1 within	10	30	60	60	100	90%
Ancillary Providers 1 within • Laboratory Services	5	10	60	60	100	90%
• Ambulatory Surgical Services • Radiology • Urgent Care	10	30	60	60	100	90%
• Home Health • Skilled Nursing Facilities	10	30	60	60	85	90%
• Outpatient Dialysis	10	30	50	50	90	90%

Mental Health/Substance Use

Provider Type	Standard (Urban)	Standard (Suburban)	Standard (Rural)	Performance Goal
Prescriber (MD, DO, Nurse Practitioner, Physician's Assistant)	Estimated 10 miles	Estimated 20 miles	Estimated 45 miles	90%
Doctoral / Master's Level Clinician	Estimated 10 miles	Estimated 20 miles	Estimated 30 miles	90%
Child / Adolescent Clinician (MD, PhD, and MA)	Estimated 10 miles	Estimated 20 miles	Estimated 45 miles	90%
Acute Inpatient Care (mental health & substance abuse)	Estimated 15 miles	Estimated 30 miles	Estimated 60 miles	90%
Intermediate Care / Partial Hospitalization / Residential (mental health & substance abuse)	Estimated 15 miles	Estimated 30 miles	Estimated 60 miles	90%
Intensive Outpatient Care (mental health & substance abuse)	Estimated 15 miles	Estimated 30 miles	Estimated 60 miles	90%

Provider Type	Standard
Prescriber (MD, DO, Nurse Practitioner, Physician's Assistant)	0.50 per Thousand Members
Doctoral (PhD) Clinician	0.50 per Thousand Members
Master's-Level Clinician	1.0 per Thousand Members
Child / Adolescent Clinician (MD, PhD, and MA)	1.0 per Thousand Members
Acute Inpatient Care (mental health & substance abuse)	1.0 per 15 Thousand Members
Intermediate Care/ Partial Hospitalization/ Residential (mental health & substance abuse)	1.0 per 20 Thousand Members
Intensive Outpatient Care (mental health & substance abuse)	1.0 per 20 Thousand Members

Non-Quantitative Treatment Limitations	General Medical/Surgical	Mental Health/Substance Use
What is the Basis for Provider Reimbursement?	**In Network** Medical/Surgical providers are reimbursed based on negotiated contract rates. Several factors being taken into consideration in the rate-setting process, including CMS benchmarks, as well as regional market dynamics and current business needs. Depending on provider type, contract rates may be based on a MS-DRG, Per Diem, Per Case, Per Visit, Per Unit, Fee Schedule, etc. Inpatient and outpatient contract rates are negotiated on a facility by facility basis. Contract rates are typically negotiated for a 2-3 year term with agreed upon escalators for each year. **Out of Network** Fees are established using a percentage of the CMS fee amounts for the same or similar service within the applicable geographic market based on provider type, or by using an outside vendor network that uses contractual methodologies. Certain services are reimbursed using a reduced percentage of CMS rates – such as laboratory services and durable medical equipment. If there is no CMS rate then a default rate of 50% of billed charges is used.	**In Network** Behavioral network reimbursement methodology is a fee for service model. Inpatient per diems are negotiated on a facility by facility basis. Schedules are reviewed annually with several factors being taken into consideration in the rate-setting process, including CMS guidelines, as well as regional market dynamics and current business needs. **Out of Network** Fees are established using a percentage of CMS fees for the same or similar services within the applicable geographic market based on the provider type, or an outside vendor network that uses contractual methodologies. When percentage of CMS fee is used, then the percentage used would match the percentage used under the medical/surgical plan. If there is no CMS rate for a particular service or facility type then a default rate of 50% of billed charges is used. Charges for services provided by psychologists and master's level clinicians are adjusted to reflect differences in the nature of service, provider type, market dynamics, and market need availability.
Does the Plan Have Exclusions for Failure to Complete a Course of Treatment?	**In Network & Out of Network** The medical/surgical benefit does not include exclusions based on a failure to complete a course of treatment.	**In Network & Out of Network** The behavioral benefit does not include exclusions based on a failure to complete a course of treatment.

Non-Quantitative Treatment Limitations	General Medical/Surgical	Mental Health/Substance Use
Does the Plan Include Fail First Requirements (also known as step therapy protocols)?	**In Network & Out of Network** Application of a "fail first" or "step therapy" requirement is based on use of nationally recognized clinical standards, which may be incorporated into the plan's review guidelines. Based on, and consistent with, these nationally recognized clinical standards, some of the plan's medical/surgical review guidelines have what may be considered to be "fail first" or "step therapy" protocols. The full list of the guidelines (Medical & Drug Policies and Coverage Determination Guidelines) is available at www.unitedhealthcareonline.com. Go to Quick Links > Policies, Protocols and Administrative Guides.	**In Network & Out of Network** Application of "fail first" or "step therapy" requirements is based on use of nationally recognized clinical standards which may be incorporated into the plan's guidelines. Based on, and consistent with, these nationally recognized clinical standards, some of the plan's MH/SUD review guidelines have what may be considered to be "fail first" or "step therapy" protocols. Further, application of "fail first" or "step therapy" protocols must be distinguished from the following: 1. Re-direction to an alternative level of care, when appropriate, based on the specific clinical needs of the particular patient. 2. Prior treatment failure criteria that support the need for a higher level of care when such failure is not a prerequisite for the higher level of care.

Non-Quantitative Treatment Limitations	General Medical/Surgical	Mental Health/Substance Use
Formulary Design for Prescription Drugs	**In Network & Out of Network** The plan's Prescription Drug List (PDL) is created utilizing all medications approved by the FDA as a starting point. Certain drugs may then be excluded from the PDL coverage based on a variety of clinical, pharmacoeconomic and financial factors. These factors are also utilized to determine inclusion and tier placement on the PDL. For example, the plan excludes coverage of prescription drugs for which a therapeutic equivalent over-the-counter drug is available. This process is conducted by a national Pharmacy & Therapeutics Committee which reviews and evaluates all clinical and therapeutic factors. The committee meets no less than quarterly and assesses the medication's place in therapy, and its relative safety and efficacy. The committee reviews decisions consistent with published evidence relative to these factors developed by a pharmacoeconomic work group which extensively reviews medical and outcomes literature and financial models which assess the impact of cost versus potential offsets from the use of a prescription drug such as decreases in hospital stays, or reduction in lab tests or medical utilization due to side effects etc. The committee and work group do not utilize any factors which take into account the prescription drug's primary indication as a mental health or substance use disorder prescription drug. Such drugs are assessed under the process above without regard to their primary indication being related to mental health or substance use disorder.	**In Network & Out of Network** The plan's Prescription Drug List (PDL) is created utilizing all medications approved by the FDA as a starting point. Certain drugs may then be excluded from the PDL coverage based on a variety of clinical, pharmacoeconomic and financial factors. These factors are also utilized to determine inclusion and tier placement on the PDL. For example, the plan excludes coverage of prescription drugs for which a therapeutic equivalent over-the-counter drug is available. This process is conducted by a national Pharmacy & Therapeutics Committee which reviews and evaluates all clinical and therapeutic factors. The committee meets no less than quarterly and assesses the medication's place in therapy, and its relative safety and efficacy. The committee reviews decisions consistent with published evidence relative to these factors developed by a pharmacoeconomic work group which extensively reviews medical and outcomes literature and financial models which assess the impact of cost versus potential offsets from the use of a prescription drug such as decreases in hospital stays, or reduction in lab tests or medical utilization due to side effects etc. The committee and work group do not utilize any factors which take into account the prescription drug's primary indication as a mental health or substance use disorder prescription drug. Such drugs are assessed under the process above without regard to their primary indication being related to mental health or substance use disorder.
Are There Restrictions Based on Geographic Location?	**In Network & Out of Network** The medical/surgical benefit does not include restrictions based on geographic location.	**In Network & Out of Network** The behavioral benefit does not include restrictions based on geographic location.

Non-Quantitative Treatment Limitations	General Medical/Surgical	Mental Health/Substance Use
Does the Plan Require Notification for Inpatient Admissions?	**In Network** Requirement: Yes. Network facilities must provide notification of all inpatient admissions. The specific requirements for providing inpatient notification are described in the current UnitedHealthcare Administrative Guide which can be found online at www.unitedhealthcareonline.com. Go to Quick Links > Policies, Protocols and Administrative Guides. Admission Notification by the facility is required even if Advanced Notification was supplied by the physician and a pre-service coverage approval is on file. Benefit reductions are applied to providers who fail to provide timely notification. **Out of Network** All inpatient services require notification. When these services are provided out of network, the member is responsible for providing the notification and relevant information. Members should provide notice of emergent admissions within 24 hours or as soon as reasonably possible given the circumstances. Members are allowed to delegate their responsibility to provide notification to the non-network facility. Initial notification results in a medical necessity review based on plan requirements and may result in an adverse benefit determination. If admission notification is not obtained by the member within the required timeframe, a benefit reduction is applied to the member. The reduction percentage will vary by plan.	**In Network** Requirement: Yes. Network facilities must provide notification of all inpatient admissions, including all Residential Treatment Center (RTC) admissions. Admission Notification by the facility is required even if Advanced Notification was supplied by the physician and a pre-service coverage approval is on file. Failure to coordinate authorizations through the UnitedHealthcare Life Insurance Company or its Designee/Subcontractor clinician may result in full or partial denial of claims. Benefit reductions are applied to providers who fail to provide timely notification. **Out of Network** All inpatient services require notification. When these services are provided out of network, the member is responsible for providing the notification and relevant information. Members should provide notice of emergent admissions within 24 hours or as soon as reasonably possible given the circumstances. Members are allowed to delegate their responsibility to provide notification to the non-network facility. Initial notification results in a medical necessity review based on plan requirements and may result in an adverse benefit determination. If admission notification is not obtained by the member within the required timeframe, a benefit reduction is applied to the member. The reduction percentage will vary by plan.

Non-Quantitative Treatment Limitations	General Medical/Surgical	Mental Health/Substance Use
Does the Plan Require Prior Authorization for Inpatient Services?	**In Network** Yes, network providers are required to obtain prior authorization for several services/procedures. A current listing of these services can be found at www.unitedhealthcareonline.com. Go to Quick Links > Policies, Protocols and Administrative Guides. These services/procedures were selected based on the following strategies, processes, evidentiary standards and other factors: 1) Practice Variation/variability by a) Level of care b) Geographic region c) Diagnosis d) Provider/facility 2) Significant drivers of cost trend 3) Outlier performance against established benchmarks 4) Disproportionate Utilization 5) Preference/System driven care a) Preference driven b) Supply/demand factors 6) Gaps in Care that negatively impact cost, quality and/or utilization 7) Outcome yield from the UM activity/Administrative cost analysis Upon request, even when prior authorization is not required for a particular service or procedure, the facility/provider can request that the medical plan provide a medical necessity review of a proposed service prior to the provision of such service. This enables the facility/provider to avoid retrospective medical necessity or other coverage review, which can result in full or partial denial of claims.	**In Network** Yes, network providers are required to obtain prior authorization for the following services/procedures based on the following strategies, processes, evidentiary standards and other factors: 1) Practice Variation/variability by a) Level of care b) Geographic region c) Diagnosis d) Provider/facility 2) Significant drivers of cost trend 3) Outlier performance against established benchmarks 4) Disproportionate Utilization 5) Preference/System driven care a) Preference driven b) Supply/demand factors 6) Gaps in Care that negatively impact cost, quality and/or utilization 7) Outcome yield from the UM activity/Administrative cost analysis Based on these strategies, processes, evidentiary standards and other factors the behavioral plan requires prior authorization for a small range of planned behavioral services that are covered under the inpatient benefit: • Admission planned following observation. • Admission to a residential treatment center (RTC) • Electroconvulsive therapy (ECT) when scheduled as inpatient Upon request, even when prior authorization is not required, the facility/provider can request that the medical plan provide a medical necessity review of a proposed service prior to the provision of such service. This enables the facility/provider to avoid retrospective medical necessity or other coverage review, which can result in full or partial denial of claims.

Non-Quantitative Treatment Limitations	General Medical/Surgical	Mental Health/Substance Use
	Out of Network Members are responsible for obtaining prior authorization for all inpatient services to non-network facilities. Members are required to obtain the prior authorization within certain timeframes, depending on the member's specific plan requirements. Clinical information necessary to perform reviews is required. Some inpatient services require prior authorization "as soon as possible" before the services/treatment are received. Examples of these benefits include, but are not limited to, transplants. Other inpatient services require prior authorization 5 days before receiving the benefit. Examples of services requiring prior authorization 5 business days before admission include, but are not limited to, planned inpatient admissions, scheduled maternity admissions, reconstructive procedures, rehabilitation/habilitative services, and SNF admissions. Members should provide notice of emergent admissions within 24 hours of admission or as soon as reasonably possible given the circumstances. Members are allowed to delegate their responsibility to obtain prior authorization to the non-network provider. A prior authorization review involves a medical necessity review based on plan requirements and may result in an adverse benefit determination. If prior authorization is not obtained by the member within the required timeframe, a benefit reduction is applied to the member. The reduction percentage will vary by plan.	**Out of Network** Members are responsible for obtaining prior authorization for all inpatient services to non-network facilities. Members are required to obtain the prior authorization within certain timeframes, depending on the member's specific plan requirements. Clinical information necessary to perform reviews is required. Some inpatient services require prior authorization "as soon as possible" before the services/treatment are received. Examples of these benefits include, but are not limited to, scheduled admissions for inpatient MH/SUD services (including services at a residential treatment center). Other inpatient services require prior authorization 5 days before receiving the benefit. Examples of benefits requiring prior authorization 5 business days before admission include, but are not limited to, planned inpatient admissions. Members should provide notice of emergent admissions within 24 hours of admission or as soon as reasonably possible given the circumstances. Members are allowed to delegate their responsibility to obtain prior authorization to the non-network provider. A prior authorization review involves a medical necessity review based on plan requirements and may result in an adverse benefit determination. If prior authorization is not obtained by the member within the required timeframe, a benefit reduction is applied to the member. The reduction percentage will vary by plan.

Non-Quantitative Treatment Limitations	General Medical/Surgical	Mental Health/Substance Use
Does the Plan Conduct Concurrent Reviews for Inpatient Services?	**In Network** Inpatient review is a component of the medical plan's utilization management activities. The Medical Director and other clinical staff review hospitalizations to detect and better manage over- and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. Inpatient review also gives the plan the opportunity to contribute to decisions about discharge planning and case management. In addition, the plan may identify opportunities for quality improvement and cases that are appropriate for referral to one of our disease management programs. Reviews usually begin on the first business day following admission. If a nurse reviewer believes that an admission or continued stay is not an appropriate use of benefit coverage, the facility will be asked for more information concerning the treatment and case management plan. The nurse may also refer the case to our Medical Director for a peer-to-peer discussion. If the plan Medical Director determines that an admission or continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified. Non-reimbursable charges are not billable to the member. The facility and the attending physician have sole authority and responsibility for the medical care of patients. The plan's medical management decisions do not override those obligations. We do not ever direct an attending physician to discharge a patient. We simply inform the member of our determination. • Participating facilities are required to cooperate with all medical plan requests for information, documents or discussions for purposes of concurrent review and discharge planning including, but not limited to: primary and secondary diagnosis, clinical information, treatment plan, patient status, discharge planning needs, barriers to discharge and discharge date.	**In Network** Inpatient review is a component of the medical plan's utilization management activities. The Medical Director and other clinical staff review hospitalizations to detect and better manage over- and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. Inpatient review also gives the plan the opportunity to contribute to decisions about discharge planning and case management. In addition, the plan may identify opportunities for quality improvement and cases that are appropriate for referral to one of our disease management programs. Reviews usually begin on the first business day following admission. If a UnitedHealthcare Life Insurance Company or its Designee/Subcontractor reviewer believes that an admission or continued stay is not an appropriate use of benefit coverage, the facility will be asked for more information concerning the treatment and case management plan. The reviewer may also refer the case to our Medical Director for a peer-to-peer discussion. If the plan Medical Director determines that an admission or continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified. Non-reimbursable charges are not billable to the member. The facility and the attending physician have sole authority and responsibility for the medical care of patients. The plan's medical management decisions do not override those obligations. We do not ever direct an attending physician to discharge a patient. We simply inform the member of our determination.

Non-Quantitative Treatment Limitations	General Medical/Surgical	Mental Health/Substance Use
	• Initial and concurrent review can be conducted by telephone, on- site and when available, facilities can provide clinical information via access to Electronic Medical Records (EMR). • Participating facilities must cooperate with all medical plan requests from the inpatient care management team and/or medical director to engage our members directly face-to-face or telephonically. • The medical plan uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. The medical plan clinical criteria can be requested from the Case Reviewer. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay. • Medical and Drug Policies and Coverage Determination Guidelines are available online at www.unitedhealthcareonline.com	• Participating facilities are required to cooperate with all medical plan requests for information, documents or discussions for purposes of concurrent review and discharge planning including, but not limited to: primary and secondary diagnosis, clinical information, treatment plan, patient status, discharge planning needs, barriers to discharge and discharge date. • Initial and concurrent review can be conducted by telephone, on-site and when available, facilities can provide clinical information via access to Electronic Medical Records (EMR). • Participating facilities must cooperate with all medical plan requests from the inpatient care management team and/or medical director to engage our members directly face-to-face or telephonically. • UnitedHealthcare Life Insurance Company or its Designee/ Subcontractor uses guidelines, based on nationally recognized clinical guidelines, to assist clinicians in making informed decisions. This includes acute and sub-acute behavioral treatment. UnitedHealthcare Life Insurance Company's or its Designee's/Subcontractor's clinical criteria can be requested from the Case Reviewer and are available online at www.providerexpress.com/html/guidelines/index.html. Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Physician Reviewer considers community resources and the availability of alternative care settings, and the ability of the facilities to provide all necessary services within the estimated length of stay.

Non-Quantitative Treatment Limitations	General Medical/Surgical	Mental Health/Substance Use
	Out of Network All inpatient care is reviewed concurrently for appropriate use of benefit coverage. Concurrent clinical information is required, and is used to develop a discharge plan and ensure appropriate use of the benefit, based on medical necessity. A concurrent review can result in a modification of the services requested. The facility and the attending physician have sole authority and responsibility for the medical care of patients. The plan's medical management decisions do not override those obligations. We do not ever direct an attending physician to discharge a patient. We simply inform the member of our determination.	**Out of Network** All inpatient care is reviewed concurrently for appropriate use of benefit coverage. Concurrent clinical information is required, and is used to develop a discharge plan and ensure appropriate use of the benefit, based on medical necessity. A concurrent review can result in a modification of the services requested. The facility and the attending physician have sole authority and responsibility for the medical care of patients. UnitedHealthcare Life Insurance Company's or its Designee/ Subcontractor's medical management decisions do not override those obligations. We do not ever direct an attending physician to discharge a patient. We simply inform the member of our determination.
Does the Plan Conduct Retrospective Reviews for Inpatient Services?	**In Network & Out of Network** Yes, post-service, pre-claim reviews are conducted on inpatient services. Network providers should follow the same process as is applied for a standard Prior Authorization request. A clinical coverage review will be done to determine whether the service is medically necessary and payment may be withheld if the services are determined not to have been medically necessary. Urgent services rendered without a required Prior Authorization number will also be subject to retrospective review for medical necessity, and payment may be withheld if the services are determined not to have been medically necessary. Network providers/facilities may not balance bill the member for any denied charges under these circumstances.	**In Network & Out of Network** Yes, post-service reviews are conducted on inpatient services. Network providers should follow the same process as is applied for a standard Prior Authorization request. A clinical coverage review will be done to determine whether the service is medically necessary and payment may be withheld if the services are determined not to have been medically necessary. Urgent services rendered without a required Prior Authorization number will also be subject to retrospective review for medical necessity, and payment may be withheld if the services are determined not to have been medically necessary. Network providers/facilities may not balance bill the member for any denied charges under these circumstances.

Non-Quantitative Treatment Limitations	General Medical/Surgical	Mental Health/Substance Use
Does the Plan Require Prior Authorization for Outpatient Services?	**In Network** Based on selected strategies, processes, evidentiary standards and other factors the medical/surgical plan requires prior authorization for a range of planned medical/surgical services that are covered under the outpatient benefit. A current listing of these services can be found at www.unitedhealthcareonline.com. Go to Quick Links > Policies, Protocols and Administrative Guides. A benefit reduction may be imposed for failure to obtain a prior authorization. The amount of reduction depends on the benefit plan. The member cannot be balance billed for any denied charges under these circumstances. **Out of Network** When the services on the prior authorization list are obtained from a non-network provider, the member is responsible for obtaining the prior authorization. Clinical information necessary to perform reviews is required. The member can delegate this responsibility to the non-network provider. A prior authorization review involves a medical necessity review based on plan requirements and can result in a medical necessity denial. Members should notify the plan of emergent admissions within 24 hours or as soon as reasonably possible given the circumstances. If prior authorization is not obtained by the member within the required timeframe, a benefit reduction is applied to the member. The reduction percentage will vary by plan.	**In Network** Based on selected strategies, processes, evidentiary standards and other factors the behavioral plan requires prior authorization for a small range of planned behavioral services that are covered under the outpatient benefit: • Electroconvulsive therapy (ECT) when scheduled as outpatient • Partial Hospitalization Programs • Intensive outpatient program treatment • Psychological testing (5 hours or less only requires notification) • Methadone maintenance • Extended outpatient treatment visits 50+ minutes in duration • Applied Behavioral Analysis (ABA) for the treatment of autism A benefit reduction may be imposed for failure to obtain a prior authorization. The amount of the reduction depends on the benefit plan. The member cannot be balance billed for any denied charges under these circumstances. **Out of Network** When MH/SUD services requiring prior authorization are obtained from a non-network provider, the member is responsible for obtaining the prior authorization. Clinical information necessary to perform reviews is required. The member can delegate this responsibility to the non-network provider. A prior authorization review involves a medical necessity review based on plan requirements and can result in a medical necessity denial. Members should notify the plan of emergent admissions within 24 hours or as soon as reasonably possible given the circumstances. If prior authorization is not obtained by the member within the required timeframe, a benefit reduction is applied to the member. The reduction percentage will vary by plan.

Non-Quantitative Treatment Limitations	General Medical/Surgical	Mental Health/Substance Use
Does the Plan Conduct Outlier Management & Concurrent Review for Outpatient Services?	**In Network & Out of Network** Yes, subject to prior authorization and the plan's medical necessity provision. Using the above criteria, the medical/surgical plan has identified the following services in the outpatient classification: • Chiropractic • Occupational Therapy • Physical Therapy Outpatient medical/surgical services rendered using E/M codes are not included in this outlier program. In order to ensure members have access to services available to them through their COC/SPD and the sponsor does not pay for non-covered services a utilization review program is then applied to the identified medical/surgical services. This utilization review program has the following attributes: • Differentiated UR process based on historical provider performance • Business rules identify attributes of cases with a high likelihood for medically unnecessary services currently or in the relatively near future • Identified cases are clinically reviewed • In cases with apparent medically unnecessary services, peer to peer telephonic contact is initiated to make sure complete information is available • In cases where ongoing services have been determined to be unnecessary an adverse benefit determination is made and member/provider communication, compliant with all state and federal regulatory requirements, is issued • Appeals process is available for adverse determination	**In Network & Out of Network** Yes, subject to prior authorization and the plan's medical necessity provision. Using the above criteria, MH/SUD has identified the following services in the outpatient classification: • Psychotherapy Outpatient MH/SUD services rendered using E/M codes were not identified for inclusion in the program. In order to ensure members have access to services available to them through their COC/SPD and the sponsor does not pay for non-covered services a utilization review program is then applied to the identified MH/SUD services. The medical/surgical utilization program and MH/SUD program (ALERT) have the same attributes: • Differentiated UR process based on historical provider performance • Business rules identify attributes of cases with a high likelihood for medically unnecessary services currently or in the relatively near future • Identified cases are clinically reviewed • In cases with apparent medically unnecessary services, peer to peer telephonic contact is initiated to make sure complete information is available • In cases where ongoing services have been determined to be unnecessary an adverse benefit determination is made and member/provider communication, compliant with all state and federal regulatory requirements, is issued • Appeals process is available for adverse determination

Non-Quantitative Treatment Limitations	General Medical/Surgical	Mental Health/Substance Use
Does the Plan Conduct Retrospective Review for Outpatient Services?	**In Network & Out of Network** Yes, post-service, pre-claim reviews are conducted on outpatient services. Network providers should follow the same process as is applied for a standard Prior Authorization request. A clinical coverage review will be done to determine whether the service is medically necessary and payment may be withheld if the services are determined not to have been medically necessary.	**In Network & Out of Network** Yes, post-service reviews are conducted on outpatient services. Network providers should follow the same process as is applied for a standard Prior Authorization request. A clinical coverage review will be done to determine whether the service is medically necessary and payment may be withheld if the services are determined not to have been medically necessary.