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## Summary of Various Non-Quantitative Treatment Limitations

### Mental Health Parity and Addiction Equity Act

### All Savers Insurance Company

### Non-Exchange (with Medical Necessity)

### Non-Quantitative Treatment Limitations

<table>
<thead>
<tr>
<th>General Medical/Surgical</th>
<th>Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Are services subject to a medical necessity standard?</strong></td>
<td>Yes, services received from both Network and non-Network providers must meet the following definition of medical necessity:</td>
</tr>
<tr>
<td>Medical Necessity or Medically Necessary – Medical services that are:</td>
<td>Medical Necessity or Medically Necessary – Medical services that are:</td>
</tr>
<tr>
<td>• medically appropriate and consistent to treat an Injury or Sickness;</td>
<td>• medically appropriate and consistent to treat an Injury or Sickness;</td>
</tr>
<tr>
<td>• not excessive in scope, duration or intensity;</td>
<td>• not excessive in scope, duration or intensity;</td>
</tr>
<tr>
<td>• safe, effective and appropriate with regard to accepted standards or medical practice at the time when the medical service is provided;</td>
<td>• safe, effective and appropriate with regard to accepted standards or medical practice at the time when the medical service is provided;</td>
</tr>
<tr>
<td>• not provided primarily for the comfort or convenience of the Covered Person, a family member or a health care provider;</td>
<td>• not provided primarily for the comfort or convenience of the Covered Person, a family member or a health care provider;</td>
</tr>
<tr>
<td>• not able to be omitted without an adverse effect; and</td>
<td>• not able to be omitted without an adverse effect; and</td>
</tr>
<tr>
<td>• the most cost-effective. This means there is no other similar or alternate medical service available at a lower cost.</td>
<td>• the most cost-effective. This means there is no other similar or alternate medical service available at a lower cost.</td>
</tr>
</tbody>
</table>

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.

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.

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<th>Non-Quantitative Treatment Limitations</th>
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</table>

### How Does the Plan Detect Fraud, Waste and Abuse?

**In Network & Out of Network**

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 through 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

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.

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<tbody>
<tr>
<td>amount involved or potential recovery probability. The audit and investigation will involve review of contemporaneous treatment records as well as member and provider interviews.</td>
<td></td>
<td>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 will not exceed one year under current policy and uses a sampling and extrapolation methodology. For mental health and substance use disorder claims however, audits are limited to cases where the amount of claims exceeds a $10,000 threshold as a specified minimum amount involved or potential probable recovery. The audit and investigation will involve review of contemporaneous treatment records as well as member and provider interviews.</td>
</tr>
</tbody>
</table>

Is there Exclusions for Experimental, Investigational and Unproven Services?

Yes, services received from both Network and non-Network providers are subject to the following exclusions:

**Experimental or investigational services** are medical, surgical, diagnostic, psychiatric, mental health, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time a determination regarding coverage in a particular case is made, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

**Unproven services** are services, including medications, which are determined not to be effective.

Yes, services received from both Network and non-Network providers are subject to the following exclusions:

**Experimental or investigational services** are behavioral health services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time a determination regarding coverage in a particular case is made, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the

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# Summary of Various Non-Quantitative Treatment Limitations

## Mental Health Parity and Addiction Equity Act

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<tr>
<td><strong>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.</strong></td>
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</tr>
<tr>
<td>- 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.)</td>
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<tr>
<td>- 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.)</td>
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</tr>
<tr>
<td>Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.</td>
<td></td>
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<tr>
<td>definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.</td>
<td></td>
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</tr>
<tr>
<td>Unproven behavioral health services are services, including medications, which are determined not to be effective for treatment of the behavioral 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.</td>
<td></td>
<td></td>
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<td>- 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.)</td>
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</tbody>
</table>

## Network Admission Criteria

<table>
<thead>
<tr>
<th>In Network</th>
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</thead>
<tbody>
<tr>
<td>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 <a href="http://www.unitedhealthcareonline.com">www.unitedhealthcareonline.com</a>. Go to Quick Links &gt; Policies, Protocols and Administrative Guides.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers must meet all credentialing criteria outlined in the Optum Behavioral Health Credentialing Policies to remain eligible for network participation. The Credentialing Plan is available online at <a href="http://www.providerexpress.com">www.providerexpress.com</a></td>
</tr>
</tbody>
</table>

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<th>General Medical/Surgical</th>
<th>Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation criteria for practitioners include:</td>
<td>1. Education</td>
<td>1. Education</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>• Chiropractors: graduation from chiropractic college</td>
<td>• Physicians without a residency in psychiatry may be accepted if they are board certified by the America Society of Addictions Medicine (ASAM)</td>
</tr>
<tr>
<td></td>
<td>• Dentists: graduation from dental school</td>
<td>• Physician addictionologists must be board certified by ASAM or have added qualifications in Addiction Psychiatry through the ABPN.</td>
</tr>
<tr>
<td></td>
<td>• Podiatrists: graduation from podiatry school and successful completion of a hospital residency program</td>
<td>• Developmental Behavioral Pediatricians (DBP) must provide evidence of passing the National Certification Exam.</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
<td>Non-physician providers must be:</td>
</tr>
<tr>
<td></td>
<td>2. Licensing</td>
<td>• A doctorand/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.</td>
</tr>
<tr>
<td></td>
<td>Applicants must maintain current, valid licensure or certification, without material restrictions, conditions or other disciplinary actions in all states where the applicant practices.</td>
<td>Any board certification claimed by an applicant shall be verified by the credentialing committee.</td>
</tr>
<tr>
<td></td>
<td>3. Admitting privileges</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Medicare/Medicaid Program Participation Eligibility</td>
<td></td>
</tr>
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</thead>
<tbody>
<tr>
<td><strong>Licensing</strong>&lt;br&gt;Applicants must maintain current, valid licensure or certification, without material restrictions, conditions or other disciplinary actions in all states where the applicant practices.</td>
<td><strong>2. Licensing</strong>&lt;br&gt;Applicants must maintain current, valid licensure or certification, without material restrictions, conditions or other disciplinary actions in all states where the applicant practices.</td>
</tr>
<tr>
<td><strong>Admitting privileges</strong>&lt;br&gt;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.</td>
<td><strong>3. Admitting privileges</strong>&lt;br&gt;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.</td>
</tr>
<tr>
<td><strong>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).</strong></td>
<td><strong>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).</strong></td>
</tr>
<tr>
<td><strong>Medicare/Medicaid Program Participation Eligibility</strong>&lt;br&gt;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.</td>
<td><strong>5. Medicare/Medicaid Program Participation Eligibility</strong>&lt;br&gt;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.</td>
</tr>
<tr>
<td><strong>Work History</strong>&lt;br&gt;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.</td>
<td><strong>6. Work History</strong>&lt;br&gt;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.</td>
</tr>
<tr>
<td><strong>Insurance or state approved alternative</strong>&lt;br&gt;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.</td>
<td><strong>Insurance or state approved alternative</strong>&lt;br&gt;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.</td>
</tr>
<tr>
<td><strong>Site visit</strong>&lt;br&gt;If required by the credentialing committee must agree to a site visit and obtain a passing score.</td>
<td><strong>Site visit</strong>&lt;br&gt;If required by the credentialing committee must agree to a site visit and obtain a passing score.</td>
</tr>
<tr>
<td><strong>Network participation</strong>&lt;br&gt;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.</td>
<td><strong>Network participation</strong>&lt;br&gt;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.</td>
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</table>

**Participation criteria for facilities includes:**

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## Non-Quantitative Treatment Limitations

### General Medical/Surgical

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.

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.

### Behavioral Health

(or earlier if required by state regulations) must be explained by the applicant and found acceptable by the credentialing committee.

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.
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:

Standards for the Geographic Distribution of Participating Practitioners and Providers

<table>
<thead>
<tr>
<th>Practitioner/Provider Type</th>
<th>Large</th>
<th>Metro</th>
<th>Micro</th>
<th>Rural</th>
<th>CEAC</th>
<th>Goal-All Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
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<td>1 within</td>
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<tr>
<td>Family Practice</td>
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<tr>
<td>General Practice</td>
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<tr>
<td>Internal Medicine</td>
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<tr>
<td>Gerontology</td>
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<tr>
<td>Pediatrics</td>
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<tr>
<td>OB/GYN (in states where applicable)</td>
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</tbody>
</table>

Primary Care
- Family Practice
- General Practice
- Internal Medicine
- Gerontology
- Pediatrics
- OB/GYN (in states where applicable)

Primary Care
- 5
- 10
- 20
- 30
- 60
- 90%

Specialty Care Physician
- 1 within

Specialty Care Physician
- Cardiology
- General Surgery
- Ophthalmology
- Orthopedics

Specialty Care Physician
- 10
- 20
- 35
- 60
- 85
- 90%

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.

Optum applies the criteria to those clinicians who apply for participation in the Optum 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.
### Summary of Various Non-Quantitative Treatment Limitations

**Mental Health Parity and Addiction Equity Act**

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<tr>
<td>- Dermatology</td>
<td>of participating medical/surgical practitioners and providers based on the following strategies, processes, evidentiary standards and other factors:</td>
</tr>
<tr>
<td>- Gastroenterology</td>
<td>1. Geographic factors</td>
</tr>
<tr>
<td>- Endocrinology</td>
<td>2. Provider/facility availability</td>
</tr>
<tr>
<td>- Neurology</td>
<td>3. Supply/demand factors</td>
</tr>
<tr>
<td>- Oncology</td>
<td>Based on these strategies, processes, evidentiary standards and other factors the plan analyzes the network against the following established standards at least annually:</td>
</tr>
<tr>
<td>- Pulmonology</td>
<td><strong>Provider</strong></td>
</tr>
<tr>
<td>- Rheumatology</td>
<td><strong>Type</strong></td>
</tr>
<tr>
<td>- Urology</td>
<td><strong>(Large Metro)</strong></td>
</tr>
<tr>
<td>- Allergy/Immunology</td>
<td><strong>(Metro)</strong></td>
</tr>
<tr>
<td>- ENT</td>
<td><strong>(Micro)</strong></td>
</tr>
<tr>
<td>- OB/GYN</td>
<td><strong>(Rural)</strong></td>
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<tr>
<td>- Dermatology</td>
<td><strong>(CEAC)</strong></td>
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<td>- Gastroenterology</td>
<td><strong>Goal-All</strong></td>
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<td>- Endocrinology</td>
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<td>- Neurology</td>
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<td>- Oncology</td>
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<td>- Allergy/Immunology</td>
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<td>- ENT</td>
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<td>- OB/GYN</td>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Inpatient Care (mental health &amp; substance abuse)</td>
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<tr>
<td></td>
<td></td>
<td>Intermediate Care / Partial Hospitalization / Residential (mental health &amp; substance abuse)</td>
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<td></td>
<td></td>
<td>Intensive Outpatient Care (mental health &amp; substance abuse)</td>
</tr>
<tr>
<td>PROVIDER TYPE</td>
<td>STANDARD</td>
<td>Prescriber (MD, DO, Nurse Practitioner, Physician's Assistant)</td>
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<tr>
<td></td>
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<td>Doctoral (PhD) Clinician</td>
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<td>Master’s-Level Clinician</td>
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<td></td>
<td>Child / Adolescent Clinician (MD, PhD, and MA)</td>
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<td>Acute Inpatient Care (mental health &amp; substance abuse)</td>
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## Summary of Various Non-Quantitative Treatment Limitations

### Mental Health Parity and Addiction Equity Act

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<td><strong>Intermediate Care / Partial Hospitalization / Residential (mental health &amp; substance abuse)</strong></td>
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<td>1.0 per 20 Thousand Members</td>
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<tr>
<td><strong>Intensive Outpatient Care (mental health &amp; substance abuse)</strong></td>
<td></td>
<td>1.0 per 20 Thousand Members</td>
</tr>
</tbody>
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### What is the Basis for Provider Reimbursement? - General Medical/Surgical

**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 lesser of:
- available data resources of competitive fees in the geographic area,
- negotiated fees agreed to by the provider,
- a percentage of billed charges (between 50% -100%, depending on the plan), or
- a fee scheduled developed by All Savers.

### What is the Basis for Provider Reimbursement? - Behavioral Health

**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 lesser of:
- available data resources of competitive fees in the geographic area,
- negotiated fees agreed to by the provider,
- a percentage of billed charges (between 50% -100%, depending on the plan), or
- a fee scheduled developed by All Savers.

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

**In Network & Out of Network**
The medical/surgical benefit does not include exclusions based on a failure to complete a

**In Network & Out of Network**
The behavioral benefit does not include exclusions based on a failure

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<td>for Failure to Complete a Course of Treatment?</td>
<td>course of treatment.</td>
<td>to complete a course of treatment.</td>
</tr>
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</table>
| 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](http://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. |
| 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 | In Network & Out of Network  
The process applied by the plan for prescription drug formulary design is the same process as that used for medical/surgical prescription drugs using the same committee and work group and factors noted in |

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## Summary of Various Non-Quantitative Treatment Limitations

### Mental Health Parity and Addiction Equity Act

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<td>of prescription drugs for which a therapeutic equivalent over-the-counter drug is available.</td>
<td>The response to the left for medical/surgical prescription drugs.</td>
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<tr>
<td>This process is conducted by a national Pharmacy &amp; 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.</td>
<td>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.</td>
<td></td>
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<tr>
<td>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.</td>
<td>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.</td>
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### Non-Quantitative Treatment Limitations

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<tr>
<td><strong>Are There Restrictions Based on Geographic Location?</strong></td>
<td><strong>In Network &amp; Out of Network</strong> &lt;br&gt;The medical/surgical benefit does not include restrictions based on geographic location.</td>
</tr>
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## Non-Quantitative Treatment Limitations Compliance Summary

### Mental Health Parity and Addiction Equity Act

**All Savers Insurance Company**  
Non-Exchange  
(with Medical Necessity)  
Applicable to Inpatient Classification

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| **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 2014 UnitedHealthcare Administrative Guide which can be found online at [www.unitedhealthcareonline.com](http://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.  
All Skilled Nursing Facility admissions (members receiving Medicare Part A skilled services) must be authorized by a plan Nurse Practitioner or Physician's Assistant.  
Failure to coordinate authorizations through the plan clinician may result in full or partial denial of claims.  
Benefit reductions are applied to providers who fail to provide timely notification. | In Network  
Requirement:  
Yes. Network facilities must provide notification of all inpatient admissions. The specific requirements for providing inpatient notification are described in the 2014 UnitedHealthcare Administrative Guide which can be found online at [www.unitedhealthcareonline.com](http://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.  
Failure to coordinate authorizations through the plan 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. | 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. |

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<tr>
<td>Members are allowed to delegate their responsibility to provide notification to the non-network facility.</td>
<td></td>
<td>Initial notification results in a medical necessity review based on plan requirements and may result in an adverse benefit determination.</td>
</tr>
<tr>
<td>Initial notification results in a medical necessity review based on plan requirements and may result in an adverse benefit determination.</td>
<td></td>
<td>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.</td>
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<tr>
<td>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.</td>
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<tr>
<th>Does the Plan Require Prior Authorization for Inpatient Services?</th>
<th>In Network and Out of Network</th>
<th>In Network and Out of Network</th>
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<tbody>
<tr>
<td>No, the plan does not require prior authorization for inpatient services.</td>
<td>No, the plan does not require prior authorization for inpatient services.</td>
<td></td>
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<tr>
<td>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.</td>
<td>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.</td>
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<tr>
<td><strong>Does the Plan Conduct Concurrent Reviews for Inpatient Services?</strong></td>
<td><strong>In Network</strong>&lt;br&gt;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.&lt;br&gt; 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.&lt;br&gt; 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.&lt;br&gt; 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.</td>
<td><strong>In Network</strong>&lt;br&gt;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.&lt;br&gt; 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.&lt;br&gt; 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 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.&lt;br&gt; 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.</td>
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## Non-Quantitative Treatment Limitations Compliance Summary

**Mental Health Parity and Addiction Equity Act**

- **All Savers Insurance Company**
- **Non-Exchange** *(with Medical Necessity)*
- **Applicable to Inpatient Classification**

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<tr>
<td><strong>information, treatment plan, patient status, discharge planning needs, barriers to discharge and discharge date.</strong></td>
<td></td>
<td><strong>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.</strong></td>
</tr>
<tr>
<td><strong>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).</strong></td>
<td></td>
<td><strong>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).</strong></td>
</tr>
<tr>
<td><strong>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.</strong></td>
<td></td>
<td><strong>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.</strong></td>
</tr>
<tr>
<td><strong>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, and the ability of the facilities to provide all necessary services within the estimated length of stay.</strong></td>
<td></td>
<td><strong>The plan uses guidelines based on nationally recognized clinical guidelines to assist clinicians in making informed decisions. This includes acute and sub-acute behavioral health treatment. The clinical criteria can be requested from the Case Reviewer. 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, a plan Medical Director 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.</strong></td>
</tr>
<tr>
<td><strong>Medical and Drug Policies and Coverage Determination Guidelines are available online at <a href="http://www.unitedhealthcareonline.com">www.unitedhealthcareonline.com</a></strong></td>
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Non-Quantitative Treatment Limitations Compliance Summary
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<tr>
<td><strong>Out of Network</strong></td>
<td></td>
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<tr>
<td>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.</td>
<td></td>
<td>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.</td>
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<tr>
<th>Does the Plan Conduct Retrospective Reviews for Inpatient Services?</th>
<th>In Network &amp; Out of Network</th>
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<tr>
<td>Yes, retrospective reviews are conducted on inpatient services. Network providers should follow the same process as is applied for a standard Prior Notification. 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. Inpatient and Urgent services rendered without a required Prior Notification 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.</td>
<td>Yes, retrospective reviews are conducted on inpatient services. Network providers should follow the same process as is applied for a standard Prior Notification 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. Inpatient and Urgent services rendered without a required Prior Notification 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.</td>
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| Does the Plan Require Prior Authorization for Outpatient Services? | In Network  
No, the plan does not require prior authorization for outpatient services.  
However, notification must be provided for the following outpatient services:  
Breast pumps, clinical trials, durable medical equipment over $1000, prosthetic devices, and pre-transplant evaluations | In Network  
No, the plan does not require prior authorization for outpatient services. |
| Does the Plan Conduct Outlier Management & Concurrent Review for Outpatient Services? | In Network & Out of Network  
No, the plan does not conduct outlier management or require concurrent review on outpatient services. | In Network & Out of Network  
No, the plan does not conduct outlier management or require concurrent review on outpatient services. |
| Does the Plan Conduct Retrospective Review for Outpatient Services? | In Network & Out of Network  
Yes, retrospective reviews are conducted on the following outpatient services.  
Breast pumps, clinical trials, durable medical equipment over $1000, prosthetic devices, and pre-transplant evaluations if prior notification was not provided. | In Network & Out of Network  
Yes, retrospective 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.  
Urgent services rendered without a required Prior Authorization number |
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<td>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.</td>
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