INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting and administering behavioral health benefit plans that are managed by Optum, and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California (“Optum-CA”)). When deciding coverage, the member-specific benefit plan document must be referenced. The terms of the member-specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Coverage Determination Guideline is based. In the event of a conflict, the member’s specific benefit plan document supersedes this Coverage Determination Guideline.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the COC/SPD prior to using this Coverage Determination Guideline. Other Policies and Coverage Determination Guidelines may apply. Optum reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

BENEFIT CONSIDERATIONS

Before using this document, please check the member’s specific benefit plan requirements and any federal or state mandates, if applicable.

Pre-Service Notification
Admissions to an inpatient, residential treatment center, intensive outpatient, or a partial hospital/day treatment program require pre-service notification. Notification of a scheduled admission must occur at least five (5) business days before admission. Notification of an unscheduled admission (including emergency admissions) should occur as soon as is reasonably possible. Benefits may be reduced if Optum is not notified of an admission to these levels of
care. Check the member’s specific benefit plan document for the applicable penalty and provision for a grace period before applying a penalty for failure to notify Optum as required.

**Additional Information**
The lack of a specific exclusion for a service does not necessarily mean that the service is covered. For example, depending on the specific plan requirements, services that are inconsistent with Level of Care Guidelines and/or prevailing medical standards and clinical guidelines may be excluded. Please refer to the member’s benefit document for specific plan requirements.

**Essential Health Benefits for Individual and Small Group**
For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member-specific benefit document to determine benefit coverage.

**COVERAGE RATIONALE**

Available benefits for **Oppositional Defiant Disorder** include the following services:
- Diagnostic evaluation, assessment, and treatment planning
- Treatment and/or procedures
- Medication management and other associated treatments
- Individual, family, and group therapy
- Provider-based case management services
- Crisis intervention

**Impulse-Control Disorders (including Intermittent Explosive Disorder, Pyromania, and Kleptomania)** as a principal diagnosis, as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, are typically excluded. Indications for coverage are limited to circumstances where:
- Impulse Control Disorder is a secondary diagnosis; and
- The principal diagnosis is a covered condition; and
- Treatment is primarily focused on the principal diagnosis; or
- Impulse Control Disorders are covered by the member’s benefit plan.

**Conduct Disorder** as a principal diagnosis, as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, is typically excluded. Indications for coverage are limited to circumstances where:
- Conduct Disorder is a secondary diagnosis; and
- The principal diagnosis is a covered condition; and
- Treatment is primarily focused on the principal diagnosis; or
- Conduct Disorder is covered by the member’s benefit plan.

A principal diagnosis is defined as the condition that, after a complete evaluation, is determined to be chiefly responsible for the member seeking treatment, and also becomes the focus of clinical attention during treatment. When a person has multiple diagnoses, the first disorder listed is assumed to be the principal diagnosis, unless the provider specified otherwise (American Psychiatric Association, 2013).

The requested service or procedure must be reviewed against the language in the member’s benefit document. When the requested service or procedure is limited or excluded from the member’s benefit document, or is otherwise defined differently, it is the terms of the member’s benefit document that prevails.

Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with generally accepted standards and clinical guidelines:

**Optum Level of Care Guidelines**

**UnitedHealthcare Benefit Plan Definitions**

**Evidence-Based Clinical Guidelines**

Disruptive, Impulse-Control, & Conduct Disorders
Optum Coverage Determination Guideline

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Effective February, 2017
All services must be provided by or under the direction of a properly qualified behavioral health provider.

**APPLICABLE CODES**

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other policies and guidelines may apply.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90785</td>
<td>Interactive complexity (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90791</td>
<td>Psychiatric diagnostic evaluation</td>
</tr>
<tr>
<td>90792</td>
<td>Psychiatric diagnostic evaluation with medical services</td>
</tr>
<tr>
<td>90832</td>
<td>Psychotherapy, 30 minutes with patient</td>
</tr>
<tr>
<td>90833</td>
<td>Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy, 45 minutes with patient</td>
</tr>
<tr>
<td>90836</td>
<td>Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy, 60 minutes with patient</td>
</tr>
<tr>
<td>90838</td>
<td>Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)</td>
</tr>
<tr>
<td>90839</td>
<td>Psychotherapy for crisis; first 60 minutes</td>
</tr>
<tr>
<td>90840</td>
<td>Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)</td>
</tr>
<tr>
<td>90846</td>
<td>Family psychotherapy (without the patient present), 50 minutes</td>
</tr>
<tr>
<td>90847</td>
<td>Family psychotherapy (conjoint psychotherapy) (with the patient present), 50 minutes</td>
</tr>
<tr>
<td>90849</td>
<td>Multiple-family group psychotherapy</td>
</tr>
<tr>
<td>90853</td>
<td>Group psychotherapy (other than of a multiple-family group)</td>
</tr>
<tr>
<td>90863</td>
<td>Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0177</td>
<td>Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)</td>
</tr>
<tr>
<td>G0410</td>
<td>Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes</td>
</tr>
<tr>
<td>G0411</td>
<td>Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes</td>
</tr>
<tr>
<td>H0004</td>
<td>Behavioral health counseling and therapy, per 15 minutes</td>
</tr>
<tr>
<td>H0015</td>
<td>Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education</td>
</tr>
<tr>
<td>H0017</td>
<td>Behavioral health; residential (hospital residential treatment program), without room and board, per diem</td>
</tr>
<tr>
<td>H0018</td>
<td>Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem</td>
</tr>
</tbody>
</table>

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Optum Coverage Determination Guideline

Effective February, 2017

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<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0019</td>
<td>Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem</td>
</tr>
<tr>
<td>H0025</td>
<td>Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)</td>
</tr>
<tr>
<td>H0035</td>
<td>Mental health partial hospitalization, treatment, less than 24 hours</td>
</tr>
<tr>
<td>H2001</td>
<td>Rehabilitation program, per 1/2 day</td>
</tr>
<tr>
<td>H2011</td>
<td>Crisis intervention service, per 15 minutes</td>
</tr>
<tr>
<td>H2012</td>
<td>Behavioral health day treatment, per hour</td>
</tr>
<tr>
<td>H2013</td>
<td>Psychiatric health facility service, per diem</td>
</tr>
<tr>
<td>H2017</td>
<td>Psychosocial rehabilitation services, per 15 minutes</td>
</tr>
<tr>
<td>H2018</td>
<td>Psychosocial rehabilitation services, per diem</td>
</tr>
<tr>
<td>H2019</td>
<td>Therapeutic behavioral services, per 15 minutes</td>
</tr>
<tr>
<td>H2020</td>
<td>Therapeutic behavioral services, per diem</td>
</tr>
<tr>
<td>H2033</td>
<td>Multisystemic therapy for juveniles, per 15 minutes</td>
</tr>
<tr>
<td>S0201</td>
<td>Partial hospitalization services, less than 24 hours, per diem</td>
</tr>
<tr>
<td>S9480</td>
<td>Intensive outpatient psychiatric services, per diem</td>
</tr>
<tr>
<td>S9482</td>
<td>Family stabilization services, per 15 minutes</td>
</tr>
<tr>
<td>S9484</td>
<td>Crisis intervention mental health services, per hour</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DSM Diagnosis Code</th>
<th>ICD-10 Diagnosis Code</th>
<th>ICD-10 Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>313.81</td>
<td>F91.3</td>
<td>Oppositional Defiant Disorder</td>
</tr>
<tr>
<td>312.34</td>
<td>F63.81</td>
<td>Intermittent Explosive Disorder</td>
</tr>
<tr>
<td>312.81</td>
<td>F91.1</td>
<td>Conduct Disorder: Childhood-onset type</td>
</tr>
<tr>
<td>312.82</td>
<td>F91.2</td>
<td>Conduct Disorder: Adolescent-onset type</td>
</tr>
<tr>
<td>312.33</td>
<td>F63.1</td>
<td>Pyromania</td>
</tr>
<tr>
<td>312.32</td>
<td>F63.2</td>
<td>Kleptomania</td>
</tr>
</tbody>
</table>

LEVEL OF CARE GUIDELINES

Optum / OptumHealth Behavioral Solutions of California Level of Care Guidelines are available at: https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html

The Level of Care Guidelines are a set of objective and evidence-based behavioral health guidelines used to standardize coverage determinations, promote evidence-based practices, and support members’ recovery, resiliency, and wellbeing.

UNITEDHEALTHCARE BENEFIT PLAN DEFINITIONS

For plans using 2001 and 2004 generic UnitedHealthcare COC/SPD, unless otherwise specified

Covered Health Service(s)
Those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in Section 1: What’s Covered--Benefits as a Covered Health Service, which is not excluded under Section 2: What’s Not Covered--Exclusions.

For plans using 2007 and 2009 generic UnitedHealthcare COC/SPD, unless otherwise specified

Covered Health Service(s)
Those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
- Provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.
• Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
• Not provided for the convenience of the Covered Person, Physician, facility or any other person.
• Described in the Certificate of Coverage under Section 1: Covered Health Services and in the Schedule of Benefits.
• Not otherwise excluded in the Certificate of Coverage under Section 2: Exclusions and Limitations.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:
• "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
• "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

For plans using 2011 and more recent generic UnitedHealthcare COC/SPD, unless otherwise specified Covered Health Care Service(s) - health care services, including supplies or Pharmaceutical Products, which we determine to be all of the following:
• Medically Necessary.
• Described as a Covered Health Care Service in the Certificate under Section 1: Covered Health Care Services and in the Schedule of Benefits.
• Not excluded in the Certificate under Section 2: Exclusions and Limitations.

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by us or our designee.
• In accordance with Generally Accepted Standards of Medical Practice.
• Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
• Not mainly for your convenience or that of your doctor or other health care provider.
• Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Doctor specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Doctor specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services.

**EVIDENCE-BASED CLINICAL GUIDELINES**

**Oppositional Defiant Disorder**

**A. Initial evaluation**

• Youth with oppositional defiant disorder have been found to have higher rates of comorbid psychiatric disorders, such as attention-deficit/hyperactivity disorder, anxiety disorders, mood disorders, and substance abuse (American Academy of Child and Adolescent Psychiatry 2007).
• Assessment includes information obtained from the child and parents regarding core symptoms, age of onset, duration of symptoms, and degree of functional impairment (American Academy of Child and Adolescent Psychiatry 2007)
• Diagnostic tools for attention-deficit/hyperactivity disorder, such as the Vanderbilt ADHD Diagnostic Parent Rating Scale and the Conners 3 scales, have comorbidity screening scales that can help in identifying oppositional defiant disorder (Riley et al 2016).

B. Differential diagnosis for Oppositional Defiant Disorder includes (American Psychiatric Association, 2013):
• Conduct disorder;
• Attention-deficit/hyperactivity disorder;
• Depressive and bipolar disorders;
• Disruptive mood dysregulation disorder;
• Intermittent explosive disorder;
• Intellectual disability;
• Language disorder;
• Social anxiety disorder.

C. Treatment planning
• Successful assessment and treatment require establishing therapeutic alliances with both the child and family (American Academy of Child and Adolescent Psychiatry 2007).
• Children with oppositional defiant disorder who are not treated are at increased risk for conduct disorder, substance abuse, and delinquency (American Academy of Child and Adolescent Psychiatry 2009).
  o Early intervention may help to prevent other disorders (Riley et al 2016).
• The most effective treatment plans are tailored to the needs and behavioral symptoms of each child (American Academy of Child and Adolescent Psychiatry 2009).

D. Treatment of oppositional defiant disorder
• Treatment often consists of a combination of therapies, including behavioral therapy, parent training, and family therapy (American Academy of Child and Adolescent Psychiatry 2009).
  o In school-age children, parent management strategies (e.g., psychoeducational packages targeting social skills, conflict resolution, anger management) are the most empirically supported programs (Riley et al 2016; American Academy of Child and Adolescent Psychiatry 2007).
  o In adolescence, cognitive interventions and skills training, vocational training, and academic preparations appear to reduce disruptive behaviors (American Academy of Child and Adolescent Psychiatry 2007).
  o Medication alone has not been proven effective in treating oppositional defiant disorder, however it may be helpful as an adjunct to treatment packages, for symptomatic treatment, and for treatment of comorbid conditions (Riley et al 2016; American Academy of Child and Adolescent Psychiatry 2009; 2007).
• Experts agree that therapies such as boot camps or scare tactics are not effective for children and adolescents with oppositional defiant disorder, and may do more harm than good (American Academy of Child and Adolescent Psychiatry 2009).

E. Discharge planning
• see "Common Criteria and Best Practices for All Levels of Care": https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html

Impulse-Control Disorders

This section is applicable in the event that the member’s Impulse-Control Disorder (e.g., Intermittent Explosive Disorder, Pyromania, Kleptomania) or its treatments are covered:

A. Initial evaluation
• Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
  o http://www.psychiatry.org > Psychiatrists > Practice > Clinical Practice Guidelines
• Intermittent explosive disorder (IED) has emerged as a specific predictor of suicide attempt (Fanning et al 2016).
• IED is associated with substantial comorbidity, particularly posttraumatic stress disorder, and its presence should be assessed when evaluating individuals with trauma exposure (Reardon et al 2014).
• Tools such as the screening questionnaire for DSM-5 intermittent explosive disorder (IED-SQ) can be useful to identify the presence of intermittent explosive disorder (Coccaro et al 2017).
• Juvenile firsetting has been associated with conduct disorder and attention-deficit/hyperactivity disorder in some studies (Peters & Freeman 2016).
• The adult literature has suggested an association between psychiatric illness and firsetting behavior, particularly affective disorders and substance use disorders (Peters & Freeman 2016).

B. Differential diagnosis for Impulse-Control Disorders includes (American Psychiatric Association, 2013):
• Disruptive mood dysregulation disorder;
• Antisocial personality disorder or borderline personality disorder;
• Substance intoxication or withdrawal;
• Attention-deficit/hyperactivity disorder;
• Autism spectrum disorder;
• Oppositional defiant disorder or conduct disorder.

C. Treatment planning
• See "Common Criteria and Best Practices for All Levels of Care”, available at: https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html
• Optum recognizes the American Psychiatric Association’s Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
  o http://www.psychiatry.org > Psychiatrists > Practice > Clinical Practice Guidelines

D. Treatment of impulse-control disorders
• Treatment for intermittent explosive disorder often includes multicomponent cognitive-behavioral therapy (e.g., McCloskey et al 2008) and/or SSRI antidepressants (e.g., Coccaro et al 2009).
• In general, interventions for juvenile firsetting have included educational programs and interventions based in cognitive behavior therapy (CBT) (Peters & Freeman 2016).
  o Little is known about short-term and long-term effectiveness and efficacies of the available treatments for arsonists (Horley & Bowlby 2011).

E. Discharge planning
• See "Common Criteria and Best Practices for All Levels of Care": https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html

Conduct Disorder

This section is applicable in the event that the member’s Conduct Disorder or its treatments are covered:

A. Initial evaluation
• See "Common Criteria and Best Practices for All Levels of Care”, available at: https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html
• Many children with a conduct disorder may have coexisting conditions, such as mood or anxiety disorder, posttraumatic stress disorder, substance abuse, attention-deficit/hyperactivity disorder, and learning problems (Silberg et al 2015; American Academy of Child and Adolescent Psychiatry 2013; Morcillo et al 2012).
  o Higher severity of conduct disorder increases risk of comorbid disorders (Morcillo et al 2012).
• Assessment should be multifaceted, including information from the school and other agencies, the care providers, and the child (Baker 2016).

B. Differential diagnosis for conduct disorder includes (American Psychiatric Association, 2013):
• Oppositional defiant disorder;
• Attention-deficit/hyperactivity disorder;
• Depressive and bipolar disorders;
• Intermittent explosive disorder;
• Adjustment disorders.

C. Treatment planning
• See “Common Criteria and Best Practices for All Levels of Care”, available at: 

• In developing a comprehensive treatment plan, information from the child, family, teachers, and other medical specialties is used to understand the causes of the disorder (American Academy of Child and Adolescent Psychiatry 2013).

• Engagement of the family is important, because dropout from treatment is high (National Collaborating Center for Mental Health 2013)

D. Treatment of conduct disorder

• Treatment of conduct disorder can be complex and challenging, especially if long-standing (Baker 2016). Behavior therapy and psychotherapy are usually necessary to help the child appropriately express and control anger (American Academy of Child and Adolescent Psychiatry 2013). A multimodal approach is likely to see greater changes (National Collaborating Center for Mental Health 2013).
  o For young children, parent management training has the strongest support (Baker 2016).
  o Multisystemic therapy is the most promising intervention for adolescents with serious conduct disorders (Baker 2016).

• Early treatment offers a better chance for improvement (American Academy of Child and Adolescent Psychiatry 2013).

F. Discharge planning


REFERENCES*


*Additional reference materials can be found in the reference section(s) of the applicable Level of Care Guidelines

**ADDITIONAL RESOURCES**

**Clinical Protocols**
Optum maintains clinical protocols that include the Level of Care Guidelines and Best Practice Guidelines which describe the scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding treatment. These clinical protocols are available to Covered Persons upon request, and to Physicians and other behavioral health care professionals on www.providerexpress.com.

**Peer Review**
Optum will offer a peer review to the provider when services do not appear to conform to this guideline. The purpose of a peer review is to allow the provider the opportunity to share additional or new information about the case to assist the Peer Reviewer in making a determination including, when necessary, to clarify a diagnosis.

**Second Opinion Evaluations**
Optum facilitates obtaining a second opinion evaluation when requested by an member, provider, or when Optum otherwise determines that a second opinion is necessary to make a determination, clarify a diagnosis or improve treatment planning and care for the member.

**Referral Assistance**
Optum provides assistance with accessing care when the provider and/or member determine that there is not an appropriate match with the member’s clinical needs and goals, or if additional providers should be involved in delivering treatment.

**HISTORY/REVISION INFORMATION**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
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<tr>
<td>02/14/2017</td>
<td>•  Version 1 (Approved by UMC)</td>
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