Mental Health Parity and Addiction Equity Act Non-Quantitative Treatment Limitations – Answers to Key Questions	
This summary describes the general non-quantitative treatment limitations (NQTLs) that are applied to the behavioral benefits provided by United Behavioral Health ("Optum"). A comparable summary of the NQTLs applied to the medical/surgical benefit can be requested from the member's medical/surgical plan.	
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NON-QUANTITATIVE TREATMENTS LIMITATIONS INCLUDED IN THIS SUMMARY:

OPTUM™	Summary of Various Non-Quantitative Treatment Limitations Mental Health Parity and Addiction Equity Act	Applicable to All Classifications

Non-Quantitative Treatment Limitations	Optum Behavioral Health
Are services subject to a medical necessity standard? .	Yes, services received from both Network and non-Network providers meet the following definition of medical necessity: Mental health and substance use disorder ("MH/SUD") services provided for the purpose of preventing, evaluating, diagnosing or treating a MH/SUD, or its symptoms that are all of the following as determined by Optum Behavioral Health Services ("Optum") or our designee, within our sole discretion: • 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 member's MH/SUD or its symptoms. • Not mainly for the member's convenience or that of the member's 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 the member's MH/SUD, or its 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 Physician specialty society recommendations or professional standards of care may be considered. Optum reserves the right to consult expert opinions in determining whether mental health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion. Optum develops and maintains 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. These clinical policies (as developed by Optum and revised from time to time), are available to Covered Persons on Optum's member website or by calling the telephone number on the Covered Person's ID card. They are available to Physicians and other health care professionals on Optum's provider website or by calling the telephone number on the Covered Person's ID card.
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 include 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.

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	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 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.
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: *Experimental or investigational services* are medical, surgical, diagnostic, psychiatric, 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 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

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	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.) 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.
Network Admission Criteria	**In Network** Providers must meet all credentialing criteria outlined in the Optum Credentialing Policies to remain eligible for network participation. The Credentialing Plan is available online at www.providerexpress.com Participation criteria for providers includes: 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

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	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 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. 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.

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	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. 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.

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What is the Basis for Provider Reimbursement?	**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 comparable methodology to that of the medical/surgical plan, for example: 1. Percentage of billed charges; 2. Percentage of CMS fees for the same or similar services within the applicable geographic market based on the provider type. 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 behavioral benefit does not include exclusions based on a failure to complete a course of treatment.
Does the Plan Include Fail First Requirements (also known as step therapy protocols)?	**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:

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	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** Please refer to the pharmacy benefit manager (PBM) for information regarding the process applied by the plan for prescription drug formulary design.
Are There Restrictions Based on Geographic Location?	**In Network & Out of Network** Most plans do not have geographic restrictions. However, when a plan does include a geographic restriction, the behavioral benefits align with that requirement.

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Does the Plan Require Notification for Inpatient Admissions?	**In Network** Optum aligns the notification requirements for the behavioral benefit with those of the medical/surgical plan. In many cases, in network facilities must provide notification of all inpatient admissions, including all Residential Treatment Center (RTC) admissions. Any benefit reductions for failure to provide timely notification that are applied to the behavioral benefit are aligned with those applied to the medical/surgical benefit. **Out of Network** Optum aligns the notification requirements for the behavioral benefit with those of the medical/surgical plan. In many cases, notification must be provided for all inpatient admissions, including all Residential Treatment Center (RTC) admissions. Any benefit reductions for failure to provide timely notification that are applied to the behavioral benefit are aligned with those applied to the medical/surgical benefit. 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 as soon as reasonably possible given the circumstances. Members are allowed to delegate their responsibility to provide notification to the non-network facility.
Does the Plan Require Prior Authorization for Inpatient Services?	**In Network** Optum aligns the authorization requirements for the behavioral benefit with those of the medical/surgical plan. In many cases, in network facilities must provide authorization for all inpatient admissions, including all Residential Treatment Center (RTC) admissions and electroconvulsive therapy (ECT) when scheduled as inpatient, although plan-specific requirements may vary. Any benefit reductions for failure to provide timely authorization that are applied to the behavioral benefit are aligned with those applied to the medical/surgical benefit. In alignment with the processes used by most medical/surgical plans, Optum selects services for notification, authorization, and concurrent review based on a variety of strategies, processes, evidentiary standards and other factors, including: 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

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	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 **Out of Network** Optum aligns the authorization requirements for the behavioral benefit with those of the medical/surgical plan. In many cases, authorization must be provided for all inpatient admissions, including all Residential Treatment Center (RTC) admissions and electroconvulsive therapy (ECT) when scheduled as inpatient, although plan-specific requirements may vary. Any benefit reductions for failure to provide timely authorization that are applied to the behavioral benefit are aligned with those applied to the medical/surgical benefit. When these services are provided out of network, the member is responsible for obtaining authorization and providing relevant information. Members are allowed to delegate their responsibility to provide authorization to the non-network facility. Notice of emergent admissions must be provided as soon as reasonably possible given the circumstances.

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Does the Plan Conduct Concurrent Reviews for Inpatient Services?	**In Network & Out of Network** Optum aligns concurrent review of the behavioral benefit with that of the relevant medical/surgical plan. Inpatient review is a component of many medical/surgical plans' 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. Participating facilities cannot bill non-reimbursable charges 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. Optum never directs an attending physician to discharge a patient. Optum simply informs 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. • Optum uses guidelines, based on nationally recognized clinical guidelines, to assist clinicians in making informed decisions. This includes acute and sub-acute behavioral treatment. Optum's clinical criteria can be requested from the Case Reviewer and are available online at: https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies.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 Optum 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.
Does the Plan Conduct Retrospective Reviews for Inpatient Services?	**In Network & Out of Network** Optum aligns retrospective review of the behavioral benefit with that of the relevant medical/surgical plan. For many medical/surgical plans, retrospective reviews can be conducted on inpatient services. In these instances, 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.

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Does the Plan Require Prior Authorization for Outpatient Services?	**In Network** Optum aligns the authorization requirements for the behavioral benefit with those of the medical/surgical plan. Network providers are required to obtain prior authorization for a small range of planned behavioral services that are covered under the outpatient benefit, although plan-specific requirements may vary: • 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 Any benefit reductions for failure to provide timely authorization that are applied to the behavioral benefit are aligned with those applied to the medical/surgical benefit. In alignment with the processes used by most medical/surgical plans, Optum selects services for notification, authorization, and concurrent review based on a variety of strategies, processes, evidentiary standards and other factors, including: 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

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	Out of Network Optum aligns the authorization requirements for the behavioral benefit with those of the medical/surgical plan. For most plans, prior authorization is required for a small range of planned behavioral health services covered under the outpatient benefit, although plan-specific requirements may vary: • 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 Any benefit reductions for failure to provide timely authorization that are applied to the behavioral benefit are aligned with those applied to the medical/surgical benefit. When these services are provided out of network, the member is responsible for obtaining authorization and providing relevant information. Members are allowed to delegate their responsibility to provide authorization to the non-network provider.
Does the Plan Conduct Outlier Management & Concurrent Review for Outpatient Services?	**In Network & Out of Network** Optum aligns outpatient outlier management and concurrent review processes for the behavioral benefit with those of the medical/surgical plan. For most medical/surgical plans, outpatient outlier management and concurrent reviews can be conducted on outpatient services. In these instances outlier management and concurrent review is based on a variety of strategies, processes, evidentiary standards and other factors, including: • The likelihood for treatment being medically unnecessary increasing with higher number of visits • The likelihood for treatment being medically unnecessary increasing with longer treatment durations • The likelihood for treatment being medically unnecessary increasing with higher number of services per visit • Potential to bill for the same service using multiple levels of coding • Relatively low/modest cost per service • Variable rates of patient progress during a treatment plan • Variable approaches to patient care among providers • Coverage up to and including the point of maximum therapeutic benefit being attained, after which additional improvement is no longer expected, and coverage for the same services may no longer exist

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Does the Plan Conduct Retrospective Review for Outpatient Services?	**In Network & Out of Network** Optum aligns retrospective review of the behavioral benefit with that of the relevant medical/surgical plan. For many medical/surgical plans, retrospective reviews can be conducted on outpatient services. In these instances, 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.