UnitedHealthcare – Individual and Family Plan
12/30/2022

Concurrent Review: In-Network Inpatient Services

Strategy: Concurrent Review is a component of the Plan's utilization management (UM) program that helps ensure hospitalized members receive appropriate care, based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices to reduce unnecessary variation in clinical use of services.

Process: Concurrent review begins after notification of admission. The clinical reviewer's assessment of whether an admission or continued inpatient stay is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria, and nationally recognized guidelines. When appropriately qualified clinical reviewers (e.g., Medical Directors) determine that a continued stay at the facility was not medically necessary, and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided. An in-network provider, depending on the provider contract, may bill the member for non-covered charges.[1]

Inpatient Services Subject to Concurrent Review: In-Network		**Step 1 - Factors Used to Determine the Listed Inpatient Services are Subject to Concurrent Review**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health/ Substance Use Disorder**					
[redacted]	[redacted]	The Plan's methodology used to determine whether the listed M/S and MH/SUD in-network inpatient services are subject to concurrent review are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted]
		• **Clinical Appropriateness**: The application of concurrent review promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those inpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria,	• Expert Medical Review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			and nationally recognized guidelines		[redacted]	**Findings**: The comparative analysis revealed the shared factors, evidentiary standards, and source information used to subject MH/SUD benefits to concurrent review were comparable to, and applied no more stringently than the shared factors, evidentiary standards and source information used to subject M/S benefits to concurrent review. Additionally, the Plan will conduct an analysis of in operations' outcomes data when a sufficient amount of data is available. [2] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN inpatient services are subject to concurrent review "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to concurrent review "in operation."
		• **Value**: The value of applying concurrent review reduces unnecessary variation in inpatient utilization [redacted]	• Value is defined as reducing unnecessary variation in inpatient utilization of services	[redacted]	**Findings**: The findings of the analysis confirmed the strategy, process, factors, evidentiary standards, and source information used to subject certain MH/SUD inpatient services to concurrent review were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S inpatient services to concurrent review "as written." **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN inpatient services are subject to concurrent review "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to concurrent review "as written."	

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of the River Valley and UnitedHealthcare of Georgia, Inc.
12/30/2022

Concurrent Review: In-Network Inpatient Services

Strategy: Concurrent Review is a component of the Plan's utilization management (UM) program that helps ensure hospitalized members receive appropriate care, based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices to reduce unnecessary variation in clinical use of services.

Process: Concurrent review begins after notification of admission. The clinical reviewer's assessment of whether an admission or continued inpatient stay is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria, and nationally recognized guidelines. When appropriately qualified clinical reviewers (e.g., Medical Directors) determine that a continued stay at the facility was not medically necessary, and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided. An in-network provider, depending on the provider contract, may bill the member for non-covered charges.[1]

Inpatient Services Subject to Concurrent Review: In-Network		**Step 1 - Factors Used to Determine the Listed Inpatient Services are Subject to Concurrent Review**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health/ Substance Use Disorder**					
[redacted]	[redacted]	The Plan's methodology used to determine whether the listed M/S and MH/SUD in-network inpatient services are subject to concurrent review are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted]
		• **Clinical Appropriateness**: The application of concurrent review promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those inpatient services that as determined by internal medical experts, are in accordance with objective, evidence-	• Expert Medical Review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		**Findings**: The findings of the analysis of the shared factors as

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.
[3] The process for concurrent level of care reviews for M/S services changed on 05/01/21 as a result of the M/S change to external third-party clinical criteria used in concurrent level of care reviews. Prior to 05/01/21, the external clinical criteria used by M/S informed which diagnosis were associated with inpatient admissions for goal length of stays resulting in approvals for certain diagnoses. From 05/01/21 to 08/31/21 and forward, the external clinical criteria used by M/S does not include length of stay criteria, resulting in reviews of all admissions.

[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			based clinical criteria, and nationally recognized guidelines		[redacted]	evidenced by the factor grid and the findings of the analysis of outcomes data indicated the concurrent review medical necessity approval and denial rates and appeals outcomes for MH/SUD inpatient services were comparable to the concurrent review medical necessity approval and denial rates and appeals outcomes for M/S inpatient services.[2] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN inpatient services are subject to concurrent review "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to concurrent review "in operation."
		• **Value**: The value of applying concurrent review reduces unnecessary variation in inpatient utilization [redacted]	• Value is defined as reducing unnecessary variation in inpatient utilization of services	[redacted]	**Findings**: The findings of the analysis confirmed the strategy, process, factors, evidentiary standards, and source information used to subject certain MH/SUD inpatient services to concurrent review were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S inpatient services to concurrent review "as written." **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN inpatient services are subject to concurrent review "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to concurrent review "as written."	

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.
[3] The process for concurrent level of care reviews for M/S services changed on 05/01/21 as a result of the M/S change to external third-party clinical criteria used in concurrent level of care reviews. Prior to 05/01/21, the external clinical criteria used by M/S informed which diagnosis were associated with inpatient admissions for goal length of stays resulting in approvals for certain diagnoses. From 05/01/21 to 08/31/21 and forward, the external clinical criteria used by

[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Individual and Family Plan
12/30/2022

Concurrent Review: In-Network Outpatient Services

Strategy: Concurrent review is a component of the Plan's utilization management program (UM) that helps ensure members receive appropriate care, based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices to reduce unnecessary variation in clinical use of services.

Process: Concurrent reviews include requests for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services. This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by the Plan. Review for in-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., urgent or non-urgent). If the request is not "urgent", the request may be reclassified as a non-urgent pre-service request. A pre-service concurrent review is a review of all reasonably necessary supporting information that occurs prior to the delivery of provision of a health care service and results in a decision to approve or deny payment for the health care services.[1]

The reviewer's assessment of whether a continuing course of outpatient treatment is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria and nationally recognized guidelines, and the terms of the Plan. When the Medical Director, Physical Therapist, Chiropractor or Psychologist determines that the continuing course of treatment is not medically necessary, and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided. An in-network provider, depending on the provider contract, may bill the member for non-covered charges.

Outpatient Services Subject to Concurrent Review: In-Network		**Step 1 - Factors Used to Determine the Listed Outpatient Services are Subject to Concurrent Review**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
[redacted]	[redacted]	The Plan's methodology used to determine whether the listed M/S and MH/SUD in-network outpatient services are subject to concurrent review are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted]

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

[redacted]		• **Clinical Appropriateness:** The application of concurrent review promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those outpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines	• Expert medical review of objective, evidence-based clinical criteria, and nationally recognized guidelines	[redacted]	[redacted] **Findings**: The comparative analysis revealed the shared factors, evidentiary standards, and source information used to subject MH/SUD benefits to concurrent review were comparable to, and applied no more stringently than the shared factors, evidentiary standards and source information used to subject M/S benefits to concurrent review. Additionally, the Plan will conduct an analysis of in operations' outcomes data when a sufficient amount of data is available. [2] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN outpatient services are subject to concurrent review "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to concurrent review "in operation."
		• **Value:** The value of applying concurrent review outweighs the associated costs	• Value is defined as the value of subjecting the outpatient services to concurrent review exceeds the administrative costs by at least 1:1	• Internal claims data • UM program operating costs • UM authorization data		
		• **Variation Identified**: Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits	• Variability is defined as cost per episode of service (service units X unit cost) that trigger 2x the mean of other outpatient services and provided to a minimum of twenty unique Plan members	• Internal claims data	**Findings:** The findings of the analysis indicated the strategy, process, factors, evidentiary standards, and source information	

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

					used to subject certain MH/SUD outpatient services to concurrent review were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S outpatient services to concurrent review "as written." **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN outpatient services are subject to concurrent review "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to concurrent review "as written."	

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company and UnitedHealthcare of Georgia, Inc.
12/30/2022

Concurrent Review: In-Network Outpatient Services

Strategy: Concurrent review is a component of the Plan's utilization management program (UM) that helps ensure members receive appropriate care, based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices to reduce unnecessary variation in clinical use of services.

Process: Concurrent reviews include requests for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services. This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by the Plan. Review for in-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., urgent or non-urgent). If the request is not "urgent", the request may be reclassified as a non-urgent pre-service request. A pre-service concurrent review is a review of all reasonably necessary supporting information that occurs prior to the delivery of provision of a health care service and results in a decision to approve or deny payment for the health care services.[1]

The reviewer's assessment of whether a continuing course of outpatient treatment is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria and nationally recognized guidelines, and the terms of the Plan. When the Medical Director, Physical Therapist, Chiropractor or Psychologist determines that the continuing course of treatment is not medically necessary, and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided. An in-network provider, depending on the provider contract, may bill the member for non-covered charges.

Outpatient Services Subject to Concurrent Review: In-Network		**Step 1 - Factors Used to Determine the Listed Outpatient Services are Subject to Concurrent Review**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
[redacted]	[redacted]	The Plan's methodology used to determine whether the listed M/S and MH/SUD in-network outpatient services are subject to concurrent review are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted]

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.

[redacted] tcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

[redacted]		• **Clinical Appropriateness:** The application of concurrent review promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those outpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines	• Expert medical review of objective, evidence-based clinical criteria, and nationally recognized guidelines	[redacted]	[redacted] **Findings:** The findings of the analysis of the shared factors as evidenced by the factor grid and the findings of the analysis of outcomes data indicated the concurrent review medical necessity approval and denial rates and appeals outcomes for MH/SUD outpatient services were comparable to the concurrent review medical necessity approval and denial rates and appeals outcomes for M/S outpatient services.[3] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN outpatient services are subject to concurrent review "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to concurrent review "in operation."
		• **Value:** The value of applying concurrent review outweighs the associated costs	• Value is defined as the value of subjecting the outpatient services to concurrent review exceeds the administrative costs by at least 1:1	• Internal claims data • UM program operating costs • UM authorization data		
		• **Variation Identified**: Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits	• Variability is defined as cost per episode of service (service units X unit cost) that trigger 2x the mean of other outpatient services and provided to a minimum of twenty unique Plan members	• Internal claims data		

Findings: The findings of the analysis indicated the strategy, process, factors, evidentiary

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.

[redacted] tcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

					standards, and source information used to subject certain MH/SUD outpatient services to concurrent review were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S outpatient services to concurrent review "as written." **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN outpatient services are subject to concurrent review "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to concurrent review "as written."	

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable. [redacted] comes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company and UnitedHealthcare Insurance Company of the River Valley
12/30/2022

Concurrent Review: Out-of-Network Inpatient Services

Strategy: Concurrent Review is a component of the Plan's utilization management (UM) program that helps ensure hospitalized members receive appropriate care, based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices to reduce unnecessary variation in clinical use of services.

Process: When the plan has out-of-network (OON) benefits, concurrent review begins after notification of admission. The clinical reviewer's assessment of whether an admission or continued inpatient stay is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria, and nationally recognized guidelines. When appropriately qualified clinical reviewers (e.g., Medical Directors) determine that an admission or continued stay at the facility is not medically necessary, and will not be covered, the member, facility, and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided. An OON provider may bill the member for non-covered charges.[1]

Inpatient Services Subject to Concurrent Review: Out-of-Network		**Step 1 - Factors Used to Determine the Listed Inpatient Services are Subject to Concurrent Review**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health/ Substance Use Disorder**					
[redacted]	[redacted]	The Plan's methodology used to determine whether the listed M/S and MH/SUD OON inpatient services are subject to concurrent review are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted] **Findings:** The findings of the analysis of the shared factors as evidenced by the factor grid and the findings of the analysis of outcomes data indicated
		• **Clinical Appropriateness:** The application of concurrent review promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those inpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria,	• Expert Medical Review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.
[3] The process for concurrent level of care reviews for M/S services changed on 05/01/21 as a result of the M/S change to external third-party clinical criteria used in concurrent level of care reviews. Prior to 05/01/21, the external clinical criteria used by M/S informed which diagnosis were associated with inpatient admissions for goal length of stays resulting in approvals for certain diagnoses. From 05/01/21 to 08/31/21 and forward, the external clinical criteria used by

[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			and nationally recognized guidelines			the concurrent review medical necessity approval and denial rates and appeals outcomes for MH/SUD inpatient services were comparable to the concurrent review medical necessity approval and denial rates and appeals outcomes for M/S inpatient services.[2] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD OON inpatient services are subject to concurrent review "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON inpatient services are subject to concurrent review "in operation."
		• **Value:** The value of applying concurrent review reduces unnecessary variation in inpatient utilization [redacted]	• Value is defined as reducing unnecessary variation in inpatient utilization of services	[redacted]	[redacted] **Findings:** The findings of the analysis reflected the strategy, process, factors, evidentiary standards, and source information used to subject certain MH/SUD inpatient services to concurrent review were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S inpatient services to concurrent review "as written." **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD OON inpatient services are subject to concurrent review "as written" were comparable to and applied no more stringently than the methodology used to determine which M/S OON inpatient services are subject to concurrent review "as written."	

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.
[3] The process for concurrent level of care reviews for M/S services changed on 05/01/21 as a result of the M/S change to external third-party clinical criteria used in concurrent level of care reviews. Prior to 05/01/21, the external clinical criteria used by M/S informed which diagnosis were associated with inpatient admissions for goal length of stays resulting in approvals for certain diagnoses. From 05/01/21 to 08/31/21 and forward, the external clinical criteria used by

[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company
12/30/2022

Concurrent Review: Out-of-Network Outpatient Services

Strategy: Concurrent Review is a component of the Plan's utilization management (UM) program that helps ensure members receive appropriate care, based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices to reduce unnecessary variation in clinical use of services.

Process: When the plan has out-of-network (OON) benefits, concurrent reviews include requests for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services. This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by the Plan. Review for out-of-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., urgent or non-urgent). If the request is not "urgent", the request may be reclassified as a non-urgent pre-service request. A pre-service concurrent review is a review of all reasonably necessary supporting information that occurs prior to the delivery of provision of a health care service and results in a decision to approve or deny payment for the health care services.[1]

The reviewer's assessment of whether a continuing course of outpatient treatment is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria and nationally recognized guidelines and the terms of the Plan. When the Medical Director, Physical Therapist, Chiropractor or Psychologist determines that the continuing course of treatment is not medically necessary, and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided. An OON provider may bill the member for non-covered charges.

Outpatient Services Subject to Concurrent Review: Out-of-Network [redacted]		**Step 1 - Factors Used to Determine the Listed Outpatient Services are Subject to Concurrent Review**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings. and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings. and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
[redacted]	[redacted]	The Plan's methodology used to determine whether the listed M/S and MH/SUD out-of-network outpatient services are subject to concurrent review are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted]
		• **Clinical Appropriateness:** The application of concurrent review	• Clinical Appropriateness is defined as those outpatient services that as determined by	• Expert Medical Review • Objective, evidence-based clinical criteria,		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.

[redacted] tcomes data are not dispositive of parity compliance.

[4] Services may not be covered benefits when provided by out of network providers. Utilization review is not applied to non-covered services.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

[redacted],		promotes optimal clinical outcomes	internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines	and nationally recognized guidelines	[redacted]	[redacted] **Findings:** The findings of the analysis of the shared factors as evidenced by the factor grid and the findings of the analysis of outcomes data indicated the concurrent review medical necessity approval and denial rates and appeals outcomes for MH/SUD outpatient services were comparable to the concurrent review medical necessity approval and denial rates and appeals outcomes for M/S outpatient services.[3] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD OON outpatient services are subject to concurrent review "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to concurrent review "in operation."
		• **Value:** The value of applying concurrent review outweighs the associated costs	• Value is defined as the value of subjecting the outpatient services to concurrent review exceeds the administrative costs by at least 1:1	• Internal claims data • UM program operating costs • UM authorization data		
		• **Variation Identified**: Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits	• Variability is defined as cost per episode of service (service units X unit cost) that trigger 2x the mean of other outpatient services and provided to a minimum of twenty unique Plan members	• Internal claims data		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable. [redacted]
[3] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.
[4] Services may not be covered benefits when provided by out of network providers. Utilization review is not applied to non-covered services.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

[redacted]					**Findings:** The findings of the analysis reflected the strategy, process, factors, evidentiary standards, and source information used to subject certain MH/SUD outpatient services to concurrent review were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S outpatient services to concurrent review "as written." **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD OON outpatient services are subject to concurrent review "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to concurrent review "as written."	

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable. [redacted]

[3] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.
[4] Services may not be covered benefits when provided by out of network providers. Utilization review is not applied to non-covered services.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

Credentialing: Inpatient In-Network; Outpatient In-Network; and Emergency Care Services

Strategy: Credentialing is performed to determine if a provider or facility meets standards to join (credential) or maintain (recredential) their status in the Plan's network of participating providers. The Plan uses its credentialing and recredentialing processes to validate that its network of contracted providers and facilities providing inpatient, outpatient, and emergency services meet the baseline criteria, as applicable, to the State and practicing specialty.

Process: The process is triggered by a provider or facility seeking to join or continue participation in the Plan's network to determine whether the provider or facility has the appropriate level of education/licensure/certification and satisfies additional qualifications (as applicable) to provide covered care to Plan members. The Plan uses credentialing processes and plans based on NCQA standards and applicable state or Federal regulatory requirements when determining whether to credential M/S and MH/SUD providers or facilities. To successfully complete the credentialing process, both M/S and MH/SUD providers and facilities must meet the baseline criteria as applicable to the State and practicing specialty, which can be found in the UnitedHealthcare (UHC) Credentialing Plan or United Behavioral Health (UBH) d/b/a Optum Credentialing Plan or state addendum. Individual (and certain facility-based) providers must complete the CAQH application, or state-mandated application where applicable, and attestation.

Credentialing: Inpatient In-Network, Outpatient In-Network, Emergency Care		**Step 1 - Factors Used to Determine Whether to Credential a Provider or Facility** The Plan's methodology used to determine if a provider or facility meets standards to join (credential) or maintain (recredential) their status in the Plan's network of participating providers. The factors are not weighted.	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor** The plans evidentiary standards that define and/or trigger the identification of a factor	**Step 3 - Sources Used to Define the Factors** The sources used to define the factors include	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical (M/S)	**Mental Health / Substance Use Disorder (MH/SUD)**					
Credentialing applies to all in-network providers and facilities providing covered services in the Inpatient In-Network, Outpatient In-Network, and Emergency Care classifications	Same as M/S	• The provider or facility completes and attests to the accuracy of the content of the application	• Submission of application	• Submission of application	For M/S, the UHC National Credentialing Committee ("NCC") is responsible for implementing the UHC Credentialing Plan. The NCC is comprised of Participating Licensed Individual Providers (LIPs) from the Credentialing Entities, UHC Medical Directors, and a designated Medical Director Chairperson, unless a different committee composition is otherwise required by applicable Credentialing Authorities. The NCC informs providers of credentialing decisions within applicable state or federally mandated timeframes.	Both M/S and MH/SUD use the credentialing and recredentialing process to ensure its network of contracted providers, who require credentialing, and providers seeking to join the Plan's network, have the appropriate qualifications in order to provide care to Plan members according to the UHC and UBH Credentialing Plans. The UBH Credentialing Plan can be referenced on the website https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelin
		• The Plan verifies certain information, i.e., primary source verification, in the application	• The UHC and UBH Credentialing plans describe the information, i.e., primary source verification, that is required	• The UHC and UBH Credentialing plans describes the information, i.e., primary source verification, that is required		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

		• The provider or facility continues to meet the requirements set forth in the credentialing plan while they are contracted with the Plan	• State and federal regulatory requirements, for example, Medicare Managed Care Manual, Section 6 • National accreditation standards, for example NCQA CR3 and CR4 • The UHC and UBH Credentialing Plans	• State and federal regulatory requirements, for example, Medicare Managed Care Manual, Section 6 • National accreditation standards, for example NCQA CR3 and CR4 • The UHC and UBH Credentialing plans	For MH/SUD, the Plan delegates credentialing of behavioral health network providers to its affiliate Optum. The UBH Credentialing Committee is responsible for implementing its Credentialing Plan. The Optum Credentialing Committee is multi-disciplinary and must have at least two Optum Medical Directors as members. At least two of the 12 members must be external participating clinicians from each major discipline (i.e., MD, PhD, and MSW). The Optum Credentialing Committee informs providers of credentialing decisions within applicable state or federally mandated timeframes. The UHC and UBH Credentialing Plans are both accredited by NCQA. UHC and Optum review the Credentialing Plans annually. UHC and Optum conduct a comparability analysis at least annually to assess parity. At times, UHC and Optum may delegate credentialing to third parties. We perform oversight of delegated credentialing as outlined in the UHC and UBH Credentialing Plans. **Findings:** The findings of the parity analysis revealed the Credentialing Plan for MH/SUD network providers was comparable to, and applied no more stringently than, the Credentialing Plan for M/S network providers. **Conclusion:** In light of the above, the Plan concluded the credentialing requirements applied to MH/SUD network providers were comparable to, and applied no more stringently than, the credentialing	es/credPlans/credPlanUBH.pdf to access the regulatory and accreditation timeframes. The UHC Credentialing Plan can be referenced on the website https://www.uhcprovider.com/en/resource-library/Join-Our-Network.html to access the regulatory and accreditation timeframes. M/S and MH/SUD review credentialing applications received, denied, and credentialed for organizations and clinicians. A comparative analysis of the number of credentialing applications received, denied, credentialed, and cancelled for organizations and clinicians was conducted. **Findings:** The findings revealed there were no significant disparate outcomes for MH/SUD providers as compared to M/S providers **Conclusion:** The Plan concluded the credentialing requirements applied to MH/SUD network providers were comparable to, and applied no more stringently than, the credentialing requirements applied to M/S network providers “in operation.”

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

					requirements applied to M/S network providers “as written.”	

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Student Resources
12/30/2022

Experimental/Investigational- All Benefit Classifications

Strategy: The Plan excludes coverage of technologies determined to be experimental, investigational, or unproven (EIU) for specific diagnoses based on medical/behavioral clinical policies and plan documents. The Plan develops evidence-based medical/behavioral clinical policies for select M/S and MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.).

[redacted]

[redacted] All medical/behavioral clinical policies are reviewed and/or updated at least once annually.

Technologies Determined to be Experimental, Investigational or Unproven (EIU)		**Step 1 - Factors Used to Assess Whether a Technology is Experimental, Investigational or Unproven**	**Steps 2 and 3 - Evidentiary Standards and Sources Used to Define the Factors**		**Step 4 – NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 – NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical (M/S)	**Mental Health/ Substance Use Disorder (MH/SUD)**	The factors are not weighted.	**Medical/Surgical (M/S)**	**Mental Health/ Substance Use Disorder (MH/SUD)**	[redacted]	[redacted]
All technologies determined to be EIU The Plan excludes coverage of M/S technologies (e.g., services, interventions, devices, etc.) determined to be experimental, investigational, and unproven as defined by the governing Certificate of Coverage	All technologies determined to be EIU The Plan excludes coverage of MH/SUD technologies (e.g., services, interventions, etc.), determined to be experimental, investigational and unproven as defined by the governing Certificate of Coverage.	• Plan exclusions for EIU technologies and EIU definitions as outlined in plan documents [redacted]	• Plan documents [redacted]	• Plan documents [redacted]	MH/SUD and M/S reference plan documents to determine if the EIU	

definitions of Elective Surgery or Elective Treatment. Experimental or Investigational Service or Unproven Service.	definitions of Elective Surgery or Elective Treatment. Experimental or Investigational Service or Unproven Service.		[redacted]	[redacted]	technologies are excluded. If EIU technologies are excluded, MH/SUD and M/S defer to the plan definitions of EIU. [redacted] **Findings:** The findings of the analysis reflected the strategies, processes, factors, evidentiary standards, and source information MH/SUD used to (1) assess whether technologies are EIU and (2) develop evidenced-based behavioral clinical policies were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information M/S used to 1) assess whether a technology is EIU and (2) develop evidence-based medical clinical policies “as written.” **Conclusion:** The Plan concluded the methodologies MH/SUD used to 1) assess whether a technology is EIU and (2) develop evidence-based behavioral clinical policies were comparable to, the methodologies M/S used to 1) assess whether a technology is EIU and (2) develop evidence-based medical clinical policies “as written.”	The Plan confirmed M/S and MH/SUD use the same definitions of EIU as defined in plan documents. [redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

				[redacted]		**Findings**: The comparative analysis revealed the strategies, processes and methodology MH/SUD used to assess EIU technologies and develop behavioral clinical policies "in operation" was comparable to, and applied no more stringently than, the strategies, processes and methodology M/S used to assess EIU technologies and develop of medical clinical policies. [redacted] methodologies MH/SUD used to 1) assess whether a technology is EIU and (2) develop evidence-based behavioral clinical policies were comparable to, the methodologies M/S used to 1) assess whether a technology is EIU and (2) develop evidence-based medical clinical policies "in-operation."

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of the River Valley, UnitedHealthcare of Georgia, Inc. and Individual and Family Plan
12/30/2022

Experimental/Investigational – All Benefit Classifications

Strategy: The Plan excludes coverage of technologies determined to be experimental, investigational, or unproven (EIU) for specific diagnoses based on medical/behavioral clinical policies and plan documents. The Plan develops evidence-based medical/behavioral clinical policies for select M/S and MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.).

[redacted]

[redacted]All medical/behavioral clinical policies are reviewed and/or updated at least once annually.

<table>
<tr><th colspan="2">Technologies Determined to be Experimental, Investigational or Unproven (EIU)</th><th rowspan="2">Step 1 - Factors Used to Assess Whether a Technology is Experimental, Investigational or Unproven

The factors are not weighted.</th><th colspan="2">Steps 2 and 3 - Evidentiary Standards and Sources Used to Define the Factors</th><th rowspan="2">Step 4 – NQTL “As Written” Comparability and Stringency Analysis, Findings, and Conclusions</th><th rowspan="2">Step 5 – NQTL “In Operation” Comparability and Stringency Analysis, Findings, and Conclusions</th></tr>
<tr><th>Medical/ Surgical (M/S)</th><th>Mental Health/ Substance Use Disorder (MH/SUD)</th><th>Medical/Surgical (M/S)</th><th>Mental Health/ Substance Use Disorder (MH/SUD)</th></tr>
<tr><td rowspan="2">All technologies determined to be EIU</td><td rowspan="2">All technologies determined to be EIU</td><td>• Plan exclusions for EIU technologies and EIU definitions as outlined in plan documents</td><td>• Plan documents</td><td>• Plan documents</td><td rowspan="2">The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information MH/SUD used to (1) assess whether a technology is EIU and (2) develop evidence-based behavioral clinical policies are comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information M/S used to (1) assess whether a technology is EIU and (2) develop evidence-based medical clinical policies “as written.”

MH/SUD and M/S reference plan documents to determine if the EIU</td><td rowspan="2">The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information MH/SUD used to (1) assess whether a technology is EIU and (2) develop evidence-based behavioral clinical policies are comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information M/S used to (1) assess whether a technology is EIU and (2) develop evidence-based medical clinical policies “in operation.”</td></tr>
<tr><td>[redacted]</td><td>[redacted]</td><td>[redacted]</td></tr>
</table>

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			[redacted]	[redacted]	technologies are excluded. If EIU technologies are excluded, MH/SUD and M/S defer to the plan definitions of EIU. [redacted] **Findings:** The findings of the analysis reflected the strategies, processes, factors, evidentiary standards, and source information MH/SUD used to (1) assess whether technologies are EIU and (2) develop evidenced-based behavioral clinical policies were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information M/S used to 1) assess whether a technology is EIU and (2) develop evidence-based medical clinical policies "as written." **Conclusion:** The Plan concluded the methodologies MH/SUD used to 1) assess whether a technology is EIU and (2) develop evidence-based behavioral clinical policies were comparable to, the methodologies M/S used to 1) assess whether a technology is EIU and (2) develop evidence-based medical clinical policies "as written."	The Plan confirmed M/S and MH/SUD use the same definitions of EIU as defined in plan documents. [redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

				[redacted]		**Findings**: The comparative analysis revealed the strategies, processes and methodology MH/SUD used to assess EIU technologies and develop behavioral clinical policies "in operation" was comparable to, and applied no more stringently than, the strategies, processes and methodology M/S used to assess EIU technologies and develop of medical clinical policies. [redacted] **Conclusion**: The Plan concluded the methodologies MH/SUD used to 1) assess whether a technology is EIU and (2) develop evidence-based behavioral clinical policies were comparable to, the methodologies M/S used to 1) assess whether a technology is EIU and (2) develop evidence-based medical clinical policies "in-operation."

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Student Resources
12/30/2022

Geographic Restrictions for Out-of-Network Non-Emergent, Subacute Inpatient and Outpatient Services Received Outside Covered Person's State of Residence

Strategy: Geographic Restrictions, out-of-network, out-of-area service limitation is intended to encourage members to utilize in-network providers. The out-of-network, out-of-area, geographic restriction does not limit coverage for out-of-network benefits within the member's service area, nor does it limit in-network services nationally. The goal is to promote access to evidence-based care and improved treatment outcomes.

Process: A member's request for care is assessed to determine whether the servicing provider is an in- or out-of-network provider and within a level of care subject to the restriction. Service requests rendered by an out-of-network provider, out of the member's service area are denied administratively as a non-covered benefit.

Services Subject to Geographic Restrictions		**Step 1 - Factors Used to Determine the Services are Subject to the NQTL**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical (M/S)	**Mental Health / Substance Use Disorder (MH/SUD)**					
Student Resources does not use Geographic Restrictions.	Student Resources does not use Geographic Restrictions.	The Plan's methodology used to determine whether the listed M/S and MH/SUD services are subject to the NQTL are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	• N/A	• N/A
		• N/A	• N/A	• N/A		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of the River Valley and UnitedHealthcare of Georgia, Inc.
12/30/2022

Geographic Restrictions for Out-of-Network Non-Emergent, Subacute Inpatient and Outpatient Services Received Outside Covered Person's State of Residence

Strategy: Geographic Restrictions, out-of-network, out-of-area service limitation is intended to encourage members to utilize in-network providers. The out-of-network, out-of-area, geographic restriction does not limit coverage for out-of-network benefits within the member's service area, nor does it limit in-network services nationally. The goal is to promote access to evidence-based care and improved treatment outcomes.

Process: A member's request for care is assessed to determine whether the servicing provider is an in- or out-of-network provider and within a level of care subject to the restriction. Service requests rendered by an out-of-network provider, out of the member's service area are denied administratively as a non-covered benefit.

Services Subject to Geographic Restrictions		**Step 1 - Factors Used to Determine the Services are Subject to the NQTL**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical (M/S)	**Mental Health / Substance Use Disorder (MH/SUD)**					
Under the Plan benefit documents, services received at the following facilities are subject to the out-of-network geographic restriction: Health care services from an Out-of-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Inpatient Rehabilitation Facility, or Skilled Nursing Facility received outside of the Covered Person's state of residence.	Under the Plan benefit documents, services received at the following facilities are subject to the out-of-network geographic restriction: Health care services from an Out-of-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, or Residential Treatment/Rehabilitation Facility received outside of the Covered Person's state of residence.	The Plan's methodology used to determine whether the listed M/S and MH/SUD services are subject to the NQTL are based upon the following factors. The factors are not weighted. • Out-of-network (OON) facilities providing non-emergent, subacute inpatient and/or outpatient services located outside of the member's state of residence Services not subject to geographic restriction include: • Out-of-network facilities providing emergency acute inpatient and/or outpatient services located outside of the member's state of residence; • Out-of-network facilities providing non-emergent, subacute	The Plan's evidentiary standards that define and/or trigger the identified factors include • Facility is out-of-network; AND • Facility provides non-emergent, subacute inpatient and/or outpatient services; AND • Facility is located outside of the member's state of residence "State of residence" is defined as: • The state where the Covered Person is a legal resident; plus any geographically bordering adjacent state; or • For a Covered Person who is a	The sources used to define the factors include • Provider Directory • Treatment type requested and/or billed. e.g., revenue codes, HCPCS, etc. • Facility service location/address • Member address • Plan benefit documents	[redacted] **Findings:** The findings of the analysis revealed that both M/S and MH/SUD services received at comparable OON facilities outside of the member's state of residence were subject to the Geographic Restriction. The same triggering events for the NQTL were applied to both M/S and MH/SUD services and the State of Residence was defined similarly for all services. The same sources of information were used to define the factors. **Conclusion:** Based on this comparative analysis, the Plan	[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

		inpatient and/or outpatient services located within the member's state of residence and • All in-network services	student, the state where the student is attending school, during the school year		concluded the strategy, process, factors, evidentiary standards, and source information used to develop the Geographic Restriction applied to MH/SUD services were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards and source information applied to M/S services "as written."	

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Student Resources
12/30/2022

In-Network Provider Reimbursement: Facility-Based Services

[redacted]

In-Network Facility-Based Services Subject to Reimbursement Methodology		Step 1 - Factors Used to Determine In-Network Provider Reimbursement Rates Provider reimbursements for in-network M/S and MH/SUD facility-based services are determined through a negotiated process and are based upon the following factors. The factors are not weighted.	Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor The Plan's evidentiary standards that define, trigger and/or implicate a factor include	Step 3 - Sources Used to Define the Factors Sources used to define the factors include	Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions	Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions
Medical/ Surgical (M/S)	**Mental Health / Substance Use Disorder (MH/SUD)**					
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			[redacted]	[redacted]	[redacted]	[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

						[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of the River Valley, UnitedHealthcare of Georgia, Inc. and Individual and Family Plan
12/30/2022

In-Network Provider Reimbursement: Facility-Based Services

[redacted]

In-Network Facility-Based Services Subject to Reimbursement Methodology		**Step 1 - Factors Used to Determine In-Network Provider Reimbursement Rates** Provider reimbursements for in-network M/S and MH/SUD facility-based services are determined through a negotiated process and are based upon the following factors. The factors are not weighted.	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor** The Plan's evidentiary standards that define, trigger and/or implicate a factor include	**Step 3 - Sources Used to Define the Factors** Sources used to define the factors include	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical (M/S)	**Mental Health / Substance Use Disorder (MH/SUD)**					
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			[redacted]	[redacted]	[redacted]	[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

						[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Student Resources
12/30/2022

In-Network Provider Reimbursement: Professional Services

[redacted]

Professional Services Subject to In-Network Provider Reimbursement Methodology		Step 1 - Factors Used to Determine In-Network Provider Reimbursement Rates	Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor	Step 3 - Sources Used to Define the Factors	Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions	Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions
Medical/ Surgical (M/S)	**Mental Health / Substance Use Disorder (MH/SUD)**	Provider reimbursements for In-network M/S and MH/SUD professional services are determined based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define, trigger and/or implicate a factor include	Sources used to define the factors include		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			[redacted]		[redacted]	[redacted]
		[redacted]	[redacted]	[redacted]		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

						[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

						[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

						[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

						[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

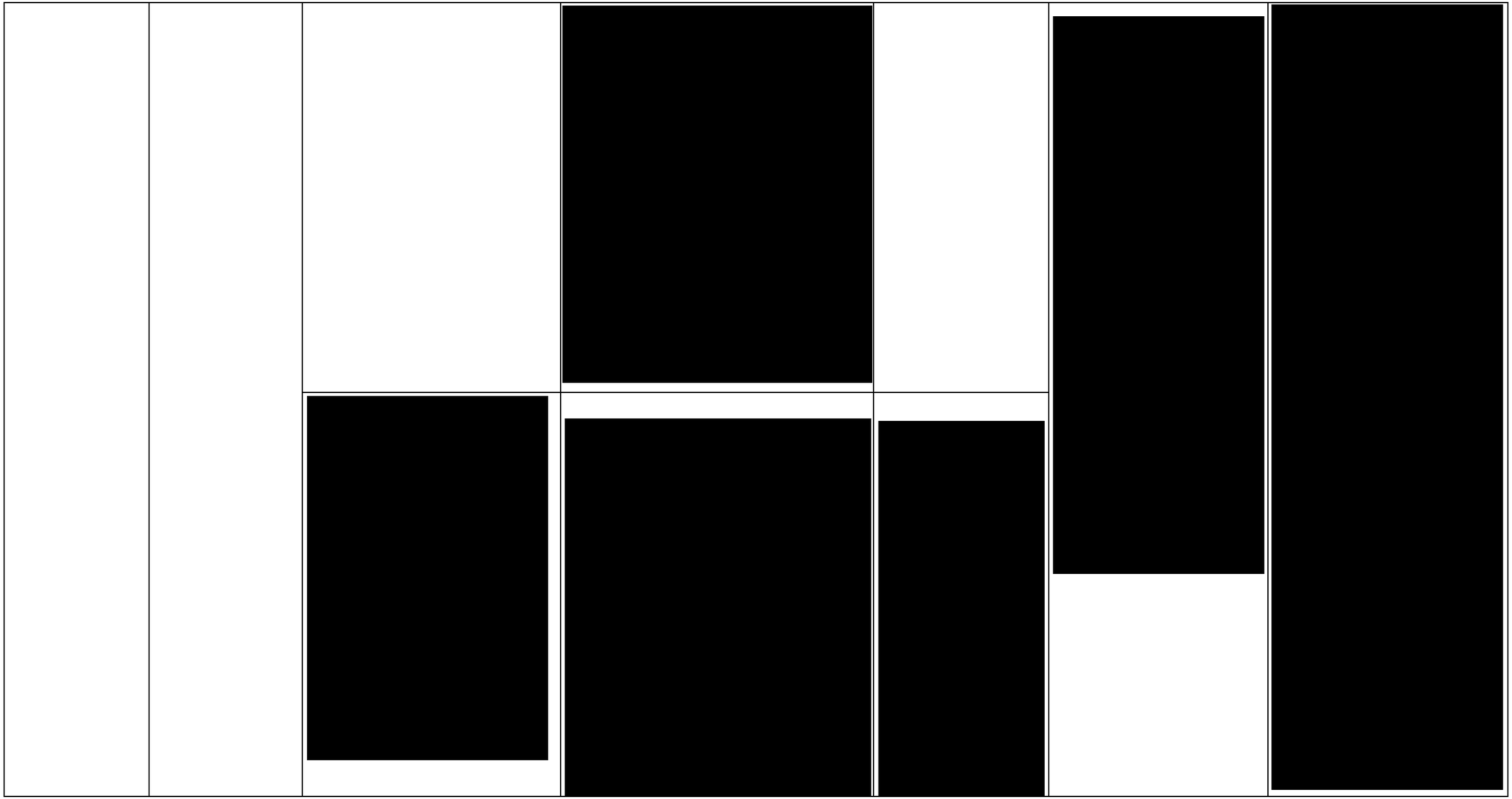
UnitedHealthcare – UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of the River Valley, UnitedHealthcare of Georgia, Inc. and Individual and Family Plan
12/30/2022

In-Network Provider Reimbursement: Professional Services

[redacted]

Professional Services Subject to In-Network Provider Reimbursement Methodology		Step 1 - Factors Used to Determine In-Network Provider Reimbursement Rates	Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor	Step 3 - Sources Used to Define the Factors	Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions	Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions
Medical/ Surgical (M/S)	**Mental Health / Substance Use Disorder (MH/SUD)**	Provider reimbursements for In-network M/S and MH/SUD professional services are determined based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define, trigger and/or implicate a factor include	Sources used to define the factors include		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.



Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

						[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

						[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

						[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

						[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Student Resources
12/30/2022

Medical Necessity – All Benefit Classifications

[redacted]

Process: To approve medical policy/behavioral clinical policy and/or clinical criteria, committees have been established and a standard process is followed. [redacted]

Technologies Subject to Medical Necessity		Step 1 - Factors Used to Approve and Develop Medical and Behavioral Clinical Policies a/k/a Medical Necessity Criteria The factors are not weighted.	Steps 2 and 3 - Evidentiary Standards and Sources Used to Define, Trigger and/or Implicate a Factor		Step 4 – NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions	Step 5 – NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions
Medical/ Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)		Medical/ Surgical (M/S)	Mental Health/Substance Use Disorder (MH/SUD)		
[redacted]	[redacted]	Committee considerations: • Clinical efficacy • Safety • Appropriateness of the proposed technology	[redacted]	[redacted]	[redacted]	[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

				[redacted]	[redacted] **Findings:** The findings of the analysis reflected the strategy, processes, factors, evidentiary standards, and source information MH/SUD used to (1) develop internal evidence-based medical/clinical policies and (2) approve externally developed criteria for use in utilization management were comparable to, and applied no more stringently than, the strategy, processes, factors, evidentiary standards, and source information M/S used to develop evidenced-based medical policies “as written.” **Conclusion:** The Plan concluded the methodologies used to (1) develop MH/SUD internal evidence-based	[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			[redacted]		medical/clinical policies and (2) approve MH/SUD externally developed criteria for use in utilization management were comparable to, and applied no more stringently than, the methodologies used to (1) develop M/S internal evidence-based medical/clinical policies and (2) approve M/S externally developed criteria for use in utilization management "in-writing."	[redacted] **Findings:** The findings of the analysis revealed the processes and methodology MH/SUD used to assess and develop clinical policies "in operation" was comparable to, and applied no more stringently than, the processes and methodology M/S used to assess and develop medical policies. **Conclusion:** The Plan concluded the methodologies used to (1) develop MH/SUD internal evidence-based medical/clinical policies and (2) approve MH/SUD externally developed criteria for use in utilization management were comparable to, and applied no more stringently than, the methodologies used to (1) develop M/S internal evidence-based medical/clinical policies and (2) approve M/S externally developed criteria for use in utilization management "in-operation."

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of the River Valley, UnitedHealthcare of Georgia, Inc. and Individual and Family Plan
12/30/2022

Medical Necessity – All Benefit Classifications

[redacted]

Process: To approve medical policy/behavioral clinical policy and/or clinical criteria, committees have been established and a standard process is followed. [redacted]

Technologies Subject to Medical Necessity		Step 1 - Factors Used to Approve and Develop Medical and Behavioral Clinical Policies a/k/a Medical Necessity Criteria The factors are not weighted.	Steps 2 and 3 - Evidentiary Standards and Sources Used to Define, Trigger and/or Implicate a Factor		Step 4 – NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions	Step 5 – NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions
Medical/ Surgical (M/S)	**Mental Health/Substance Use Disorder (MH/SUD)**		**Medical/ Surgical (M/S)**	**Mental Health/Substance Use Disorder (MH/SUD)**		
[redacted]	[redacted]	Committee considerations: • Clinical efficacy • Safety • Appropriateness of the proposed technology	[redacted]	[redacted]	[redacted]	[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

				[redacted]	[redacted] **Findings:** The findings of the analysis reflected the strategy, processes, factors, evidentiary standards, and source information MH/SUD used to (1) develop internal evidence-based medical/clinical policies and (2) approve externally developed criteria for use in utilization management were comparable to, and applied no more stringently than, the strategy, processes, factors, evidentiary standards, and source information M/S used to develop evidenced-based medical policies “as written.” **Conclusion:** The Plan concluded the methodologies used to (1) develop MH/SUD internal evidence-based	[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			[redacted]		medical/clinical policies and (2) approve MH/SUD externally developed criteria for use in utilization management were comparable to, and applied no more stringently than, the methodologies used to (1) develop M/S internal evidence-based medical/clinical policies and (2) approve M/S externally developed criteria for use in utilization management "in-writing."	[redacted] **Findings:** The findings of the analysis revealed the processes and methodology MH/SUD used to assess and develop clinical policies "in operation" was comparable to, and applied no more stringently than, the processes and methodology M/S used to assess and develop medical policies. **Conclusion:** The Plan concluded the methodologies used to (1) develop MH/SUD internal evidence-based medical/clinical policies and (2) approve MH/SUD externally developed criteria for use in utilization management were comparable to, and applied no more stringently than, the methodologies used to (1) develop M/S internal evidence-based medical/clinical policies and (2) approve M/S externally developed criteria for use in utilization management "in-operation."

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Student Resources
12/30/2022

Network Management - Network Adequacy

Strategy: The Plan assesses the adequacy of its network based on regulatory requirements and/or whether business or organizational needs are satisfied.

Process: The Plan assesses network adequacy based on access standards that are in accordance with Centers for Medicare & Medicaid Services and/or applicable state laws. When determining whether to recruit providers in a given geographic market (such as a county or metropolitan area), the Plan considers network adequacy and access reports, which standards are based by the Centers for Medicare & Medicaid Services and/or applicable state laws.

Network adequacy and access reports are prepared on a regular basis (no less than quarterly) and shared with the Plan's network teams for recruitment purposes to ensure regulatory network access requirements are met. If the Plan determines it does not meet network adequacy requirements for a specialty or provider type, within set time and distance thresholds as determined by state or federal requirements, the Plan will actively seek to add providers to the network in that specialty or provider type.

If there is a supply gap, the Plan language allows members to seek an exception and receives services from an out-of-network provider at the in-network benefit level.

When implementing a new Plan, the implementation team will run network disruption reports to determine whether new providers are needed to meet the needs of the new plan's membership. The Plan's Sales team may also notify the network team about a customer request to contract with a specific provider. In response, the network team will review adequacy and access reports and determine whether there are available in-network alternatives, whether it's necessary to expand or enhance the network panel and pursue a contract with the provider, as appropriate.

Network Management – Network Adequacy		**Step 1 - Factors Used to Determine the Adequacy of the Network** The Plan's methodology used to assess the adequacy of the network is based on the following factors. The factors are not weighted.	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor** The Plan's evidentiary standards that define and/or trigger the identification of a factor	**Step 3 - Sources Used to Define the Factors** The sources used to define the factors include	**Step 4 – NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 – NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**MH/SUD**					
All In-Network M/S services	All In-Network MH/SUD services	• State-specific standards when state regulations identify a quantifiable network adequacy measurement for geographic and numeric availability • Centers for Medicare & Medicaid Services (CMS)/ Health Services Delivery (HSD) Table [redacted]	• Applicable state regulatory requirements • CMS/Health Services Delivery (HSD) Table	• Applicable state regulatory requirements • CMS/Health Services Delivery (HSD) Table	The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards. and source information used to determine network adequacy for M/S and MH/SUD "as written." Both M/S and MH/SUD run network adequacy reports no less than quarterly to assess the continued adequacy of the network.	The Plan conducted a comparative analysis of the methodology and process MH/SUD used to assess network adequacy to determine whether the methodology and process is comparable to, and applied no more stringently than, the methodology and process M/S used to assess network adequacy "in operation." M/S and MH/SUD network teams review network adequacy data, no less than quarterly, and

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			[redacted]	[redacted]	M/S and MH/SUD network adequacy standards are in accordance with Centers for Medicare & Medicaid Services and/or applicable state established time and distance thresholds. If a geographic access report identifies a potential network gap, both M/S and MH/SUD network teams will work to close the gap through provider recruitment Both M/S and MH/SUD have a process in place to authorize benefit coverage of an out-of-network provider at the in-network benefit level upon member or provider request if a supply gap is identified based on state and federal time and distance thresholds. **Findings**: The findings of that analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine MH/SUD network adequacy were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to	if there is a gap identified both M/S and MH/SUD network teams will work to close the gap through provider recruitment. The outcomes of the network adequacy review are discussed at least quarterly and include findings and subsequent planned actions and interventions for provider recruitment. **Findings:** The findings of the comparative analysis revealed the process and methodology MH/SUD used to assess network adequacy “in operation” was comparable to, and applied no more stringently than, the process and methodology M/S used to assess network adequacy. **Conclusion**: Based upon these findings, the Plan concluded the methodology and processes that M/S and MH/SUD use to determine network adequacy are comparable "in operation.”

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

					determine M/S network adequacy “as written.” Both MH/SUD and M/S run network adequacy reports at least quarterly which are in accordance with CMS and/or state established time and distance thresholds to assess the continued adequacy of the network. Additionally, both M/S and MH/SUD have a process in place to authorize benefit coverage to an out-of-network provider at the in-network benefit level if a supply gap is identified. **Conclusion:** Based upon these findings, the Plan concluded its methodology used to determine network adequacy for MH/SUD was comparable to, and applied no more stringently than, the methodology used to determine network adequacy for M/S “as written.”	

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of the River Valley, UnitedHealthcare of Georgia, Inc. and Individual and Family Plan
12/30/2022

Network Management - Network Adequacy

Strategy: The Plan assesses the adequacy of its network based on regulatory requirements and/or whether business or organizational needs are satisfied.

Process: The Plan assesses network adequacy based on access standards that are in accordance with Centers for Medicare & Medicaid Services and/or applicable state laws. When determining whether to recruit providers in a given geographic market (such as a county or metropolitan area), the Plan considers network adequacy and access reports, which standards are based by the Centers for Medicare & Medicaid Services and/or applicable state laws.

Network adequacy and access reports are prepared on a regular basis (no less than quarterly) and shared with the Plan's network teams for recruitment purposes to ensure regulatory network access requirements are met. If the Plan determines it does not meet network adequacy requirements for a specialty or provider type, within set time and distance thresholds as determined by state or federal requirements, the Plan will actively seek to add providers to the network in that specialty or provider type.

If there is a supply gap, the Plan language allows members to seek an exception and receives services from an out-of-network provider at the in-network benefit level.

[redacted]

Network Management – Network Adequacy		**Step 1 - Factors Used to Determine the Adequacy of the Network** The Plan's methodology used to assess the adequacy of the network is based on the following factors. The factors are not weighted.	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor** The Plan's evidentiary standards that define and/or trigger the identification of a factor	**Step 3 - Sources Used to Define the Factors** The sources used to define the factors include	**Step 4 – NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 – NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**MH/SUD**					
All In-Network M/S services	All In-Network MH/SUD services	• State-specific standards when state regulations identify a quantifiable network adequacy measurement for geographic and numeric availability • Centers for Medicare & Medicaid Services (CMS)/ Health Services Delivery (HSD) Table	• Applicable state regulatory requirements • CMS/Health Services Delivery (HSD) Table	• Applicable state regulatory requirements • CMS/Health Services Delivery (HSD) Table	The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards. and source information used to determine network adequacy for M/S and MH/SUD "as written." Both M/S and MH/SUD run network adequacy reports no less than quarterly to assess the continued adequacy of the network.	The Plan conducted a comparative analysis of the methodology and process MH/SUD used to assess network adequacy to determine whether the methodology and process is comparable to, and applied no more stringently than, the methodology and process M/S used to assess network adequacy "in operation." M/S and MH/SUD network teams review network adequacy data, no less than quarterly, and

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

					M/S and MH/SUD network adequacy standards are in accordance with Centers for Medicare & Medicaid Services and/or applicable state established time and distance thresholds. If a geographic access report identifies a potential network gap, both M/S and MH/SUD network teams will work to close the gap through provider recruitment Both M/S and MH/SUD have a process in place to authorize benefit coverage of an out-of-network provider at the in-network benefit level upon member or provider request if a supply gap is identified based on state and federal time and distance thresholds. **Findings**: The findings of that analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine MH/SUD network adequacy were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to	if there is a gap identified both M/S and MH/SUD network teams will work to close the gap through provider recruitment.  **Findings:** The findings of the comparative analysis revealed the process and methodology MH/SUD used to assess network adequacy “in operation” was comparable to, and applied no more stringently than, the process and methodology M/S used to assess network adequacy. **Conclusion**: Based upon these findings, the Plan concluded the methodology and processes that M/S and MH/SUD use to determine network adequacy are comparable "in operation.”

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

					determine M/S network adequacy “as written.” Both MH/SUD and M/S run network adequacy reports at least quarterly which are in accordance with CMS and/or state established time and distance thresholds to assess the continued adequacy of the network. Additionally, both M/S and MH/SUD have a process in place to authorize benefit coverage to an out-of-network provider at the in-network benefit level if a supply gap is identified. **Conclusion:** Based upon these findings, the Plan concluded its methodology used to determine network adequacy for MH/SUD was comparable to, and applied no more stringently than, the methodology used to determine network adequacy for M/S “as written.”	

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Student Resources
12/30/2022

Out-of-Network Reimbursement: Out-of-Network Emergency Care

[redacted]

Out-of-Network Reimbursement: Emergency Care		Step 1 - Factors Used to Determine the Plans Out of Network Reimbursement Methodology The Plan's methodology used to determine the M/S and MH/SUD out-of-network reimbursement for emergency care is based upon the following factors and benefit plan specifications. The factors are not weighted.	Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor The plans evidentiary standards that define and/or trigger the identification of a factor	Step 3 - Sources Used to Define the Factors The sources used to define the factors include	Step 4 – NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions	Step 5 – NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions
Medical/ Surgical	Mental Health/ Substance Use Disorder					
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

				[redacted]	[redacted]	[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

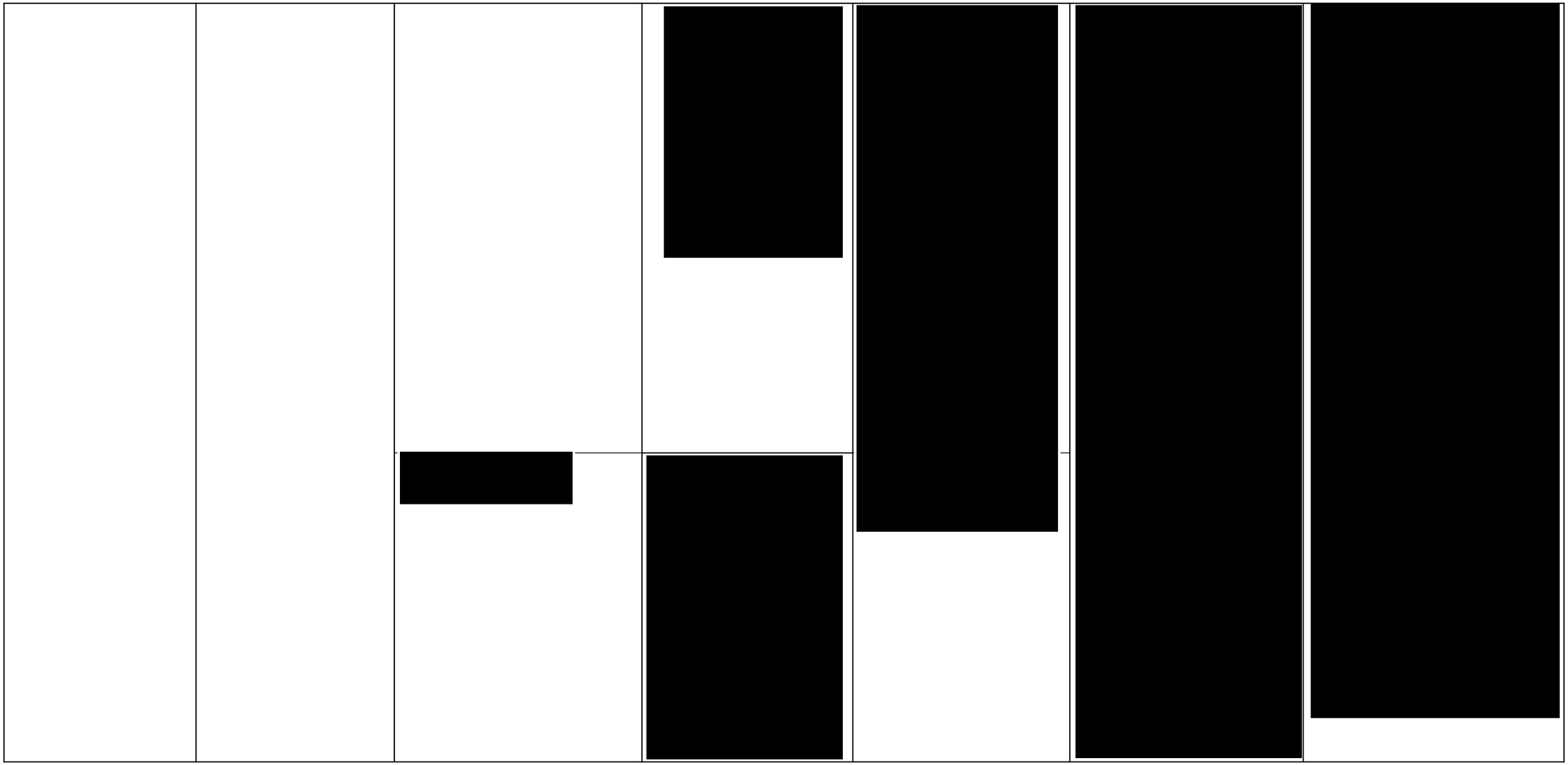
			[redacted]	[redacted]		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

[redacted]

Out-of-Network Reimbursement: Emergency Care		**Step 1 - Factors Used to Determine the Plans Out of Network Reimbursement Methodology** The Plan's methodology used to determine the M/S and MH/SUD out-of-network reimbursement for emergency care is based upon the following factors and benefit plan specifications. The factors are not weighted.	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor** The plans evidentiary standards that define and/or trigger the identification of a factor	**Step 3 - Sources Used to Define the Factors** The sources used to define the factors include	**Step 4 – NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 – NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health/ Substance Use Disorder**					
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.



Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			[redacted]			

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

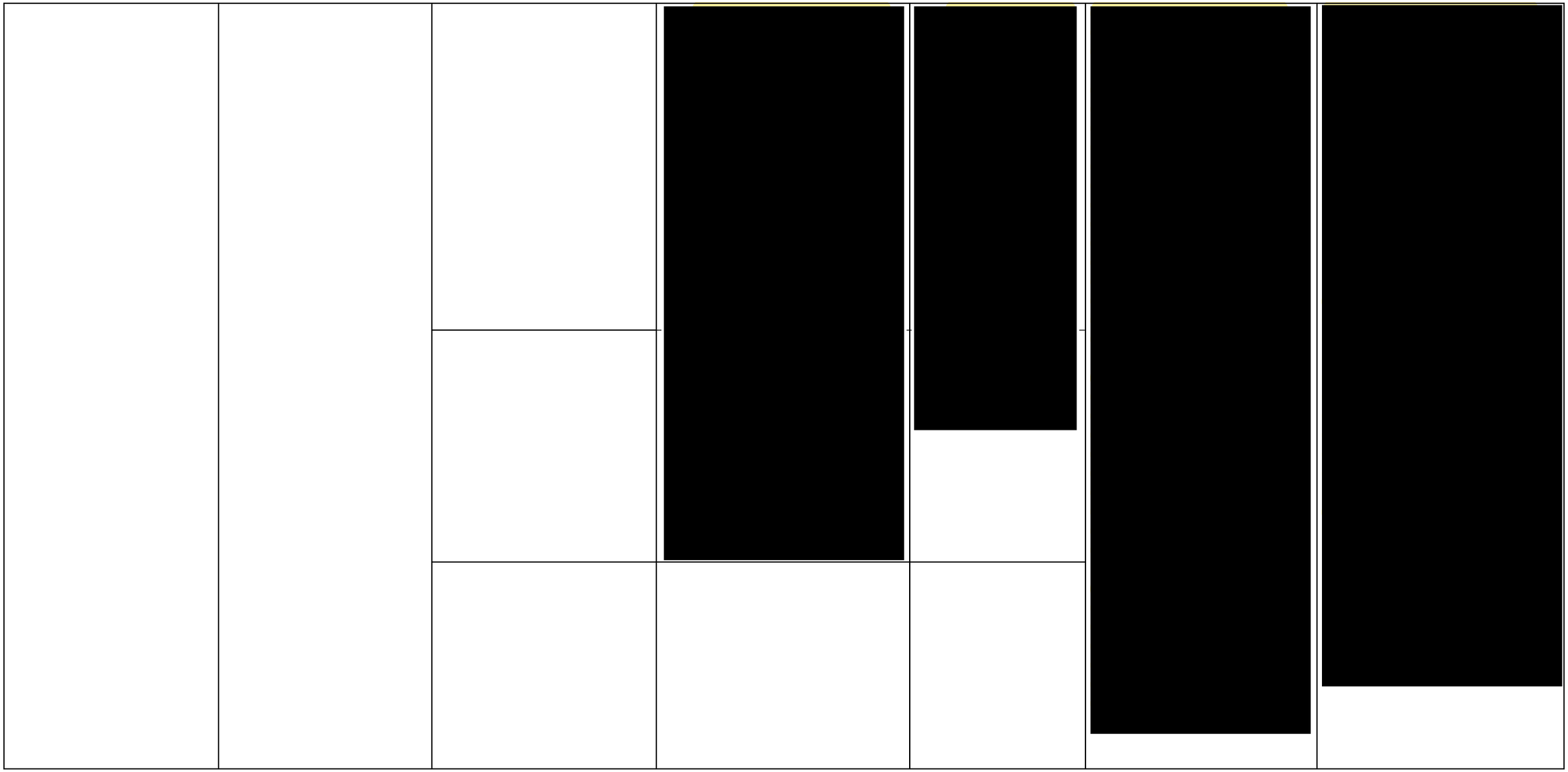
UnitedHealthcare – Student Resources
12/30/2022

Out-of-Network Reimbursement: Out-of-Network Inpatient and Outpatient Services

[redacted]

Out-of-Network Reimbursement: Out-of-Network Inpatient, Outpatient Services		Step 1 - Factors Used to Determine the Plans Out-of- Network Reimbursement Methodology	Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor	Step 3 - Sources Used to Define the Factors	Step 4 – NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions	Step 5 – NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions
Medical/ Surgical	**Mental Health/ Substance Use Disorder**	The Plan's methodology used to determine the M/S and MH/SUD OON reimbursement is based upon the following factors and benefit plan specifications. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identification of a factor	The sources used to define the factors include		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.



Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company and UnitedHealthcare Insurance Company of the River Valley
12/30/2022

Out-of-Network Reimbursement: Out-of-Network Inpatient and Outpatient Services

[redacted]

Out-of-Network Reimbursement: Out-of-Network Inpatient, Outpatient Services		Step 1 - Factors Used to Determine the Plans Out-of- Network Reimbursement Methodology	Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor	Step 3 - Sources Used to Define the Factors	Step 4 – NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions	Step 5 – NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions
Medical/ Surgical	**Mental Health/ Substance Use Disorder**	The Plan's methodology used to determine the M/S and MH/SUD OON reimbursement is based upon the following factors and benefit plan specifications. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identification of a factor	The sources used to define the factors include		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
		[redacted]	[redacted]			

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			[redacted]	[redacted]	[redacted]	[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

					[redacted]	
		[redacted]	[redacted]	[redacted]		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Individual and Family Plan
12/30/2022

Prior Authorization: In-Network Inpatient Services

Strategy: Prior authorization is a component of the Plan's utilization management (UM) program that helps ensure members receive appropriate care, based on their specific clinical status, and health care needs before care is received.

Process: For any service that can be performed on an inpatient basis on the prior authorization list, the in-network provider or facility is contractually responsible for obtaining the Prior Authorization. There may be some in-network benefits for which the member is responsible for obtaining prior authorization, which are identified in the Plan documents e.g., Schedule of Benefits. The member is not financially responsible for failure to obtain Prior Authorization unless the plan documents require it. For any inpatient service on the prior authorization List, the in-network facility or provider must confirm, prior to rendering the service that the prior authorization approval is on file. Providers may submit prior authorization requests by telephone, fax, or online portal in accordance with plan requirements. Members may submit prior authorization requests via telephone, fax, or mail in accordance with plan requirements. The purpose of prior authorization is to enable the provider and the member to have an informed pre-service review regarding coverage for the service and level of care; in cases where it is determined that the service will not be covered the member can then decide whether to receive and pay for the service. When the in-network provider or facility or member requests prior authorization, the Plan reviews the request utilizing applicable medical/clinical policies and/or guidelines, criteria, and Plan terms, and then renders a coverage determination. Adverse determinations are rendered by appropriately qualified clinical reviewers (e.g., MD). The provider, facility, and member are notified of an adverse determination, which includes the credentials of the individual who rendered the decision, and is consistent with state, federal and accreditation requirements and applicable appeal rights are provided.[1]

Inpatient Services Subject to Prior Authorization: In-Network		**Step 1 - Factors Used to Determine the Listed Inpatient Services are Subject to Prior Authorization**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
	[redacted]	The Plan's methodology used to determine whether the listed M/S and MH/SUD in-network inpatient services are subject to prior authorization are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted]
		• **Clinical Appropriateness:** The application of prior authorization promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those inpatient services that as determined by internal medical experts, are in accordance with	• Expert Medical Review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

[redacted]			objective, evidence-based clinical criteria, and nationally recognized guidelines		[redacted]	[redacted]
		• **Value:** The value of applying prior authorization review outweighs the associated costs	• Value is defined as the value of subjecting the inpatient services to prior authorization review exceeds the administrative costs by at least 1:1	• Internal claims data • UM program operating costs • UM authorization data	**Findings:** The findings of the analysis confirmed the strategy, process, factors, evidentiary standards, and source information used to subject MH/SUD inpatient services to prior authorization were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S inpatient services to prior authorization "as written." **Conclusion**: The Plan concluded the methodology used to determine which MH/SUD INN inpatient services are subject to prior authorization "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to prior authorization "as written."	**Findings**: The comparative analysis revealed the shared factors, evidentiary standards, and source information used to subject MH/SUD benefits to prior authorization were comparable to, and applied no more stringently than the shared factors, evidentiary standards and source information used to subject M/S benefits to prior authorization. Additionally, the Plan will conduct an analysis of in operations' outcomes data when a sufficient amount of data is available. [2] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN inpatient services are subject to prior authorization "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to prior authorization "in operation."

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company and UnitedHealthcare of Georgia, Inc.
12/30/2022

Prior Authorization: In-Network Inpatient Services

Strategy: Prior authorization is a component of the Plan's utilization management (UM) program that helps ensure members receive appropriate care, based on their specific clinical status, and health care needs before care is received.

Process: For any service that can be performed on an inpatient basis on the prior authorization list, the in-network provider or facility is contractually responsible for obtaining the Prior Authorization. There may be some in-network benefits for which the member is responsible for obtaining prior authorization, which are identified in the Plan documents e.g., Schedule of Benefits. The member is not financially responsible for failure to obtain Prior Authorization unless the plan documents require it. For any inpatient service on the prior authorization List, the in-network facility or provider must confirm, prior to rendering the service that the prior authorization approval is on file. Providers may submit prior authorization requests by telephone, fax, or online portal in accordance with plan requirements. Members may submit prior authorization requests via telephone, fax, or mail in accordance with plan requirements. The purpose of prior authorization is to enable the provider and the member to have an informed pre-service review regarding coverage for the service and level of care; in cases where it is determined that the service will not be covered the member can then decide whether to receive and pay for the service. When the in-network provider or facility or member requests prior authorization, the Plan reviews the request utilizing applicable medical/clinical policies and/or guidelines, criteria, and Plan terms, and then renders a coverage determination. Adverse determinations are rendered by appropriately qualified clinical reviewers (e.g., MD). The provider, facility, and member are notified of an adverse determination, which includes the credentials of the individual who rendered the decision, and is consistent with state, federal and accreditation requirements and applicable appeal rights are provided.[1]

Inpatient Services Subject to Prior Authorization: In-Network[2]		**Step 1 - Factors Used to Determine the Listed Inpatient Services are Subject to Prior Authorization**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
[redacted]	[redacted]	The Plan's methodology used to determine whether the listed M/S and MH/SUD in-network inpatient services are subject to prior authorization are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted]
		• **Clinical Appropriateness:** The application of prior authorization promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those inpatient services that as determined by internal medical experts, are in	• Expert Medical Review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable. [redacted]

[3] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

[redacted]			accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines		[redacted]	[redacted]
		• **Value:** The value of applying prior authorization review outweighs the associated costs	• Value is defined as the value of subjecting the inpatient services to prior authorization review exceeds the administrative costs by at least 1:1	• Internal claims data • UM program operating costs • UM authorization data	**Findings:** The findings of the analysis confirmed the strategy, process, factors, evidentiary standards, and source information used to subject MH/SUD inpatient services to prior authorization were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S inpatient services to prior authorization "as written." **Conclusion**: The Plan concluded the methodology used to determine which MH/SUD INN inpatient services are subject to prior authorization "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to prior authorization "as written."	**Findings:** The findings of the analysis of the shared factors as evidenced by the factor grid and the findings of the analysis of outcomes data indicated the prior authorization medical necessity approval and denial rates and appeals outcomes for MH/SUD inpatient services were comparable to the prior authorization medical necessity approval and denial rates and appeals outcomes for M/S inpatient services.[3] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN inpatient services are subject to prior authorization "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to prior authorization "in operation."

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[redacted] outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Individual and Family Plan
12/30/2022

Prior Authorization: In-Network Outpatient Services

Strategy: Prior authorization is a component of the Plan's utilization management (UM) program that helps ensure members receive appropriate care, based on their specific clinical status and health care needs before care is received.

Process: For any outpatient service on the prior authorization List, the in-network provider or facility is contractually responsible for obtaining the prior authorization. There may be some in-network benefits for which the member is responsible for obtaining prior authorization, which are identified in the Plan document's e.g., Schedule of Benefits. The member is not financially responsible for failure to obtain prior authorization unless the plan documents require it. For any outpatient service on the prior authorization List, the in-network facility or provider must confirm, prior to rendering the service that the prior authorization approval is on file. Providers may submit prior authorization requests by telephone, fax, or online portal in accordance with plan requirements. Members may submit prior authorization requests via telephone, fax, or mail in accordance with plan requirements. The purpose of prior authorization is to enable the facility or provider and the member to have an informed pre-service review; in cases where it is determined that the service will not be covered the member can then decide whether to receive and pay for the service. When the in-network provider or facility or member requests prior authorization, the Plan reviews the request utilizing applicable medical/clinical policies and/or guidelines, criteria, and Plan terms, and then renders a coverage determination. Adverse determinations are rendered by appropriately qualified clinical reviewers (e.g., MD or PhD/PsyD). The provider, facility, and member are notified of an adverse determination, which includes the credentials of the individual who rendered the decision, and is consistent with state, federal and accreditation requirements and applicable appeal rights are provided.[1]

Outpatient Services Subject to Prior Authorization: In-Network		**Step 1 - Factors Used to Determine the Listed Outpatient Services are Subject to Prior Authorization**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
	[redacted]	The Plan's methodology used to determine whether the listed M/S and MH/SUD in-network outpatient services are subject to prior authorization are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted]
		• **Clinical Appropriateness:** The application of Prior Authorization promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those outpatient services that as determined by internal medical experts, are in accordance with objective, evidence-	• Expert medical review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

[redacted]			based clinical criteria, and nationally recognized guidelines		[redacted]	[redacted]
		• **Value:** The value of applying prior authorization outweighs the associated costs	• Value is defined as the value of subjecting the outpatient services to prior authorization exceeds the administrative costs by at least 1:1	• Internal claims data • UM program operating costs • UM authorization data		**Findings**: The comparative analysis revealed the shared factors, evidentiary standards, and source information used to subject MH/SUD benefits to prior authorization were comparable to, and applied no more stringently than the shared factors, evidentiary standards and source information used to subject M/S benefits to prior authorization. Additionally, the Plan will conduct an analysis of in operations' outcomes data when a sufficient amount of data is available. [2] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN outpatient services are subject to prior authorization "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to prior authorization "in operation."
		• **Variation Identified:** Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits	• Variability is defined as cost per episode of service (service units X unit cost) that trigger 2x the mean of other outpatient services and provided to a minimum of twenty unique Plan members	• Internal claims data	**Findings:** The findings of the analysis indicated the strategy, process, factors, evidentiary standards, and source	

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

[redacted]					information used to subject certain MH/SUD outpatient services to prior authorization were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S outpatient services to prior authorization “as written.” **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN outpatient services are subject to prior authorization “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to prior authorization “as written.”	

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company and UnitedHealthcare of Georgia, Inc.
12/30/2022

Prior Authorization: In-Network Outpatient Services

Strategy: Prior authorization is a component of the Plan's utilization management (UM) program that helps ensure members receive appropriate care, based on their specific clinical status and health care needs before care is received.

Process: For any outpatient service on the prior authorization List, the in-network provider or facility is contractually responsible for obtaining the prior authorization. There may be some in-network benefits for which the member is responsible for obtaining prior authorization, which are identified in the Plan document's e.g., Schedule of Benefits. The member is not financially responsible for failure to obtain prior authorization unless the plan documents require it. For any outpatient service on the prior authorization List, the in-network facility or provider must confirm, prior to rendering the service that the prior authorization approval is on file. Providers may submit prior authorization requests by telephone, fax, or online portal in accordance with plan requirements. Members may submit prior authorization requests via telephone, fax, or mail in accordance with plan requirements. The purpose of prior authorization is to enable the facility or provider and the member to have an informed pre-service review; in cases where it is determined that the service will not be covered the member can then decide whether to receive and pay for the service. When the in-network provider or facility or member requests prior authorization, the Plan reviews the request utilizing applicable medical/clinical policies and/or guidelines, criteria, and Plan terms, and then renders a coverage determination. Adverse determinations are rendered by appropriately qualified clinical reviewers (e.g., MD or PhD/PsyD). The provider, facility, and member are notified of an adverse determination, which includes the credentials of the individual who rendered the decision, and is consistent with state, federal and accreditation requirements and applicable appeal rights are provided.[1]

Outpatient [redacted]rvices Subject to Prior Authorization: In-Network [redacted]		**Step 1 - Factors Used to Determine the Listed Outpatient Services are Subject to Prior Authorization**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
[redacted]	[redacted]	The Plan's methodology used to determine whether the listed M/S and MH/SUD in-network outpatient services are subject to prior authorization are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted]
		• **Clinical Appropriateness:** The application of Prior Authorization promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those outpatient services that as determined by internal medical experts, are in accordance with	• Expert medical review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable. [redacted] mes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

[redacted]			objective, evidence-based clinical criteria, and nationally recognized guidelines		[redacted]	[redacted] **Findings:** The findings of the analysis of the shared factors as evidenced by the factor grid and the findings of the analysis of outcomes data indicated the prior authorization medical necessity approval and denial rates and appeals outcomes for MH/SUD outpatient services were comparable to the prior authorization medical necessity approval and denial rates and appeals outcomes for M/S outpatient services.[3] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN outpatient services are subject to prior authorization "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to prior authorization "in operation."
		• **Value:** The value of applying prior authorization outweighs the associated costs	• Value is defined as the value of subjecting the outpatient services to prior authorization exceeds the administrative costs by at least 1:1	• Internal claims data • UM program operating costs • UM authorization data		
		• **Variation Identified:** Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits	• Variability is defined as cost per episode of service (service units X unit cost) that trigger 2x the mean of other outpatient services and provided to a minimum of twenty unique Plan members	• Internal claims data		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable. [redacted]

[3] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

[redacted]					process, factors, evidentiary standards, and source information used to subject certain MH/SUD outpatient services to prior authorization were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S outpatient services to prior authorization “as written.” **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN outpatient services are subject to prior authorization “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to prior authorization “as written.”	

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable. [redacted] tcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company
12/30/2022

Prior Authorization: Out-of-Network Inpatient Services

Strategy: Prior authorization is a component of the Plan's utilization management (UM) program that helps ensure members receive appropriate care, based on their specific clinical status and health care needs before care is received.

Process: When the plan has out-of-network (OON) benefits and the member chooses to receive certain Covered Health Care Services from an OON provider/facility, the member is responsible for obtaining prior authorization before receiving these services. The member's obligation to obtain prior authorization is also applicable when an OON provider/facility intends to admit the member to a network facility or to an OON facility. Providers may submit prior authorization requests by telephone or fax in accordance with plan requirements. Members may submit prior authorization requests via telephone, fax, or mail in accordance with plan requirements. The purpose of prior authorization is to enable the provider and the member to have an informed pre-service review regarding the service and level of care; in cases where it is determined that the service will not be covered the member can then decide whether to receive and pay for the service. When the OON provider or facility or member requests prior authorization, the Plan reviews the request utilizing applicable medical/clinical policies and/or guidelines, criteria, and Plan terms, and then renders a coverage determination. Adverse determinations are rendered by appropriately qualified clinical reviewers (e.g., MD). The provider, facility, and member are notified of an adverse determination, which includes the credentials of the individual who rendered the decision, and is consistent with state, federal and accreditation requirements and applicable appeal rights are provided.[1]

Inpatient Services Subject to Prior Authorization: Out-of-Network		**Step 1 - Factors Used to Determine the Listed Inpatient Services are Subject to Prior Authorization**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
[redacted]	[redacted]	The Plan's methodology used to determine whether the listed M/S and MH/SUD out-of-network inpatient services are subject to prior authorization are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted]
		• **Clinical Appropriateness:** The application of prior authorization promotes optimal clinical outcomes	Clinical Appropriateness is defined as those inpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria,	• Expert medical review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable. [redacted] mes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

[redacted]			and nationally recognized guidelines			**Findings:** The findings of the analysis of the shared factors as evidenced by the factor grid and the findings of the analysis of outcomes data indicated the prior authorization medical necessity approval and denial rates and appeals outcomes for MH/SUD inpatient services were comparable to the prior authorization medical necessity approval and denial rates and appeals outcomes for M/S inpatient services.[3] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD OON inpatient services are subject to prior authorization "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON inpatient services are subject to prior authorization "in operation."
		• **Value:** The value of applying prior authorization review outweighs the associated costs	Value is defined as the value of subjecting the inpatient services to prior authorization review exceeds the administrative costs by at least 1:1	• Internal claims data • UM program operating costs • UM authorization data	[redacted] **Findings:** The findings of the analysis confirmed the strategy, process, factors, evidentiary standards, and source information used to subject MH/SUD inpatient services to prior authorization were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S inpatient services to prior authorization "as written." **Conclusion**: The Plan concluded the methodology used to determine which MH/SUD OON inpatient services are subject to prior authorization "as written" were comparable to, and applied no more	

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[redacted] outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

					stringently than, the methodology used to determine which M/S OON inpatient services are subject to prior authorization “as written.”	

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] Addendum A provides a complete list of services subject to prior authorization
[3] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company
12/30/2022

Prior authorization: Out-of-Network Outpatient Services

Strategy: Prior authorization is a component of the Plan's utilization management (UM) program that helps ensure members receive appropriate care, based on their specific clinical status and health care needs before care is received.

Process: For Plans that include out-of-network (OON) benefits, M/S requires the member to obtain prior authorization for some OON outpatient services as noted on the Schedule of Benefits. An OON provider/facility may request prior authorization on behalf of the member. Providers may submit prior authorization requests by telephone or fax, in accordance with plan requirements. Members may submit prior authorization requests via telephone, fax, or mail in accordance with plan requirements. The purpose of prior authorization is to enable the facility or provider and the member to have an informed pre-service review; in cases where it is determined that the service will not be covered the member can then decide whether to receive and pay for the service. When the OON provider or facility or member requests prior authorization, the Plan reviews the request utilizing applicable medical/clinical policies and/or guidelines, criteria, and Plan terms, and then renders a coverage determination. Adverse determinations are rendered by appropriately qualified clinical reviewers (e.g., MD or PhD/PsyD). The provider, facility, and member are notified of an adverse determination, which includes the credentials of the individual who rendered the decision, and is consistent with state, federal and accreditation requirements and applicable appeal rights are provided.[1]

Outpatient Services Subject to Prior Authorization: Out-of-Network		**Step 1 - Factors Used to Determine the Listed Outpatient Services are Subject to Prior authorization**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
[redacted]	[redacted]	The Plan's methodology used to determine whether the listed M/S and MH/SUD OON outpatient services are subject to prior authorization are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted]
		• **Clinical Appropriateness:** The application of prior authorization promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those outpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally	• Expert Medical Review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.

[redacted] utcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

[redacted]			recognized guidelines		[redacted]	**Findings:** The findings of the analysis of the shared factors as evidenced by the factor grid and the findings of the analysis of outcomes data indicated the prior authorization medical necessity approval and denial rates and appeals outcomes for MH/SUD outpatient services were comparable to the prior authorization medical necessity approval and denial rates and appeals outcomes for M/S outpatient services.[3] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD OON outpatient services are subject to prior authorization "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to prior authorization "in operation."
		• **Value:** The value of applying prior authorization outweighs the associated costs	• Value is defined as the value of subjecting the outpatient services to prior authorization exceeds the administrative costs by at least 1:1	• Internal claims data • UM program operating costs • UM authorization data		
		• **Variation Identified:** Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits	• Variability is defined as cost per episode of service (service units X unit cost) that trigger 2x the mean of other outpatient services and provided to a minimum of twenty unique Plan members	• Internal claims data	**Findings:** The findings of the analysis indicated the strategy, process, factors, evidentiary standards, and source information used to subject certain MH/SUD outpatient services to prior	

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable. [redacted]

[3] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

[redacted]					authorization were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S outpatient services to prior authorization “as written.” **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD OON outpatient services are subject to prior authorization “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to prior authorization “as written.”	

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable. [redacted]

[3] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

[redacted]						

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.

[redacted]

[3] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Individual and Family Plan
12/30/2022

Provider Reimbursement/Coding Edits - Inpatient (INN and OON), Outpatient (INN and OON), and Emergency

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

Provider Reimbursement/Coding Edits Applies to Inpatient (INN and OON), Outpatient (INN and OON), and Emergency		**Step 1 - Factors Used to Develop the Plan's Provider Reimbursement/Coding Edits Policies**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 – NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 – NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical (M/S)	**Mental Health/Substance Use Disorder (MH/SUD)**	The Plan's methodology used to develop the Plan's Provider Reimbursement/Coding Edits policies. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identification of a factor	The sources used to define the factors include		
[redacted]						

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

						[redacted]

[1] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data is not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Student Resources
12/30/2022

Provider Reimbursement/Coding Edits - Inpatient (INN and OON), Outpatient (INN and OON), and Emergency

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

Provider Reimbursement/Coding Edits Applies to Inpatient (INN and OON), Outpatient (INN and OON), and Emergency		**Step 1 - Factors Used to Develop the Plan's Provider Reimbursement/Coding Edits Policies**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 – NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 – NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical (M/S)	**Mental Health/Substance Use Disorder (MH/SUD)**	The Plan's methodology used to develop the Plan's Provider Reimbursement/Coding Edits policies. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identification of a factor	The sources used to define the factors include		
[redacted]						

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

		[redacted]

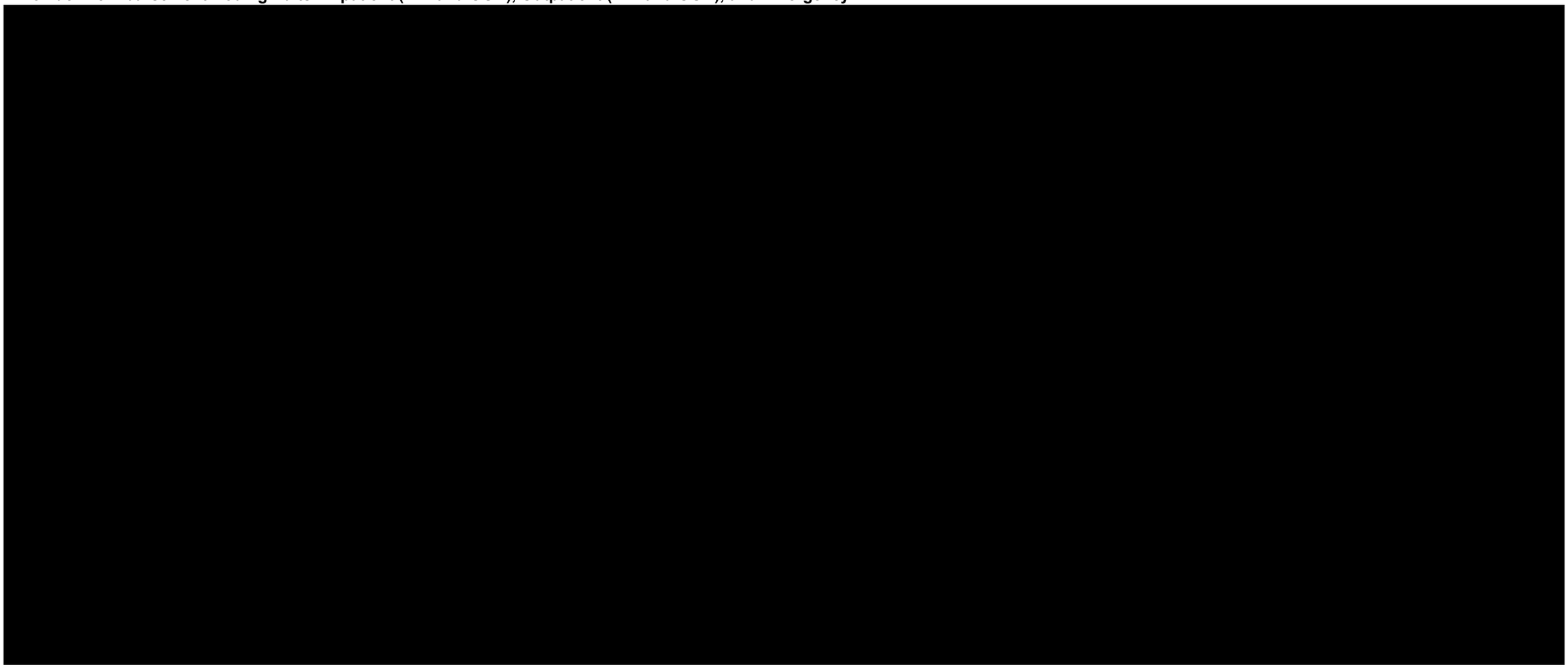
Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

						[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of the River Valley and UnitedHealthcare of Georgia, Inc.
12/30/2022

Provider Reimbursement/Coding Edits - Inpatient (INN and OON), Outpatient (INN and OON), and Emergency



Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

Provider Reimbursement/Coding Edits Applies to Inpatient (INN and OON), Outpatient (INN and OON), and Emergency		**Step 1 - Factors Used to Develop the Plan's Provider Reimbursement/Coding Edits Policies**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 – NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 – NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical (M/S)	**Mental Health/Substance Use Disorder (MH/SUD)**	The Plan's methodology used to develop the Plan's Provider Reimbursement/Coding Edits policies. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identification of a factor	The sources used to define the factors include		
[redacted]						

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			[redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

						[redacted]

[1] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data is not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Individual and Family Plan
12/30/2022

Retrospective Review: In-Network Inpatient Services

Strategy: Retrospective review is a component of the Plan's utilization management (UM) program.

Process: Retrospective review begins after the Plan receives notification post-discharge or post-service and/or after a submission of a claim. Inpatient services are reviewed based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria, and nationally recognized guidelines. If an appropriately qualified clinical reviewer (e.g., Medical Directors) determines that an inpatient service was not medically necessary and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided. An in-network provider, depending on the provider contract, may bill the member for certain non-covered charges.[1]

Inpatient Services Subject to Retrospective review: In-Network		**Step 1 - Factors Used to Determine the Listed Inpatient Services are Subject to Retrospective Review**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
[redacted]		The Plan's methodology used to determine whether the listed M/S and MH/SUD in-network inpatient services are subject to Retrospective review are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors	The sources used to define the factors	The Plan conducted a comparative analysis of the strategy, process, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD in-network inpatient services are subject to Retrospective review "as written." M/S and MH/SUD inpatient services are determined by an internal panel of medical experts (with expertise in M/S conditions and MH/SUD conditions, respectively) as being clinically appropriate in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. In addition, a consistent process exists for evaluating the value of subjecting certain inpatient services to Retrospective review for M/S and MH/SUD. The process includes a review of inpatient utilization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when	The Plan assessed the shared factors and evidentiary standards used as the basis for subjecting medical/surgical (M/S) and mental health and substance use disorder (MH/SUD) inpatient, in-network benefits to retrospective review. When there is a sufficient amount of data available, the Plan will conduct a comparison analysis where we have a minimum of 100 data points available (e.g., requests for benefit authorization, etc.) for reporting of medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to retrospective review medical necessity coverage for M/S and MH/SUD in-network inpatient services. **Findings**: The comparative analysis revealed the shared factors, evidentiary standards, and source information used to subject MH/SUD benefits to retrospective review were comparable to, and applied no more
		• **Clinical Appropriateness:** The application of Retrospective review promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those inpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines	• Expert Medical Review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		
		• **Value:** The value of applying retrospective review outweighs the associated costs	• Value is defined as the value of subjecting the inpatient services to retrospective review	• Internal claims data • UM program operating costs • UM authorization data		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

			exceeds the administrative costs by at least 1:1		Retrospective review is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering retrospective review to determine the value. The Plan confirmed M/S and MH/SUD inpatient services subject to retrospective review included inpatient services that provided a value that exceeded the administrative cost of 1:1 and promoted the use of evidence-based practices. **Findings:** The findings of the analysis confirmed the strategy, process, factors, evidentiary standards, and source information used to subject certain MH/SUD inpatient services to retrospective review were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S inpatient services to Retrospective review "as written." **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN inpatient services are subject to retrospective review "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to retrospective review "as written."	stringently than the shared factors, evidentiary standards and source information used to subject M/S benefits to retrospective review. Additionally, the Plan will conduct an analysis of in operations' outcomes data when a sufficient amount of data is available. [2] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN inpatient services are subject to retrospective review "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to retrospective review "in operation."

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

UnitedHealthcare – Student Resources
12/30/2022

Retrospective Review: In-Network Inpatient Services

Strategy: Retrospective review is a component of the Plan's utilization management (UM) program.

Process: Retrospective review begins after the Plan receives notification post-discharge or post-service and/or after a submission of a claim. Inpatient services are reviewed based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria, and nationally recognized guidelines. If an appropriately qualified clinical reviewer (e.g., Medical Directors) determines that an inpatient service was not medically necessary and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided. An in-network provider, depending on the provider contract, may bill the member for certain non-covered charges.[1]

Inpatient Services Subject to Retrospective review: In-Network		**Step 1 - Factors Used to Determine the Listed Inpatient Services are Subject to Retrospective Review**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
[redacted]		The Plan's methodology used to determine whether the listed M/S and MH/SUD in-network inpatient services are subject to Retrospective review are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors	The sources used to define the factors	The Plan conducted a comparative analysis of the strategy, process, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD in-network inpatient services are subject to Retrospective review "as written." M/S and MH/SUD inpatient services are determined by an internal panel of medical experts (with expertise in M/S conditions and MH/SUD conditions, respectively) as being clinically appropriate in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. In addition, a consistent process exists for evaluating the value of subjecting certain inpatient services to Retrospective review for M/S and MH/SUD. The process includes a review of inpatient utilization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when	The Plan assessed the shared factors and evidentiary standards used as the basis for subjecting medical/surgical (M/S) and mental health and substance use disorder (MH/SUD) inpatient, in-network benefits to retrospective review. The Plan conducted a comparative analysis of medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to retrospective review for M/S and MH/SUD in-network inpatient services. Data was evaluated where a minimum threshold of 100 cases were available. **Findings:** The findings of the analysis of the shared factors and the findings of the analysis of outcomes data indicated the retrospective review medical necessity approval and denial rates and appeals outcomes for MH/SUD inpatient services were comparable to the retrospective review medical
		• **Clinical Appropriateness:** The application of Retrospective review promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those inpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines	• Expert Medical Review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		
		• **Value:** The value of applying retrospective review outweighs the associated costs Student Resources does not restrict length of stay or level	• Value is defined as the value of subjecting the inpatient services to retrospective review exceeds the administrative costs by at least 1:1	• Internal claims data • UM program operating costs • UM authorization data		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

[redacted]		of care to Inpatient services for M/S or MH/SUD. However, medical necessity, State and federal mandates and the definition of a covered medical expense may be applied during a retrospective review	Our reviews are based upon policy language, such as medical necessity and state and federal mandates that apply for those services/supplies/procedures		Retrospective review is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering retrospective review to determine the value. The Plan confirmed M/S and MH/SUD inpatient services subject to retrospective review included inpatient services that provided a value that exceeded the administrative cost of 1:1 and promoted the use of evidence-based practices. **Findings:** The findings of the analysis confirmed the strategy, process, factors, evidentiary standards, and source information used to subject certain MH/SUD inpatient services to retrospective review were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S inpatient services to Retrospective review “as written.” **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN inpatient services are subject to retrospective review “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to retrospective review “as written.”	necessity approval and denial rates and appeals outcomes for M/S inpatient services.[2] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN inpatient services are subject to retrospective review “in operation” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to retrospective review “in operation.”

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

UnitedHealthcare – UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of the River Valley and UnitedHealthcare of Georgia, Inc.
12/30/2022

Retrospective Review: In-Network Inpatient Services

Strategy: Retrospective review is a component of the Plan's utilization management (UM) program.

Process: Retrospective review begins after the Plan receives notification post-discharge or post-service and/or after a submission of a claim. Inpatient services are reviewed based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria, and nationally recognized guidelines. If an appropriately qualified clinical reviewer (e.g., Medical Directors) determines that an inpatient service was not medically necessary and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided. An in-network provider, depending on the provider contract, may bill the member for certain non-covered charges.[1]

Inpatient Services Subject to Retrospective review: In-Network		**Step 1 - Factors Used to Determine the Listed Inpatient Services are Subject to Retrospective Review**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
[redacted]		The Plan's methodology used to determine whether the listed M/S and MH/SUD in-network inpatient services are subject to Retrospective review are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors	The sources used to define the factors	The Plan conducted a comparative analysis of the strategy, process, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD in-network inpatient services are subject to Retrospective review "as written." M/S and MH/SUD inpatient services are determined by an internal panel of medical experts (with expertise in M/S conditions and MH/SUD conditions, respectively) as being clinically appropriate in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. In addition, a consistent process exists for evaluating the value of subjecting certain inpatient services to Retrospective review for M/S and MH/SUD. The process includes a review of inpatient utilization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when	The Plan assessed the shared factors and evidentiary standards used as the basis for subjecting medical/surgical (M/S) and mental health and substance use disorder (MH/SUD) inpatient, in-network benefits to retrospective review. The Plan conducted a comparative analysis of medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to retrospective review for M/S and MH/SUD in-network inpatient services. Data was evaluated where a minimum threshold of 100 cases were available. **Findings:** The findings of the analysis of the shared factors and the findings of the analysis of outcomes data indicated the retrospective review medical necessity approval and denial rates and appeals outcomes for MH/SUD inpatient services were comparable to the retrospective review medical necessity approval
		• **Clinical Appropriateness:** The application of Retrospective review promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those inpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines	• Expert Medical Review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		
		• **Value:** The value of applying retrospective review outweighs the associated costs	• Value is defined as the value of subjecting the inpatient services to retrospective review	• Internal claims data • UM program operating costs • UM authorization data		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

			exceeds the administrative costs by at least 1:1		Retrospective review is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering retrospective review to determine the value. The Plan confirmed M/S and MH/SUD inpatient services subject to retrospective review included inpatient services that provided a value that exceeded the administrative cost of 1:1 and promoted the use of evidence-based practices. **Findings:** The findings of the analysis confirmed the strategy, process, factors, evidentiary standards, and source information used to subject certain MH/SUD inpatient services to retrospective review were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S inpatient services to Retrospective review "as written." **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN inpatient services are subject to retrospective review "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to retrospective review "as written."	and denial rates and appeals outcomes for M/S inpatient services.[2] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN inpatient services are subject to retrospective review "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN inpatient services are subject to retrospective review "in operation."

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

UnitedHealthcare – Individual and Family Plan
12/30/2022

Retrospective Review: In-Network Outpatient Services

Strategy: Retrospective review is a component of the Plan's utilization management (UM) program.

Process: Retrospective review begins after the Plan receives notification post-service and/or after a submission of a claim. Outpatient services are reviewed based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria, and nationally recognized guidelines. If an appropriately qualified clinical reviewer (e.g., Medical Directors) determines that a service was not medically necessary and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided.[1]

Outpatient Services Subject to Retrospective Review: In-Network[3]		**Step 1 - Factors Used to Determine the Listed Outpatient Services are Subject to Retrospective Review**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
[redacted]		The Plan's methodology used to determine whether the listed M/S and MH/SUD in-network outpatient services are subject to Retrospective Review are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	The Plan conducted a comparative analysis of the strategy, process, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD in-network outpatient services are subject to retrospective review "as written." M/S and MH/SUD outpatient services are determined by an internal panel of medical experts (with expertise in M/S conditions and MH/SUD conditions, respectively) as being clinically appropriate in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. In addition, a consistent process exists for evaluating the value of subjecting certain outpatient services to retrospective review for M/S and	The Plan assessed the shared factors and evidentiary standards used as the basis for subjecting medical/surgical (M/S) and mental health and substance use disorder (MH/SUD) outpatient, in-network benefits to retrospective review. When there is a sufficient amount of data available, the Plan will conduct a comparison analysis where we have a minimum of 100 data points available (e.g., requests for benefit authorization, etc.) for reporting of medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to retrospective review medical necessity coverage for M/S and MH/SUD in-network outpatient services.
		• **Clinical Appropriateness:** The application of retrospective review promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those outpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines	• Expert Medical Review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.
[3] Services subject to retro review are the same services that are on the Prior Authorization list.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

[redacted]	• **Value:** The value of applying retrospective review outweighs the associated costs	• Value is defined as the value of subjecting the outpatient services to retrospective review exceeds the administrative costs by at least 1:1	• Internal claims data • UM program operating costs • UM authorization data	MH/SUD. The process includes a review of outpatient utilization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when retrospective review is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering retrospective review to determine the value. The Plan confirmed the list of M/S and MH/SUD outpatient services subject to retrospective review included outpatient services that provided a value that exceeded the administrative cost of 1:1 and promoted the use of evidence-based practices. Lastly, the Plan confirmed all M/S outpatient services and all MH/SUD outpatient services with variability in cost per episode defined as 2x the mean of other outpatient services and provided to a minimum of twenty unique members were subject to retrospective review. (The Plan established a materiality threshold of 20 members for a variation analysis). **Findings:** The findings of the analysis confirmed the strategy, process, factors, evidentiary standards, and source information used to subject certain MH/SUD outpatient services to retrospective review were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain	**Findings**: The comparative analysis revealed the shared factors, evidentiary standards, and source information used to subject MH/SUD benefits to retrospective review were comparable to, and applied no more stringently than the shared factors, evidentiary standards and source information used to subject M/S benefits to retrospective review. Additionally, the Plan will conduct an analysis of in operations' outcomes data when a sufficient amount of data is available. [2] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN outpatient services are subject to retrospective review "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to retrospective review "in operation."
	• **Variation Identified**: Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits	• Variability is defined as cost per episode of service (service units X unit cost) that trigger 2x the mean of other outpatient services and provided to a minimum of twenty unique Plan members	• Internal claims data		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.
[3] Services subject to retro review are the same services that are on the Prior Authorization list.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

[redacted]				M/S outpatient services to Retrospective Review “as written.” **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN outpatient services are subject to retrospective review “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to retrospective review “as written.”	

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.
[3] Services subject to retro review are the same services that are on the Prior Authorization list.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

[redacted]						

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.
[3] Services subject to retro review are the same services that are on the Prior Authorization list.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

UnitedHealthcare – Student Resources
12/30/2022

Retrospective Review: In-Network Outpatient Services

Strategy: Retrospective review is a component of the Plan's utilization management (UM) program.

Process: Retrospective review begins after the Plan receives notification post-service and/or after a submission of a claim. Outpatient services are reviewed based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria, and nationally recognized guidelines. If an appropriately qualified clinical reviewer (e.g., Medical Directors) determines that a service was not medically necessary and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided.[1]

Outpatient Services Subject to Retrospective Review: In-Network[3]		**Step 1 - Factors Used to Determine the Listed Outpatient Services are Subject to Retrospective Review**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
[redacted]		The Plan's methodology used to determine whether the listed M/S and MH/SUD in-network outpatient services are subject to Retrospective Review are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	The Plan conducted a comparative analysis of the strategy, process, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD in-network outpatient services are subject to retrospective review "as written." M/S and MH/SUD outpatient services are determined by an internal panel of medical experts (with expertise in M/S conditions and MH/SUD conditions, respectively) as being clinically appropriate in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. In addition, a consistent process exists for evaluating the value of subjecting certain outpatient services to retrospective review for M/S and MH/SUD. The process includes a review of outpatient utilization or claims data to identify if there is opportunity to improve	The Plan assessed the shared factors and evidentiary standards used as the basis for subjecting medical/surgical (M/S) and mental health and substance use disorder (MH/SUD) outpatient, in-network benefits to retrospective review. The Plan conducted a comparative analysis of medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to retrospective review for M/S and MH/SUD in-network outpatient services. Data was evaluated where a minimum threshold of 100 cases were available. **Findings:** The findings of the analysis of the shared factors and the findings of the analysis of outcomes data indicated the retrospective review medical necessity approval and denial rates and appeals outcomes for MH/SUD outpatient services were comparable to the retrospective
		• **Clinical Appropriateness:** The application of retrospective review promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those outpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines	• Expert Medical Review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		
		• **Value:** The value of applying retrospective review outweighs the associated costs	• Value is defined as the value of subjecting the outpatient services to retrospective review exceeds the administrative costs by at least 1:1	• Internal claims data • UM program operating costs • UM authorization data		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

[redacted]	• Medical necessity, State and federal mandates and the definition of a covered medical expense may be applied during a retrospective review	• Our reviews are based upon policy language, such as medical necessity and state and federal mandates that apply for those services/supplies/procedures		quality and reduce unnecessary costs when retrospective review is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering retrospective review to determine the value. The Plan confirmed the list of M/S and MH/SUD outpatient services subject to retrospective review included outpatient services that provided a value that exceeded the administrative cost of 1:1 and promoted the use of evidence-based practices. Lastly, the Plan confirmed all M/S outpatient services and all MH/SUD outpatient services with variability in cost per episode defined as 2x the mean of other outpatient services and provided to a minimum of twenty unique members were subject to retrospective review. (The Plan established a materiality threshold of 20 members for a variation analysis). **Findings:** The findings of the analysis confirmed the strategy, process, factors, evidentiary standards, and source information used to subject certain MH/SUD outpatient services to retrospective review were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S outpatient services to Retrospective Review “as written.”	review medical necessity approval and denial rates and appeals outcomes for M/S outpatient services.[2] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN outpatient services are subject to retrospective review “in operation” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to retrospective review “in operation.”

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

					Conclusion: The Plan concluded the methodology used to determine which MH/SUD INN outpatient services are subject to retrospective review “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to retrospective review “as written.”	

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

UnitedHealthcare – UnitedHealthcare Insurance Company and UnitedHealthcare of Georgia, Inc.
12/30/2022

Retrospective Review: In-Network Outpatient Services

Strategy: Retrospective review is a component of the Plan's utilization management (UM) program.

Process: Retrospective review begins after the Plan receives notification post-service and/or after a submission of a claim. Outpatient services are reviewed based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria, and nationally recognized guidelines. If an appropriately qualified clinical reviewer (e.g., Medical Directors) determines that a service was not medically necessary and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided.[1]

Outpatient Services Subject to Retrospective Review: In-Network[3]		**Step 1 - Factors Used to Determine the Listed Outpatient Services are Subject to Retrospective Review**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
[redacted]		The Plan's methodology used to determine whether the listed M/S and MH/SUD in-network outpatient services are subject to Retrospective Review are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	The Plan conducted a comparative analysis of the strategy, process, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD in-network outpatient services are subject to retrospective review "as written." M/S and MH/SUD outpatient services are determined by an internal panel of medical experts (with expertise in M/S conditions and MH/SUD conditions, respectively) as being clinically appropriate in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. In addition, a consistent process exists for evaluating the value of subjecting certain outpatient services to retrospective review	The Plan assessed the shared factors and evidentiary standards used as the basis for subjecting medical/surgical (M/S) and mental health and substance use disorder (MH/SUD) outpatient, in-network benefits to retrospective review. The Plan conducted a comparative analysis of medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to retrospective review for M/S and MH/SUD in-network outpatient services. Data was evaluated where a minimum threshold of 100 cases were available. **Findings:** The findings of the analysis of the shared factors and the findings of the analysis of outcomes data indicated the retrospective review medical
		• **Clinical Appropriateness:** The application of retrospective review promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those outpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines	• Expert Medical Review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.
[3] Services subject to retro review are the same services that are on the Prior Authorization list. [redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

[redacted]	• **Value:** The value of applying retrospective review outweighs the associated costs	• Value is defined as the value of subjecting the outpatient services to retrospective review exceeds the administrative costs by at least 1:1	• Internal claims data • UM program operating costs • UM authorization data	for M/S and MH/SUD. The process includes a review of outpatient utilization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when retrospective review is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering retrospective review to determine the value. The Plan confirmed the list of M/S and MH/SUD outpatient services subject to retrospective review included outpatient services that provided a value that exceeded the administrative cost of 1:1 and promoted the use of evidence-based practices. Lastly, the Plan confirmed all M/S outpatient services and all MH/SUD outpatient services with variability in cost per episode defined as 2x the mean of other outpatient services and provided to a minimum of twenty unique members were subject to retrospective review. (The Plan established a materiality threshold of 20 members for a variation analysis). **Findings:** The findings of the analysis confirmed the strategy, process, factors, evidentiary standards, and source information used to subject certain MH/SUD outpatient services to retrospective review were	necessity approval and denial rates and appeals outcomes for MH/SUD outpatient services were comparable to the retrospective review medical necessity approval and denial rates and appeals outcomes for M/S outpatient services.[2] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN outpatient services are subject to retrospective review "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to retrospective review "in operation."
	• **Variation Identified**: Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits	• Variability is defined as cost per episode of service (service units X unit cost) that trigger 2x the mean of other outpatient services and provided to a minimum of twenty unique Plan members	• Internal claims data		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.
[3] Services subject to retro review are the same services that are on the Prior Authorization list. [redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

[redacted]					comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S outpatient services to Retrospective Review “as written.” **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD INN outpatient services are subject to retrospective review “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to retrospective review “as written.”	

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.
[3] Services subject to retro review are the same services that are on the Prior Authorization list. [redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

UnitedHealthcare – Student Resources
12/30/2022

Retrospective Review: Out-of-Network Inpatient Services

Strategy: Retrospective review is a component of the Plan's utilization management (UM) program.

Process: Retrospective review begins after the Plan receives notification post-discharge or post-service and/or after a submission of a claim. Inpatient services are reviewed based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria, and nationally recognized guidelines. If an appropriately qualified clinical reviewer (e.g., Medical Director) determines that an inpatient service was not medically necessary, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided.

Out-of-network (OON) providers and facilities have no obligation to cooperate with the Plan's requests for information, documents, or discussions for purposes of Retrospective Review. The provider may bill non-reimbursable charges to the member.[1]

Inpatient Services Subject to Retrospective Review: Out-of-Network		**Step 1 - Factors Used to Determine the Listed Inpatient Services are Subject to Retrospective Review**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
[redacted]		The Plan's methodology used to determine whether the listed M/S and MH/SUD OON inpatient services are subject to retrospective review are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	The Plan conducted a comparative analysis of the strategy, process, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD out-of-network inpatient services are subject to retrospective review "as written." M/S and MH/SUD inpatient services are determined by an internal panel of medical experts (with expertise in M/S conditions and MH/SUD conditions, respectively) as being clinically appropriate in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines.	The Plan assessed the shared factors and evidentiary standards used as the basis for subjecting medical/surgical (M/S) and mental health and substance use disorder (MH/SUD) inpatient, out-of-network benefits to retrospective review. The Plan conducted a comparative analysis of medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to retrospective review for M/S and MH/SUD out-of-network inpatient services. Data was evaluated where a minimum threshold of 100 cases were available.
		• **Clinical Appropriateness:** The application of retrospective review promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those inpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines	• Expert Medical Review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

[redacted]	• **Value:** The value of applying retrospective review outweighs the associated costs • The Company does not restrict length of stay or level of care to Inpatient services for M/S or MH/SUD. • However, medical necessity, State and federal mandates and the definition of a covered medical expense may be applied during a retrospective review	• Value is defined as the value of subjecting the inpatient services to retrospective review exceeds the administrative costs by at least 1:1 • Our reviews are based upon policy language, such as medical necessity and state and federal mandates that apply for those services/supplies/procedures	• Internal claims data • UM program operating costs • UM authorization data	In addition, a consistent process exists for evaluating the value of subjecting certain inpatient services to retrospective review for M/S and MH/SUD. The process includes a review of inpatient utilization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when retrospective review is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering retrospective review to determine the value. The Plan confirmed M/S and MH/SUD inpatient services subject to retrospective review included inpatient services that provided a value that exceeded the administrative cost of 1:1 and promoted the use of evidence-based practices. **Findings:** The findings of the analysis confirmed the strategy, process, factors, evidentiary standards, and source information used to subject certain MH/SUD inpatient services to retrospective review were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S inpatient services to retrospective review “as written.” **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD OON inpatient services are subject to retrospective review “as written” were comparable	**Findings:** The findings of the analysis of the shared factors and the findings of the analysis of outcomes data indicated the retrospective review medical necessity approval and denial rates and appeals outcomes for MH/SUD inpatient services were comparable to the retrospective review medical necessity approval and denial rates and appeals outcomes for M/S inpatient services.2 **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD OON inpatient services are subject to retrospective review “in operation” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON inpatient services are subject to retrospective review “in operation.”

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

					to, and applied no more stringently than, the methodology used to determine which M/S OON inpatient services are subject to retrospective review “as written.”	

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company and UnitedHealthcare Insurance Company of the River Valley
12/30/2022

Retrospective Review: Out-of-Network Inpatient Services

Strategy: Retrospective review is a component of the Plan's utilization management (UM) program.

Process: Retrospective review begins after the Plan receives notification post-discharge or post-service and/or after a submission of a claim. Inpatient services are reviewed based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria, and nationally recognized guidelines. If an appropriately qualified clinical reviewer (e.g., Medical Director) determines that an inpatient service was not medically necessary, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided.

Out-of-network (OON) providers and facilities have no obligation to cooperate with the Plan's requests for information, documents, or discussions for purposes of Retrospective Review. The provider may bill non-reimbursable charges to the member.[1]

Inpatient Services Subject to Retrospective Review: Out-of-Network		**Step 1 - Factors Used to Determine the Listed Inpatient Services are Subject to Retrospective Review**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
[redacted]		The Plan's methodology used to determine whether the listed M/S and MH/SUD OON inpatient services are subject to retrospective review are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	The Plan conducted a comparative analysis of the strategy, process, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD out-of-network inpatient services are subject to retrospective review "as written." M/S and MH/SUD inpatient services are determined by an internal panel of medical experts (with expertise in M/S conditions and MH/SUD conditions, respectively) as being clinically appropriate in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. In addition, a consistent process exists for evaluating the value of subjecting certain inpatient services to retrospective review for M/S and	The Plan assessed the shared factors and evidentiary standards used as the basis for subjecting medical/surgical (M/S) and mental health and substance use disorder (MH/SUD) inpatient, out-of-network benefits to retrospective review. The Plan conducted a comparative analysis of medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to retrospective review for M/S and MH/SUD out-of-network inpatient services. Data was evaluated where a minimum threshold of 100 cases were available. **Findings:** The findings of the analysis of the shared factors and the findings of the analysis of outcomes data indicated the retrospective review medical necessity approval and denial
		• **Clinical Appropriateness:** The application of retrospective review promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those inpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines	• Expert Medical Review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

		• **Value:** The value of applying retrospective review outweighs the associated costs	• Value is defined as the value of subjecting the inpatient services to retrospective review exceeds the administrative costs by at least 1:1	• Internal claims data • UM program operating costs • UM authorization data	MH/SUD. The process includes a review of inpatient utilization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when retrospective review is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering retrospective review to determine the value. The Plan confirmed M/S and MH/SUD inpatient services subject to retrospective review included inpatient services that provided a value that exceeded the administrative cost of 1:1 and promoted the use of evidence-based practices. **Findings:** The findings of the analysis confirmed the strategy, process, factors, evidentiary standards, and source information used to subject certain MH/SUD inpatient services to retrospective review were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S inpatient services to retrospective review "as written." **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD OON inpatient services are subject to retrospective review "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON inpatient services are subject to retrospective review "as written."	rates and appeals outcomes for MH/SUD inpatient services were comparable to the retrospective review medical necessity approval and denial rates and appeals outcomes for M/S inpatient services.2 **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD OON inpatient services are subject to retrospective review "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON inpatient services are subject to retrospective review "in operation."

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Student Resources
12/30/2022

Retrospective Review: Out-of-Network Outpatient Services

Strategy: Retrospective review is a component of the Plan's utilization management (UM) program.

Process: Retrospective review begins after the Plan receives notification post-service and/or after a submission of a claim. Outpatient services are reviewed based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria, and nationally recognized guidelines. If an appropriately qualified clinical reviewer (e.g., Medical Directors) determines that a service was not medically necessary and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided.

Out-of-network (OON) providers and facilities have no obligation to cooperate with the Plan's requests for information, documents, or discussions for purposes of retrospective review. The provider may bill non-reimbursable charges to the member.[1]

Outpatient Services Subject to Retrospective Review: Out-of-Network[3]		**Step 1 - Factors Used to Determine the Listed Outpatient Services are Subject to Retrospective Review**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
[redacted]		The Plan's methodology used to determine whether the listed M/S and MH/SUD OON outpatient services are subject to retrospective review are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	The Plan conducted a comparative analysis of the strategy, process, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD out-of-network outpatient services are subject to retrospective review "as written." M/S and MH/SUD outpatient services are determined by an internal panel of medical experts (with expertise in M/S conditions and MH/SUD conditions, respectively) as being clinically appropriate in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. In addition, a consistent process exists for evaluating the value of subjecting certain outpatient services to Retrospective Review for M/S and MH/SUD. The process	The Plan assessed the shared factors and evidentiary standards used as the basis for subjecting medical/surgical (M/S) and mental health and substance use disorder (MH/SUD) outpatient, out-of-network benefits to retrospective review. The Plan conducted a comparative analysis of medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to retrospective review for M/S and MH/SUD out-of-network outpatient services. Data was evaluated where a minimum threshold of 100 cases were available. **Findings:** The findings of the analysis of the shared factors and the findings of the analysis of outcomes data indicated the retrospective review medical
		• **Clinical Appropriateness:** The application of retrospective review promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those outpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines	• Expert Medical Review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		
		• **Value:** The value of applying retrospective review	• Value is defined as the value of subjecting the outpatient services to retrospective review exceeds the	• Internal claims data • UM program operating costs		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

[redacted]	outweighs the associated costs	administrative costs by at least 1:1	• UM authorization data	includes a review of outpatient utilization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when Retrospective Review is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering Retrospective Review to determine the value. The Plan confirmed the list of M/S and MH/SUD outpatient services subject to Retrospective Review included outpatient services that provided a value that exceeded the administrative cost of 1:1 and promoted the use of evidence-based practices. Lastly, the Plan confirmed all M/S outpatient services and all MH/SUD outpatient services with variability in cost per episode defined as 2x the mean of other outpatient services and provided to a minimum of twenty unique members were subject to Retrospective Review. (The Plan established a materiality threshold of 20 members for a variation analysis). **Findings:** The findings of the analysis confirmed the strategy, process, factors, evidentiary standards, and source information used to subject certain MH/SUD outpatient services to retrospective review were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain	necessity approval and denial rates and appeals outcomes for MH/SUD outpatient services were comparable to the retrospective review medical necessity approval and denial rates and appeals outcomes for M/S outpatient services.[2] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD OON outpatient services are subject to retrospective review “in operation” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to retrospective review “in operation.”
		• Our reviews are based upon policy language, such as medical necessity and state and federal mandates that apply for those services/supplies/procedures	• Expert Medical Review • Nationally recognized evidence-based guidelines • Internal claims data		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

[redacted]					M/S outpatient services to retrospective review “as written.” **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD OON outpatient services are subject to retrospective review “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to retrospective review “as written.”	

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

UnitedHealthcare – UnitedHealthcare Insurance Company
12/30/2022

Retrospective Review: Out-of-Network Outpatient Services

Strategy: Retrospective review is a component of the Plan's utilization management (UM) program.

Process: Retrospective review begins after the Plan receives notification post-service and/or after a submission of a claim. Outpatient services are reviewed based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria, and nationally recognized guidelines. If an appropriately qualified clinical reviewer (e.g., Medical Directors) determines that a service was not medically necessary and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided.

Out-of-network (OON) providers and facilities have no obligation to cooperate with the Plan's requests for information, documents, or discussions for purposes of retrospective review. The provider may bill non-reimbursable charges to the member.[1]

Outpatient Services Subject to Retrospective Review: Out-of-Network[3]		**Step 1 - Factors Used to Determine the Listed Outpatient Services are Subject to Retrospective Review**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health / Substance Use Disorder**					
[redacted]		The Plan's methodology used to determine whether the listed M/S and MH/SUD OON outpatient services are subject to retrospective review are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	The Plan conducted a comparative analysis of the strategy, process, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD out-of-network outpatient services are subject to retrospective review "as written." M/S and MH/SUD outpatient services are determined by an internal panel of medical experts (with expertise in M/S conditions and MH/SUD conditions, respectively) as being clinically appropriate in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. In addition, a consistent process exists for evaluating the value of subjecting certain outpatient	The Plan assessed the shared factors and evidentiary standards used as the basis for subjecting medical/surgical (M/S) and mental health and substance use disorder (MH/SUD) outpatient, out-of-network benefits to retrospective review. The Plan conducted a comparative analysis of medical necessity approval and denial rates, internal appeals outcomes, and external appeals outcomes related to retrospective review for M/S and MH/SUD out-of-network outpatient services. Data was evaluated where a minimum threshold of 100 cases were available. **Findings:** The findings of the analysis of the shared factors and the findings of the analysis of
		• **Clinical Appropriateness:** The application of retrospective review promotes optimal clinical outcomes	• Clinical Appropriateness is defined as those outpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and	• Expert Medical Review • Objective, evidence-based clinical criteria, and nationally recognized guidelines		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.
[3] Services subject to retro review are the same services that are on the Prior Authorization list. [redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

[redacted]		nationally recognized guidelines		services to Retrospective Review for M/S and MH/SUD. The process includes a review of outpatient utilization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when Retrospective Review is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering Retrospective Review to determine the value. The Plan confirmed the list of M/S and MH/SUD outpatient services subject to Retrospective Review included outpatient services that provided a value that exceeded the administrative cost of 1:1 and promoted the use of evidence-based practices. Lastly, the Plan confirmed all M/S outpatient services and all MH/SUD outpatient services with variability in cost per episode defined as 2x the mean of other outpatient services and provided to a minimum of twenty unique members were subject to Retrospective Review. (The Plan established a materiality threshold of 20 members for a variation analysis). **Findings:** The findings of the analysis confirmed the strategy, process, factors, evidentiary standards, and source information used to subject certain MH/SUD outpatient services to retrospective review were comparable to, and	outcomes data indicated the retrospective review medical necessity approval and denial rates and appeals outcomes for MH/SUD outpatient services were comparable to the retrospective review medical necessity approval and denial rates and appeals outcomes for M/S outpatient services.[2] **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD OON outpatient services are subject to retrospective review "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to retrospective review "in operation."
	• **Value:** The value of applying retrospective review outweighs the associated costs	• Value is defined as the value of subjecting the outpatient services to retrospective review exceeds the administrative costs by at least 1:1	• Internal claims data • UM program operating costs • UM authorization data		
	• **Variation Identified**: Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits	• Variability is defined as cost per episode of service (service units X unit cost) that trigger 2x the mean of other outpatient services and provided to a minimum of twenty unique Plan members	• Expert Medical Review • Nationally recognized evidence-based guidelines • Internal claims data		

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.
[3] Services subject to retro review are the same services that are on the Prior Authorization list. [redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

[redacted]					applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S outpatient services to retrospective review “as written.” **Conclusion:** The Plan concluded the methodology used to determine which MH/SUD OON outpatient services are subject to retrospective review “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to retrospective review “as written.”	

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.
[3] Services subject to retro review are the same services that are on the Prior Authorization list. [redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

[redacted]						

[1] UnitedHealthcare (UHC) and Optum Behavioral Health (OBH) generally structure UM processes to comply with Federal ERISA, National Committee Quality Assurance (NCQA) UM standards, and state law where applicable.
[2] The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.
[3] Services subject to retro review are the same services that are on the Prior Authorization list. [redacted]

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections

UnitedHealthcare – Individual and Family Plan
12/30/2022

Pharmacy Prescription Drug List (PDL) a/k/a Formulary Design

Strategy: Prescription Drug List (PDL) a/k/a Formulary Design is a component of the Plan's utilization management (UM) program. The goal of PDL/Formulary Design is to assess the prescription drug's place in therapy.

Process: The Individual and Family Plan Pharmacy Management Committee (IPMC) assesses a prescription drug's place in therapy, and its relative safety and efficacy, in order to provide a clinical recommendation/designation used in determining coverage and tier assignment. The IPMC is comprised of a diverse set of clinical disciplines including behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs. PDL a/k/a Formulary Design is based on the Plan's policy to assign tiers for prescription drugs. Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the PDL and/or benefit coverage. Generic prescription drug includes a prescription drug: (1) that is chemically equivalent to a brand drug; or (2) that UnitedHealthcare (UHC) identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on a number of factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug.

Prescription Drug Services Subject to PDL a/k/a Formulary Design		**Step 1 - Factors Used to Determine the Listed Prescription Drug Services are Subject to PDL a/k/a Formulary Design**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health/ Substance Use Disorder**					
• All prescription drugs apply to PDL a/k/a Formulary design • The prescription drug lists generally contain brand and generics that provide the highest overall value on Tiers 1 and 2, with brand and generics that provide the lowest overall value on Tier 3/4	• All prescription drugs apply to PDL a/k/a Formulary design • The prescription drug lists generally contain brand and generics that provide the highest overall value on Tiers 1 and 2, with brand and generics that provide the lowest overall value on Tier 3/4	The Plan's methodology used to determine whether the listed M/S and MH/SUD prescription drug services are subject to PDL a/k/a/ Formulary design are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	
		• Assessment of the prescription drug's place in therapy	• The Initial Tier Placement and Product Coverage Policy is used to assign tiers for all prescription drugs • Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the	• FDA approved product labeling • Peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects,		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			PDL and/or benefit coverage. Generic prescription drug includes a prescription drug: (1) that is chemically equivalent to a brand drug; or (2) that UHC identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on a number of factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug	and potential for off label use • Claims data	[redacted] **Findings:** The findings of the analysis revealed the strategies, processes, factors, evidentiary standards, and source information MH/SUD used to administer the PDL a/k/a formulary design were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information M/S used to administer the PDL a/k/a Formulary design "as written." Further, both M/S and MH/SUD utilize generally accepted types of data, evidentiary sources, and trend analysis in order to create and maintain the PDL/formulary design. **Conclusion:** The Plan concluded the methodologies to administer the PDL a/k/a Formulary design for use in utilization management (UM) for MH/SUD are comparable to, and applied no more stringently than, the methodologies to administer the PDL a/k/a Formulary design for use in utilization management (UM) for M/S "as written."	**Findings:** The findings of the analysis revealed that for all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create and develop clinical policies. Furthermore, all documents are reviewed by one Individual and Family Plan Pharmacy Management Committee (IPMC). There is no distinction between MH/SUD and M/S prescription drugs, and the processes are administered in the same fashion and not applied more stringently to MH/SUD prescription drugs. The tiering for MH/SUD and M/S prescription drugs shows the majority are placed on Tiers 1 and 2 allowing for easier access and in compliance with MHPAEA. **Conclusion**: The Plan concluded the methodologies to administer the PDL a/k/a Formulary design for use in utilization management (UM) for MH/SUD are comparable to, and applied no more stringently than, the methodologies to administer the PDL a/k/a Formulary design for use in utilization management (UM) for M/S "in operation."
		• Relative safety and efficacy	• The Initial Tier Placement and Product Coverage Policy is used to assign tiers for all prescription drugs • Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the PDL and/or benefit coverage. Generic prescription drug includes a	• FDA approved product labeling • Peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, and potential for off label use		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			prescription drug: (1) that is chemically equivalent to a brand drug; or (2) that UHC identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on a number of factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug	• Claims data		
		• Available therapeutic equivalent prescription drugs	• The Initial Tier Placement and Product Coverage Policy is used to assign tiers for all prescription drugs • Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the PDL and/or benefit coverage. Generic prescription drug includes a	• FDA approved product labeling • Peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, and potential for off label use		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			prescription drug: (1) that is chemically equivalent to a brand drug; or (2) that UHC identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on a number of factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug	• Claims data		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Student Resources
12/30/2022

Pharmacy Prescription Drug List (PDL) a/k/a Formulary Design

Strategy: Prescription Drug List (PDL) a/k/a Formulary Design is a component of the Plan's utilization management (UM) program. The goal of PDL/Formulary Design is to assess the prescription drug's place in therapy.

Process: The Pharmacy & Therapeutics (P&T) Committee assesses a prescription drug's place in therapy, and its relative safety and efficacy, in order to provide a clinical recommendation/designation used in determining coverage and tier assignment. The P&T Committee is comprised of a diversity of clinical disciplines including behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs. PDL a/k/a Formulary Design is based on the Plan's policy to assign tiers for prescription drugs. Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the PDL and/or benefit coverage. Generic prescription drug includes a prescription drug: (1) that is chemically equivalent to a brand drug; or (2) that UnitedHealthcare (UHC) identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on a number of factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug.

Prescription Drug Services Subject to PDL a/k/a Formulary Design		**Step 1 - Factors Used to Determine the Listed Prescription Drug Services are Subject to PDL a/k/a Formulary Design**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health/ Substance Use Disorder**					

• All prescription drugs apply to PDL a/k/a Formulary design.
 	
• The prescription drug lists generally contain brand and generics that provide the highest overall value on Tiers 1 and 2, with brand and generics that provide the lowest overall value on Tier 3/4.
	• All prescription drugs apply to PDL a/k/a Formulary design.
	
	• The prescription drug lists generally contain brand and generics that provide the highest overall value on Tiers 1 and 2, with brand and generics that provide the lowest overall value on Tier 3/4.
		The Plan's methodology used to determine whether the listed M/S and MH/SUD prescription drug services are subject to PDL a/k/a/ Formulary design are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted]
						
						The following are results of each analysis in 2021:
						• **January 2021** –
						  ○ 58.9% of MH/SUD drugs are on Tiers 1 and 2
						  ○ 54% of M/S drugs are on Tiers 1 and 2
						• **May 2021** –
						  ○ 59.1% of MH/SUD drugs are on Tiers 1 and 2
						  ○ 53.6% of M/S drugs are on Tiers 1 and 2
						• **September 2021** –
						  ○ 60.0% of MH/SUD drugs are on Tiers 1 and 2

		• Assessment of the prescription drug's place in therapy	• The Initial Tier Placement and Product Coverage Policy is used to assign tiers for all prescription drugs. • Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the	• FDA approved product labeling • Peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects,		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			PDL and/or benefit coverage. Generic prescription drug includes a prescription drug: (1) that is chemically equivalent to a brand drug; or (2) that UHC identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on a number of factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug.	and potential for off label use • Claims data	[redacted] **Findings:** The findings of the analysis revealed the strategy, processes, factors, evidentiary standards, and source information MH/SUD used to administer the PDL a/k/a formulary design were comparable to, and applied no more stringently than, the strategy, processes, factors, evidentiary standards, and source information M/S used to administer the PDL a/k/a Formulary design "as written". Further, both M/S and MH/SUD utilize generally accepted types of data, evidentiary sources, and trend analysis in order to create and maintain the PDL/formulary design. **Conclusion:** The Plan concluded the methodologies to administer the PDL a/k/a Formulary design for use in utilization management (UM) for MH/SUD are comparable to, and applied no more stringently than, the methodologies to administer the PDL a/k/a Formulary design for use in utilization management (UM) for M/S "as written."	○ 53.7% of M/S drugs are on Tiers 1 and 2 [redacted] **Findings:** The findings of the analysis revealed for all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create and develop clinical policies. Furthermore, all documents are reviewed by one P&T Committee. There is no distinction between MH/SUD and M/S prescription drugs, and the processes are administered in the same fashion and not applied more stringently to MH/SUD prescription drugs. The tiering for MH/SUD and M/S prescription drugs shows the majority are placed on Tiers 1 and 2 allowing for easier access and in compliance with MHPAEA. **Conclusion**: The Plan concluded the methodologies to administer the PDL a/k/a Formulary design for use in utilization management (UM) for MH/SUD are comparable to, and applied no more stringently than, the methodologies to administer the PDL a/k/a Formulary design for use in utilization management (UM) for M/S "in operation."
		• Relative safety and efficacy	• The Initial Tier Placement and Product Coverage Policy is used to assign tiers for all prescription drugs. • Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the PDL and/or benefit coverage. Generic prescription drug includes a	• FDA approved product labeling • Peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, and potential for off label use		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			prescription drug: (1) that is chemically equivalent to a brand drug; or (2) that UHC identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on a number of factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug.	• Claims data		
		• Available therapeutic equivalent prescription drugs	• The Initial Tier Placement and Product Coverage Policy is used to assign tiers for all prescription drugs. • Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the PDL and/or benefit coverage. Generic prescription drug includes a	• FDA approved product labeling • Peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, and potential for off label use		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			prescription drug: (1) that is chemically equivalent to a brand drug; or (2) that UHC identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on a number of factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug.	• Claims data		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of the River Valley and UnitedHealthcare of Georgia, Inc.
12/30/2022

Pharmacy Prescription Drug List (PDL) a/k/a Formulary Design

Strategy: Prescription Drug List (PDL) a/k/a Formulary Design is a component of the Plan's utilization management (UM) program. The goal of PDL/Formulary Design is to assess the prescription drug's place in therapy.

Process: The Pharmacy & Therapeutics (P&T) Committee assesses a prescription drug's place in therapy, and its relative safety and efficacy, in order to provide a clinical recommendation/designation used in determining coverage and tier assignment. The P&T Committee is comprised of a diversity of clinical disciplines including behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs. PDL a/k/a Formulary Design is based on the Plan's policy to assign tiers for prescription drugs. Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the PDL and/or benefit coverage. Generic prescription drug includes a prescription drug: (1) that is chemically equivalent to a brand drug; or (2) that UnitedHealthcare (UHC) identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on a number of factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug.

Prescription Drug Services Subject to PDL a/k/a Formulary Design		**Step 1 - Factors Used to Determine the Listed Prescription Drug Services are Subject to PDL a/k/a Formulary Design**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical	**Mental Health/ Substance Use Disorder**					

• All prescription drugs apply to PDL a/k/a Formulary design.
 	
• The prescription drug lists generally contain brand and generics that provide the highest overall value on Tiers 1 and 2, with brand and generics that provide the lowest overall value on Tier 3/4.
	• All prescription drugs apply to PDL a/k/a Formulary design.
	
	• The prescription drug lists generally contain brand and generics that provide the highest overall value on Tiers 1 and 2, with brand and generics that provide the lowest overall value on Tier 3/4.
		The Plan's methodology used to determine whether the listed M/S and MH/SUD prescription drug services are subject to PDL a/k/a/ Formulary design are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted]
						
						The following are results of each analysis in 2021:
						• **January 2021** –
						  ○ 58.9% of MH/SUD drugs are on Tiers 1 and 2
						  ○ 54% of M/S drugs are on Tiers 1 and 2
						• **May 2021** –
						  ○ 59.1% of MH/SUD drugs are on Tiers 1 and 2
						  ○ 53.6% of M/S drugs are on Tiers 1 and 2
						• **September 2021** –
						  ○ 60.0% of MH/SUD drugs are on Tiers 1 and 2

		• Assessment of the prescription drug's place in therapy	• The Initial Tier Placement and Product Coverage Policy is used to assign tiers for all prescription drugs. • Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the	• FDA approved product labeling • Peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects,		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			PDL and/or benefit coverage. Generic prescription drug includes a prescription drug: (1) that is chemically equivalent to a brand drug; or (2) that UHC identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on a number of factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug.	and potential for off label use • Claims data	[redacted] **Findings:** The findings of the analysis revealed the strategy, processes, factors, evidentiary standards, and source information MH/SUD used to administer the PDL a/k/a formulary design were comparable to, and applied no more stringently than, the strategy, processes, factors, evidentiary standards, and source information M/S used to administer the PDL a/k/a Formulary design "as written". Further, both M/S and MH/SUD utilize generally accepted types of data, evidentiary sources, and trend analysis in order to create and maintain the PDL/formulary design. **Conclusion:** The Plan concluded the methodologies to administer the PDL a/k/a Formulary design for use in utilization management (UM) for MH/SUD are comparable to, and applied no more stringently than, the methodologies to administer the PDL a/k/a Formulary design for use in utilization management (UM) for M/S "as written."	○ 53.7% of M/S drugs are on Tiers 1 and 2 [redacted] **Findings:** The findings of the analysis revealed for all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create and develop clinical policies. Furthermore, all documents are reviewed by one P&T Committee. There is no distinction between MH/SUD and M/S prescription drugs, and the processes are administered in the same fashion and not applied more stringently to MH/SUD prescription drugs. The tiering for MH/SUD and M/S prescription drugs shows the majority are placed on Tiers 1 and 2 allowing for easier access and in compliance with MHPAEA. **Conclusion**: The Plan concluded the methodologies to administer the PDL a/k/a Formulary design for use in utilization management (UM) for MH/SUD are comparable to, and applied no more stringently than, the methodologies to administer the PDL a/k/a Formulary design for use in utilization management (UM) for M/S "in operation."
		• Relative safety and efficacy	• The Initial Tier Placement and Product Coverage Policy is used to assign tiers for all prescription drugs. • Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the PDL and/or benefit coverage. Generic prescription drug includes a	• FDA approved product labeling • Peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, and potential for off label use		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			prescription drug: (1) that is chemically equivalent to a brand drug; or (2) that UHC identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on a number of factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug.	• Claims data		
		• Available therapeutic equivalent prescription drugs	• The Initial Tier Placement and Product Coverage Policy is used to assign tiers for all prescription drugs. • Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the PDL and/or benefit coverage. Generic prescription drug includes a	• FDA approved product labeling • Peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, and potential for off label use		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			prescription drug: (1) that is chemically equivalent to a brand drug; or (2) that UHC identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on a number of factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug.	• Claims data		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Individual and Family Plan
12/30/2022

Prescription Drugs Medical Necessity Criteria

Strategy: The Plan uses internally developed evidence-based medical and behavioral clinical policies when making medical necessity coverage determinations related to Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) prescription drugs.

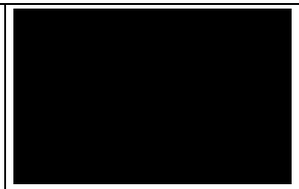
Process: For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop medical/behavioral clinical policies through one Individual and Family Plan Pharmacy Management Committee (IPMC). The IPMC is comprised of a diverse set of clinical disciplines including behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs. To approve medical/behavioral clinical policies, the established committee follows a standard process. The IPMC Committee evaluates FDA approved product labeling, peer-reviewed medical literature, published clinical practice guidelines, including randomized clinical trials, drug comparison studies, outcomes research data, pharmacoeconomic studies, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant as part of the review and approval process of medical and behavioral clinical policies. The IPMC assesses external clinical evidence and nationally recognized evidence-based guidelines and benchmarks, as well as a prescription drug's place in therapy, and its relative safety and efficacy to approve medical/behavioral clinical policies for select M/S and MH/SUD prescription drugs.

Prescription Drug Services Subject to Medical Necessity Criteria		**Step 1 - Factors Used to Determine Listed Prescription Drug Services are subject to Medical Necessity Criteria**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical (M/S)	**Mental Health / Substance Use Disorder (MH/SUD)**					
• Prior Authorization (Medical Necessity) requirements are indicated on the Prescription Drug List (PDL) [redacted]	• Prior Authorization (Medical Necessity) requirements are indicated on the Prescription Drug List (PDL)	The Plan's methodology used to determine whether the listed M/S and MH/SUD prescription drugs services are subject to Medical Necessity Criteria are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted] **Conclusion**: The Plan concluded the methodologies used to determine the prescription drugs services that are subject to Medical Necessity Criteria "in operation" for MH/SUD were comparable and no-more stringent than the methodologies used to determine the prescription drugs services that are subject to Medical
		• Assessment of the prescription drug's place in therapy	[redacted]			

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

[redacted]				[redacted]	**Findings:** The findings of the analysis reflected the strategies, processes, factors, evidentiary standards, and source information MH/SUD used to determine whether the requirement will apply for a particular prescription drug service were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information M/S used to determine whether the requirement will apply for a particular prescription drug service "as written." Further, both M/S and MH/SUD utilize FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmaco-economic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data to develop prescription drug medical and clinical policies. **Conclusion:** The Plan concluded the methodologies used to develop internal evidence-based medical and behavioral clinical policies for use in utilization management for MH/SUD were comparable to, and no more stringent than, methodologies to develop internal evidence-based medical and behavioral clinical policies for use in utilization management for M/S.	Necessity Criteria for M/S "in operation."
		• Availability of clinically similar lower cost medications to treat the condition • Administrative burden to implement prior authorization	[redacted]			
		• Relative safety and efficacy • Prevention of off-label use or unproven uses				

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Student Resources
12/30/2022

Prescription Drugs Medical Necessity Criteria

Strategy: The Plan uses internally developed evidence-based medical and clinical policies when making medical necessity coverage determinations related to Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) prescription drugs.

Process: For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop medical/clinical policies through one Pharmacy & Therapeutics (P&T) Committee. The P&T Committee is comprised of a diversity of clinical disciplines including behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs. To approve medical/clinical policies, the established committee follows a standard process. The P&T Committee evaluates FDA approved product labeling, peer-reviewed medical literature, published clinical practice guidelines, including randomized clinical trials, drug comparison studies, outcomes research data, pharmacoeconomic studies, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant as part of the review and approval process of medical and clinical policies. The P&T Committee assesses external clinical evidence and nationally recognized evidence-based guidelines and benchmarks, as well as a prescription drug's place in therapy, and its relative safety and efficacy to approve medical/clinical policies for select M/S and MH/SUD prescription drugs.

Prescription Drug Services Subject to Medical Necessity Criteria		**Step 1 - Factors Used to Determine Listed Prescription Drug Services are subject to Medical Necessity Criteria**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical (M/S)	**Mental Health / Substance Use Disorder (MH/SUD)**					
[redacted]		The Plan's methodology used to determine whether the listed M/S and MH/SUD prescription drugs services are subject to Medical Necessity Criteria are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted] **Findings:** The following are results of each analysis in 2021: **January 2021** – 20.6% (114) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits, while 16.1% (1,241) of M/S drugs are subject to these programs. **May 2021** – 17% (94) of MH/SUD drugs are subject to Prior
		• Assessment of the prescription drug's place in therapy	[redacted]			

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

				[redacted]	**Findings:** The findings of the analysis reflected the strategy, processes, factors, evidentiary standards, and source information MH/SUD used to determine whether the requirement will apply for a particular prescription drug service were comparable to, and applied no more stringently than, the strategy, processes, factors, evidentiary standards, and source information M/S used to determine whether the requirement will apply for a particular prescription drug service "as written." Further, both M/S and MH/SUD utilize FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmaco-economic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data to develop prescription drug medical and clinical policies. **Conclusion:** The Plan concluded the methodologies used to develop internal evidence-based medical and clinical policies for use in utilization management for MH/SUD were comparable to, and no more stringent than, methodologies to develop internal evidence-based medical and clinical policies for use in utilization management for M/S.	Authorization, Step Therapy, and/or Quantity Limits, while 16.1% (1,242) of M/S drugs are subject to these programs. **September 2021** – 16% (94) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits, while 16.3% (1,249) of M/S drugs are subject to these programs. **Conclusion**: The Plan concluded the methodologies used to determine the prescription drugs services that are subject to Medical Necessity Criteria "in operation" for MH/SUD were comparable and no-more stringent than the methodologies used to determine the prescription drugs services that are subject to Medical Necessity Criteria for M/S "in operation."
		• Availability of clinically similar lower cost medications to treat the condition • Administrative burden to implement prior authorization	[redacted]			
		• Relative safety and efficacy • Prevention of off-label use or unproven uses				

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of the River Valley and UnitedHealthcare of Georgia, Inc.
12/30/2022

Prescription Drugs Medical Necessity Criteria

Strategy: The Plan uses internally developed evidence-based medical and clinical policies when making medical necessity coverage determinations related to Medical/Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) prescription drugs.

Process: For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop medical/clinical policies through one Pharmacy & Therapeutics (P&T) Committee. The P&T Committee is comprised of a diversity of clinical disciplines including behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs. To approve medical/clinical policies, the established committee follows a standard process. The P&T Committee evaluates FDA approved product labeling, peer-reviewed medical literature, published clinical practice guidelines, including randomized clinical trials, drug comparison studies, outcomes research data, pharmacoeconomic studies, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant as part of the review and approval process of medical and clinical policies. The P&T Committee assesses external clinical evidence and nationally recognized evidence-based guidelines and benchmarks, as well as a prescription drug's place in therapy, and its relative safety and efficacy to approve medical/clinical policies for select M/S and MH/SUD prescription drugs.

Prescription Drug Services Subject to Medical Necessity Criteria		**Step 1 - Factors Used to Determine Listed Prescription Drug Services are subject to Medical Necessity Criteria**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical (M/S)	**Mental Health / Substance Use Disorder (MH/SUD)**					
[redacted]		The Plan's methodology used to determine whether the listed M/S and MH/SUD prescription drugs services are subject to Medical Necessity Criteria are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted] **Findings:** The following are results of each analysis in 2021: **January 2021** – 20.6% (114) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits, while 16.1% (1,241) of M/S drugs are subject to these programs. **May 2021** – 17% (94) of MH/SUD drugs are subject to Prior
		• Assessment of the prescription drug's place in therapy	[redacted]			

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			[redacted]	**Findings:** The findings of the analysis reflected the strategy, processes, factors, evidentiary standards, and source information MH/SUD used to determine whether the requirement will apply for a particular prescription drug service were comparable to, and applied no more stringently than, the strategy, processes, factors, evidentiary standards, and source information M/S used to determine whether the requirement will apply for a particular prescription drug service "as written." Further, both M/S and MH/SUD utilize FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmaco-economic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data to develop prescription drug medical and clinical policies. **Conclusion:** The Plan concluded the methodologies used to develop internal evidence-based medical and clinical policies for use in utilization management for MH/SUD were comparable to, and no more stringent than, methodologies to develop internal evidence-based medical and clinical policies for use in utilization management for M/S.	Authorization, Step Therapy, and/or Quantity Limits, while 16.1% (1,242) of M/S drugs are subject to these programs. **September 2021** – 16% (94) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits, while 16.3% (1,249) of M/S drugs are subject to these programs. **Conclusion**: The Plan concluded the methodologies used to determine the prescription drugs services that are subject to Medical Necessity Criteria "in operation" for MH/SUD were comparable and no-more stringent than the methodologies used to determine the prescription drugs services that are subject to Medical Necessity Criteria for M/S "in operation."
		• Availability of clinically similar lower cost medications to treat the condition • Administrative burden to implement prior authorization	[redacted]		
		• Relative safety and efficacy • Prevention of off-label use or unproven uses			

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

				[redacted]		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Individual and Family Plan
12/30/2022

Prescription Drug Prior Authorization and Step Therapy

Strategy: Prior Authorization and Step Therapy are components of the Plan's utilization management (UM) program. The comparative analysis "as written" and "in operation" are the same for Prior Authorization and Step Therapy; therefore, the analysis has been combined. The goal of Prior Authorization and Step Therapy is to ensure cost-effective and clinically effective prescription drugs are covered to achieve a positive clinical outcome. Prior Authorization and Step Therapy applies to prescription drugs provided to a member at the point-of-sale.

Process: Prior Authorization and Step Therapy begin after a provider or member requests coverage for prescription drug services and receipt of clinical information. A Prior Authorization or Step Therapy request may be submitted by fax, telephone, or electronically. The Medical Director or healthcare professional assesses whether a prescription drug should be covered. The Prior Authorization or Step Therapy request is approved based on whether the member's clinical condition meets criteria for coverage as determined by the application of clinical policies. If a Medical Director or healthcare professional determines that the prescription drug is not medically necessary and will not be covered, the member and the prescriber will be notified consistent with state, federal, or accreditation requirements and applicable appeal rights will be provided.

Prescription Drug Services Covered Under the Prescription Drug Benefit Subject to Prior Authorization		**Step 1 - Factors Used to Determine the Listed Prescription Drug Services are Subject to Prior Authorization and Step Therapy**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical (M/S)	**Mental Health / Substance Use Disorder (MH/SUD)**					
• Prior Authorization and Step Therapy requirements are indicated on the Prescription Drug List (PDL)	• Prior Authorization and Step Therapy requirements are indicated on the Prescription Drug List (PDL)	The Plan's methodology used to determine whether the listed M/S and MH/SUD prescription drug services are subject to prior authorization/step therapy are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted] **Conclusion** The plan concluded the strategies, processes, factors, evidentiary standards, and source information MH/SUD used to determine whether the requirement will apply for a particular prescription drug service were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information M/S used to determine whether the requirement will apply
[redacted]		• Assessment of the prescription drug's place in therapy	• State and/or Federal regulations and guidelines • Review of external clinical evidence • Nationally recognized evidence-based	• FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

[redacted]			guidelines and benchmarks • Individual and Family Plan Pharmacy Management Committee (IPMC)	clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant	**Findings:** The findings of the analysis reflected the strategies, processes, factors, evidentiary standards, and source information MH/SUD used to determine whether the requirement will apply for a particular prescription drug service were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information M/S used to determine whether the requirement will apply for a particular prescription drug service "as written." Further, both M/S and MH/SUD utilize generally accepted types of data, evidentiary sources, and trend analysis in order to create and maintain a Prior Authorization or Step Therapy requirement. **Conclusion:** The plan concluded the strategies, processes, factors, evidentiary standards, and source information MH/SUD used to determine whether the requirement will apply for a particular prescription drug service were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information M/S used to determine whether the requirement will apply for a particular prescription drug service "as written."	for a particular prescription drug service "in operation."
		• Availability of clinically similar lower cost medications to treat the condition • Administrative burden to implement Prior Authorization/Step Therapy	• State and/or Federal regulations and guidelines • Review of external clinical evidence • Nationally recognized evidence-based guidelines and benchmarks	• FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant		
		• Relative safety and efficacy • Prevention of off-label use or unproven uses	• State and/or Federal regulations and guidelines • Review of external clinical evidence • Nationally recognized evidence-based guidelines and benchmarks • Individual and Family Plan Pharmacy Management Committee (IPMC) assesses the	• FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			prescription drug's place in therapy, and its relative safety and efficacy. The committee reviews decisions consistent with published evidence relative to these factors.			

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – Student Resources
12/30/2022

Prescription Drug Prior Authorization and Step Therapy

Strategy: Prior Authorization and Step Therapy are components of the Plan's utilization management (UM) program. The comparative analysis "as written" and "in operation" are the same for Prior Authorization and Step Therapy; therefore, the analysis has been combined. The goal of Prior Authorization and Step Therapy is to ensure cost-effective and clinically effective prescription drugs are covered to achieve a positive clinical outcome. Prior Authorization and Step Therapy applies to prescription drugs provided to a member at the point-of-sale.

Process: Prior Authorization and Step Therapy begin after a provider or member requests coverage for prescription drug services and receipt of clinical information. A Prior Authorization or Step Therapy request may be submitted by fax, telephone, or electronically. The Medical Director or healthcare professional assesses whether a prescription drug should be covered. The Prior Authorization or Step Therapy request is approved based on whether the member's clinical condition meets criteria for coverage as determined by the application of clinical policies. If a Medical Director or healthcare professional determines that the prescription drug is not medically necessary and will not be covered, the member and the prescriber will be notified consistent with state, federal, or accreditation requirements and applicable appeal rights will be provided.

Prescription Drug Services Covered Under the Prescription Drug Benefit Subject to Prior Authorization		**Step 1 - Factors Used to Determine the Listed Prescription Drug Services are Subject to Prior Authorization and Step Therapy**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical (M/S)	**Mental Health / Substance Use Disorder (MH/SUD)**					
[redacted]		The Plan's methodology used to determine whether the listed M/S and MH/SUD prescription drug services are subject to prior authorization/step therapy are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted]
		• Assessment of the prescription drug's place in therapy	• State and/or Federal regulations and guidelines • Review of external clinical evidence • Nationally recognized evidence-based	• FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes	**Findings:** The findings of the analysis reflected the strategy, processes, factors,	**Findings:** The following are results of each analysis in 2021: **January 2021** - 20.6% (114) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits, while 16.1% (1,241) of M/S drugs are subject to these programs. **May 2021** - 17% (94) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			guidelines and benchmarks • Pharmacy & Therapeutics (P&T) Committee	research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant	evidentiary standards, and source information MH/SUD used to determine whether the requirement will apply for a particular prescription drug service were comparable to, and applied no more stringently than, the strategy, processes, factors, evidentiary standards, and source information M/S used to determine whether the requirement will apply for a particular prescription drug service "as written." Further, both M/S and MH/SUD utilize generally accepted types of data, evidentiary sources, and trend analysis in order to create and maintain a Prior Authorization or Step Therapy requirement. **Conclusion:** The plan concluded the strategy, processes, factors, evidentiary standards, and source information MH/SUD used to determine whether the requirement will apply for a particular prescription drug service were comparable to, and applied no more stringently than, the strategy, processes, factors, evidentiary standards, and source information M/S used to determine whether the requirement will apply for a particular prescription drug service "as written."	Quantity Limits, while 16.1% (1,242) of M/S drugs are subject to these programs. **September 2021** – 16% (94) of MH/SUD drugs are subject to Prior Auth, Step Therapy, and/or Quantity Limits, while 16.3% (1,249) of M/S drugs are subject to these programs. **Conclusion** The plan concluded the strategy, processes, factors, evidentiary standards, and source information MH/SUD used to determine whether the requirement will apply for a particular prescription drug service were comparable to, and applied no more stringently than, the strategy, processes, factors, evidentiary standards, and source information M/S used to determine whether the requirement will apply for a particular prescription drug service "in operation."
		• Availability of clinically similar lower cost medications to treat the condition • Administrative burden to implement Prior Authorization/Step Therapy	• State and/or Federal regulations and guidelines • Review of external clinical evidence • Nationally recognized evidence-based guidelines and benchmarks	• FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant		
		• Relative safety and efficacy • Prevention of off-label use or unproven uses	• State and/or Federal regulations and guidelines • Review of external clinical evidence • Nationally recognized evidence-based guidelines and benchmarks • Pharmacy & Therapeutics (P&T) Committee assesses the prescription drug's	• FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects,		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			place in therapy, and its relative safety and efficacy. The committee reviews decisions consistent with published evidence relative to these factors.	potential for off label use and claims data analysis as relevant		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

UnitedHealthcare – UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of the River Valley and UnitedHealthcare of Georgia, Inc.
12/30/2022

Prescription Drug Prior Authorization and Step Therapy

Strategy: Prior Authorization and Step Therapy are components of the Plan's utilization management (UM) program. The comparative analysis "as written" and "in operation" are the same for Prior Authorization and Step Therapy; therefore, the analysis has been combined. The goal of Prior Authorization and Step Therapy is to ensure cost-effective and clinically effective prescription drugs are covered to achieve a positive clinical outcome. Prior Authorization and Step Therapy applies to prescription drugs provided to a member at the point-of-sale.

Process: Prior Authorization and Step Therapy begin after a provider or member requests coverage for prescription drug services and receipt of clinical information. A Prior Authorization or Step Therapy request may be submitted by fax, telephone, or electronically. The Medical Director or healthcare professional assesses whether a prescription drug should be covered. The Prior Authorization or Step Therapy request is approved based on whether the member's clinical condition meets criteria for coverage as determined by the application of clinical policies. If a Medical Director or healthcare professional determines that the prescription drug is not medically necessary and will not be covered, the member and the prescriber will be notified consistent with state, federal, or accreditation requirements and applicable appeal rights will be provided.

Prescription Drug Services Covered Under the Prescription Drug Benefit Subject to Prior Authorization		**Step 1 - Factors Used to Determine the Listed Prescription Drug Services are Subject to Prior Authorization and Step Therapy**	**Step 2 - Evidentiary Standards Used to Define, Trigger and/or Implicate a Factor**	**Step 3 - Sources Used to Define the Factors**	**Step 4 - NQTL "As Written" Comparability and Stringency Analysis, Findings, and Conclusions**	**Step 5 - NQTL "In Operation" Comparability and Stringency Analysis, Findings, and Conclusions**
Medical/ Surgical (M/S)	**Mental Health / Substance Use Disorder (MH/SUD)**					
[redacted]		The Plan's methodology used to determine whether the listed M/S and MH/SUD prescription drug services are subject to prior authorization/step therapy are based upon the following factors. The factors are not weighted.	The Plan's evidentiary standards that define and/or trigger the identified factors include	The sources used to define the factors include	[redacted]	[redacted]
		• Assessment of the prescription drug's place in therapy	• State and/or Federal regulations and guidelines • Review of external clinical evidence • Nationally recognized evidence-based	• FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes	**Findings:** The findings of the analysis reflected the strategy, processes, factors,	**Findings:** The following are results of each analysis in 2021: **January 2021** - 20.6% (114) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits, while 16.1% (1,241) of M/S drugs are subject to these programs. **May 2021** - 17% (94) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			guidelines and benchmarks • Pharmacy & Therapeutics (P&T) Committee	research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant	evidentiary standards, and source information MH/SUD used to determine whether the requirement will apply for a particular prescription drug service were comparable to, and applied no more stringently than, the strategy, processes, factors, evidentiary standards, and source information M/S used to determine whether the requirement will apply for a particular prescription drug service "as written." Further, both M/S and MH/SUD utilize generally accepted types of data, evidentiary sources, and trend analysis in order to create and maintain a Prior Authorization or Step Therapy requirement. **Conclusion:** The plan concluded the strategy, processes, factors, evidentiary standards, and source information MH/SUD used to determine whether the requirement will apply for a particular prescription drug service were comparable to, and applied no more stringently than, the strategy, processes, factors, evidentiary standards, and source information M/S used to determine whether the requirement will apply for a particular prescription drug service "as written."	Quantity Limits, while 16.1% (1,242) of M/S drugs are subject to these programs. **September 2021** – 16% (94) of MH/SUD drugs are subject to Prior Auth, Step Therapy, and/or Quantity Limits, while 16.3% (1,249) of M/S drugs are subject to these programs. **Conclusion** The plan concluded the strategy, processes, factors, evidentiary standards, and source information MH/SUD used to determine whether the requirement will apply for a particular prescription drug service were comparable to, and applied no more stringently than, the strategy, processes, factors, evidentiary standards, and source information M/S used to determine whether the requirement will apply for a particular prescription drug service "in operation."
		• Availability of clinically similar lower cost medications to treat the condition • Administrative burden to implement Prior Authorization/Step Therapy	• State and/or Federal regulations and guidelines • Review of external clinical evidence • Nationally recognized evidence-based guidelines and benchmarks	• FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant		
		• Relative safety and efficacy • Prevention of off-label use or unproven uses	• State and/or Federal regulations and guidelines • Review of external clinical evidence • Nationally recognized evidence-based guidelines and benchmarks • Pharmacy & Therapeutics (P&T) Committee assesses the prescription drug's	• FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects,		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.

			place in therapy, and its relative safety and efficacy. The committee reviews decisions consistent with published evidence relative to these factors.	potential for off label use and claims data analysis as relevant		

Please note that the information contained herein is confidential and proprietary commercial information. Accordingly, UnitedHealthcare hereby requests that this document be afforded confidential treatment and be protected from disclosure under applicable public records laws and market conduct exam protections.