

## **Policy Title: Clinical Decision Support Tools**

**Purpose:**

To define the primary clinical decision support tools that may be utilized by the Utilization Management Organization.

**Policy Statement:**

The Utilization Management organization will utilize for clinical review criteria, nationally recognized criteria guidelines and/or other corporate guidelines and policies in making medical necessity decisions. Criteria is developed and or evaluated for updates at least annually in conjunction with appropriate providers or prescribers with current knowledge relevant to the criteria. Review criteria will be based on current medical or scientific evidence where available, as well as widely accepted, consensus-driven standards of clinical practice. All criteria will be approved by the medical director, and P&T committee or other equivalent clinical oversight body at least annually.

Staff is provided information on how the application of clinical hierarchy is to be administered by external vendors and internal clinical reviewers. This process is as follows:

1. There should be appropriate identification of which UHC Medical Policies are applicable to the case, along with any state specific guidelines that should be applied.
2. Each case should include the appropriate justification (i.e. use of nationally recognized external guidelines and if no applicable guidelines exist then use of approved evidentiary sources to be professionally cited).

The Plan approves the following in clinical evidence hierarchy application:

- InterQual for all ages of treatment, to be used for all medical/surgical criteria.
- The ASAM Criteria for treatment for adolescents and adults, to be used for the levels of care in addiction treatment as comprehensive set of standards for facility-based placement and or outpatient levels of care admission, continued stay, and transfer/discharge of patients with addiction and co-occurring conditions.
- The Level of Care Utilization System (LOCUS) instrument guide to be used for treatment decisions for adults aged 18+ for Level of care and placement decision for psychiatric conditions and treatment.
- Child and Adolescent Level of Care Utilization System (CALOCUS-CASII) instrument guide to be used for treatment decision for ages 6-18 years old, for Level of care and placement decision for psychiatric conditions and treatment.
- Early Childhood Service Intensity (ECSII) instrument guide to be used for treatment of ages 0-5 years old, for Level of care and placement decision for psychiatric conditions and treatment.

If the above Nationally recognized criteria guidelines do not provide means by which to evidence below are the approved sources:

- Clinical position papers based upon rigorous review of scientific evidence or clinical registry data from professional specialty societies when their statements are based upon referenced clinical evidence.
- Statistically Robust Clinical Trials, which consist of randomized controlled clinical trials constructed to allow for meaningful comparison of results of interventions. Interventions should be objectively measured in terms of clinically important outcomes that positively impact a member's health and trials must be professionally cited if utilized in basis of opinion.
- Physician specialty society recommendations, professional standards of care, scientifically based clinical evidenced and national guidelines and consensus statements by recognized authorities may be considered.
- Examples (This list is not all-inclusive):
  - Advisory Committee on Immunization Practices (ACIP) recommendations
  - Agency for Health Care Research and Quality (AHRQ) clinical statements
  - American College of Physicians (ACP)
  - American College of Cardiology (ACC)
  - American Psychiatric Association (APA)
  - American Medical Directors Association (AMDA)
  - American Academy of Family Physicians (AAFP)

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- Centers for Disease Control and Prevention (CDC) advisories
- Centers for Medicare and Medicaid Services (CMS) National Coverage Decisions (NCDs)
- National Institutes of Health (NIH) clinical statements
- National Comprehensive Cancer Network (NCCN)
- United States Preventive Services Task Force (USPSTF)

**Review Flow:**

For initial screening, the organization limits the use of non-clinical administrative staff to (a) review service requests for completeness of information, (b) collect and transfer non-clinical data, and (c) acquire structured clinical data. During the initial screening process, non-clinical administrative staff does not evaluate or interpret clinical information.

A clinical staff member will (a) not issue non-certifications, (b) assign a unique identifier to each request for certification, (c) provides readily available resources to staff, (d) adhere to applicable utilization management requirements and procedures (f) designate a licensed health professional to conduct a clinical peer review and provide guidance as needed.

All clinical review criteria that may be utilized by the Utilization Management organization will be reviewed and approved for utilization on an annual basis and, upon request, made available to state Insurance Departments.

The *clinical review criteria* utilized to render an adverse determination will be made available to the treating physician, provider, and patient upon request.

Scripted clinical screening criteria may be used by a clinical staff member.

- Clinical review scripts are:
  - a) Developed with and evaluated in conjunction with appropriate providers or prescribers with current knowledge relevant to the criteria.
  - b) Based on current medical or scientific evidence where available, as well as widely accepted, consensus-driven standards of clinical practice.
  - c) Evaluated at least annually by:
    - i. the organization and
    - ii. appropriate, actively practicing physician, pharmacists, and other providers with current knowledge relevant to the criteria or scripts under review.
  - d) Approved by the medical director or clinical director or equivalent designate or Pharmacy and Therapeutics (P&T) Committee or other equivalent clinical oversight body.

Clinical decisions are based upon review and consideration of relevant information obtained from clinical records pertinent to the service or treatment under review and clinical records are accepted from any reliable source.

Review staff will utilize appropriate clinical criteria and consider the patient's clinical information and when available: plan benefit design, age, co-morbidities, complication, progress of treatment, psychosocial situation, and where applicable, the home environment or ability of the facility to deliver services.

Review determinations are based solely on the medical information (a) obtained by the organization at the time of the review determination for prospective and concurrent review and (b) available to the attending physician or ordering provider at the time the medical or behavioral health care was provided for retrospective review.

**Coordinating Provisions – State/Federal Laws:**

Certain federal and/or state laws and regulations may make it necessary or appropriate to include specific provisions applicable to this Policy. All coordinating provisions for such federal/state laws are contained in the Exhibit attached hereto. In the event of any conflict between the provisions of the Exhibit and provisions contained elsewhere in this Policy, the provisions of the Exhibit will govern.

**Clinical Decision Support Tools**  
**Policy Number: C-UM-11.00**

**APPLICABLE ACCREDITATION STANDARDS:**

- URAC v8.1: UM 2-1: Review Criteria Requirements, UM 3-1: Initial Screening Policy, UM 4-1: Initial Screening Staff Resources. UM 4-2: Non-Clinical Staff Provide Administrative Support, UM 5-1: Initial Clinical Review Policy, UM 11-3: Information Upon Which to Base Review Determinations

Original Date: 10/1/04

Review Date:	2/25/05	8/1/05	5/23/06	5/7/07	12/10/07	4/30/08	4/14/09	4/27/10	7/19/11	7/31/12
Revision Effective Date:	NR	8/1/05	5/23/06	NR	12/10/07	NR	NR	NR	NR	NR

Review Date:	7/31/13	5/30/14	5/1/15	5/24/16	4/30/17	5/2/18	8/6/18	5/2/19	10/21/19	10/15/20
Revision Effective Date:	7/31/13	NR	NR	NR	4/30/17	NR	8/6/18	NR	NR	10/15/20

Review Date:	9/24/21	6/22/22	9/8/22	5/30/23	9/15/23					
Revision Effective Date:	NR	6/22/22	NR	5/30/23	9/15/23					

Last Review/Update By: Cristina Jones

Pharmacy Benefit Programs Drug List

Last updated 11/16/2023 (For 12/1/2023 Effective Date)

The following is a comprehensive list of medications included in our pharmacy benefit programs. Our pharmacy benefit programs range from those based on U.S. Food and Drug Administration (FDA) guidelines to innovative initiatives. We provide you with a wide range of programs that help to promote appropriate use, reduce costs, and ultimately, improve health status.

Medication Name	Therapeutic Use	Supply Limit	Notification	Step Therapy*	Prior Authorization/ Medical Necessity	Clinical Review Automation**	Designated Specialty Network	Permanent Exclusion*	Oxford Only*	Half-Tab	Multiple Copay	Extended Packaging List	Refill and Save
Abbott Diabetic Meter	Diabetic supplies							Non-Formulary					
Abilify discmelt tablets	Mental health	x								x			
Abilify tablets	Mental health							Brand Only		x			
Abilify MyCite	Mental health	x			x								
Absorica/Absorica LD	Acne				x			x					
Abstral	Cancer pain	x						x					
Acanya - 1.2 - 2.5%	Acne	x						x					
Accrufer	Iron deficiency							x					
Accu-chek diabetes test strips	Diabetic supplies	x						Non-Formulary					
Accupril	High blood pressure							Brand Only					
Aceon	High blood pressure									x			
acetaminophen 325 mg/caffeine 30 mg/dihydrocodeine 16 mg tablet	Pain							x					
Aciphex	Ulcers, heartburn & reflux	x						Brand Only					
Aciphex Sprinkle	Ulcers, heartburn & reflux	x						x					
Actemra/Actemra ACTpen (subcutaneous formulation)	Inflammatory conditions	x	x	x	x	x	x						
Acticlate	Infections							x					
Actigall	Gallstones							Brand Only					
Actimmune	Infections	x	x				x						
Actiq	Cancer pain	x	x		x			Brand Only					
Actonel	Osteoporosis	x						Brand Only					
Actoplus Met	Diabetes	x											
Actos	Diabetes	x						Brand Only					
Acuvail	Eye pain & inflammation							x		x			
Aczone	Acne	x						Brand Only					
Adagen	Enzyme deficiency						x						
Adalimumab-fkjp	Inflammatory conditions	x	x		x								
Adapalene pads	Acne	x											
Adbry	Skin conditions	x	x		x								
Adcirca	Pulmonary arterial hypertension	x	x		x	x	x	Brand Only					
Adderall	ADHD							Brand Only					
Adderall XR	ADHD	x						Generic Only					
Addyi	Sexual dysfunction	x			x								
Adefovir Dipivoxil	Hepatitis B						x						
Adempas	Pulmonary arterial hypertension	x	x		x	x	x						
Adhansia XR	ADHD	x						x					
Adlarity	Alzheimer's disease							x					
Adlyxin	Diabetes			x		x							
Admelog / Admelog Solostar	Diabetes							x					
Adoxa Pak	Infections							x					
Adrenaclick	Severe allergic reactions	x						x					
Advair Diskus / Advair HFA	Asthma/COPD	x						Generic Only					x
Advate	Hemophilia						x						
Adynovate	Hemophilia				x		x						
Adzenys XR	ADHD							x					
Aemcolo	Anti-infective	x											
Afinitor	Cancer	x	x				x	Brand Only - Select Strengths					
Afinitor Disperz	Cancer	x	x				x	Brand Only					
Afrezza	Diabetes	x			x			x					
Afstyla	Hemophilia		x		x		x						
Agrylin	Blood disorders							Brand Only					
Aimovig	Migraine	x	x	x	x	x							
Airduo Digihaler	Asthma	x											
Airduo Respiclick	Asthma/COPD	x						Brand Only					
Ajovy	Migraines	x	x	x	x	x		x					
Aklief	Acne	x	x		x			x					
Akeega	Cancer		x				x						
Albenza	Infections	x			x	x							
Albuterol Tablets	Asthma				x								
Albicansa	Cancer	x	x				x						
Aldactone	Heart failure							Brand Only					
Alevicyn Antipruiitic Gel	Skin conditions							x					
Alevicyn Antipruiitic Sg	Skin conditions							x					
Alevicyn Dermal Spray	Skin conditions							x					

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Alinia	Anti-infective	x						Brand Only					
Alkindi Sprinkle	Oral steroid				x			x					
Allegra suspension	Allergies							x					
Allegra-D 12 & 24-hour	Allergies							x					
Allopurinol - 200 mg	Gout							x					
Aliztal	Pain							x					
Alora	Hormone replacement	x											
Alphagan P	Glaucoma	x											
Alphanate	Hemophilia						x						
Alphanine SD & Alphanine SD Heat/Treat Solv	Hemophilia						x						
Alprolix	Hemophilia						x						
Alprex	Eye pain & inflammation	x											
Alsuma	Migraine	x						x					
Altamax	Infections	x											
Altace	High blood pressure							Brand Only					
Altreno	Acne	x	x					x					
Altoprev	Cholesterol/Lipid lowering							x					
Altuvilio	Hemophilia		x		x								
Alunbrig	Cancer	x	x				x						
Alvesco	Asthma	x						x					
Alyq	Pulmonary arterial hypertension		x		x								
Amaryl	Diabetes							Brand Only					
Ambien	Sleep							Brand Only					
Ambien CR	Sleep							x					
Amerge	Migraine	x						Brand only					
Amethia/Amethia Lo	Contraceptive										x	x	
Amicar	Blood disorders							Brand Only					
Amitiza	Constipation	x	x					x					
Amjevita	Inflammatory conditions	x	x		x		x						
Amlodipine / Atorvastatin (generic Caduet)	High blood pressure/Cholesterol lowering	x						x					
Amphetamine / dextroamphetamine extended-release (generic Adderall XR)	ADHD							x					
Ampyra	Multiple sclerosis	x	x				x	Brand Only					
Amrix	Muscle spasms							x					
Amturicide	High blood pressure							x					
Amzeeq	Acne	x											
Anafranil	Mental health							Brand Only					
Analapram E kit	Skin conditions	x						x					
Anaprox DS	Pain & inflammation							Brand Only					
Androderm	Testosterone replacement	x			x	x							
Androgel packets and pump	Testosterone replacement	x			x	x		x					
Annovera	Contraceptive	x											
Anoro Ellipta	COPD	x											
Antara	Cholesterol/Lipid lowering							x					
Anusol HC Suppository	Hemorrhoids							Brand Only					
Anzemet	Nausea & vomiting	x											
Apadaz	Pain							Brand Only					
ApexiCon E cream	Skin conditions	x											
Apidra / Apidra Solostar	Diabetes	x		x		x		x					
Aplenzin	Mental health	x						x					
Apokyn	Parkinson's disease	x	x		x		x						
Aptensio XR	ADHD	x						x					
Aptiom	Seizures		x		x								
Aqua Glycolic HC	Skin conditions							x					
Aquoral	Dry mouth				x								
Arakoda	Malaria	x											
Aranesp	Anemia	x					x						
Arava	Inflammatory conditions							Brand Only					
Arazlo	Acne	x	x					x					
Arcalyst	Inflammatory conditions	x	x				x						
Aricept - 5, 10 mg	Alzheimer's disease							Brand Only					
Aricept - 23 mg	Alzheimer's disease							x					
Arikayce	Lung disease	x	x		x								
Arimidex	Cancer							Brand Only					
Arixtra	Blood clots	x						Brand Only					
ArmonAir DigiHaler	Asthma	x						x					
Aromasin	Cancer							Brand Only					
Arnuity Ellipta	Asthma	x											
Arthrotec	Pain & inflammation							Brand Only					
Asacol	Inflammatory bowel disease												
Asacol HD - excluded for majority of groups	Inflammatory bowel disease							x					
Ascensia diabetes test strips	Diabetic supplies	x						Non-Formulary					
Asmalpred / Asmalpred Plus	Asthma							x					
Asmanex Twisthaler / Asmanex HFA	Asthma	x						x					
Aspruzo	Angina				x								
Astagraf XL	Transplant						x	x					
Astelin	Allergies							Brand Only					
Astepro	Allergies							x					
Atacand	High blood pressure							Brand Only		x			

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Atacand HCT	High blood pressure							Brand Only					
Atelvia	Osteoporosis	x						x					
Ativan	Anxiety							Brand Only					
Atopaderm	Skin conditions	x			x			x					
Atopiclair	Skin conditions							x					
Atorvaliq	Cholestero/Lipid lowering				x								
Atralalin	Acne	x	x					x			x		
Atrapro Antiprultic Hydrogel	Skin conditions							x					
Atrapro Cp	Skin conditions							x					
Atrapro Dermal Spray	Skin conditions							x					
Atripia	HIV	x						Brand Only					
Atrovent HFA	COPD	x											
Aubagio	Multiple sclerosis	x	x			x	x						
Augmentin	Infections							Brand Only					
Augmentin ES-600	Infections							Brand Only					
Augmentin XR	Infections							x					
Aursiat Anti-Itch Hydrogel	Skin conditions							x					
Auryxia	Elevated phosphate levels							x					
Austedo/Austedo XR	Huntington's disease	x	x		x	x	x						
Auvelity	Mental health	x	x	x									
Auvi-Q	Severe allergic reactions	x											
Avalide	High blood pressure							Brand Only					
Avapro	High blood pressure							Brand Only		x			
Avar	Acne							x					
Avar LS	Acne							x					
Avelox	Infections							Brand Only					
Avita cream & gel	Acne	x	x					x					
Avodart	Benign prostatic hypertrophy							Brand Only					
Avonex	Multiple sclerosis	x	x			x	x						
Axert	Migraine	x						Brand Only					
Axiron	Testosterone replacement	x						x					
Ayvakit	Cancer	x	x				x						
Azasite	Infections												
Azeschew Prenatal/Postnatal	Prenatal vitamin							x					
Azelex	Acne	x											
Azesco	Prenatal vitamin							x					
Azilect	Parkinson's disease							Brand Only					
Azopt	Glaucoma	x						Brand Only					
Azor	High blood pressure							x					
Azstarys	ADHD	x		x				x					
Bactroban Cream/Bactroban Ointment	Infections	x											
Bafiertam	Multiple sclerosis	x	x				x						
Balcoltra	Contraceptive							x					
Balversa	Cancer	x	x				x						
Banzel	Seizures		x		Brand Only	x							
Baqsimi	Low blood sugar	x											
Baraclude	Hepatitis B						x	Tablets Brand Only					
Basaglar	Diabetes	x						x					
Bayer Diabetic Meter	Diabetic supplies							x					
Bebulin	Hemophilia						x						
Beconase AQ	Allergies	x						x					
Belbuca	Pain	x			x								
Belsomra	Sleep	x		x		x							
Benefix	Hemophilia						x						
Benicar	High blood pressure							Brand Only		x			
Benicar HCT	High blood pressure							Brand Only					
Benlysta	Lupus	x	x				x						
BenzaClin	Acne	x						Brand Only					
BenzaClin kit	Acne							x					
BenzaClin pump	Acne							x					
Benzamycin	Acne	x											
BenzEfoam/BenzEfoam Ultra	Acne							x					
Benznidazole	Infections	x	x			x							
Bepreve	Allergies	x						x					
Beninert	Hereditary angioedema	x	x	x	x		x						
Besivance	Infections												
Besremi	Cancer	x	x	x									
Betapace	Arrhythmias							Brand Only					
Betaseron	Multiple sclerosis	x	x			x	x						
Bethkis	Cystic fibrosis	x	x				x	Brand Only					
Betimol	Glaucoma	x											
Bevespi	COPD	x											
Bevyxxa	Blood clots	x											
Beyaz	Contraceptive							x					
Biktarvy	HIV	x											
Binosto	Osteoporosis	x						x					
Bimzelx	Skin conditions		x				x						
Boniva	Osteoporosis							Brand Only				x	
Bonjesta	Nausea & vomiting				x			x					
Bosulif	Cancer	x	x	x		x	x						
Braftovi	Cancer	x	x	x		x	x						
Breeze Diabetes Test Strips	Diabetic supplies	x						x					

Medication Name	Therapeutic Use	Supply Limit	Notification	Step Therapy*	Prior Authorization/ Medical Necessity	Clinical Review Automation**	Designated Specialty Network	Permanent Exclusion+	Oxford Only*	Half-Tab	Multiple Copay	Extended Packaging List	Refill and Save
Brenzavvy	Diabetes	x		x	x								
Breo Ellipta	Asthma/COPD	x											x
Brexafemme	Fungal infections	x			x								
Breztri Aerospher	COPD	x											x
Brilinta	Stroke & heart attack prevention	x											
Brimatoprost (Lumigan)	Glaucoma	x						x					
Brisdelle	Hormone replacement	x						x					
Briviact	Seizures		x		x								
Bromday	Eye pain & inflammation							x					
BromSite	Eye pain & inflammation	x						x					
Bronchitol	Cystic fibrosis	x	x	x									
Brovana	COPD	x											
Brukinsa	Cancer	x	x	x		x	x						
Bryhall	Skin conditions	x						x					
Bulk Powders	Compounds		x										
Bunavail	Opioid dependence	x			x			x	x				
Bupap	Migraine							x					
Buphenyl	Endocrine disorders		x			x	x	Brand only					
Buprenorphine (generic Subutex)	Opioid dependence	x											
Buprenorphine/naloxone (generic Suboxone)	Opioid dependence	x											
Butalbital/Acetaminophen 50/300 mg capsule	Pain	x						x					
Butalbital/Acet/Caffeine	Pain	x											
Butalbital/Acet/Caffeine Fioricet	Pain	x											
Butalbital/Acet/Caffeine/Codeine	Pain												
Fioricet w/Codeine	Pain	x											
Butalbital/Acetaminophen/Caffeine/Codeine Phosphate 50 mg/300 mg/40 mg/30 mg (generic Fioricet with Codeine)	Pain							x					
Butorphanol NS	Migraine	x											
Butrans	Pain	x			x			x					
Bydureon Boice	Diabetes	x	x	x		x			x				
Byetta	Diabetes	x	x	x		x			x				
Bylvay	Liver disease	x	x		x								
Bystolic	High blood pressure							x					
Cabliivi	Blood disorders	x	x				x						
Cabometyx	Cancer	x	x				x						
Caduet	High blood pressure/Cholesterol lowering							x					
Cafergot	Migraine	x											
Calquence	Cancer	x	x				x						
Cambia	Migraine	x						x					
Camrese/Camrese Lo	Contraceptive										x	x	
Camzyos	Heart disease	x	x		x								
Canasa	Inflammatory bowel disease							Brand Only					
Caphosol	Dry mouth				x								
Caplyta	Mental health	x	x	x	x	x							
Caprelsa	Cancer	x	x				x						
Carafate	Ulcers, heartburn & reflux							Brand Only					
Carbaglu	Elevated ammonia levels		x				x	Brand Only					
Cardizem	High blood pressure							Brand Only					
Cardizem CD	High blood pressure							Brand Only					
Cardizem LA	High blood pressure							Brand Only					
Carospir	High blood pressure				x	x							
Carrasyn Hydrogel Wound Dressing	Skin conditions							x					
Cataflam	Pain & inflammation							Brand Only					
Catapres TTS	High blood pressure							Brand Only					
Caverject	Erectile dysfunction	x											
Cayston	Cystic fibrosis	x	x	x		x	x						
Celebrex	Pain & inflammation	x						Brand Only					
Celexa	Mental health							Brand Only					
Cellcept	Transplant						x	Brand Only					
Cenestin	Hormone replacement							x					
Centany AT	Infections							x					
Cequa	Dry eye disease	x	x		x			x					
Ceracade	Skin conditions							x					
Cerdelga	Enzyme deficiency		x				x						
Cetrotide	Infertility	x	x	x	x	x	x						
Chenodal	Endocrine disorders			x		x	x						
Chlorpromazine	Mental health	x			x								
Chlorzoxazone - 250 mg	Muscle spasms							x					
Cholbam	Enzyme deficiency	x	x				x						
Choline fenofibrate (generic Trilipix)	Cholesterol/Lipid lowering							x					
Chorionic Gonadotropin	Infertility						x						
Cialis	Erectile dysfunction	x						Brand Only					
Cibingo	Atopic dermatitis	x	x		x								
Cicloclodan Kit	Infections							x					
Cimduo	HIV	x											
Cimzia	Inflammatory conditions	x	x		x		x						
Cinryze	Hereditary angioedema	x	x		x		x	x					

Medication Name	Therapeutic Use	Supply Limit	Notification	Step Therapy*	Prior Authorization/ Medical Necessity	Clinical Review Automation**	Designated Specialty Network	Permanent Exclusion+	Oxford Only*	Half-Tab	Multiple Copay	Extended Packaging List	Refill and Save
Cipro suspension	Infections							x					
Citalopram hydrobromide	Mental health							x (capsules)					
Clarifoam EF	Acne							Brand Only					
Clarinetx/Clarinetx-D	Allergies							x					
Clemastine	Allergies							x					
Climara/ClimaraPro	Hormone replacement	x						Brand Only					
Clindacin Pac	Acne							x					
Clindagel	Acne	x						x					
Clindamycin 1%/benzoyl peroxide 5%	Acne							x					
Clindamycin 1.2%/benzoyl peroxide 5%	Acne												
Clindamycin/benzoyl peroxide topical gel 50 g (generic Benzaclin)	Acne	x											
Clindamycin gel	Acne	x											
Clobetasol 0.05% emollient foam (generic Olux-E)	Skin conditions	x						x					
Clobetasol 0.05% foam (generic Olux)	Skin conditions	x						x					
Clobetasol 0.05% lotion (generic Clobex)	Skin conditions							x					
Clobetasol shampoo (generic Clobex Shampoo)	Skin conditions	x						x					
Clobex cream	Skin conditions	x											
Clobex lotion	Skin conditions	x						x					
Clobex shampoo	Skin conditions	x						x					
Clobex spray	Skin conditions	x						Brand Only					
Clodan kit	Skin conditions	x						x					
Cloderm	Skin conditions	x		x									
Cloderm cream	Skin conditions	x						Brand Only					
Clomipramine	Mental health												
Coagadex	Hemophilia						x						
Codeine/Acet Tylenol and Codeine tablets and solution	Pain	x											
Codeine / phenylephrine / promethazine	Cough & cold	x			x								
Codeine/promethazine	Cough & cold	x			x								
Colazal	Inflammatory bowel disease							Brand Only					
Colcrys	Gout							Brand Only					
Combigan	Glaucoma	x											
CombiPatch	Hormone replacement	x											
Combivent Respimat	COPD	x											
Cometriq	Cancer	x	x				x						
Comfort Pac Tizanadine	Muscle spasms							x					
Complera	HIV	x											
Concerta	ADHD	x						Generic Only					
Conjupri	High blood pressure							x					
Consensi	High blood pressure/Pain & inflammation							x					
Continuous Glucose Monitors - Dexcom Receiver/Sensor/Transmitter	Diabetes	x	x		x								
Continous Glucose Monitors - Guardian REAL-Time Continuous Glucose Monitoring System	Diabetes	x	x		x								
Contour Diabetes Test Strips	Diabetic supplies	x											
Conzip	Pain	x						x					
Copaxone	Multiple sclerosis	x	x			x	x	Brand & Non-Mylan Generic					
Copiktra	Cancer	x	x				x						
Cordran	Skin conditions	x		x				Lotion, Ointment - Brand Only			x		
Cordran Tape	Skin conditions	x											
Coreg CR	High blood pressure							Brand Only					
Corifact	Hemophilia						x						
Corlanor	Heart failure	x	x		x								
Cosentyx	Inflammatory conditions	x	x	x	x	x	x						
Cosopt PF	Glaucoma	x						x					
Cotellic	Cancer	x	x				x						
Cotempla XR-ODT	ADHD	x						x					
Covid-19 Vaccine	Vaccine	x											
Cozaar	High blood pressure							Brand Only		x			
Crestor	Cholesterol/Lipid lowering							Brand Only		x			
Crinone	Infertility			x									
Cuprimine	Wilson's disease						x	Generic only					
Cutivate lotion	Skin conditions	x		x							x		
Cuvrior	Wilson's disease	x	x										
Cyclosporine/Cyclosporine Modified	Transplant						x						



Medication Name	Therapeutic Use	Supply Limit	Notification	Step Therapy*	Prior Authorization/ Medical Necessity	Clinical Review Automation**	Designated Specialty Network	Permanent Exclusion*	Oxford Only*	Half-Tab	Multiple Copay	Extended Packaging List	Refill and Save
Cyltezo	Inflammatory conditions	x	x		x								
Cymbalta	Mental health							Brand Only					
Cystadane	Endocrine disorders						x						
Cystadrops	Cystinosis	x	x										
Cystagon	Endocrine disorders						x						
Cystaran	Cystinosis	x	x			x	x						
Cytomel	Thyroid replacement							Brand Only					
D-Penamine	Endocrine disorders						x						
D. H. E. 45	Migraine							Brand Only					
Daliresp	COPD	x	x										
Daraprim	Anti-infective				x		x						
Dartisla ODT	Excessive secretions	x						x					
Daurismo	Cancer	x	x				x						
Daxbia	Infections							x					
Daybue	Rett Syndrome	x	x		x								
Daytrana	ADHD	x						x					
Dayvigo	Sleep	x		x									
DDAVP Injection & Tablets	Endocrine disorders					x		Brand Only					
Decadron	Oral steroid							Brand Only					
Decadron elixir	Oral steroid							Brand Only					
Delos	Acne							x					
Delstrigo	HIV	x											
Delzicol	Inflammatory bowel disease							x					
Denavir	Infections							x					
Depakote	Seizures				Brand Only	x							
Depakote ER	Seizures				Brand Only	x							
Depen Titratabs	Endocrine disorders						x						
Depo-Provera	Contraceptive	x										x	
Derma-Smoothie FS	Skin conditions	x											
Dermasorb AF 3-0.5%	Infections							x					
Dermasorb XM 39% Kit	Infections							x					
Descovy	HIV	x		x	x			Non-Formulary					
Desloratadine (generic Clarinex)	Allergies							x					
Desonate	Skin conditions	x		x									
Desoxyn	ADHD							Brand Only					
DesOwen	Skin conditions	x											
Desvenlafaxine	Mental health	x						x					
Desvenlafaxine (fumarate)	Mental health							x					
Detrol	Overactive bladder							Brand Only					
Detrol LA	Overactive bladder							x					
Devices - Skin conditions	Skin conditions				x								
Dexedrine	ADHD	x						Brand Only					
Dexilant	Ulcers, heartburn & reflux	x						x					
Dhivy	Parkinson's disease							x					
Diab	Skin conditions							x					
Diab F.D.G. Freeze-Dried	Skin conditions							x					
Diabetic Supplies - Insulin syringes	Diabetic supplies	x											
Diabetic Supplies - Pen Needles	Diabetic supplies	x											
Diabetic Test Strips	Diabetic supplies	x											
Diabetic Lancing Device	Diabetic supplies	x											
Diacomit	Seizures		x				x						
Diagnostic Agents	Diagnostic agents								x				
Diastat	Seizures	x											
Dibenzyline	High blood pressure							Brand Only					
Diclegis	Nausea & vomiting				x			x					
Dicferin cream, gel & lotion	Acne	x	x					x					
Diflacid	Infections	x											
Diflorasone diacetate	Skin conditions	x											
Diflucan - 100, 150, 200 mg & suspension	Infections							Brand Only					
Dihydrocodeine/Acet/Caffeine	Pain	x											
Dilaudid	Pain							Brand Only					
Diovan	High blood pressure							Brand Only		x			
Diovan HCT	High blood pressure							Brand Only					
Disalcid	Pain							Brand Only					
Dojolvi	Fatty acid disorder				x								
Doptelet	Liver disease	x	x										
Doral	Sleep disorders							x					
Doryx	Infections							x					
Dovato	HIV	x											
Dovonex	Skin conditions	x						Brand Only					
Doxycycline 75 mg (generic Monodox)	Infections							x					
Drizalma	Mental health	x											
Dryrenium	High blood pressure							Brand Only					
Duac/Duac CS	Acne	x											
Duaklir	COPD	x						x					
Duavee	Hormone replacement	x											
Duetact	Diabetes	x											
Duexis	Pain	x						x					
Dulera	Asthma/COPD	x		x				x					

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Duobrii	Skin conditions	x						x					
Duopa	Parkinson's disease				x								
Dupixent	Skin conditions	x	x		x		x						
Duragesic	Pain	x			x			Brand Only					
Durezol	Eye pain & inflammation												
Durlaza	Stroke & heart attack prevention	x											
Dutoprol	High blood pressure							x					
Duzallo	Gout	x						x					
Dvorah	Pain							x					
Dyanavel XR	ADHD	x						x					
Dymista	Allergies	x						x					
Dynacin	Acne							Generic Only					
Dxevo 11 day	Oral steroid							x					
E.E.S. 400	Infections							Brand Only					
Ecoza	Infections							x					
Edecrin	Heart failure							Brand Only					
Edex	Erectile dysfunction	x											
Edluar	Sleep	x						x					
Effexor XR	Mental health							Brand Only					
Effient	Stroke & heart attack prevention	x						Brand Only					
Egrifta	Endocrine disorders	x	x			x	x						
Elepsia XR	Seizures							x					
Elestat	Allergies	x						x					
Eletone/Eletone Twinpack	Skin conditions				x			x					
Elidel	Skin conditions	x						Brand Only					
Eligard	Hormone replacement		x									x	
Elimiron	Bladder pain			x		x							
Eliquis	Blood clots	x											
Ella	Contraceptive	x											
Eloctate	Hemophilia		x		x		x						
Elyxyb	Pain & inflammation	x						x					
Embeda	Pain							x					
Emend	Nausea & vomiting	x						Brand Only					
Emflaza	Duchenne muscular dystrophy		x	x	x		x	x					
Emgality	Migraine	x	x	x	x	x							
Empaveli	Blood disorders	x	x		x								
Emulsion Sb	Skin conditions							x					
Emverm	Infections	x			x	x							
Enablex	Overactive bladder							x					
Enbrel/Enbrel Mini/SureClick	Inflammatory conditions	x	x		x		x						
Endari	Sickle cell disease	x			x								
EndeavorRx	Device				x								
Enstilar Foam	Skin conditions	x											
Enspryng	Neurologic autoimmune disorder	x	x		x		x						
Entadfi	Benign prostatic hyperplasia	x						x					
Entecavir	Hepatitis B						x						
Entocort EC	Inflammatory bowel disease							Brand Only					
Entresto	Heart failure	x	x		x								
Entty	Skin conditions				x			x					
Envarsus XR	Transplant		x				x	x					
Epaned	High blood pressure				x	x							
Epclusa	Hepatitis C	x	x		x		x						
EpiCeram	Skin conditions				x			x					
Epidiolex	Seizures				x		x						
Epiduo	Acne	x						x					
Epiduo Forte	Acne	x						x					
EpiPen/EpiPen Jr	Severe allergic reactions	x						Brand Only					
Eplivir HBV	Hepatitis B						x						
Epogen	Anemia	x					x	x					
Eprontia	Seizures				x			x					
Epsolay	Skin Conditions	x			x			x					
Epzicom	HIV	x						Brand Only					
Ergomar	Migraine	x			x								
Erivedge	Cancer	x	x				x						
Erleada	Cancer	x	x				x						
Ermeza	Thyroid replacement				x								
Ertaczo	Infections							x					
Esbriet	Pulmonary fibrosis	x	x		x		x	Brand Only					
Esperoct	Hemophilia		x	x	x			x					
Estrace	Hormone replacement							Brand Only					
Estring	Hormone replacement	x										x	
Estrostep FE	Contraceptive							Brand Only					
Estrogel HRT	Hormone replacement	x											
Eucrisa	Skin conditions	x		x		x							
Eulixin	Cancer							Brand Only					
Evekeo ODT	ADHD							x					
Eversense Sensor, Transmitter	Diabetes		x										
Evista	Osteoporosis							Brand Only					
Evoxac	Dry mouth							Brand Only					
Evrysdi	Spinal muscular atrophy	x	x		x								

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Evzio	Narcotic overdose	x						x					
Exelon Patch	Alzheimer's disease							x					
Exforge	High blood pressure							x					
Exforge HCT	High blood pressure							Generic is Non-Formulary Brand Only					
Exjade	Iron overload		x				x						
Exkivity	Cancer	x	x				x						
Exservan	Amyotrophic lateral sclerosis (ALS)		x		x			x					
Extavia	Multiple sclerosis	x	x	x		x	x	x					
Extina	Skin conditions			x		x							
Eysuvis	Dry eye disease	x											
Ezallor Sprinkles	Cholesterol/Lipid lowering				x								
Fabior	Acne	x	x					x					
FaLessa kit	Contraceptive							x					
Fanapt	Mental health	x											
Fareston	Cancer							Brand Only					
Farxiga	Diabetes	x		x				x					
Fasenra	Asthma	x	x		x		x						
Feiba, Feiba NF & Feiba VH Immuno	Hemophilia						x						
Felbatol	Seizures					x							
Female Condoms	Contraceptive	x											
Femara	Cancer							Brand Only					
Femhrt	Hormone replacement							Brand Only					
Femring	Hormone replacement	x										x	
Fenofibrate - 43 mg, 130 mg (generic Antara)	Cholesterol/Lipid lowering							x					
Fenofibrate - 48 mg, 145 mg (generic Tricor)	Cholesterol/Lipid lowering							x					
Fenofibrate - 50 mg, 150 mg (generic Lipofen)	Cholesterol/Lipid lowering							x					
Fenofibrate - 67 mg, 134 mg, 200 mg (generic Lofibra)	Cholesterol/Lipid lowering							x					
Fenofibric acid (generic Fibracor)	Cholesterol/Lipid lowering							x					
Fenoglide	Cholesterol/Lipid lowering							x					
Fenortho	Pain							x					
fentanyl citrate bulk powder	Cancer pain		x		x								
Fentanyl Transdermal Patches	Pain	x			x			x					
Fentora	Cancer pain	x	x		x			x					
Ferriprox	Iron overload		x				x						
Fetzima	Mental health	x		x		x							
Fexmia	Muscle spasms							x					
Fexmid	Muscle spasms							Generic Only					
Fiasp / Fiasp Flex	Diabetes	x		x		x		x					
Fibracor	Cholesterol/Lipid lowering							x					
Filspari	Kidney disease	x	x		x								
Fintepla	Seizures		x		x								
Floriset with Codeine - 50 mg/300 mg/40 mg/30 mg	Pain							x					
Floriset with Codeine - 50 mg/325 mg/40 mg/30 mg	Pain							Brand Only					
Firazyr	Hereditary angioedema	x	x		x		x	Brand Only					
Firdapse	Neuromuscular disorder	x	x		x		x						
Firmagon	Endocrine disorders						x						
First-Omeprazole	Ulcers, heartburn & reflux		x										
First-Lansoprazole	Ulcers, heartburn & reflux		x										
Flector	Pain & inflammation							x					
Fleqsuvy	Muscle spasms				x								
Flolipid	Cholesterol/Lipid lowering				x	x							
Flomax	Benign prostatic hypertrophy							x					
Flonase	Allergies	x											
Flo-prad	Inflammatory conditions							x					
Flovent Diskus & Flovent HFA	Asthma	x											
Flowtuss	Cough & cold	x			x			x					
Floxin Otic	Infections							Brand Only					
Fluocinolone	Skin conditions	x											
Fluoroplex 1%	Cancer												
fluorouracil 0.5% cream (Carac authorized generic)	Skin conditions							x					
Fluoxetine - 60 mg	Mental health							x					
Fluoxetine (generic Prozac) - 10 mg tablets	Mental health	x											
Focalin XR	ADHD	x						x					
Follistim AQ	Infertility						x						
Forfivo XL	Mental health	x						x					
Fortamet	Diabetes				x			x					
Forteo	Osteoporosis		x	x			x	x					
Fortesta Gel	Testosterone replacement	x			x	x		x					
Fosrenol Chewable Tablets	Elevated phosphate levels			x		x		Brand Only					
Fotivda	Cancer	x	x										
Fragmin	Blood clots	x											
Freestyle diabetes test strips	Diabetic supplies	x						Non-Formulary					

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Freestyle InsuLinx diabetes test strips	Diabetic supplies	x						Non-Formulary					
Freestyle Libre	Diabetes	x	x		x								
Frova	Migraine	x						Brand Only					
Fulphila	Neutropenia							x					
Furoscix	Heart failure	x	x		x								
Fuzeon	HIV		x										
Fycompa	Seizures		x		x								
Fylnetra	Neutropenia							x					
Galafold	Fabry disease	x	x										
Ganirelix Acetate	Infertility	x					x						
Gastrocrom	Inflammation							x					
Gattex	Endocrine disorders	x	x				x						
Gavreto	Cancer	x	x										
Gelnique	Overactive bladder							x					
Gemtesa	Overactive bladder							x					
Genadur Kit	Brittle nails							x					
Gendur	Skin conditions							x					
Genress FE	Contraceptive							x					
Gengraf	Transplant						x						
Genotropin	Growth hormones	x	x		x		x	x					
Gentamicin Sulfate	Infections	x											
Genvoya	HIV	x											
Geodon	Mental health							Brand Only					
Glazo	Bowel preparations							x					
Gilenya	Multiple sclerosis	x	x			x	x	Brand Only					
Gilotrif	Cancer	x	x				x						
Gimoti	Reflux	x						x					
Glatopa	Multiple sclerosis	x	x				x						
Gleevec	Cancer	x	x				x	Brand Only					
Gleostine	Cancer						x						
Gloperba	Gout				x								
Glucagon/Glucagen	Diabetes	x				x		x					
Glumetza	Diabetes				x			x					
Glycate	Excessive secretions							x					
Glyxambi	Diabetes	x		x		x							
Gocovri	Parkinson's disease	x						x					
Golytely	Bowel preparations	x											
Gonal-F/Gonal-F RFF	Infertility		x	x	x		x						
Gralise	Pain	x						x					
Granisol	Nausea & vomiting	x											
Granix	Neutropenia						x	x					
Grastek	Allergies	x	x		x								
Gvoke	Diabetes	x						x					
H.P. Acthar	Endocrine disorders	x	x	x	x		x						
Hadlima/Hadlima Pushtouch	Inflammatory conditions	x	x		x								
Haegarda	Hereditary angioedema	x	x		x		x						
Halog	Skin conditions	x		x				x (Cream - Brand Only)					
Halucort	Skin conditions				x								
Harvoni	Hepatitis C	x	x	x	x		x						
Hecoria	Transplant						x						
Helidac	Ulcers due to <i>H. pylori</i>	x						x					
Helixate FS	Hemophilia						x	x					
Hemady	Oral steroid							x					
Hemangeol	Birthmark (Hemangioma)							x					
Hemlibra	Hemophilia		x		x		x						
Hemofil M	Hemophilia						x						
Hepsera	Hepatitis B						x	Brand Only					
Hetlioz, Hetlioz LQ	Sleep-wake disorder	x	x		x		x						
HiDex 6 day	Oral steroid							x					
Horizant	Seizures	x						x					
HPR / HPR Plus	Skin conditions				x			x					
HPR Plus Hydrogel	Skin conditions							x					
HPR Plus/MB Hydrogel	Skin conditions							x					
Huilo	Inflammatory conditions	x	x		x								
Humalog	Diabetes	x											
Humalog Mix 50/50	Diabetes	x											
Humalog Mix 75/25	Diabetes	x											
Human Chorionic Gonadotropin	Infertility						x						
Humatin	Infections							Brand Only					
Humate-P	Hemophilia						x						
Humatrope	Growth hormones	x	x		x		x	x					
Humira	Inflammatory conditions	x	x		x		x						
Humulin	Diabetes	x											
Humulin 70/30	Diabetes	x											
Humulin N	Diabetes	x											
Humulin R	Diabetes	x											
Humulin R U-500	Diabetes	x											
Hycamtin	Cancer	x	x				x						
Hyclodex	Skin conditions				x								
Hycodan	Cough & cold							Brand Only					
Hycofenix	Cough & cold	x						x					

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Hydrocodone/acetaminophen 5/300 mg, 10/300 mg & 7.5/300 mg	Pain							x					
Hydrocodone/guainfenesin	Cough & cold							x					
Hydrocodone/homatropine	Cough & cold	x			x								
Hydromorphone XR (generic Exalgo)	Pain	x			x			Brand Only					
Hyftor	Dermatologic Agents	x	x										
Hylaguard	Skin conditions				x								
Hylatopic / Hylatopic Plus	Skin conditions				x			x					
Hyrimoz	Inflammatory conditions	x	x		x								
Hysingla ER	Pain	x			x			Brand Only					
Hyzaar	High blood pressure							Brand Only					
Ibrance	Cancer	x	x				x						
Ibsrela	Constipation	x	x	x	x			x					
Iclusig	Cancer	x	x				x						
Idacio	Inflammatory conditions	x	x		x								
Idhifa	Cancer	x	x				x						
Ilevro	Eye pain & inflammation							x					
Ilumya	Inflammatory conditions	x	x	x	x	x	x	x					
Imbruvica	Cancer	x	x				x						
Imitrex nasal spray	Migraine	x											
Imitrex tablets and injection	Migraine	x						Brand Only					
Impavido	Infections	x	x										
Impeklo	Skin conditions	x						x					
Impoyz	Skin conditions	x						x					
Imuran	Transplant							Brand Only					
Imvexxy	Sexual dysfunction	x											
Inbrija	Parkinson's disease	x	x		x		x						
Increlex	Growth hormones	x	x		x		x						
Incruse Ellipta	COPD	x						x					
Inderal LA	High blood pressure							Brand Only					
Inderal XL	High blood pressure							x					
Indocin suppository/suspension	Pain				x								
Infergen	Cancer	x	x										
Ingrezza	Tardive dyskinesia	x	x	x	x	x	x	x					
Inlyta	Cancer	x	x				x						
Innohep	Blood clots	x											
Innopran XL	High blood pressure							x					
Inqovi	Cancer	x	x				x						
Inrebic	Cancer	x	x	x		x	x						
Inspra	Heart failure							Brand Only					
Insulin glargine (generic Lantus/Solostar ABA)	Diabetes							x					
Insulin Pens/Cartridges (Includes all brands and strengths: Apidra Solostar, Lantus Solostar, Humulin, Humulin N, Humulin 70/30, Humalog, Humalog Mix 50/50, Humalog Mix 75/25, Novolog, Novolog Mix)	Diabetes	x											
Insulin Vials (Includes all brands and strengths: Apidra, Lantus, Humulin, Humulin N, Humulin R, Humulin 70/30, Humalog, Humalog Mix 50/50, Humalog Mix 75/25, Novolin R, Novolin N, Novolin 70/30, Novolog, Novolog Mix)	Diabetes	x				x							
Intermezzo	Sleep	x						x					
Intrarosa	Sexual dysfunction				x								
Intron-A	Cancer		x				x						
Introvale	Contraceptive										x	x	
Intuniv	ADHD												
Invega	Mental health	x						Brand Only					
Invokamet	Diabetes	x		x				x	x				
Invokamet XR	Diabetes	x		x				x	x				
Invokana	Diabetes	x		x				Non-Formulary	x				
Ippefa	Heart failure	x		x					x				
Irenka	Mental health							x					
Iressa	Cancer	x	x				x						
Isordil Titradose	Angina							Brand Only					
Isosorbide dinitrate	Heart failure							x					
Isturisa	Cushing's disease	x	x										
Ixinity	Hemophilia			x	x		x	x					
Ivermectin	Infections	x	x			x							
Jadenu / Jadenu Sprinkles	Iron overload		x				x	Brand Only					
Jakafi	Cancer	x	x				x						
Jalyn	Benign prostatic hypertrophy							x					
Janumet / Janumet XR	Diabetes	x		x				x					
Januvia	Diabetes	x		x				x					
Jardiance	Diabetes	x											
Jatenzo	Testosterone replacement	x			x			x					
Jaypirca	Cancer	x	x										
Javygtor	Endocrine disorders	x						x					

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Jentadueto / Jentadueto XR	Diabetes	x											
Jivi	Hemophilia		x		x		x						
Joenja	Immunological Agents	x			x		x						
Jolesa	Contraceptive										x	x	
Jornay PM	ADHD	x		x				x					
Jubila	Infections	x		x	x								
Juluca	HIV	x											
Juxtapid	Cholesterol/Lipid lowering	x	x	x	x		x						
Jynarque	Endocrine disorders	x	x			x	x						
Kalydeco	Cystic fibrosis	x	x		x		x						
Kamdoy	Skin conditions				x								
Kapvay	ADHD							Brand Only					
Karbinal ER	Allergies							x					
Katerzia	High blood pressure				x								
Kazano	Diabetes	x						Authorized Generic Only					
Kenalog	Skin conditions	x						Brand Only					
Kendall Amorphous Hydrogel Wound Dressing	Skin conditions							x					
Keppra	Seizures				Brand Only	x							
Keppra XR	Seizures				Brand Only	x							
Keralac	Infections							x					
Keralyt Scalp Kit	Infections							x					
Kerendia	Chronic kidney disease prevention	x	x		x								
Kerydin	Infections	x		x	x			Brand Only					
Kesimpta	Multiple sclerosis	x	x				x						
Ketocon	Infections							x					
Ketoconazole 2% cream	Infections	x											
Ketodan	Infections							x					
Ketoprofen/Ketoprofen ER	Pain	x		x		x		x					
Keveyis	Paralysis secondary to potassium levels	x	x				x						
Kevzara	Inflammatory conditions	x	x	x	x	x	x						
Khedezia	Mental health							x					
Kilsyri	Acinic keratosis	x											
Klonopin	Mental health											Brand Only	
Kloxxado	Opioid dependence	x											
Kineret	Inflammatory conditions		x	x		x	x						
Kisqali	Cancer	x	x	x		x	x						
Kitabis Pak	Cystic fibrosis	x	x				x	x					
Koate	Hemophilia						x						
Koate-DVI	Hemophilia						x						
Kogenate FS, Kogenate FS Bio-Set	Hemophilia						x						
Kombiglyze XR	Diabetes	x											
Korlym	Endocrine disorders	x	x				x						
Koselugo	Cancer	x	x				x						
Kovaltry	Hemophilia						x						
Krazati	Cancer	x											
Krintafel	Malaria	x											
Kristalose	Constipation							x					
Kuvan	Endocrine disorders	x	x			x	x	Brand Only					
Kynamro	Cholesterol/Lipid lowering						x						
Kynmobi	Parkinson's disease		x		x								
Kyzatrex	Testosterone replacement	x			x								
Lamictal	Seizures				x	x							
Lamictal ODT	Seizures				Brand Only								
Lamictal XR	Seizures				Brand Only	x							
Lampit	Infections	x	x										
Lamivudine	Hepatitis B						x						
Lanreotide	Endocrine disorders							x					
Lansoprazole	Ulcers, heartburn & reflux												
Lantus	Diabetes	x											
Lantus SoloSTAR	Diabetes												
Lastacraft	Allergies	x											
Latuda	Mental health	x											
Lazanda	Cancer pain	x	x		x								
Lenvima	Cancer	x	x				x						
Lescol XL	Cholesterol/Lipid lowering			x								Brand Only	
Letalris	Pulmonary arterial hypertension	x	x		x	x	x	Brand Only					
Leukine	Neutropenia						x						
Leuprolide	Hormone replacement		x										
Levalbuterol nebs (generic Xopenex nebs)	Asthma							x					
Levemir	Diabetes	x			x			Non-formulary					
Levemir Flexpen	Diabetes							x					
Levitra	Erectile dysfunction	x						Brand Only					
Levonorg-eth	Contraceptive											x	
Levorphanol Tartrate	Pain	x		x		x							
Lexapro tablets	Mental health							Brand Only		x			
Lexette	Skin conditions	x						x					
Lexiva	HIV							Brand Only					

Medication Name	Therapeutic Use	Supply Limit	Notification	Step Therapy*	Prior Authorization/ Medical Necessity	Clinical Review Automation**	Designated Specialty Network	Permanent Exclusion+	Oxford Only*	Half-Tab	Multiple Copay	Extended Packaging List	Refill and Save
Librax	Irritable bowel disease							Brand Only					
Licart	Pain							x					
Lidocaine 5% ointment	Pain	x											
Lidoderm	Pain	x	x			x		Brand Only					
Lindane shampoo	Lice	x											
Linzess	Constipation	x	x			x							
Lipitor	Cholesterol/Lipid lowering	x						Brand Only		x			
Lipofen	Cholesterol/Lipid lowering							x					
Liptruzet	Cholesterol/Lipid lowering							x					
Liqrev	Pulmonary arterial hypertension	x											
Litfulo	Alopecia areata	x	x				x						
Lithobid	Mental health				x								
Livalo	Cholesterol/Lipid lowering			x				x	x				
Livencity	Antivirals	x											
Livixli Pak	Pain	x											
Livmarli	Itching due to liver disease	x	x		x								
Locoid lipocream	Skin conditions	x						x					
Locoid lotion	Skin conditions	x						x					
Locort	Oral steroid							x					
Lodine	Pain							Brand Only					
Lodosyn	Parkinson's disease												
Loestrin FE 1.5/30	Contraceptive							Brand Only					
Loestrin FE 1/20	Contraceptive							Brand Only					
Lofena	Pain & inflammation							x					
Lofibra	Cholesterol/Lipid lowering							x					
Lokelma	Elevated potassium levels	x			x								
Lonhala Magnair	COPD	x			x			x					
Lonsurf	Cancer	x	x				x						
Loprox Shampoo	Infections							Brand Only					
Loprox Suspension & Cream	Infections							Brand Only			x		
Lorbrena	Cancer		x	x		x	x						
Loreev XR Sprinkle	Mental health							x					
Lorzzone	Muscle spasms							x					
Losartan	High blood pressure									x			
Loseasonique	Contraceptive											x	
Lotemax gel	Eye pain & inflammation							x					
Lotemax suspension	Eye pain & inflammation	x						Brand Only					
Lotemax SM	Eye pain & inflammation	x											
Lotrel	High blood pressure							Brand Only					
Lotrisone	Skin conditions	x											
Lotronex	Irritable bowel disease	x	x					Brand Only					
Lovaza	Cholesterol/Lipid lowering							Brand Only					
Lovenox	Blood clots	x						Brand Only					
Lucemyra	Opioid withdrawal symptoms	x			x								
Lucentis	Eye conditions						x						
Lumakras	Cancer	x	x										
Lumryz	Narcolepsy	x											
Lunesta	Sleep							Brand Only					
Lupkynis	Lupus	x	x		x								
Luvox CR	Mental health	x											
Luxiq	Skin conditions	x						x					
Luzu	Infections				x			x					
Lybalvi	Mental health	x						x					
Lymepak	Infections							x					
Lynparza	Cancer	x	x				x						
Lyrca	Seizures				Brand Only	x							
Lyrca CR	Seizures	x		x		x		x					
Lysteda	Blood disorders	x											
Lytgobi	Cancer	x	x										
Lymjev	Diabetes	x											
Lyvispah	Muscle spasms				x			x					
Matulane	Cancer						x						
Mavenclad	Multiple sclerosis	x	x	x		x	x			x			
Mavik	High blood pressure												
Mavyret	Hepatitis C	x	x		x		x						
Mayzent	Multiple sclerosis	x	x				x						
Maxalt / Maxalt-MLT	Migraine	x						Brand Only					
MB Hydrogel	Skin conditions							x					
Medroxyprogesterone Injectable	Contraceptive										x	x	
Medtronic Enlite Sensor	Diabetes		x		x								
Medtronic Mini-Link Transmitter	Diabetes		x		x								
Medtronic Sof-sensor	Diabetes	x	x		x								
Mekinist	Cancer	x	x				x						
Mektovi	Cancer	x	x	x		x							
Meloxicam	Pain				x								
Melphalan	Cancer						x						
Menopur	Infertility						x						
Menostar	Hormone replacement	x											
Mephyton	Vitamins	x						Brand Only					
Mepron suspension	Infections							Brand Only					
Mesalamine Enema	Inflammatory bowel disease	x											
Mesalamine Suppository	Inflammatory bowel disease	x											
Mesnex	Cystitis						x						

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Mestinon	Myasthenia gravis							Brand Only					
Mestinon Timespan	Myasthenia gravis							Brand Only					
Metadate CD	ADHD	x						Brand Only					
Metadate ER	ADHD	x											
Metaxalone	Muscle spasms												
Metformin - 625 mg	Diabetes							x					
Methodone (generic Dolophine)	Pain	x			x								
Methadone Intensol	Pain	x											
Methadose	Pain	x											
Methergine	Uterine bleeding	x											
Methocarbamol - 1000 mg	Muscle spasms							x					
Methyldopa	High blood pressure			x	x								
metoprolol tartrate - 37.5, 75 mg	High blood pressure							x					
Metozolv	Reflux							x					
Metrogel 0.75% Vaginal	Infections							Brand Only					
Metrogel 1%	Infections							x			x		
Metronidazole 1% gel (generic Metrogel)	Infections							x			x		
Micardis / Micardis HCT	High blood pressure							Brand Only					
Micort HC	Skin conditions							x					
Microcyn	Skin conditions							x					
Micronor	Hormone replacement												
Miebo	Dry eye disease	x	x		x								
Migranal	Pain	x			x			Brand Only					
Minastrin 24 Fe	Contraceptive							x					
Minivelle	Hormone replacement	x						Brand Only					
Minocin - 50 mg, 75 mg, 100 mg	Infections							Brand Only					
Minolira	Infections				x			x					
Mirapex ER	Parkinson's disease							x					
Mircette	Contraceptive							Brand Only					
Mirvaso	Rosacea	x	x										
Mitigare	Gout							Generic Only					
Mobic	Pain & inflammation							Brand Only					
Moderiba	Hepatitis C						x	x					
Moexipril	High blood pressure									x			
Molnupiravir	COVID Treatment	x											
Momexin combo pack	Skin conditions							x					
Monoclate-P	Hemophilia						x						
Monodox	Infections							Brand Only					
Monoline	Hemophilia						x						
Morgidox Kit	Infections							x					
Morphine sulfate ER (generic Avinza)	Pain	x			x			Brand Only					
Morphine sulfate ER (generic Kadian)	Pain	x			x								
Motegrity	Constipation	x	x		x								
Motofen	Diarrhea							x					
Mounjaro	Diabetes	x	x	x		x							
Movantik	Constipation	x	x		x			x					
MoviPrep	Bowel preparations	x											
Moxeza	Infections												
Mozobil	Neutropenia						x						
MS Contin	Pain	x			x			Brand Only					
Mulpleta	Blood disorders	x	x				x						
Multaq	Arrhythmias		x										
MUSE	Erectile dysfunction	x											
Myalept	Endocrine disorders	x	x		x		x						
Mycapssa	Endocrine disorders	x	x		x			Non-formulary					
Mydayis	ADHD	x						x					
Myfembree	Uterine bleeding	x			x								
Myfortic	Transplant						x	Brand Only					
Myrbetriq	Overactive bladder							x					
Mysoline	Seizures				x	x							
Mytesi	Diarrhea associated with HIV	x	x			x							
Naftin	Infections							x					
Nalofon	Pain							x					
Nalocet	Pain	x						x					
Namenda	Mental health							Brand Only					
Namenda XR	Mental health							x					
Namzaric	Alzheimer's disease							x					
Naprelan / Naprelan CR Dose Card	Pain & inflammation							x					
Naprosyn Suspension	Pain & inflammation				x	x		x					
Naproxyn Tablets	Pain & inflammation							Brand Only					
Narcan Nasal Spray	Narcotic overdose	x											
Nasacort AQ	Allergies							x					
Nasonex	Allergies	x						x					
Natesto	Testosterone replacement	x			x	x		x					
Natpara	Endocrine disorders	x	x		x		x						
Natroba	Lice							Brand Only					
Nayzilam	Seizures	x	x										
Neobenz Micro	Acne							x					
Neocera	Skin conditions				x								
Neoral	Transplant						x	Brand Only					



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Neosalus / Neosalus Cp	Skin conditions				x			x					
Neo-Synalar	Infections	x											
Neo-Synalar cream	Skin conditions							x					
Neo-Synalar kit	Skin conditions							x					
Nerlynx	Cancer	x	x				x						
Nesina	Diabetes	x						Authorized Generic Only					
Nextstellis	Contraceptive							x					
Neuac	Acne							x					
Neulasta	Neutropenia						x						
Neupogen	Neutropenia						x	x					
Neurontin	Seizures				x	x							
Neutrasal	Dry mouth				x								
Nevanac	Eye pain & inflammation												
Nexavar	Cancer						x	Brand Only					
Nexiclon XR	High blood pressure	x	x					x					
Nexium capsules	Ulcers, heartburn & reflux	x						x					
Nexium packets	Ulcers, heartburn & reflux	x		x	x	x							
Nexletol	Cholesterol/Lipid lowering			x	x	x							
Nextlizet	Cholesterol/Lipid lowering	x		x	x	x							
Ngenla	Growth hormone deficiency		x				x						
Niacor	Cholesterol/Lipid Lowering							x					
Niaspan	Cholesterol/Lipid lowering							Brand Only					
NicAzel Doxy Kits	Acne							x					
Nilandron	Cancer						x	x					
Ninlaro	Cancer	x	x				x						
Nitrolingual Pump/Spray	Chest pain							x					
Nitromist	Chest pain	x											
Nitromist lingual aerosol	Chest pain	x											
Nityr	Endocrine disorders		x				x	x					
Nivatopic Plus	Skin conditions							x					
Nivestym	Neutropenia						x	x					
Nocdurna	Excessive nighttime urination	x			x								
Noctiva	Excessive nighttime urination							x					
Norco	Pain							Brand Only					
Norditropin Flexpro	Growth hormones	x	x		x		x						
Norgesic Forte	Pain							x					
Noritate	Infections							x			x		
Norliqva	High blood pressure				x								
Northera	Low blood pressure	x			x		x	Brand Only					
Norvasc	High blood pressure							Brand Only					
Norvir	HIV							Brand Only					
Noxafil	Infections	x						Brand Only					
Nourianz	Parkinson's disease	x			x								
Novarel	Infertility						x						
Novoeight	Hemophilia						x						
Novolin 70/30	Diabetes	x		x				x					
Novolin N	Diabetes	x		x				x					
Novolin R	Diabetes	x		x				x					
Novolin/Novolin Mix	Diabetes	x		x				x					
Novolog	Diabetes	x		x				x					
Novolog Mix 70/30	Diabetes	x		x				x					
Novolog/Novolog Mix/Novolog Flexpen	Diabetes	x		x				x					
Novoseven RT	Hemophilia						x						
Nubeqa	Cancer	x	x				x						
Nucala	Asthma	x	x		x		x						
Nucynta /Nucynta ER	Pain	x			x								
Nuedexta	Pseudobulbar affect	x	x		x	x							
Nulytely	Bowel preparations	x											
Nuplazid	Mental health	x	x										
Nurtec ODT	Migraine	x	x	x									
Nutraseb	Skin conditions				x								
Nutrestore	Nutritional supplements	x											
Nutropin / Nutropin AQ	Growth hormones	x	x		x		x						
Nutropin AQ NuSpin	Growth hormones	x	x		x		x						
NuvaRing	Contraceptive							Brand Only					
Nuessa	Infections							x					
Nuvigil	Narcolepsy	x						Brand Only					
Nuwiq	Hemophilia						x						
Nuzyra	Infections	x											
Nyamyc	Infections	x											
Nystatin	Infections	x											
Nystatin/Triamcinolone cream & ointment (generic Mycolog II)	Infections	x						x					
Nystop	Infections	x											
Nyvepria	Neutropenia							x					
Obredon	Cough & cold	x											
Ocaliva	Liver disease	x	x	x	x	x							
Octreotide Acetate	Endocrine disorders		x				x						
Odactra	Allergies	x											
Odefsey	HIV	x											
Odomzo	Cancer	x	x				x						

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Ofev	Pulmonary fibrosis	x	x		x		x						
Oijaara	Cancer		x										
Olepro	Mental health							x					
Olpruva	Endocrine disorders	x											
Olumiant	Inflammatory conditions	x	x		x								
Olux / Olux E	Skin conditions	x						x					
Olux-CP	Skin conditions							x					
Omeclamox-Pak	Ulcers due to <i>H. pylori</i>	x											
Omeprazole/Sodium Bicarbonate Capsule	Ulcers, heartburn & reflux							x					
Ompreprazole + Syrspond SF Alka	Ulcers, heartburn & reflux		x										
Omniaris	Allergies	x						x					
Omnipod 5	Diabetic supplies	x	x		x								
Omnitrope	Growth hormones	x	x		x		x	x					
Omnitrope Pen 5,10	Growth hormones	x			x		x	x					
Omntryg	Cholesterol/Lipid lowering		x										
One Touch Diabetes Test Strips	Diabetic supplies	x											
Onexton	Acne	x						x					
Onfi	Seizures		x		Brand Only	x							
Ongentys	Parkinson's disease	x						x					
Onglyza	Diabetes	x											
Onmel	Infections							x					
Onureg	Cancer	x	x				x						
Onzetra Xsall	Migraine	x						x					
Opana	Pain	x											
Opioids, long acting	Pain	Cumulative dose (MED LIMIT)											
Opioids, short acting	Pain	Cumulative dose (MED LIMIT) New to therapy											
Opsumit	Pulmonary arterial hypertension	x	x		x	x	x						
Optium / Optium EZ Diabetes Test Strips	Diabetic supplies	x											
Optivar	Allergies							Brand Only					
Opzelura	Skin conditions	x	x		x								
Oracea	Rosacea							x					
Oralair	Allergies		x		x								
Oravig	Infections	x											
Orencia/Orencia Clickjet (subcutaneous formulation)	Inflammatory conditions	x	x	x	x	x	x						
Orenitram	Pulmonary arterial hypertension	x	x		x	x	x						
Orfadin	Enzyme deficiency		x			x	x	Generic Only					
Orgovyx	Cancer	x	x										
Oriahnn	Uterine bleeding	x			x								
Orilissa	Endometriosis				x								
Orkambi	Cystic fibrosis	x	x		x		x						
Orladeyo	Hereditary angioedema	x			x			x					
Orphengestic Forte	Pain							x					
Orserdu	Cancer	x	x										
Ortho Cyclen	Contraceptive												
Ortho Evra	Contraceptive							Brand Only					
Ortho Micronor	Contraceptive												
Ortho Novum	Contraceptive												
Ortho Tri-Cyclen Lo	Contraceptive							Brand Only					
Ortikos	Inflammatory bowel disease							x					
Oseni	Diabetes	x						Authorized Generic Only					
Osmolex ER	Parkinson's disease							x					
OsmoPrep	Bowel preparations							x					
Osphena	Sexual dysfunction	x											
Otezla	Inflammatory conditions	x	x				x						
Otovel	Infections							x					
Otrexup	Inflammatory conditions	x						x					
Ovace Plus	Acne							x					
Ovidrel	Infertility						x						
Oxaliplatin	Cancer						x						
Oxaydo	Pain	x			x			x					
Oxbryta	Sickle cell disease	x	x		x								
Oxervate	Eye conditions	x	x		x		x						
oxymorphone ER (generic Opana ER)	Pain	x			x			x					
Oxistat Cream	Infections	x		x									
Oxistat Lotion	Infections							x					
Oxtellar XR	Seizures							x					
OxyContin	Pain	x			x			x					
Oxytrol	Overactive bladder							x					
Ozempic	Diabetes	x	x	x		x			x				
Ozobax	Muscle spasms				x								
Pachex HP/Pachex LP	Acne							x					
Palforzia	Immunotherapy	x	x		x								
Palynziq	Endocrine disorders	x	x	x	x	x	x						

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Pamelor	Mental health							Brand Only					
Pancreaze	Pancreatic enzyme replacement			x		x							
Panlor (acetaminophen 325 mg/caffeine 30 mg/dihydrocodeine 16 mg)	Pain							x					
Parlodel	Parkinson's disease							Brand Only					
Patanase	Allergies	x						Brand Only					
Paxil	Mental health							Brand Only					
Paxil CR	Mental health	x						Brand Only					
Paxlovid	COVID Treatment	x											
PCP 100 Kit	Constipation							x					
Pedipriox-4	Infections							x					
Pegasys	Hepatitis C						x						
Peglntron	Hepatitis C	x					x						
Pemazyre	Cancer	x	x				x						
Penicillamin	Endocrine disorders						x						
Penlac Nail Lacquer	Infections							Brand Only					
Penlon	Skin conditions				x								
Pennsaid 2% solution	Pain & inflammation							x					
Pennsaid Drops	Pain & inflammation							x					
Pentasa	Inflammatory bowel disease							x					
Percocet	Pain							Brand Only					
Perforomist	COPD	x											
Perindopril	High blood pressure									x			
Pertzye	Pancreatic enzyme replacement			x		x							
Pexeva	Mental health	x						x		x			
Pheburane	Endocrine disorders	x	x					x					
Phexxi	Contraceptive				x			x					
Picato	Skin conditions	x											
Piqray	Cancer	x	x				x						
Plaquenil	Inflammatory conditions							Brand Only					
Pirfenidone	Pulmonary disease	x					x						
Plavix	Stroke & heart attack prevention							Brand Only					
Plegridy	Multiple sclerosis	x	x			x	x						
Plenvu	Bowel preparations	x											
Plexion	Acne							x					
Pomalyst	Cancer	x	x				x						
Ponvory	Multiple sclerosis	x	x					x					
PR Cream	Skin conditions							x					
Pradaxa	Blood clots	x			x (pellet pack)								
Praluent	Cholesterol/Lipid lowering	x	x	x	x			x					
Pramosone E	Skin conditions							x					
Brandin	Diabetes	x											
Pravachol	Cholesterol/Lipid lowering							Brand Only		x			
Pravastatin	Cholesterol/Lipid lowering									x			
Pred Forte 1%	Eye inflammation							Brand Only					
Prednisolone	Steroid	x						x					
Precision Diabetes Test Strips	Diabetic supplies	x						Non-Formulary					
Pregenna	Prenatal vitamin							x					
Pregnyl w/ diluent benzyl	Infertility						x						
Premarin	Hormone replacement												
Prempro	Hormone replacement												
Prenara	Prenatal vitamin							x					
Prenatrix	Prenatal vitamin							x					
Prepopik	Bowel preparations	x											
Presera	Skin conditions							x					
Prestalia	High blood pressure							x					
Prevacid capsules & ODT	Ulcers, heartburn & reflux	x						x					
Prevacid Solutab	Ulcers, heartburn & reflux			x	x	x		Brand Only					
Prevpac Consumer Pak	Ulcers due to <i>H. pylori</i>	x						x					
Prevymis	Infections		x										
Prilosec suspension	Ulcers, heartburn & reflux							x					
Primlev	Pain							x					
Pristiq	Mental health	x						Brand Only					
Proair HFA/ProAir Digihaler	Asthma	x						x - Digihaler HFA (Brand Only)					
Proair Respiclick	Asthma	x						x					
Procardia XL	High blood pressure							Brand Only					
Procor	Skin conditions							x					
Procrit	Anemia	x					x	x					
Proctocort	Hemmoroids							Brand Only					
Procysbi	Endocrine disorders		x	x		x	x						
Prodrin	Pain							Brand Only					
Profilnine, Profilnine SD	Hemophilia						x						
Proglycem	Hypoglycemia							Brand Only					
Prograf	Transplant						x	Brand Only					
Prograf Granules	Transplant				x		x						
Prolate	Pain							Brand and authorized generic					
Prolensa	Eye pain & inflammation							x					
Promacta	Blood disorders		x				x						
Prometrium	Hormone replacement							Brand Only					

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Promiseb	Skin conditions				x								
Proscar	Benign prostatic hypertrophy							Brand Only					
Protonix	Ulcers, heartburn & reflux							Brand Only					
Protonix granules for suspension	Ulcers, heartburn & reflux							x					
Protopic	Skin conditions	x		x		x		Brand Only					
Proventil HFA	Asthma	x						Brand Only					
Provigil (modafinil)	Narcolepsy	x						Brand Only					
Prozac	Mental health							Brand Only					
Prozac Weekly	Mental health	x						Brand Only					
Prucalair	Skin conditions							x					
Prudoxin	Skin conditions	x	x		x			Brand Only					
Prumyx	Skin conditions							x					
Psorcon	Skin conditions	x						Generic Only					
Pulmicort Flexhaler	Asthma	x											
Pulmicort Respules	Asthma	x						Brand Only					
Pulmozyme	Cystic fibrosis	x	x			x	x						
Purixan	Cancer						x						
Pylera	Ulcers due to <i>H. pylori</i>	x											
Pyridostigmine	Myasthenia gravis							x					
Pyrukynd	Anemia	x	x		x								
Qelbree	ADHD	x			x			Non-Formulary					
Qbrelis	High blood pressure				x	x							
Qdolo	Pain	x											
Qinlock	Cancer	x	x		x		x	x					
Qnasl	Allergies	x						x					
Qtern	Diabetes	x		x				x					
Quartette	Contraceptive							x					
Quasense	Contraceptive										x	x	
Qudexy XR	Seizures							x					
Quillichew ER	ADHD	x						x					
Quillivant XR	ADHD	x						x					
Qulipta	Migraine	x	x	x	x			x					
Quviviq	Sleep	x		x				x					
Qmilz ODT	Pain & inflammation							x					
QVAR Redihaler	Asthma	x						x					
Radiagel	Skin conditions							x					
RadiaPlexRX	Skin conditions							x					
Radicava ORS	Amyotrophic lateral sclerosis (ALS)	x	x		x								
Ragwitek	Allergies		x		x								
Ranexa	Angina							Brand Only					
Rapaflo	Benign prostatic hypertrophy							Brand Only					
Rapamune	Transplant						x	Brand Only					
Rasuvo	Inflammatory conditions	x											
Ravicti	Endocrine disorders	x	x	x	x	x	x						
Rayaldee	Elevated parathyroid hormone							x					
Rayos	Inflammatory conditions							x					
Rebif / Rebif Rebidose	Multiple sclerosis	x	x			x	x	x					
Rebinyln	Hemophilia						x	x					
Recombinate	Hemophilia						x						
Recorlev	Cushing's disease	x	x					x					
Rectiv	Anal fissures	x											
RediTrex	Inflammatory conditions	x						x					
Regranex	Diabetic ulcers	x	x										
Relafen DS	Pain & inflammation												
Releuko	Neutropenia						x	Brand Only					
Relexxii	ADHD	x						x					
ReiiOn Ultima diabetes test strips	Diabetic supplies	x						x					
Relistor	Constipation	x			x			Tablets Only					
Relpax	Migraine	x						Brand Only					
Reltone	Gallstones							x					
Relyvrio	Amyotrophic lateral sclerosis (ALS)	x	x		x								
Remeron / Remeron SolTab	Mental health												
Renagel	Elevated phosphate levels							Brand Only					
Renvela	Elevated phosphate levels				x			Brand Only					
Repatha / Repatha Pushtronix / Surclicik	Cholesterol/Lipid lowering	x	x	x	x	x							
Requip XL	Parkinson's disease							x					
reSET, reSET-O	Device				x								
Restasis Single dose vial	Dry eye disease	x	x			x		Generic Only					
Restasis Multidose vial	Dry eye disease	x	x		x			x					
Retacrit	Anemia	x					x						
Retevmo	Cancer	x			x		x						
Retin-A Gel	Acne	x	Brand Only					Brand Only					
Retin-A Cream	Acne	x	Brand Only					Brand Only					
Retin-A Micro	Acne	x	x					x					
Revatio	Pulmonary arterial hypertension	x					x	Brand Only					
Revlimid	Cancer	x	x				x						
Rexulti	Mental health	x		x	x	x							
Reyataz	HIV							Brand Only					
Reyvow	Migraine	x	x	x	x								

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Rezlidhia	Cancer	x											
Rezurock	Graft versus Host	x	x										
Rezvoglar KwikPen	Diabetes	x											
Rhinocort Aqua	Allergies							x					
Rhofade 1% Pump	Rosacea	x	x										
Rhopressa	Glaucoma	x						x					
Ribapak	Hepatitis C							x					
Ridaura	Inflammatory conditions						x						
Rilutek	Amyotrophic lateral sclerosis (ALS)							Brand Only					
Rinvoq ER	Inflammatory conditions	x	x		x		x						
Riomet	Diabetes							Brand Only					
Risperdal	Mental health							x					
Ritalin IR	ADHD							Brand Only					
Ritalin LA	ADHD	x						Brand Only					
Rixubis	Hemophilia						x						
Robinul/Robinul Forte	Excessive secretions							Brand Only					
Roche Diabetic Meter	Diabetic supplies							Non-Formulary					
Rocklatan	Glaucoma	x											
Ropinirole extended-release (generic)	Parkinson's disease							x					
Requip XL)													
Rosadan Kit	Infections							x					
Roszet	Cholesterol/Lipid lowering	x						x					
Roxicodone	Pain							Brand Only					
Roxybond	Pain	x						x					
Rozeren	Sleep	x		x		x		Brand Only					
Rozlytrek	Cancer	x	x				x						
Rubraca	Cancer	x	x	x		x	x						
Ruconest	Hereditary angioedema	x	x		x		x						
Rukobia	HIV		x										
Ruzurgi	CNS disorders	x					x						
Ryaltiris	Allergies	x						x					
Rybelsus	Diabetes	x	x	x		x			x				
Ryclora	Allergies							x					
Rydapt	Cancer	x	x				x						
Rytary	Parkinson's disease							x					
Rythmol SR	Arrhythmias							Brand Only					
Ryvent	Allergies							x					
Ryzolt	Pain	x						x					
Sabril	Seizures	x	x		x	x	x	Brand Only					
Safyral	Contraceptive							x					
Saizen	Growth hormones	x	x		x		x	x					
Sajazir	Hereditary angioedema				x								
Salivamax	Dry mouth				x								
Samsca	Endocrine disorders	x	x				x						
Sanctura	Overactive bladder							Brand Only					
Sanctura XR	Overactive bladder							x					
Sancuso	Nausea & vomiting	x						x					
Sandimmune	Transplant						x	Brand Only					
Sandostatin	Endocrine disorders		x				x	Brand Only					
Santyl	Skin conditions	x											
Saphris	Mental health	x											
Sarafem	Mental health							x					
Savaysa	Blood clots	x		x									
Savella	Pain	x											
Scemblix	Cancer	x	x										
Seasonale	Contraceptive											x	
Seasonique	Contraceptive							Brand Only				x	
Secuado	Mental health	x						x					
Seglentis	Pain & inflammation	x						x					
Segluromet	Diabetes	x		x				x					
Selzentry	HIV		x										
Sensipar	Endocrine disorders				x		x	Brand Only					
Sermglee	Diabetes							x					
Serevent diskus	Asthma/COPD	x											
Sernivo	Skin conditions	x						x					
Seroquel	Mental health							Brand Only					
Seroquel XR	Mental health							Brand Only					
Serostim	Growth hormones	x	x		x		x						
Sertraline - 150, 200 mg capsules	Mental health	x						x		x			
Seysara	Acne							x					
SevenFACT	Hemophilia							x					
Signifor	Endocrine disorders	x	x				x						
Siklos	Sickle cell disease							x					
Sildenafil	Pulmonary arterial hypertension				x		x						
Silenor	Sleep	x						x					
Siliq	Inflammatory conditions	x	x	x	x	x		x					
SilvaSorb	Skin conditions							x					
Simbrinza	Glaucoma	x						x					
Simponi	Inflammatory conditions	x	x		x		x						
Simvastatin	Cholesterol/Lipid lowering									x			
Singulair granules	Asthma							Brand Only					
Sitavig	Infections	x						x					
Sivextro	Infections	x											

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Skelaxin	Muscle spasms							Brand Only					
Skyclarys	CNS agents	x	x		x		x						
Skyrizi	Inflammatory conditions	x	x		x		x						
Skytrofa	Growth hormones	x	x		x			x					
Slynd	Contraceptive			x	x								
Soaanz	Heart failure	x						x					
Sodium Pheny	Endocrine						x						
Sodium sulfacetamide/sulfur 9%-4.5% kit (generic Sumadan Kit)	Acne							x					
Sogroya	Growth hormones	x	x				x						
Sohonos	Bone growth disorder		x										
Solaraze	Skin conditions	x	x										
Soliqua	Diabetes	x											
Solodyn	Acne				x			Minocycline ER 45 mg, 90 mg, 135 mg NonFormulary					
Solosec	Infections	x		x									
Soltamox	Cancer							x					
Soma - 250 mg	Muscle spasms							x					
Soma - 350 mg	Muscle spasms							Brand Only					
Somatuline Depot	Endocrine disorders						x						
Somavert	Endocrine disorders	x	x		x		x						
Somryst	Device				x								
Soolantra	Acne	x											
Sorlatane	Psoriasis							Brand Only					
Sorlux Foam	Skin conditions	x						x					
Sotyktu	Psoriasis	x	x	x									
Sotylize	Arrhythmias				x	x							
Sovaldi	Hepatitis C	x	x	x	x		x						
Spectragel	Skin conditions							x					
Spiriva & Spiriva Respimat	Asthma/COPD	x											
Sporanox capsules	Infections	x											
Spravato	Mental health	x	x		x								
Spritam	Seizures							x					
Sprix	Pain	x		x		x							
Sprycel	Cancer	x	x	x		x	x						
Starlix	Diabetes	x											
Staxyn	Erectile dysfunction	x						x					
Steglatro	Diabetes	x		x				x					
Steglujan	Diabetes	x		x				x					
Stelara	Inflammatory conditions	x	x		x		x						
Stendra	Erectile dysfunction	x			x								
Stimufend	Neutropenia							x					
Stiolto Respimat	COPD	x											
Stivarga	Cancer	x	x				x						
Strattera	ADHD	x						Brand Only					
Strensiq	Enzyme deficiency	x	x		x		x						
Stribild	HIV	x											
Striverdi Respimat	COPD	x											
Suboxone	Opioid dependence	x			x			Brand Only	x				
Subsys	Cancer pain	x	x		x			x					
Sucraid	Enzyme deficiency		x		x		x						
Sumadan Kit & Cleanser	Acne							x					
Sumavel DosePro	Migraine							x					
Sumaxin CP	Acne							x					
Sumaxin TS	Acne							x					
Sunlenca	HIV	x	x										
Sunosi	Narcolepsy	x	x		x								
Suprax	Infections												
Suprep	Bowel preparations	x											
Sustiva	HIV							Brand Only					
Sutent	Cancer	x	x				x	Brand Only					
Sylatron	Cancer						x						
Symbicort	Asthma/COPD	x						Generic Only					x
Symbyax	Mental health	x											
Symdeko	Cystic fibrosis	x	x		x		x						
Symlin	Diabetes	x											
Symjetli	Severe allergic reactions	x											
Sympazan	Seizures		x					x					
Symproic	Constipation	x	x										
Symtuza	HIV	x						x					
Synalar & Synalar topical solution	Skin conditions	x						Brand Only					
Synalar Kit	Skin conditions							x					
Synalar TS	Skin conditions							x					
Syndros	Nausea & vomiting	x			x	x							
Synderm	Skin conditions				x								
Synribo	Cancer	x	x										
Synjardy	Diabetes	x											
Synjardy XR	Diabetes	x											
Synthroid	Thyroid replacement							Brand Only					
Synprine	Blood disorders		x				x	Brand Only					
Tabloid	Cancer						x						
Tabrecta	Cancer	x	x				x						

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Taclonex	Skin conditions	x						Generic only					
Taclonex Scalp	Skin conditions	x											
Tadliq	Pulmonary hypertension	x	x										
Tafinlar	Cancer	x	x				x						
Tagrisso	Cancer	x	x				x						
Takhzyro	Hereditary angioedema	x	x		x		x						
Talicia	Ulcers due to <i>H. pylori</i>	x						x					
Taltz	Inflammatory conditions	x	x	x	x	x	x	x					
Talzenna	Cancer	x	x	x		x	x						
Tamiflu Capsules & Suspension	Infections	x						Capsules Brand Only					
		Suspension Only											
Tanzeum	Diabetes	x											
Tarceva	Cancer	x	x				x	Brand Only					
Targadox	Acne							x					
Targretin Capsules	Cancer						x	Generic Only					
Targretin Gel	Cancer	x					x						
Tarka	High blood pressure							Brand Only					
Tarpeyo	Kidney disease	x			x		x						
Tascenso ODT	Multiple sclerosis	x						x					
Tasigna	Cancer	x	x	x		x	x						
Tasmar	Parkinson's disease				x			Brand Only					
Taytulla	Contraceptive							x					
Tavalise	Blood disorders	x	x				x						
Tavneos	Cancer	x	x		x								
Tazorac cream & gel	Acne	x	x		x			Generic 1% cream only					
Tazverik	Cancer	x					x						
Tecfidera	Multiple sclerosis	x	x			x	x	Brand Only					
Technivie	Hepatitis C	x					x						
Tegsedi	CNS disorders	x	x		x								
Tegretol	Seizures												
Tekamlo	High blood pressure							x					
Temixys	HIV	x						x					
Temodar	Cancer		x				x	Brand Only					
Temovate	Skin conditions	x											
Temovate-E	Skin conditions	x											
Tenoretic	High blood pressure							Brand Only					
Tenormin	High blood pressure							Brand Only					
Tepmetko	Cancer	x	x										
Terbinex	Infections	x						x					
Teriparatide	Osteoporosis		x										
Testim	Testosterone replacement	x			x	x							
Tetrabenazine	Huntington's disease		x			x	x	Brand Only					
Testosterone topical gel	Testosterone replacement							x					
Tetrix	Skin conditions				x								
Tezspire	Asthma	x	x		x								
Thalitone	High blood pressure							x					
Thalomid	Cancer	x	x				x						
Therahoney	Skin conditions							x					
Thyquidity	Thyroid replacement							x					
Tibsovo	Cancer		x				x						
Thiola	Endocrine disorders						x						
Tiglutik	Amyotrophic lateral sclerosis (ALS)				x	x							
Tirosint/Tirosint-Sol	Thyroid replacement				x			x					
Tivorbex	Pain							x					
Tlando	Testosterone replacement	x			x			x					
TOBI	Cystic fibrosis	x	x			x	x	x					
TOBI Podhaler	Cystic fibrosis	x	x			x	x						
Tobradex ST	Infections							x					
Tobrex	Infections	x											
Tolak	Skin conditions							x					
Tolsura	Infections							x					
Topamax	Seizures				Brand Only	x							
Topicort	Skin conditions	x						x					
Topiramate extended-release sprinkle	Seizures			x	Brand Only			x					
Toprol XL	High blood pressure							Brand Only					
Tosymra	Migraine	x						x	x				
Toujeo Max Solostar/Toujeo Solostar	Diabetes	x											
Toviaz	Overactive bladder							x					
Tracleer	Pulmonary arterial hypertension	x	x		x	x	x						
Tradjenta	Diabetes	x											
Tramadol extended-release (generic Ryzolt)	Pain							x					
Trandolapril	High blood pressure									x			
Transderm Scop	Nausea & vomiting							Brand Only					
Travatan Z	Glaucoma	x						x					
Trelegy Ellipta	Asthma/COPD	x											x
Tremfya	Inflammatory conditions	x	x		x		x						

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Tresiba	Diabetes	x						x					
Tretinoin (oral)	Cancer	x					x						
Tretten	Hemophilia						x						
Treximet	Migraine	x						x					
Trezix	Pain	x											
Trinaz	Prenatal vitamin							x					
Trianex	Skin conditions							x					
Triaz foaming cloths	Acne							x					
Tribenzor	High blood pressure							x					
Tricor (48 mg & 145 mg)	Cholesterol/Lipid lowering							x					
Triderm cream	Skin conditions	x											
Triglide	Cholesterol/Lipid lowering							x					
Trijardy XR	Diabetes	x											
Trikafta	Cystic fibrosis	x	x		x		x						
Trileptal	Seizures				Brand Only	x							
Trilipix	Cholesterol/Lipid lowering							x					
Trintellix	Mental health	x		x		x							
Triumeq/Triumeq PD	HIV	x											
Trokendi XR	Seizures							x					
Tropazone	Skin conditions							x					
Troxyc	Pain	x		x	x								
Trudhesa	Migraine	x			x			x					
Truetest Test Strips	Diabetic supplies	x											
Truetrack Test Strips	Diabetic supplies	x											
Trulance	Constipation	x	x	x	x			x					
Trulicity	Diabetes	x	x	x		x			x				
Truseltiq	Cancer	x					x						
Truvada	HIV	x						Brand Only					
Tukysa	Cancer	x	x				x						
Tudorza Pressair	COPD	x						x					
Turalio	Cancer	x	x				x						
TussiCaps	Cough & cold	x			x								
Tussionex	Cough & cold	x			x								
Tuxarin	Cough & cold	x			x								
Tuzistra XR	Cough & cold	x			x								
Twirla	Contraceptive							x					
Twynéo	Acne	x						x					
Twynsta	High blood pressure							x					
Tykerb	Cancer	x					x	Brand Only					
Tymlos	Osteoporosis		x				x						
Tyrvaya	Dry eye disease	x	x		x								
Tyvaso	Pulmonary arterial hypertension	x	x		x	x	x						
Tyzeka	Hepatitis B						x						
Ubrelvy	Migraine	x	x	x	x								
Udenyca	Neutropenia						x	x					
Ukoniq	Cancer	x											
Uloric	Gout							Brand Only					
Ultima Test Strips	Diabetic supplies							x					
Ultracet	Pain	x											
Ultram	Pain	x						Brand Only					
Ultram ER	Pain												
Ultravate	Skin conditions	x		x									
Ultravate 0.05% Lotion	Skin conditions	x						x					
Ultravate X Combination Pack	Skin conditions							x					
Umecta/Umecta PD / Umecta Nail Kit	Infections							x					
Univasc	High blood pressure									x			
Upneeq	Droopy eyelids	x			x								
Uptravi	Pulmonary arterial hypertension	x	x		x	x	x						
Uramaxin GT	Infections							x					
Uroxatral	Benign prostatic hypertrophy							Brand Only					
Urso / Urso Forte	Gallstones							x					
Utopic	Infections							x					
Vacustim	Skin conditions							x					
Vagifem	Hormone replacement							Brand Only					
Valchlor	Cancer	x	x				x						
Valcyte	Infections							Brand Only					
Valium	Anxiety							Brand Only					
Valsartan Oral Solution	High blood pressure				x								
Valtoco	Seizures	x	x										
Valtrex	Infections	x						Brand Only					
Valturna	High blood pressure							x					
Vanos	Skin conditions	x						x					
Vanflyta	Cancer	x	x										
Vantrela	Pain	x		x	x								
Varubi	Nausea & vomiting	x						x					
Vascepa	Cholesterol/Lipid lowering		x		x			Non-Formulary					
Vascuderm	Skin conditions							x					



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Vascuderm Hydrogel Wound Dressing	Skin conditions							x					
Vaseretic	High blood pressure							Brand Only					
Vasotec	High blood pressure							Brand Only					
Veozah	Women's Health	x			x								
Vecamyl	High blood pressure		x				x						
Vectical	Skin conditions	x						Brand Only					
Velsipity	Inflammatory bowel disease		x					x					
Veltassa	Elevated potassium levels	x			x								
Veltin	Acne	x						x					
Vemlidy	Hepatitis B				x			x					
Venclexta	Cancer	x	x				x						
Venlafaxine ER tabs	Mental health	x						x					
Ventavis	Pulmonary arterial hypertension		x		x	x	x						
Ventolin HFA	Asthma	x						x					
Veramyst	Allergies							x					
Verdeso	Skin conditions	x						x					
Veregen	Infections	x		x		x							
Verkazia	Dry eye disease	x			x								
Vermox	Infections				x	x							
Versacloz	Mental health							x					
Verquvo	Heart failure	x	x		x								
Verzenio	Cancer	x	x				x						
Vesicare	Overactive bladder							Brand Only					
Vesicare LS	Overactive bladder							x					
Vfend	Infections	x											
Viagra	Erectile dysfunction	x						Brand Only					
Viberzi	Irritable bowel disease	x			x								
Vicodin / Vicodin ES / Vicodin HP	Pain	x						x					
Victoza	Diabetes	x	x	x		x			x				
Viekira Pak	Hepatitis C		x	x	x		x						
Vigabatrin	Seizures						x						
Vigamox	Infections							Brand Only					
Vilbryd	Mental health	x						Brand Only					
Vijoice	Genetic disorder	x	x		x								
Vittrakvi	Cancer	x	x				x						
Vimovo	Pain & inflammation	x						x					
Vimpat	Seizures		x		Brand Only	x							
Viokace	Pancreatic enzyme replacement			x		x		x					
Viramune	HIV							Brand Only					
Viramune XR - 100 mg	HIV							Brand Only					
Virasal	Infections							x					
Viread	HIV							Brand Only					
Vistogard	Chemotherapy overdose	x											
Vivelle-Dot	Hormone replacement	x						Brand Only					
Vivjoa	Antifungal	x			x								
Vivlodex	Pain & inflammation	x						x					
Vizimpro	Cancer		x				x						
Vogelxo	Testosterone replacement	x			x	x		x					
Voltaren Gel	Pain & inflammation							x					
Vonjo	Cancer	x	x										
Vonvendi	Blood disorders						x						
Voquezna	H.pylori	x											
Vosevi	Hepatitis C	x	x		x		x						
Votrient	Cancer	x	x				x						
Vowst	Gastrointestinal agents	x	x		x		x						
Voxzogo	Growth disorders	x			x								
Vraylar	Mental health	x											
Vtama	Inflammatory conditions	x											
Vuity	Eye conditions	x			x			x					
Vumerity	Multiple sclerosis	x	x	x	x	x		x					
Vusion	Infections										x		
Vyleesi	Sexual dysfunction	x			x								
Vyndaqel	Amyloidosis	x	x		x		x						
Vyndamax	Amyloidosis	x			x		x						
Vytone	Skin conditions							x					
Vytorin	Cholesterol/Lipid lowering							Brand Only					
Vyvanse	ADHD	x											
Vyzulta	Glaucoma	x				x		x					
Wakix	Narcolepsy	x	x		x								
Welchol	Cholesterol/Lipid lowering							Brand Only					
Wellireg	Cancer	x	x				x						
Wellbutrin	Mental health							Brand Only					
Wellbutrin SR	Mental health							Brand Only					
Wellbutrin XL	Mental health							Brand Only					
Westcort	Skin conditions	x											
Wilate	Hemophilia						x						
Winlevi	Acne	x			x			x					
Wynzora	Skin conditions	x						x					
Xaciatro	Infections	x											
Xadago	Parkinson's disease							x					
Xalatan	Glaucoma							Brand Only					
Xalkori	Cancer	x	x				x	Non-Formulary					

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Xanax / Xanax XR	Anxiety							Brand Only					
Xarelto	Blood clots	x											
Xartemis XR	Pain							x					
Xatmep	Cancer	x		x		x							
Xcopri	Seizures		x		x								
Xdemvy	Infections		x										
Xelstrym	ADHD	x			x								
Xeljanz	Inflammatory conditions	x	x		x		x						
Xeljanz XR	Inflammatory conditions	x	x		x		x						
Xeloda	Cancer	x					x	Brand Only					
Xelpros	Glaucoma	x											
Xepi	Skin conditions	x											
Xerese	Infections	x						x					
Xermelo	Endocrine disorders	x	x				x						
Ximino	Acne							x					
Xhance	Allergies	x						x					
Xifaxan	Infections	x			x			x					
Xigduo XR	Diabetes	x		x				x					
Xiidra	Dry eye disease	x	x			x							
Xodol	Pain							x					
Xofluza	Infections	x											
Xolair	Asthma	x			x								
Xolegel	Infections										x		
Xopenex HFA	Asthma	x											
Xopenex Solution	Asthma	x						x					
Xospata	Cancer	x	x				x						
Xpovio	Cancer	x	x				x						
Xtampza ER	Pain	x			x								
Xtandi	Cancer	x	x				x						
Xultophy	Diabetes	x						x					
Xuriden	Endocrine disorders	x	x				x						
Xyntha, Xyntha Solofuse	Hemophilia			x	x		x						
Xyosted	Testosterone replacement	x			x	x		x					
Xyrem	Narcolepsy	x	x		x		x						
Xywav	Narcolepsy	x	x		x								
Yonsa	Cancer	x	x	x		x	x	x					
Yupelri	COPD	x			x								
Yuflyma	Inflammatory conditions	x	x		x		x						
Yusimry	Inflammatory conditions	x	x		x								
Zalvit	Prenatal vitamin							x					
Zanabin Antipruritic Hydrogel	Skin conditions							x					
Zarxio	Neutropenia						x						
Zavesca	Enzyme deficiency						x	Brand Only					
Zcort 7-day	Oral steroid							x					
Zegalogue	Diabetes	x											
Zegerid capsules	Ulcers, heartburn & reflux	x						x					
Zavzpret	Migraine	x	x	x	x								
Zegerid packets	Ulcers, heartburn & reflux	x		x	x	x		x					
Zejula	Cancer	x	x				x						
Zelboraf	Cancer	x	x				x						
Zelnorm	Constipation		x	x	x								
Zembrace Symtouch	Migraine	x						x					
Zemplar	Endocrine disorders												
Zenzedi	ADHD							x					
Zepatier	Hepatitis C	x	x		x		x						
Zeposia	Inflammatory conditions	x	x	x	x	x							
Zerviate	Allergies	x						x					
Zestoretic	High blood pressure							Brand Only					
Zestril	High blood pressure							Brand Only					
Zetia	Cholesterol/Lipid lowering							Brand Only					
Zetonna	Allergies	x											
Ziana	Acne	x						x					
Zilextenzo	Neutropenia						x						
Zilxi	Rosacea	x	x	x									
Zimhi	Opioid overdose	x											
Zinbryta	Multiple sclerosis	x					x						
Zioptan	Glaucoma	x		x		x							
Zipsor	Pain & inflammation							x					
Zirgan	Eye conditions	x											
Zocor	Cholesterol/Lipid lowering							Brand Only		x			
Zodex	Oral steroid							x					
Zofran	Nausea & vomiting							Brand Only					
Zohydro ER	Pain	x			x			Brand Only					
Zoladex	Cancer											x	
Zolinza	Cancer	x	x				x						
Zoloft	Mental health							Brand Only		x			
Zolpidem Tartrate	Sleep	x											
Zolpimist	Sleep	x		x		x							
Zolvit	Pain							x					
Zokinvy	Genetic disorder	x	x										
Zomacton	Growth hormones	x	x		x		x	x					
Zomig nasal spray	Migraine	x		x									
Zomig tablets & Zomig ZMT	Migraine	x						Brand Only					

Medication Name	Therapeutic Use	Supply Limit	Notification	Step Therapy <sup>+</sup>	Prior Authorization/ Medical Necessity	Clinical Review Automation <sup>**</sup>	Designated Specialty Network	Permanent Exclusion <sup>+</sup>	Oxford Only <sup>*</sup>	Half-Tab	Multiple Copay	Extended Packaging List	Refill and Save
Zonacort	Oral steroid							x					
Zonalon	Skin conditions	x	x		x			Brand Only					
Zonatuss	Cough & cold							x					
Zonegran	Seizures				x	x							
Zonisade	Seizures				x								
Zontivity	Stroke & heart attack prevention	x											
Zorbtive	Growth hormones	x	x		x		x						
Zortress	Transplant						x	Brand Only					
Zorvolex	Pain & inflammation							x					
Zoryve	Inflammatory conditions	x	x		x								
Zovirax cream	Infections	x						x					
Zovirax ointment	Infections	x						Brand Only					
Ztalmu	Seizures		x		x								
ZTLido	Pain	x	x										
Zubsolv	Opioid dependence	x											
Zuplenz	Nausea & vomiting	x						x					
Zurampic	Gout	x											
Zutripzo	Cough & cold	x						Brand Only					
Zyclara	Skin conditions	x						x					
Zydelig	Cancer	x	x				x						
Zyflo	Asthma			x		x							
Zyflo CR	Asthma			x		x							
Zykadia	Cancer	x	x				x	Non-Formulary					
Zylot	Infections												
Zymar	Cholesterol/Lipid lowering			x				x					
Zypitama	Mental health							Brand Only					
Zyprexa / Zyprexa Zydis	Cancer	x	x				x	Brand Only					
Zytiga - 250 mg	Cancer	x	x				x	x					
Zytiga - 500 mg	Cancer												
Zyvox	Infections							Brand Only					
* In addition to other applicable clinical programs, these programs are only for Oxford lines of business.													
+Referred to as First Start in New Jersey.													
** Clinical Review Automation contains Silent Authorization, Diagnosis to Drug Match (Dx2Rx), Self-lookback													

## Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits, and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits must be comparable to and cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In regard to the NQTL analysis below, the Plan Golden Rule Insurance Company (GRIC), as an affiliate entity under United Healthcare (UHC) E&I, adopts and implements policies and procedures that track those implemented by UHC. Thereby, UHC identifies the services to which the NQTL applies (step 1). The Plan also accepts UHC’s identified factors used to determine whether the NQTL applies (step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (step 4), and sets forth findings and conclusions, both “as written” and “in operation” (step 5).

### Specific NQTL

Reimbursement policies within the broader organization of UHC, describe how physicians and health care professionals should code for the covered services they provide to members in order to pay provider claims. Coding edits which are conducted by UHC and adopted by the Plan; are developed in accordance with:

- The most recent edition of the Current Procedural Terminology® (CPT), a publication of the American Medical Association (AMA), and/or the Centers for Medicare and Medicaid Services (CMS)
- As reported by generally recognized professionals or publications
- As used for Medicare
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept

In-network (INN) providers adhere to *UnitedHealthcare’s (UHC) Provider Administrative Guide (M/S)* and the *Optum National Network Manual (MH/SUD)*, while out-of-network (OON) providers are guided by the member’s Plan documents.

This document includes the following information:

- UHC processes for the development of reimbursement policies for both M/S and MH/SUD
- Description of the NQTL and application (Step 1)
- Factors UHC used to develop reimbursement policies and coding edits for both M/S and MH/SUD (Step 2)
- Evidentiary standards and sources UHC used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis conducted by UHC (Step 4)
- Findings and conclusions as determined by UHC and accepted by the Plan (Step 5)

Reimbursement Policy/Coding Edits Non-Quantitative Treatment Limitation (NQTL) Analysis  
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**This comparative analysis refers to the following attachments:**

- *Certificate of Coverage (GA\_COC\_TI GEN 25 EXD)* - Plan document that explains covered services, terms, conditions, and limitations of the member's policy

## Process

Per the M/S *UHC Provider Administrative Guide* and the MH/SUD *Optum National Network Manual*, providers are required to timely submit complete claims with accurate coding. For example, coding must comply with nationally recognized CMS' Correct Coding Initiative (CCI) standards. UHC Plan documents reflect M/S and MH/SUD coverage determinations are made in accordance with the Plan's reimbursement policies.

Both M/S *UnitedHealthcare Commercial Reimbursement Policies* and MH/SUD *Optum Reimbursement Policies* are publicly available to providers through the respective provider portals (M/S:

<https://www.uhcprovider.com/en/policies-protocols/commercial-policies/commercial-reimbursement-policies.html>

and MH/SUD: <https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/reimbursement-policies.html>). Providers are made aware of changes to these policies on

[UHCprovider.com/networknews](https://www.uhcprovider.com/networknews) > Network Bulletin.

## Step 1 – NQTL and List of M/S and MH/SUD Services Subject to NQTL

*FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.*

### Specific NQTL

- Development and application of reimbursement policies

### Benefit Classification(s)

- Applies to all benefit classifications

### Plan(s) at Issue

- Golden Rule Insurance

## Step 2 – Factors Used to Determine Coding Edits

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/ SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*

## Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the*

*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.*

Reimbursement Policy/Coding Edits Non-Quantitative Treatment Limitation (NQTL) Analysis  
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determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

## Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

*FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.*

## Step 5 – Findings and Conclusions

*FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.*

### Findings

The findings of the UHC analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to develop the MH/SUD reimbursement policies were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to develop the M/S reimbursement policies.

### Conclusions

UHC on behalf of the Plan, reviewed the M/S and MH/SUD reimbursement policies and procedures and concluded the methodology used to develop the MH/SUD reimbursement policies “as written” was comparable to, and applied no more stringently than, the methodology used to develop the M/S reimbursement policies “as written.” Additionally, the Plan concluded that the MH/SUD reimbursement policies were applied no more stringently than, the M/S reimbursement policies were applied “as written.”

UHC on behalf of the Plan, reviewed the M/S and MH/SUD processes for applying the reimbursement policies and found they were comparable and no more stringently applied for MH/SUD. Additionally, from review of the M/S and MH/SUD processes for applying the reimbursement policies, including notification, timeframes for processing, determinations, and determination communications, the Plan concluded the methodology used to apply the MH/SUD reimbursement policies “in operation” was comparable to, and applied no more stringently than, the methodology used to apply the M/S reimbursement policies “in operation.”

**Credentialing Program Non-Quantitative Treatment Limitation (NQTL) Analysis**

Golden Rule Insurance  
12/01/2023

**Overview**

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits, and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements – such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs – which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan Golden Rule Insurance Company (GRIC), as an affiliate entity under United Healthcare (UHC) E&I, adopts and implements policies and procedures that track those implemented by UHC. Thereby, the Plan accepts the identified services to which the NQTL applies (step 1). The Plan also accepts as determined by UHC identified factors considered in the design or application of the NQTL (step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (step 3). The NQTL analysis provides detailed comparative analysis that demonstrate that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (step 4). Findings and conclusions both “as written” and “in operation” are presented in step 5.

**Specific NQTL**

Credentialing is performed by UHC and the Plan relies upon and leverages their processes, systems and determinates with regards to determinations on if a provider or facility meets standards to join (credential) or maintain (recredential) their status in UHC’s network of participating providers. The Plan relies upon and leverages UHC’s systems and procedures for 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.

This document includes the following information:

- UHC’s Process for the Credentialing program for both M/S and MH/SUD
- Description of the NQTL and application (Step 1)
- Factors used to facilitate the Credentialing program for both M/S and MH/SUD (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis conducted by UHC (Step 4)
- Findings and Conclusions as determined by UHC and accepted by the Plan (Step 5)

**This comparative analysis refers to the following attachments:**

**Credentialing Program Non-Quantitative Treatment Limitation (NQTL) Analysis**

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- *Certificate of Coverage (GA\_COC\_TI GEN 25 EXD)* - Plan document that explains covered services, terms, conditions, and limitations of the member's policy

As detailed below, the Plan accepts UHC's conclusions that the credentialing requirements for MH/SUD providers and facilities are comparable to, and applied no more stringently than, the credentialing requirements for M/S providers and facilities, both "as written" and "in operation."

## Process

For both M/S and MH/SUD, UHC on behalf of the Plan uses comparable credentialing processes.

For M/S, the *UnitedHealthcare (UHC) Credentialing Plan* defines Credential, Credentialing, or Recredentialing as "the process of assessing and validating the applicable criteria and qualifications of Licensed Independent Practitioners and Facilities to become or continue as Participating Licensed Individual Providers (PLIPs) and Participating Facilities, as set forth in the Credentialing Plan and pursuant to Credentialing Authorities."

For MH/SUD, the *United Behavioral Health (UBH) Credentialing Plan* defines Credentialing or Recredentialing as "the process of assessing and validating the applicable criteria and qualifications of providers to become or continue as Participating Providers, as set forth in the Credentialing Plan."

Key steps in the credentialing process for both M/S and MH/SUD include:

- The provider/facility submits a completed application to UHC to be included in UHC's provider network
- UHC confirms the information in the application
- If the provider/facility passes the credentialing requirements as outlined in the respective credentialing plan, the provider/facility is credentialed

## Credentialing Plan

The purpose of the applicable credentialing plan is to explain the policy for credentialing. All providers/facilities included in the M/S and MH/SUD network are subject to the applicable credentialing plan. Providers/facilities that provide health care services to Covered Persons under their out-of-network benefits or on an emergency basis are not subject to the credentialing plan.

## Credentialing Plan Approval

For M/S, the National Peer Review and Credentialing Policy Committee (NPRCPC) has the authority to approve the *UHC Credentialing Plan*. M/S has the right to change the *UHC Credentialing Plan* to meet regulatory requirements or other organizational or business needs with the Quality Oversight Committee approval. 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.

The NPRCPC is comprised of stakeholders from multiple UHC regions and meets regularly. The primary role of the NPRCPC is to ensure that the Regional Peer Review Committees (RPRCs) do not rely on an improper or discriminatory basis for making their decisions. The NPRCPC has the final decision-making



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authority on all disciplinary actions the RPRC recommends that affect restriction, suspension, or termination of participation status of physicians or health care professionals. In addition, this committee is responsible for review and approval of the *UHC Credentialing Plan* and interpretation of the *UHC Credentialing Plan* as needed. The NPRCPC, when authorized by applicable state or federal law, endeavors to conduct its activities in a manner that constitutes peer review.

For MH/SUD, UHC on behalf of the Plan delegates credentialing of behavioral health network providers to its affiliate UBH d/b/a Optum Behavioral Health (OBH). The Quality Improvement Committee (QIC) has oversight of the Credentialing Committee and delegates overall responsibility and authority to its standing Credentialing Committee for credentialing. The QIC also delegates to the Credentialing Committee the authority to administer the *UBH Credentialing Plan*. The Credentialing Committee is responsible for administering the *UBH Credentialing Plan* and reviewing and approving policies related to credentialing activities on behalf of OBH, subject to oversight by the QIC. The *UBH Credentialing Plan* can be referenced on the website <https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/credPlans/credPlanUBH.pdf>.

The Credentialing Committee is multidisciplinary and must include at least two OBH Medical Directors. The committee is comprised of at a minimum two external participating clinicians. The committee must have at least seven voting members present to form a quorum. At least one representative of the quorum will be a Medical Director and two must be external clinicians. An OBH Medical Director chairs the Credentialing Committee; other OBH Medical Directors will serve as co-chairs and will chair the meeting in the absence of the chairperson. The Credentialing Committee meets at least monthly.

The OBH Credentialing Committee Chair has responsibility to see that the *UBH Credentialing Plan* and policies are administered fairly to all clinicians and organizational providers, to monitor the ongoing quality of clinician and organizational provider services, and to immediately restrict or terminate a participating clinician's or organizational provider's agreement.

**Detailed Process for Credentialing**

For M/S and MH/SUD, credentialing is a peer-review process designed to review certain information pertinent to the respective Credentialing Entity's decision whether to contract a provider or facility, either initially or on an ongoing basis. The process described in the credentialing plans will be initiated only after the Credentialing Entity makes a preliminary determination that it wishes to pursue contracting or re-contracting with the applicant.

The credentialing process begins when a provider/facility submits a completed application.

**Application Verification**

For M/S, credentialing team staff will collect information to assess whether an applicant meets the minimum credentialing requirements for practice location, specialty, and any other business needs.

A Medical Director may approve initial credentialing or recredentialing applications determined to meet all credentialing criteria. If credentialing criteria are not met, the Medical Director forwards all documentation to the National Credentialing Committee (NCC) for determination. All completed applications are also forwarded to the NCC for determination.

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The NCC will make credentialing decisions pursuant to the *UHC Credentialing Plan*. The NCC is comprised of PLIPs 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 has discretion to ask for missing information or to deny the application as incomplete. The NCC may request further information not covered by the application if necessary to make a determination. Upon receipt of a complete application, the NCC will render a decision in accordance with the timeframes as specified by the *UHC Credentialing Plan*.

Credentialing decisions are communicated to the applicant and UHC's teams. If an application is not accepted or participation is terminated, the non-acceptance or termination letter will include the reason(s) for the decision. UHC permits appeals from adverse credentialing or sanctions monitoring decisions as required by the NCQA, the Center for Medicare and Medicaid Services (CMS), and other applicable state and federal regulatory authorities. Any appeal process related to the termination, suspension, or non-renewal of providers/facilities will be communicated to the affected provider/facility with the notice of termination, suspension, or non-renewal.

For MH/SUD, credentialing decisions and actions of OBH will be guided primarily by (a) consideration of each applicant's potential contribution to the objective of providing effective and efficient health care services to UBH's members, (b) UBH's need for clinicians and organizational providers within its service area, and (c) judging each applicant for credentialing and recredentialing without discrimination due to age, race, gender, color, religion, ethnic/national identity, ancestry, disability, marital status, covered veteran status, sexual orientation, status with respect to public assistance, blindness or partial blindness, handicap, physical or mental impairment, victims of domestic violence, types of patients seen, or any other characteristic protected under state, federal, or local law.

The Credentialing Committee is responsible for making credentialing decisions about inclusion of providers and facilities in the network. Applications that meet all the credentialing criteria and require no further review by the Credentialing Committee are sent to the Medical Director for approval. Applications that require additional review are presented to the Credentialing Committee. In this instance the Credentialing Committee has the sole discretion to make a credentialing exception to the required criteria, such as network need. Decisions to make exceptions based on appropriate factors are done in compliance with state and federal regulations. The Credentialing Committee may also at its sole discretion and determination, make the decision to deny the application for network participation.

## Step 1 – NQTL and Application

*FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.*

### **Benefit Classification(s)**

Applies to all in-network (INN) M/S and MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans

### **Plan(s) at Issue**

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**Credentialing Program Non-Quantitative Treatment Limitation (NQTL) Analysis**

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**List of M/S and MH/SUD Benefits Subject to NQTL**

Applies to all In-Network M/S and MH/SUD providers and facilities providing covered services in the Inpatient In-Network, Outpatient In-Network, and Emergency Care classifications as described in the Credentialing Plan.

**Step 2 – Factors Used in the Design and Application of the NQTLs**

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH or SUD benefits and medical or surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*

The Plan relies upon the systems and processes within UHC, regarding the identified following factors to determine if a provider or facility meets standards to join (credential) or maintain (recredential) their status in UHC's network of participating providers.

- I. INN M/S providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency classification
  - II. INN MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency classification
- **The provider or facility completes and attests to the accuracy of the content of the application (Qualitative).**
    - Applies to both M/S and MH/SUD
  - **UHC verifies certain information, i.e., primary source verification, in the application (Qualitative).**
    - Applies to both M/S and MH/SUD
  - **The provider or facility continues to meet the applicable requirements set forth in the Credentialing Plan while they are contracted with UHC (Qualitative).**
    - Applies to both M/S and MH/SUD

These factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

**Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor**

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.*

Below are the sources and evidentiary standards used by UHC to define, trigger, and/or implicate the factors used to determine if a provider or facility meets standards to join (credential) or maintain (recredential) their status in UHC's network of participating providers.

**Credentialing Program Non-Quantitative Treatment Limitation (NQTL) Analysis**

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These evidentiary standards and sources apply to the following benefit classifications:

- I. INN M/S providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency classification
- II. INN MH/SUD providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency classification

**Factor – Completed Application is defined as the provider or facility completes and attests to the accuracy of the content of the application.**

**UHC’s evidentiary standards and sources that define and/or trigger the identification of the factor:**

- Submission of application

This evidentiary standard and source applies to both M/S and MH/SUD INN providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans. This evidentiary standard and source is defined in a qualitative manner.

**Factor – UHC verifies certain information, i.e., primary source verification, in the application**

**UHC’s evidentiary standards and sources that define and/or trigger the identification of the factor:**

- The UHC and UBH Credentialing Plans describe the information, i.e., primary source verification, which is required

This evidentiary standard and source applies to both M/S and MH/SUD INN providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans. This evidentiary standard and source is defined in a qualitative manner.

**Factor – The provider or facility continues to meet the applicable requirements set forth in the Credentialing Plan while they are contracted with UHC.**

**UHC’s evidentiary standards and sources that define and/or trigger the identification of the factor:**

- State and federal regulatory requirements
- National accreditation standards, for example NCQA credentialing standard

These evidentiary standards and sources apply to both M/S and MH/SUD INN providers and facilities providing covered services in the Inpatient, Outpatient, and Emergency Care classifications as described in the credentialing plans. These evidentiary standards and sources are defined in a qualitative manner.

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

## Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

*FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.*

## Step 5 – Findings and Conclusions

*FAQ 45: A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.*

### Findings

The above analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine if a MH/SUD provider or facility meets credentialing or recredentialing standards were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine if a M/S provider or facility meets credentialing or recredentialing standards, both “as written” and “in operation.”

UHC's findings of the parity analysis revealed the *UBH Credentialing Plan* for MH/SUD network providers was comparable to, and applied no more stringently than, the *UHC Credentialing Plan* for M/S network providers. The parity analysis also revealed that credentialing application requirements for MH/SUD network providers are comparable to, and applied no more stringently than, the application requirements for M/S network providers.

In addition, the findings revealed there were no significant disparate outcomes for MH/SUD providers as compared to M/S providers.

Lastly, the amount of time it takes to complete initial credentialing for both M/S and MH/SUD providers and facilities was comparable and both M/S and MH/SUD meet applicable State and Federal requirements.

### Conclusions

In light of the above findings, the Plan concludes that the credentialing requirements for M/S and MH/SUD providers and facilities are comparable and applied no more stringently for MH/SUD than for M/S, both "as written" and "in operation.”

## In-Network Facility Reimbursement Non-Quantitative Treatment Limitation (NQTL) Analysis

Golden Rule Insurance

12/01/2023

### Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits, and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements – such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs – which may limit the scope or duration of benefits for treatment under a plan or coverage

In regards to the NQTL analysis below, the Plan Golden Rule Insurance Company (GRIC), as an affiliate entity under United Healthcare (UHC) E&I, adopts and implements policies and procedures that track those implemented by UHC. Thereby, the Plan accepts the UHC identified services to which the NQTL applies (step 1). The Plan also accepts UHC’s identified factors used to determine whether the NQTL applies (step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (step 4), and sets forth findings and conclusions, both “as written” and “in operation” (step 5).

### Specific NQTL

In-Network (INN) provider reimbursement is the process by which UHC establishes reimbursement for INN facility-based services.

This document includes the following information:

- UHC’s Process for negotiating reimbursement models and rates for in-network (INN) facility-based services for both M/S and MH/SUD providers
- Description of the NQTL and application (Step 1)
- Factors used by UHC to negotiate reimbursement models and rates INN facility-based services for both M/S and MH/SUD providers (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis conducted by UHC (Step 4)
- Findings and conclusions as determined by UHC and accepted by the Plan (Step 5)

### This comparative analysis refers to the following attachments:

- *Certificate of Coverage (GA\_COC\_TI GEN 25 EXD)* - Plan document that explains covered services, terms, conditions, and limitations of the member’s policy

### Process

#### Negotiation

For both M/S and MH/SUD facilities, UHC on behalf of the Plan uses a substantially similar process to negotiate and establish reimbursement rates for INN facility services. UHC delegates negotiation of reimbursement rates for MH/SUD facility providers to United Behavioral Health d/b/a Optum Behavioral Health (OBH), it’s delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor.

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Key steps in the INN facility reimbursement negotiation process for both M/S and MH/SUD services include:

- The facility submits a completed application to UHC to be included in UHC's Network, which the Plan leverages for its members.
- UHC reviews the facility reimbursement proposal
- Based on the above, UHC accepts the reimbursement proposal or negotiates reimbursement rates with the facility using the factors described

Detailed process for the INN facility reimbursement negotiation:

Facilities newly seeking to join UHC's provider network submit a reimbursement proposal to UHC. UHC may either accept the facility's proposal or may negotiate reimbursement rates with the facility. Existing market rates are used as the baseline for negotiating rates. For MH/SUD providers, the Plan prepares an analysis of market dynamics that the Plan contracting team may access to inform negotiations. For M/S services, the Plan may document the market dynamic factors that inform a provider-specific negotiation. The Plan does not apply defined formulae to establish base rates or standard fee schedules. Both M/S and MH/SUD facilities that participate in the Plan provider network may negotiate reimbursement adjustments upon contract renewal or changing market circumstances by submitting a reimbursement proposal to the Plan. The Plan may either accept the facility's proposal or may negotiate reimbursement rates with the facility.

For facilities already in the network, the existing facility contract rates are used as the contract negotiation baseline. The Plan may take market dynamics into consideration when negotiating reimbursement rates with facilities. For MH/SUD providers, the Plan prepares an analysis of market dynamics that the Plan contracting team may access to inform negotiations. For M/S services, the Plan may document the market dynamic factors that inform a provider-specific negotiation. The Plan does not apply defined formulae to establish base rates or standard fee schedules.

**Inpatient M/S – General Acute Care, Children's, and Long-Term Acute Care Facilities**

The Plan contracts for inpatient M/S services using one of four key inpatient reimbursement methodologies: MS-Diagnosis Related Group (DRG), Per Case, Per Diem, and Percentage Payment Rate (PPR). While these methodologies provide a starting point, the rate categories, rate category definitions, and rate types can be modified based on negotiations with facilities.

In addition, a given contract will often feature a combination of inpatient reimbursement methodologies. For example, within a Per Diem contract, it's not uncommon for cases associated with a defined list of cardiac and/or musculoskeletal MS-DRGs to be reimbursed on a per-case basis, while all other M/S cases are reimbursed on a per diem basis.

The following provides an overview of the inpatient reimbursement methodologies used by the Plan:

- MS-DRG – The facility is paid using a single, negotiated base rate. The base rate is multiplied by the Centers for Medicare & Medicaid Services (CMS) MS-DRG relative weight for the MS-DRG assigned to the case. Contracts are written to use the current version of the MS-DRGs and relative weights



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- **Per Case** – The facility is paid using negotiated M/S case rates. The per case rate is paid for the entire case, regardless of the MS-DRG assigned to the case or the length of stay. There may be separate per case rates for medical cases versus surgical cases. This reimbursement method is rarely used for M/S cases; it's more likely to be used for specific types of cases "carved out" from M/S per diem rates. Examples of services that may be carved out include high-cost drugs, implants, obstetrics, NICU, and outliers
- **Per Diem** – The facility is paid using negotiated M/S per diem rates. The per diem rate is multiplied by the number of days corresponding to the per diem type. There may be separate per diem rates for medical cases versus surgical cases
- **PPR** – The facility is paid a percentage of charges. The PPR rate is multiplied by the eligible charges for the case

In addition, M/S agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics.

**Inpatient MH/SUD – Inpatient and Residential**

The Plan contracts for inpatient MH/SUD services using the following methodology:

- **Per Diem** – The facility is paid using negotiated MH/SUD per diem rates. The per diem rate is multiplied by the number of days corresponding to the per diem type

In addition, MH/SUD agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics.

**Outpatient M/S – General Acute Care, Children's, and Long-Term Acute Care Facilities**

The Plan contracts for outpatient M/S facility services using standardized reimbursement templates, each of which is organized around one of five key outpatient reimbursement methodologies: Ambulatory Payment Classifications (APC), Per Case, Per Visit, Per Unit, and PPR. While these templates provide a starting point, the rate categories, rate category definitions, and rate types reflected in the templates can be modified based on negotiations with providers.

In addition, a given contract will often feature a combination of outpatient reimbursement methodologies. For example, within a fixed outpatient contract, services may be subject to Per Case, Per Visit, and Per Unit reimbursement. At the same time, contract variations would allow any or all services to be subject to PPR reimbursement. It is also possible for a single outpatient claim (except for claims paid on a Per Case basis) to be paid using more than one of these reimbursement methodologies. For example, some services on a given claim may be subject to Per Visit reimbursement, while other services may be subject to Per Unit reimbursement.

The following provides an overview of the outpatient reimbursement methodologies used:



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- **APC** – The facility is paid using a single, negotiated APC conversion factor for services subject to such reimbursement under the Medicare outpatient prospective payment system (OPPS). The conversion factor is multiplied by the relative weights for the APCs assigned to the case by the OPPS pricing software. Services not subject to APC payment are paid using facility fee schedules (see Per Unit below). Contracts are written to use the current version of the APCs and relative weights
- **Per Case** – The facility is paid using negotiated per case rates for certain types of outpatient cases, including outpatient surgery, observation, emergency room, and urgent care. All services provided during the encounter are included in the per case payment and are not separately reimbursable
- **Per Visit** – The facility is paid using negotiated per visit rates for certain types of outpatient services. The per visit rate is multiplied by the number of visits billed on a given claim. If a given claim spans multiple dates of service, then the visits on each of the separate days are reimbursable. Examples of services that may be subject to Per Visit reimbursement include, IV therapy, oncology treatment, and dialysis
- **Per Unit** – The facility paid is using a negotiated facility fee schedule for certain types of outpatient services, including laboratory, pathology, and radiology. The per unit rate is multiplied by the number of units billed for a given Current Procedural Technology® (CPT), or Healthcare Common Procedure Coding System (HCPCS) code on a given claim. Facility fee schedules are generally based on a percentage of the CMS rate
- **PPR** – The facility is paid a percentage of charges. The PPR rate is multiplied by the eligible charges for the case

M/S agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics.

**Outpatient MH/SUD – Intensive Outpatient Programs and Partial Hospitalization Programs**

The Plan contracts for outpatient MH/SUD facility services are negotiated and mutually agreed upon with the facility. The starting point is usually a proposal from the engaged facility. The Plan will use other available information including market dynamics and CMS guidelines (when available) as benchmarks to support its negotiation position.

The Plan contracts for MH/SUD services using the following methodology:

- **Per Diem** – The facility is paid using negotiated MH/SUD per diem rates

In addition, MH/SUD agreements may include negotiated escalators or deflators, which automatically increase or modify rates for subsequent contract years. The escalators or deflators may also be based on quality and efficiency metrics.

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### **Ongoing Monitoring**

UHC convenes ongoing working groups that include representatives from both the M/S and MH/SUD network strategy and pricing teams to align business processes and ensure adherence to as-written standards and comparability in operation.

## **Step 1 – NQTL and Application**

*FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.*

### **Specific NQTL**

- **INN Facility Reimbursement**

### **Benefit Classification(s)**

Facility based, INN

### **Plan(s) at Issue**

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### **Plan Terms/Source Document(s)**

- *What Is UHC's Relationship with Providers and Groups?*  
*UHC has agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with UHC to provide Covered Health Care Services to "Covered Persons."*

### **List of M/S and MH/SUD Services Subject to NQTL**

- INN acute inpatient
- INN subacute inpatient
- INN facility-based outpatient services

## **Step 2 – Factors Used to Determine In-Network Provider Reimbursement Models and Rates**

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/ SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*

UHC relies on the following factors to establish reimbursement rates for M/S and MH/SUD facilities.

For new Facilities joining the UHC Network, existing market rates are used as the baseline for negotiating rates. For Facilities already in the UHC Network, the existing Facility contract rates are used as the contract negotiation baseline.

The factors are:

- **Facility assessment (Qualitative)**
  - Facility's licensure, certification, and/or accreditation (e.g., acute care facility; subacute care

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facility; ancillary facility, etc.)

- **Services and diagnoses/conditions the facility purports to offers (Quantitative)**
- **Market dynamics (Quantitative and Qualitative)**
  - Facility leverages within a given geographic market
  - Network need
  - Facility member volume
  - Facility proposed rate relative to market pricing
    - Market Target Rates
    - Market Prevailing Rates
  - Availability of industry standard value-based reimbursement models

The factors apply to both M/S and MH/SUD services. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

### Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.*

Below are the sources and evidentiary standards used by UHC to define, trigger, and/or implicate the three factors used in designing or applying UHC's reimbursement models and rates to M/S and MH/SUD facilities:

#### Factor – Facility assessment

- **UHC's evidentiary standards and sources that define and/or trigger the identification of the factor:**
  - Facility's licensure
  - Certification
  - Accreditation

This evidentiary standards and sources apply to both M/S and MH/SUD INN facility reimbursement and are defined in a qualitative manner.

#### Factor – Services and diagnoses/conditions the facility purports to offer or treat

- The Plan's evidentiary standard and source that triggers and/or defines the services and diagnoses/conditions the facility purports to offer or treat factor:
  - Most current version of industry standard code sets, e.g., revenue, MS-DRG (derived by International Classification of Diseases (ICD)/Diagnostic and Statics Manual (DSM), CPT, HCPCS, etc.

This evidentiary standards and sources apply to both M/S and MH/SUD INN facility reimbursement and are defined in a quantitative manner.

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**Factor – Market dynamics**

- UHC’s evidentiary standards and sources that define and/or trigger the market dynamics factor:
  - Facility leverage: facilities associated with large health systems within a given geographic market generally have more leverage
    - Internal research
  - Network need: supply and demand for a facility service is evaluated by looking at the volume of facilities with the same or similar programs and/or services within the relevant geographic region relative to the Plan’s membership and its network access and/or availability standards
    - Facility directory, state Geographic Access reports and member reported access data
  - Facility member volume: measured by looking at the volume of members treated by the facility, and/or volume of services billed by the facility in a given year relative to the same or similar program types in the same geographic market during the same timeframe
    - Internal claims data
  - Facility proposed rate relative to market pricing, targeted and prevailing rates: internally derived average market pricing based upon available data including internal claims data, state published rates, CMS Prospective Payment System (PPS)
    - Applicable CMS PPS, MS-DRG, state rate, and internal claims data
  - Availability of industry standard and proprietary value-based reimbursement models: value-based programs that reward health care providers with incentive payments for the quality of care they deliver
    - CMS value-based programs
    - Internally developed value-based programs

These evidentiary standards and sources are not specific to M/S or MH/SUD services. In addition, all of these standards are considered and used to define the factors.

The factors and evidentiary standards used as the basis for establishing UHC’s MH/SUD INN facility reimbursement rates are comparable to, and applied no more stringently than, the factors used as the basis for negotiating and establishing UHC’s M/S INN facility reimbursement rates “as written” and “in operation.” The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

**Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis**

*FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the plan’s or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both.*

UHC on behalf of the Plan, convenes ongoing working groups that include representatives from both the M/S and MH/SUD network strategy and pricing teams to align business processes and ensure

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adherence to as-written standards and comparability in operation

**As Written**

UHC on behalf of the Plan, compared the strategies, processes, factors, evidentiary standards, and source information used to negotiate and establish INN facility reimbursement “as written.”

UHC identified the shared factors and evidentiary standards used as the basis for determining offered reimbursement rates to M/S and MH/SUD facilities. The factors and evidentiary standards are applied to both M/S and MH/SUD facilities comparably and not more stringently to MH/SUD facilities.

**Review of processes by which INN facility reimbursement is established**

Both M/S and MH/SUD INN facility reimbursements are established through mutually negotiated rates based on facility assessment, services or programs provided, and market dynamics including facility leverage, network need, facility member volume, facility proposed rate relative to market pricing and/or availability of industry standard, and proprietary value-based reimbursement models.

**In Operation**

UHC compared the methodologies and processes used to negotiate and establish MH/SUD INN facility reimbursement to assess whether the methodologies and processes are comparable to, and applied no more stringently than, the methodologies and processes used to negotiate and establish reimbursement for M/S INN facility-based services “in operation.”

Given the variety of reimbursement methodologies used for inpatient M/S services, there is no meaning basis for a comparative analysis with MH/SUD. Although the median rates for MH/SUD and M/S facility outpatient rates differ, both M/S and MH/SUD INN outpatient facility reimbursements are established through mutually negotiated rates based on facility type, services or programs provided, market dynamics including facility leverage, network need, facility member volume, facility proposed rate relative to market pricing and/or availability of industry standard and proprietary value-based reimbursement models.

**Step 5 – Findings and Conclusions**

*FAQ 45: A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.*

**Findings**

Per the Plan's acceptance of UHC reported analysis of the strategies and processes by which INN facility reimbursement is established including, what services or programs are provided, what market dynamics may influence negotiation including facility leverage, supply and demand, facility volume, and/or proposed rates relative to market pricing.

The findings of that analysis reported by UHC and accepted by the plan, confirmed the strategies, processes, factors, evidentiary standards, and source information used to determine and negotiate reimbursements for MH/SUD INN facility services and/or programs were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to determine and negotiate facility reimbursement for M/S INN facility services and/or programs “as written.”

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As accepted by The Plan and as determined by UHC, that M/S facility-based services are reimbursed under a variety of different reimbursement models, including MS-DRG, case rates, per diem rates, and value-based models. Current industry norms for MH/SUD facility-based services are more narrowly limited to per diem reimbursement model only.

Based on the key distinction in the variety of industry standard reimbursement models available for M/S facility-based services as compared to a dominant model, per diem reimbursement for MH/SUD facility-based reimbursement, a statistically valid comparability of M/S and MH/SUD facility-based reimbursement models or rates could not be completed. The Plan continues to rely on reports of collaborative efforts with UHC and MH/SUD facility-based providers to explore development of value-based reimbursement models.

The Plan as apprised by reports from UHC has accepted the UHC determinations that the process and models used to determine and negotiate MS/SUD facility rates were comparable to, and applied no more stringently than, the processes and models used to negotiate M/S facility rates “in-operation.”

**Conclusions**

Based upon these findings from UHC, the Plan accepts the conclusions issued, that the INN facility reimbursement strategy for MH/SUD was comparable to, and applied no more stringently than, the INN facility reimbursement strategy for M/S “as written.”

Additionally, the Plan accepts the UHC conclusions that the factors, evidentiary standards, and source information used to determine and negotiate MH/SUD INN facility reimbursement were comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to negotiate M/S INN facility reimbursement “in operation.”

**In-Network Professional Services Reimbursement Non-Quantitative Treatment Limitation (NQTL) Analysis**

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**Overview**

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits, and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations applied to MH/SUD benefits cannot be more restrictive than the financial requirements and non-quantitative treatment limitations applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements – such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- Non-quantitative treatment limitations – which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan Golden Rule Insurance Company (GRIC), as an affiliate entity under United Healthcare (UHC) E&I, adopts and implements policies and procedures that track those implemented by UHC. Thereby, the Plan accepts the UHC identified services to which the NQTL applies (step 1). The Plan also accepts UHC’s identified factors used to determine whether the NQTL applies (step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (step 4), and sets forth findings and conclusions, both “as written” and “in operation” (step 5).

**Specific NQTL**

INN provider reimbursement is the process by which the Plan adopts and leverages UHC’s established reimbursement for INN professional services.

This document includes the following information:

- UHC’s process for negotiating reimbursement methodologies and rates for in-network (INN) professional services for both M/S and MH/SUD providers
- Description of the NQTL and application (Step 1)
- Factors used by UHC to negotiate reimbursement methodologies and rates for INN professional services for both M/S and MH/SUD providers (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis conducted by UHC (Step 4)
- Findings and conclusions as determined by UHC and accepted by the Plan (Step 5)

**This comparative analysis refers to the following attachments:**

- *Certificate of Coverage (GA\_COC\_TI GEN 25 EXD)* - Plan document that explains covered services, terms, conditions, and limitations of the member’s policy

UHC concludes and the Plan accepts determinates thereby, that its INN reimbursement methodologies for M/S and MH/SUD are comparable and applied no more stringently for MH/SUD providers than for M/S providers both “as

**In-Network Professional Services Reimbursement Non-Quantitative Treatment Limitation (NQTL) Analysis**

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written” and “in operation.”

**Process****Step 1 – NQTL and Application**

*FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.*

**Specific NQTL**

INN Professional Provider Reimbursement

**Benefit Classification(s)**

INN, Professional services,

**Plan(s) at Issue**

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**Plan Terms/Source Document(s)**

*What Is UHC’s Relationship with Providers and Groups?*

*UHC has agreements in place that govern the relationship between us, our Groups and Network providers, some of which are affiliated providers. Network providers enter into agreements with us to provide Covered Health Care Services to “Covered Persons.”*

**Step 2 – Factors Used to Determine In-Network Provider Reimbursement Rates**

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*

**Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor**

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.*



**In-Network Professional Services Reimbursement Non-Quantitative Treatment Limitation (NQTL) Analysis**

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**Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis**

*FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.*

UHC convenes ongoing workgroups that include representatives from both the M/S and MH/SUD network strategy and pricing teams to align business processes and ensure adherence to as-written standards and comparability in operation.

**Step 5 – Findings and Conclusions**

*FAQ 45: A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.*

**Medical Necessity Non-Quantitative Treatment Limitation (NQTL) Analysis**

Golden Rule Insurance  
12/01/2023

## Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits, and medical/surgical (M/S) benefits. This generally means that the financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements, such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan Golden Rule Insurance Company (GRIC), as an affiliate entity under United Healthcare (UHC) E&I, adopts and implements policies and procedures that track those implemented by UHC. The Plan identifies the services to which the NQTL applies (step 1). The Plan also identifies the factors used to determine whether the NQTL applies (step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (step 4), and sets forth findings and conclusions, both “as written” and “in operation” (step 5).

### Specific NQTL

The Plan makes medical necessity determinations using objective, evidence-based, medical/ clinical policies and clinical criteria to guide care reviews (aka medical necessity criteria). Application of clinical review criteria is integral to the utilization management (UM) processes of a clinical coverage review. The Plan develops evidence-based, clinical criteria and uses clinical criteria from third-party sources such as InterQual®, MCG®, American Society of Addiction Medicine (ASAM), Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines. Only ASAM Criteria® are used to make substance use disorder (SUD) medical necessity coverage determinations, unless otherwise mandated by state law or contract.

This document includes the following information:

- Process for developing and approving of medical necessity criteria for both M/S and MH/SUD services
- Description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

### This comparative analysis refers to the following attachments:

- *Certificate of Coverage (GA\_COC\_TI GEN 25 EXD)* - Plan document that explains covered services,

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- terms, conditions, and limitations of the member's policy
- *UHCLIC UMPD Program document*
- *C-UM-11.00 Clinical Decision Support Tools*

## Process

**The Plan adopts and leverages UHC's following standard process to develop and approve medical necessity coverage criteria:**

M/S: Golden Rule Insurance (GRI) adopts and leverages determinates from parent company United Healthcare's (UHC's) medical/clinical policy committees, which have been established and a standard process is followed. The Medical Technology Assessment Committee (MTAC) develops, assesses, and approves medical necessity criteria for M/S services. MTAC uses scientifically based clinical evidence in accordance with the *Hierarchy of Clinical Evidence* in its development, assessment, and approval of internally developed policies. MTAC reportedly conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective health services for M/S members' is comprised of but not limited to medical directors with diverse medical and surgical specialties and sub-specialties, representatives from business segments, legal services, medical policy development and operations teams, and other guests as required. The National Medical Care Management Committee (NMCMC) reviews and validates internally developed medical necessity coverage criteria endorsed by MTAC. MTAC reviews all internally developed medical clinical policies, as well as approves use of third-party externally developed clinical criteria at least annually.

MH/SUD: Golden Rule Insurance (GRI) adopts and leverages determinates from United Healthcare's (UHC's) medical/clinical policy committees, which have been established and a standard process is followed. CTAC is comprised of, but is not limited to, senior behavioral health medical directors, senior leaders of clinical operations and representatives from the clinical quality improvement department, utilization management, clinical operations, appeals, legal, compliance, network strategy, and provider experience. The Clinical Quality and Operations Committee (CQOC) validates internally developed medical necessity criteria and the CTAC review and appropriately approves internally developed medical necessity coverage criteria, as well as approves use of third-party externally developed clinical criteria.

All MH/SUD and M/S clinical policies are reviewed by UHC and made available to the Plan, at least annually or more frequently if appropriate.

## Step 1 – NQTL and Application

*FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.*

**Specific NQTL**

- Medical Necessity

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**Benefit Classification(s):** In-Network (INN) Inpatient, Out-of-Network (OON) Inpatient, INN Outpatient, and OON Outpatient

**Plan(s) at Issue:**

- Golden Rule Insurance

**Plan Terms/Source Document(s)**

- Medically Necessary- “medically necessary” means a treatment, test, procedure or confinement that is necessary and appropriate for the diagnosis or treatment of an illness or injury. This determination will be made by us based on our consultation with an appropriate medical professional. A treatment, test, procedure or confinement will not be considered medically necessary if: (A) it is provided only as a convenience to the covered person or provider; (B) it is not appropriate for the covered person’s diagnosis or symptoms; (C) it exceeds (in scope, duration, or intensity) that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment to the covered person. The fact that any particular doctor may prescribe, order, recommend, or approve a treatment, test, procedure or confinement does not, of itself, make the treatment, test, procedure or confinement medically necessary.

- *Generally Accepted Standards of Care* are evidence based independent standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties. Valid, evidence-based sources reflecting generally accepted standards of care include credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

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

UHC develops and maintains clinical policies that describe the *Generally Accepted Standards of Care* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through the telephone number on your ID card. They are also available to Physicians and other health care professionals on UHCprovider.com.

**List of M/S and MH/SUD Services and Technologies Subject to NQTL**

- All M/S and MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM.

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**Step 2 – Factors Used to Develop and Approve Medical and Behavioral Clinical Policies**

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/ SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*

The Plan relies upon UHC and leverages its determinates on the following factor to develop and approve medical necessity criteria. This factor applies to both M/S and MH/SUD benefits for the following:

- I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM
- II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM

**• M/S and MH/SUD Committee Considerations (Qualitative)**

This factor applies to M/S and MH/SUD services and technologies.

**Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor**

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.*

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in developing or approving medical necessity criteria. These evidentiary standards and sources apply for the following:

- I. All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM
- II. All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM

**Factor – M/S and MH/SUD Committee Considerations,**

These evidentiary standards and sources apply to M/S and MH/SUD services and technologies and are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for developing and approving MH/SUD medical necessity criteria are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for developing and approving M/S medical necessity criteria “as written” and “in operation.”

**Medical Necessity Non-Quantitative Treatment Limitation (NQTL) Analysis**

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**Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis**

*FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.*

**Step 5 – Findings and Conclusions**

*FAQ 45: A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.*

**Findings**

The findings of the comparative analyses confirmed the strategies, processes, factor, evidentiary standards, and source information used to develop MH/SUD medical necessity criteria, clinical policies and review externally developed criteria were comparable to, and applied no more stringently than, the strategies, processes, factor, evidentiary standards, and source information used to develop the M/S medical necessity criteria and medical clinical policies and review externally developed criteria “as written” and “in operation.”

The MH/SUD policies, procedures, and processes were found to be comparable and no more stringent than M/S policies, procedures, and processes.

Comparable processes and methodologies are identified to assess and develop internal medical/clinical policies and externally developed medical necessity criteria.

M/S and MH/SUD clinical reviewers follow the same established process of reviewing state/federal laws and regulations, followed by Plan documents when making clinical coverage benefit determinations.

The Plan's Medical Necessity definitions for M/S and MH/SUD are the same, as published in the Plan documents. Additionally, both M/S and MH/SUD clinical reviewers follow the established process of reviewing state/federal laws and regulations, followed by Plan documents and then medical/clinical policies when making clinical coverage benefit determinations.

**Conclusions**

The Plan concluded the methodologies used to develop MH/SUD internal evidence-based medical/clinical policies and approve MH/SUD externally developed medical necessity criteria for use in medical necessity clinical coverage benefit determinations were comparable to, and applied no more stringently than, the methodologies used to develop M/S internal evidence-based medical clinical policies and approve M/S externally developed medical necessity criteria for use in medical necessity clinical coverage benefit determinations both “as written” and “in operation.”

**Medical Necessity Non-Quantitative Treatment Limitation (NQTL) Analysis**

Golden Rule Insurance

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**Network Management – Network Adequacy Non-Quantitative Treatment Limitation (NQTL) Analysis**

12/01/2023

**Overview**

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan Golden Rule Insurance Company (GRIC), as an affiliate entity under United Healthcare (UHC) E&I, adopts and implements policies and procedures that track those implemented by UHC. Thereby, the Plan GRIC accepts all UHC’s identified services to which the NQTL applies (step 1). The Plan also identifies the factors considered in the design or application of the NQTL (step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (step 4), and sets forth findings and conclusions, both “as written” and “in operation” (step 5).

**Specific NQTLs**

UHC on behalf of the Plan assesses the adequacy of UHC networks based on regulatory requirements.

This document includes the following information:

- Process for both M/S and MH/SUD Network Management – Network Adequacy
- Description of the NQTL and application (Step 1)
- Factors used to facilitate Network Management – Network Adequacy for both M/S and MH/SUD (Step 2)
- Evidentiary standards and sources used to define and/or trigger each of the identified factors (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

As accepted by the Plan, UHC concludes M/S and MH/SUD Network Management – Network Adequacy processes are comparable and applied to MH/SUD no more stringently both “as written” and “in operation.”

**Process**

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

Key steps in the network management process for both M/S and MH/SUD services include:

- UHC determines Time, Distance, and Provider Threshold requirements based on state/federal requirements
- UHC conducts M/S and MH/SUD network adequacy reporting (by state/county) to determine if Time, Distance, and Provider Threshold requirements are met
- If network adequacy requirements are not met, UHC actively seeks to add providers to the network in that specialty or provider type



**Network Management – Network Adequacy Non-Quantitative Treatment Limitation (NQTL) Analysis**

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For M/S and MH/SUD, UHC conducts M/S and MH/SUD network adequacy reporting (by state/county) on a regular basis (no less than quarterly) to determine if Time, Distance, and Provider Threshold requirements are met. The network adequacy report incorporates both M/S and MH/SUD provider specialties. M/S and MH/SUD utilize the network adequacy report and ensure that the Network Variation Tracker (NVT) and Analytics tools are used when inconsistencies are identified.

For M/S, the results of the network adequacy report are sent to the UnitedHealthcare Network (UHN) Regional Director of Network Deficiencies through an NVT. If network gaps are identified, a network recruitment plan is developed by the M/S Provider Relations and Contracting teams.

For MH/SUD, the results of the network adequacy report are sent to the National Quality Improvement Committees (NQIC) as well as the respective Health Plan Oversight Committee through the NVT. The Health Plan Oversight Committee assesses and reviews the results and recommends interventions, as needed. If a network gap is identified, a network recruitment plan is developed by the MH/SUD Provider Relations and Contracting teams.

If there is a supply gap, the Plan language for both M/S and MH/SUD allows members to seek an exception and receive services from an out-of-network (OON) provider at the in-network (INN) benefit level. The Plan will work with the Member's network provider to coordinate care through an OON provider.

UHC on behalf of the Plan, notes that MH/SUD network adequacy standards are reviewed during the product filing and/or annual reporting process by the regulator as applicable.

**Step 1 – NQTL and Application**

*FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.*

**Specific NQTL**

- Network Management – Network Adequacy

**Benefit Classification(s)**

Applies to all INN, inpatient and outpatient services

**Plan(s) at Issue**

- Golden Rule Insurance

**Plan Terms/Source Document(s)**

United Healthcare networks consist of a variety of primary care and behavioral professionals, specialists, hospitals, and other facilities. To help provide members with reasonable access to providers who meet their needs, the UHN network team in conjunction with UHC partners who oversight need, look at the number of providers and the types of services offered within a geographic area. Additionally, various associated team may outreach providers as needed to recruit them into network status to fill any identified gaps if applicable. The UHN team also accepts requests from plan members, employers, and providers to join the network in good faith efforts to meet needs where available. UHC also accept requests from employers, members, and providers to accommodate needs and preferences.” (<https://www.uhc.com/legal/provider/commercial-plans>)

**List of M/S and MH/SUD Benefits Subject to NQTL**

Applies to all INN M/S and MH/SUD services

## Network Management – Network Adequacy Non-Quantitative Treatment Limitation (NQTL) Analysis

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### Step 2 – Factors Used in the Design and Application of the NQTLs

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*

UHC relies on several factors to assess the adequacy of its network. These factors apply to both MH/SUD benefits and M/S benefits in the following classifications:

- I. M/S INN inpatient/outpatient services
- II. MH/SUD INN inpatient/outpatient services

- **State-specific standards (Quantitative)**

Applies to both M/S and MH/SUD services.

- **Centers for Medicare & Medicaid Services (CMS)/Health Services Delivery (HSD) table (Quantitative)**

Applies to both M/S and MH/SUD services.

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

### Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.*

Below are the sources and evidentiary standards used to define, trigger, and/or implicate the factors used in determining adequacy of network. These evidentiary standards and sources apply to the following benefit classifications:

- I. M/S INN inpatient/outpatient services
- II. MH/SUD INN inpatient/outpatient services

#### **Factor – State-specific standards**

These evidentiary standards and sources apply to both M/S and MH/SUD INN inpatient/outpatient services. This evidentiary standard and source is defined in a quantitative manner.

#### **Factor – Centers for Medicare & Medicaid Services (CMS)/Health Services Delivery (HSD) table**

These evidentiary standards and sources apply to both M/S and MH/SUD INN inpatient/outpatient services. This evidentiary standard and source is defined in a quantitative manner.

These evidentiary standards and sources are applicable to both M/S and MH/SUD services. In addition, all of these standards/sourced are considered and used to define the factors.

### Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

*FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting*

**Network Management – Network Adequacy Non-Quantitative Treatment Limitation (NQTL) Analysis**

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*recommendations regarding both.***Step 5 – Findings and Conclusions**

*FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.*

**Findings**

The above UHC 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 strategies, processes, factors, evidentiary standards, and source information used to determine M/S network adequacy “as written.”

UHC for 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 the same process in place to authorize benefit coverage at the INN benefit level for services provided by an OON provider if a supply gap is identified. When a supply gap is identified, UHC will work with the Members network provider to coordinate care through an OON provider.

In addition, the above 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.

**Conclusions**

In light of the above findings, UHC on behalf of the Plan concluded the M/S and MH/SUD Network Management – Network Adequacy processes are applied to M/S and MH/SUD networks comparably and are applied no more stringently to MH/SUD both “as written” and “in operation.”

**Out-of-Network Reimbursement: Out-of-Network Emergency Care Non-Quantitative Treatment Limitations Analysis**  
Golden Rule Insurance  
12/01/2023

## Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits, and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements – such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs – which may limit the scope or duration of benefits for treatment under a plan or coverage

In regards to the NQTL analysis below, the Plan Golden Rule Insurance Company (GRIC), as an affiliate entity under United Healthcare (UHC) E&I, adopts and implements policies and procedures that track those implemented by UHC. hereby, the Plan accepts the identified services to which the NQTL applies (step 1). The Plan also accepts and adopts as UHC identifies, the factors used to determine whether the NQTL applies (step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (step 4), and sets forth findings and conclusions, both “as written” and “in operation” (step 5).

### Specific NQTL

Out-of-Network (OON) Emergency reimbursement is the process by which UHC establishes reimbursement for OON emergency claims and the Plan adopts and leverages these determinates of parent company UHC as applicable to the defined member plan documents.

This document includes the following information:

- OON emergency care reimbursement process for both M/S and MH/SUD services
- The description of the NQTL and application (Step 1)
- Factors UHC used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources UHC used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis conducted by UHC (Step 4)
- Findings and conclusions as determined by UHC and accepted by the Plan (Step 5)

### This comparative analysis refers to the following attachments:

- *Certificate of Coverage (GA\_COC\_TI GEN 25 EXD)* - Plan document that explains covered services, terms, conditions, and limitations of the member’s policy

UHC concludes and the Plan accepts the assertion, that the Out-of-Network Emergency reimbursement requirements for M/S and MH/SUD services are comparable and applied no more stringently both “as written” and “in operation.”

**Out-of-Network Reimbursement: Out-of-Network Emergency Care Non-Quantitative Treatment Limitations Analysis**  
Golden Rule Insurance  
12/01/2023

## Process

For both M/S and MH/SUD emergency care services, UHC on behalf of the Plan uses a comparable process to establish reimbursement rate(s).

### Step 1 – NQTL and Application

*FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.*

#### Specific NQTL

- OON Emergency Care Reimbursement

#### Benefit Classification(s)

- Out-of-Network, Emergency Care

#### Plan(s) at Issue

- Golden Rule Insurance

#### Plan Terms

- The Plan's *Certificate of Coverage* defines emergency health care services as:
  - The term "emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
    1. Placing the health of the covered person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
    2. Serious impairment to bodily functions; or
    3. Serious dysfunction of any bodily organ or part.

#### List of M/S and MH/SUD Services Subject to NQTL

- OON facility and professional emergency services for the treatment of M/S and MH/SUD conditions
- OON professional services provided in network facilities

### Step 2 – Factors Used in the Design and Application of the NQTLs

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH or SUD benefits and medical or surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of*

**Out-of-Network Reimbursement: Out-of-Network Emergency Care Non-Quantitative Treatment  
Limitations Analysis  
Golden Rule Insurance  
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*any specific data used in the determination.*

### **Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor**

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.*

### **Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis**

*FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the plan’s or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both.*

### **Step 5 – Findings and Conclusions**

*FAQ 45: A reasoned discussion of the plan’s or issuer’s findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.*

**Out-of-Network Reimbursement: Out-of-Network Inpatient and Outpatient Services  
Nonquantitative Treatment Limitations Analysis**

Golden Rule Insurance  
12/01/2023

## Overview

Pursuant to a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan Golden Rule Insurance Company (GRIC), as an affiliate entity under United Healthcare (UHC) E&I, adopts and implements policies and procedures that track those implemented by UHC. Thereby, the Plan accepts the identified services to which the NQTL applies (step 1). The Plan also accepts UHC’s identified factors used to determine whether the NQTL applies (step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (step 4), and sets forth findings and conclusions, both “as written” and “in operation” (step 5).

### Specific NQTL

Out-of-network (OON) inpatient and outpatient reimbursement is the process by which UHC establishes reimbursement for OON inpatient and outpatient claims as defined in the member’s plan documents, and the Plan adopts and leverages these determinates of parent company UHC as applicable.

This document includes the following information:

- OON inpatient and outpatient services reimbursement process for both M/S and MH/SUD services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis conducted by UHC (Step 4)
- Findings and conclusions as determined by UHC and accepted by the Plan (Step 5)

### This comparative analysis refers to the following attachments:

- *Certificate of Coverage (GA\_COC\_TI GEN 25 EXD)* - Plan document that explains covered services, terms, conditions, and limitations of the member’s policy

UHC concludes, and the Plan accepts the assertion that the OON inpatient and outpatient reimbursement process for M/S and MH/SUD services are comparable and applied no more stringently both “as written” and “in operation.”

## **Out-of-Network Reimbursement: Out-of-Network Inpatient and Outpatient Services Nonquantitative Treatment Limitations Analysis**

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### **Process**

#### **Step 1 – NQTL and Application**

*FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.*

##### **Specific NQTL**

- OON reimbursement: Inpatient and outpatient services

##### **Benefit Classification(s)**

- OON, inpatient and outpatient

##### **Plan(s) at Issue**

- Golden Rule Insurance

##### **Plan Terms**

- Out-of-Network Benefits apply to Covered Health Care Services that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility

##### **List of M/S and MH/SUD Services Subject to NQTL**

- OON inpatient and outpatient services

#### **Step 2 – Factors Used in the Design and Application of the NQTLs**

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*

#### **Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor**

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a*



## **Out-of-Network Reimbursement: Out-of-Network Inpatient and Outpatient Services Nonquantitative Treatment Limitations Analysis**

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*quantitative manner, it must include the precise definitions used and any supporting sources.*

### **Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis**

*FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.*

### **Step 5 – Findings and Conclusions**

*FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.*

#### **Findings**

The findings of the comparative analysis conducted by UHC and accepted by the Plan, revealed the process and methodology MH/SUD used to determine OON inpatient and outpatient reimbursement “as written” and “in operation” was comparable to, and applied no more stringently than, the process and methodology M/S used to determine OON inpatient and outpatient reimbursement.

#### **Conclusions**

Based upon these findings, the Plan accepts that the UHC conclusion of the methodology and processes that M/S and MH/SUD use to determine OON reimbursement was comparable “as written” and “in operation.”

## Prescription Drug List (PDL) a/k/a Formulary Design Non-Quantitative Treatment Limitation (NQTL) Analysis

Golden Rule Insurance

12/01/2023

### Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits must be comparable to and cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan Golden Rule Insurance Company (GRIC), as an affiliate entity under United Healthcare (UHC) E&I, adopts and implements policies and procedures that track those implemented by UHC. Thereby, the Plan GRIC accepts all UHC’s analysis and determinates as it relates to the below NQTL which identifies the services to which the NQTL applies (step 1). The Plan also accepts UHC’s identified factors used to determine whether the NQTL applies (step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (step 4), and sets forth findings and conclusions, both “as written” and “in operation” (step 5).

### Specific NQTL

Prescription Drug List (PDL) a/k/a formulary design is managed by Optum Rx, as an affiliate entity under United Healthcare (UHC). The goal of PDL/formulary design is to assess the prescription drug’s place in therapy.

This document includes the following information:

- PDL process for both M/S and MH/SUD prescription drugs
- The description of the NQTL and application (Step 1)
- Factors used to determine prescription drugs tier placement and/or benefit coverage (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis does not refer to any attachments.

UHC concludes and the Plan accepts, that the PDL/formulary design requirements for M/S and MH/SUD are comparable and applied no more stringently for prescription drug benefits both “as written” and “in operation.”

### 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 individuals from diverse clinical disciplines, including, behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs.

The Pharmacy & Therapeutics Committee consists of physicians specializing in Obstetrics & Gynecology, Endocrinology/Metabolism, Hematology/Oncology, Rheumatology, Geriatrics, Cardiology, Gastroenterology, Psychiatry,

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Pediatrics & Internal Medicine, and Internal Medicine. The committee also consists of 4 pharmacists, one of which specializes in Geriatrics & Psychiatry. There is a requirement that the committee consist of at least one physician specializing in psychiatry.

To approve clinical drug policies, the established committee follows a standard process. The P&T Committee evaluates the 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 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 clinical drug policies for select M/S and MH/SUD prescription drugs.

The UnitedHealthcare (UHC) Prescription Drug List Management Committee (PDL MC) makes tiering decisions by considering clinical, economic/financial and pharmacoeconomic evidence for populations with an incentive based PDL. The PDL MC makes benefit exclusion decisions using the same types of evidence. This information is provided by UHC Evidence Based Decision Support Committees, including but not limited to, the UHC P&T Committee as outlined above.

PDL a/k/a formulary design is based on UHC 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. A generic prescription drug includes a prescription drug that is chemically equivalent to a brand drug or that the Plan 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 several 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.

UHC on behalf of the Plan reviews the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis. The results are reviewed with the UM Committee to determine if any changes should be made in the PDL/formulary design.

## Step 1 – NQTL and Application

*FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.*

**Specific NQTL**

- PDL a/k/a Formulary Design

**Benefit Classification(s)**

- Prescription Drugs

**Plan(s) at Issue**

- Golden Rule Insurance

**Plan Terms**

- United Healthcare is the pharmacy benefit manager. United Healthcare uses OptumRx for certain pharmacy benefit services. Access online pharmacy services through our Resource Center at [www.myuhone.com](http://www.myuhone.com). You can find the link to our Prescription Drug List Reference Guide, a list of participating retail pharmacies, and details about medication cost.

**List of M/S and MH/SUD Services Subject to NQTL**

- All prescription drugs are part of UHC's PDL a/k/a formulary design

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- The PDLs 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 Tiers 3 and 4

**Step 2 – Factors Used to Determine Formulary Design Applies**

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*

UHC relies on the following factors to determine the PDL for both M/S and MH/SUD prescription drugs:

- **Assessment of the prescription drug's place in therapy (Qualitative)**

Applies to M/S and MH/SUD prescription drugs

- **Relative safety and efficacy (Qualitative)**

Applies to M/S and MH/SUD prescription drugs

- **Available therapeutic equivalent prescription drugs (Quantitative)**

Applies to M/S and MH/SUD prescription drugs

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. The factors apply to both M/S and MH/SUD prescription drugs.

**Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor**

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the Plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.*

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factors used in determining the PDL. These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs.

**Factor – Assessment of the prescription drug's place in therapy****Factor – Relative safety and efficacy**

- Evidentiary standard and source that defines and/or triggers the relative safety and efficacy factor:

**Factor – Available therapeutic equivalent prescription drugs**

- Evidentiary standard and source that defines and/or triggers the available therapeutic equivalent prescription drugs factor:

The factors and evidentiary standards used as the basis for determining the PDL for MH/SUD prescription drugs are comparable to, and applied no more stringently than, the factors used as the basis for determining the PDL for M/S prescription drugs “as written” and “in operation.” The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

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### Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

*FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.*

### Step 5 – Findings and Conclusions

*FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.*

#### Findings

The findings of the analysis revealed the strategies, processes, factors, evidentiary standards, and source information UHC used to administer the PDL a/k/a formulary design for MH/SUD prescription drugs were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to administer the PDL a/k/a formulary design for M/S prescription drugs “as written.”

Further, both M/S and MH/SUD utilize generally accepted types of data, evidentiary sources, and trend analyses to create and maintain the PDL/formulary design.

UHC on behalf of the Plan evaluates the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis.

The findings of the analysis revealed for all prescription drugs covered under the pharmacy benefit, UHC uses the same PDL MC to determine tier placement and/or benefit coverage. The Committee does not distinguish between M/S and MH/SUD prescription drugs, and the processes are administered in the same fashion and not applied more stringently to MH/SUD prescription drugs. The tiering for M/S and MH/SUD prescription drugs shows the majority are placed on Tiers 1 and 2 allowing for easier access and is in compliance with MHPAEA.

The findings of the Prescription Drug Tier Analysis (see data below) indicated the percent of prescription drugs by tiers for MH/SUD prescription drugs were comparable to the percent of prescription drugs by tiers for M/S prescription drugs. Data is for (January, May, and September 2022). UHC also notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

The following are results of each analysis in 2022:

- **January 2022 –**
  - 59.0% of MH/SUD drugs are on Tiers 1 and 2
  - 53.3% of M/S drugs are on Tiers 1 and 2
- **May 2022 –**
  - 57.9% of MH/SUD drugs are on Tiers 1 and 2
  - 52.9% of M/S drugs are on Tiers 1 and 2
- **September 2022 –**
  - 56.9% of MH/SUD drugs are on Tiers 1 and 2
  - 52.8% of M/S drugs are on Tiers 1 and 2

These evaluations were based on the Advantage PDL, which is the most commonly used PDL.

**Prescription Drug List (PDL) a/k/a Formulary Design Non-Quantitative Treatment Limitation (NQTL) Analysis**

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**Conclusions**

Based upon these findings, UHC concluded and the Plan accepts that the methodologies to administer the PDL a/k/a formulary design for MH/SUD prescription drugs were comparable to, and applied no more stringently than, the methodologies to administer the PDL a/k/a formulary design for M/S prescription drugs “as written.”

Based on the above review and data, UHC concluded and the Plan accepts that the methodologies to administer the PDL a/k/a formulary design for MH/SUD prescription drugs were comparable to, and applied no more stringently than, the methodologies to administer the PDL a/k/a formulary design for M/S prescription drugs “in operation.”

## Prescription Drug Step Therapy Non-Quantitative Treatment Limitation (NQTL) Analysis

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### Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits are comparable to and no more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA protections include:

- Financial requirements such as, deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs, which may limit the scope or duration of benefits for treatment under a plan or coverage

In the NQTL analysis below, the Plan Golden Rule Insurance Company (GRIC), as an affiliate entity under United Healthcare (UHC) E&I, adopts and implements policies and procedures that track those implemented by UHC. Thereby, the Plan GRIC accepts all UHC’s analysis and determinates as it relates to the below NTQL which identifies the services to which the NQTL applies (step 1). The Plan also accepts UHC’s identified factors used to determine whether the NQTL applies (step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (step 4), and sets forth findings and conclusions, both “as written” and “in operation” (step 5).

#### Specific NQTL

The Plan GRIC applies this specific NQTL which is managed by Optum Rx, as an affiliate entity under United Healthcare (UHC).

Prior Authorization is a component of UHC’s utilization management (UM) program that helps members receive appropriate coverage 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.

Prior Authorization for prescription drugs commences prior to a drug being covered. Prior Authorization is a UM process that involves applying clinical criteria to member clinical information in order to render a clinical coverage benefit determination.

The goal of Prior Authorization, Step Therapy, and Quantity Limits is to ensure cost-effective and clinically effective prescription drugs are covered to achieve a positive clinical outcome. Prior Authorization, Step Therapy, and Quantity Limits apply to prescription drugs provided to a member at the point-of-sale. Drug products are selected for Quantity Limits to encourage Food and Drug Administration (FDA) labeling, prevent abuse, address safety concerns, prevent pharmacy billing errors and encourage dose optimization.

Prior Authorization, Step Therapy, and Quantity Limits for prescription drugs begin after a provider or member requests coverage for a prescription drug and receipt of clinical information. The provider or member’s submission of a request (notification) triggers the Prior Authorization, Step Therapy, and Quantity Limits process. Quantity Limits trigger a Prior Authorization if the member is seeking more than the quantity limit set.

Note: The comparative analysis “as written” and “in operation” are the same for Step Therapy and Quantity Limits; therefore, the analysis has been combined.

This document includes the following information:

- Step Therapy, and Quantity Limits process for both M/S and MH/SUD prescription drugs
- The description of the NQTL and application (Step 1)
- Factors used to determine which prescription drugs are subject to the NQTL (Step 2)



## Prescription Drug Step Therapy Non-Quantitative Treatment Limitation (NQTL) Analysis

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- Evidentiary standards and sources used to define, trigger, and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

This analysis refers to the following attachments:

- *Certificate of Coverage (GA\_COC\_TI GEN 25 EXD)* - Plan document that explains covered services, terms, conditions, and limitations of the member’s policy
- Drugs with Clinical Programs dated 12/01/2023.

UHC concludes and the Plan accepts, that the Prior Authorization, Step Therapy, and Quantity Limit requirements for M/S and MH/SUD are comparable and applied no more stringently for M/S or MH/SUD prescription drug benefits both "as written" and "in operation."

## Process

For all prescription drugs covered under the pharmacy benefit, UHC uses the same policies and procedures to create clinical criteria and develop clinical drug policies through a single Pharmacy & Therapeutics (P&T) Committee.

The P&T Committee is comprised of individuals from diverse clinical disciplines including, behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs.

The Pharmacy & Therapeutics Committee consists of physicians specializing in Obstetrics & Gynecology, Endocrinology/Metabolism, Hematology/Oncology, Rheumatology, Geriatrics, Cardiology, Gastroenterology, Psychiatry, Pediatrics & Internal Medicine, and Internal Medicine. The committee also consists of 4 pharmacists, one of which specializes in Geriatrics & Psychiatry. There is a requirement that the committee consist of at least one physician specializing in psychiatry.

The Plan structures prescription drug Prior Authorization processes to be compliant with all applicable federal and state laws, as well as the National Committee for Quality Assurance (NCQA) accreditation standards. NCQA confirms that Plan operations and policies identify appropriate time frames for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Prior Authorization is governed at both the state and federal level, which includes consumer protections.

To approve clinical drug policies, the established committee follows a standard process. The P&T Committee evaluates the 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 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 clinical drug policies for select M/S and MH/SUD prescription drugs.

Prior Authorization, Step Therapy and Quantity Limits review of M/S and MH/SUD prescription drugs consists of the following:

Prior Authorization, Step Therapy, and Quantity Limits for prescription drugs begin after a provider or member requests coverage for a prescription drug and receipt of clinical information. The provider or member’s submission of a request (notification) triggers the Prior Authorization, Step Therapy, and Quantity Limits process. Quantity Limits trigger a Prior Authorization if the member is seeking more than the quantity limit set. A Prior Authorization (including Quantity Limits) or Step Therapy request may be



## Prescription Drug Step Therapy Non-Quantitative Treatment Limitation (NQTL) Analysis

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submitted by telephone or electronically. The Plan confirms receipt of the Prior Authorization, Step Therapy or Quantity Limit request. Non-clinical staff confirm member eligibility and benefit plan coverage. The Plan can administratively deny cases for lack of eligibility or benefit coverage.

**Determinations.** Clinical reviewers (Medical Director or healthcare professional) consult clinical drug policies when making clinical coverage benefit determinations. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical drug policies in the case review to assess whether a prescription drug should be covered. The Prior Authorization, Step Therapy, or Quantity Limit request is approved based on whether the member's clinical condition meets criteria for coverage as determined by the application of clinical drug policies. Only qualified clinical reviewers (e.g., physicians or pharmacists) can issue adverse benefit determinations. If an adverse benefit determination is issued, then the adverse benefit determination and appeal rights are communicated to the member and provider.

**Adverse Benefit Determinations.** For prescription drugs, an adverse benefit determination is an administrative or clinical review decision resulting in a reduction or termination, non-coverage or non-certification of a prescription drug. Adverse benefit determinations are recorded as administrative denials when member eligibility and benefit coverage cannot be confirmed, or benefits are exhausted. Adverse benefit determinations are recorded as clinical denials when they are based on clinical drug policies and member clinical information

**Clinical Criteria.** Clinical reviewers base Prior Authorization clinical coverage benefit determinations on objective, evidence-based clinical drug policies.

## Step 1 – NQTL and Application

*FAQ 45: A clear description of the specific NQTL, Plan terms, and policies at issue. Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.*

### Specific NQTL

- Prescription Drug Step Therapy, and/or Quantity Limits

### Benefit Classification(s)

- Prescription Drugs

### Plan(s) at Issue

- Golden Rule Insurance

### Plan Terms/Source Document(s)

- The Plan's *Certificates of Coverage* notifies members of the Prescription Drug Prior Authorization and Step Therapy policy.
- The member's benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations.

### List of M/S and MH/SUD Services Subject to NQTL

- See list of Drugs with Clinical Programs dated 12/01/2023.

## Step 2 – Factors Used to in the Design and Application of the NQTL

## Prescription Drug Step Therapy Non-Quantitative Treatment Limitation (NQTL) Analysis

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*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*

UHC relies on the following factors to determine whether prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits for both M/S and MH/SUD:

- **Assessment of the prescription drug's place in therapy (Qualitative)**

Applies to M/S and MH/SUD prescription drugs.

- **Availability of clinically similar lower cost medications to treat the condition (Quantitative)**

Applies to M/S and MH/SUD prescription drugs.

- **Value to implement Prior Authorization/Step Therapy (Qualitative)**

Applies to M/S and MH/SUD prescription drugs.

- **Relative safety and efficacy (Qualitative)**

Applies to M/S and MH/SUD prescription drugs.

- **Prevention of off-label use or unproven uses (Qualitative)**

Applies to M/S and MH/SUD prescription drugs.

The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL. The factors apply to both M/S and MH/SUD prescription drugs.

## Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.*

Below are the sources and evidentiary standards used to define, trigger, and/or implicate the factor used in designing or applying UHC's Step Therapy, or Quantity Limits requirement to prescription drugs.

### **Factor – Assessment of the prescription drug's place in therapy -**

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a qualitative manner.

### **Factor – Availability of clinically similar lower cost medications to treat the condition -**

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a quantitative manner.

### **Factor – Value to implement Prior Authorization/Step Therapy -**

## Prescription Drug Step Therapy Non-Quantitative Treatment Limitation (NQTL) Analysis

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These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a qualitative manner.

### **Factor – Relative safety and efficacy -**

### **Factor – Prevention of off-label use or unproven uses -**

These evidentiary standards and sources apply to both M/S and MH/SUD prescription drugs. These evidentiary standards and sources are defined in a qualitative manner.

These are the factors and evidentiary standards used in designing or applying UHC's Step Therapy, or Quantity Limits requirement to prescription drugs. The factors are not weighted in that no individual factor carries more value than another in imposing the NQTL.

## Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

*FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the Plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the Plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the Plan or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the Plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.*

### **As Written**

UHC on behalf of the Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD prescription drugs are subject to Step Therapy, or Quantity Limits and how Step Therapy, or Quantity Limits are administered “as written.” UHC identified the factors and evidentiary standards used as the basis for subjecting M/S and MH/SUD prescription drugs to Step Therapy, or Quantity Limits for each benefit classification.

### **Review of Factors and Evidentiary Standards**

For each prescription drug subject to Step Therapy, or Quantity Limits the Plan reviewed the factors that trigger a prescription drug to be subject to Step Therapy, or Quantity Limits. The factors and evidentiary standards were applied to both M/S and MH/SUD prescription drugs comparably and not more stringently to MH/SUD prescription drugs than to M/S prescription drugs.

### **Review of Operational Policies and Procedures**

For all prescription drugs covered under the pharmacy benefit, UHC uses the same policies and procedures to create clinical criteria and develop clinical drug policies through a single P&T Committee.

- **Committee Review.** The P&T Committee is comprised of individuals from diverse 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 clinical drug 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 clinical drug policies for select M/S and MH/SUD prescription drugs.

## Prescription Drug Step Therapy Non-Quantitative Treatment Limitation (NQTL) Analysis

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- **Clinical Criteria.** Clinical reviewers and peer clinical reviewers base clinical coverage benefit determinations on objective, evidence-based clinical drug policies. The criteria utilized to administer the Prior Authorization, Step Therapy, or Quantity Limit requirements are the same for MH/SUD and M/S prescription drugs.
- **Determinations.** The process for administering Step Therapy, or Quantity Limits is the same for M/S and MH/SUD prescription drugs. Clinical reviewers (Medical Director or healthcare professional) consult clinical drug policies when making clinical coverage benefit determinations. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical drug policies in the case review to assess whether a prescription drug should be covered. The Step Therapy, or Quantity Limit request is approved based on whether the member's clinical condition meets criteria for coverage as determined by the application of clinical drug policy. Only qualified clinical reviewers (e.g., physicians or pharmacists) can issue adverse benefit determinations. If an adverse benefit determination is issued, then the adverse benefit determination and appeal rights are communicated to the member and provider, as applicable.
- **Adverse Benefit Determination.** For prescription drugs, an adverse benefit determination is an administrative or clinical review decision resulting in a reduction or termination, non-coverage, or non-certification of a prescription drug. Adverse benefit determinations are recorded as clinical denials when they are based on clinical drug policies and member clinical information and are recorded as administrative denials when member eligibility and benefit coverage cannot be confirmed, or benefits are exhausted.

### In Operation

UHC on behalf of the Plan compared the shared strategies, processes, factors, evidentiary standards, and source information used to determine which M/S and MH/SUD prescription drugs are subject to Prior Authorization, Step Therapy, or Quantity Limits and how Prior Authorization, Step Therapy, or Quantity Limits are administered "in operation."

UHC requires members or providers to submit requests for approval of M/S and MH/SUD prescription drugs. Clinical reviews included confirmation of member eligibility and benefit availability for the requested prescription. Clinical reviewers applied benefit plan documents and clinical drug policies to member clinical information to make a benefit determination. Only qualified peer clinical reviewers issued adverse benefit determinations. The Plan communicated all adverse benefit determinations for M/S and MH/SUD prescription drugs that did not meet applicable clinical drug policies consistent with state, federal, and accreditation requirements, including appeal rights, as applicable.

UHC on behalf of the Plan reviewed the percentage of M/S and MH/SUD prescription drugs subject to various NQTLs on a tri-annual basis. The results are reviewed with the UHC UM Committee to determine if any changes should be made in the NQTLs. The UHC UM Committee is comprised of internal clinicians who review clinical guidelines and recommend changes before going to the P&T Committee.

## Step 5 – Findings and Conclusions

*FAQ 45: A reasoned discussion of the Plan or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the Plan or coverage is or is not in compliance with MHPAEA.*

### Findings

The findings of the UHC analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to subject certain MH/SUD prescription drugs to Step Therapy, or Quantity Limits were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to subject certain M/S prescription drugs to Step Therapy, or Quantity Limits "as written."

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 clinical policies.

**Prescription Drug Step Therapy Non-Quantitative Treatment Limitation (NQTL) Analysis**

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In addition, both M/S and MH/SUD utilize the same generally accepted types of data, evidentiary sources, and trend analysis in order to create and maintain a Prior Authorization, Step Therapy, or Quantity Limit requirement.

The findings of the prescription drug Step Therapy, or Quantity Limits outcomes analysis for each Plan (see data below) indicated the percentage of prescription drugs subject to Step Therapy, and/or Quantity Limits for MH/SUD prescription drugs were comparable to the percentage of prescription drugs subject to Step Therapy, and/or Quantity Limits for M/S prescription drugs. Data is for (January, May, and September 2022). The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance.

**The following are results of each analysis in 2022:**

- January 2022 – 30.6% (182) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits, while 19.6% (1,513) of M/S drugs are subject to these programs
- May 2022 – 32.5% (197) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits, while 19.8% (1,532) of M/S drugs are subject to these programs
- September 2022 – 32.7% (201) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits, while 20.4% (1,577) of M/S drugs are subject to these programs

**Conclusions**

UHC on behalf of the Plan reviewed the M/S and MH/SUD processes and noted the use of a single P&T committee which follows a standard process to create clinical criteria and develop clinical drug policies for M/S and MH/SUD prescription drugs. It is concluded the methodology used to determine which MH/SUD prescription drugs are subject to Medical Necessity (through Prior Authorization Step Therapy, or Quantity Limits) “as written” were comparable to, and applied no more stringently than, the methodology used to determine which M/S prescription drugs are subject to Medical Necessity (through Prior Authorization, Step Therapy, or Quantity Limits) “as written.” Additionally, it is concluded how Medical Necessity (through Prior Authorization, Step Therapy, or Quantity Limits) is applied to MH/SUD prescription drugs was comparable to, and applied no more stringently than, how Medical Necessity (through Prior Authorization, Step Therapy, or Quantity Limits) was applied to M/S prescription drugs “as written.”

UHC on behalf of the Plan notes that the percentage of MH/SUD drugs subject to Step Therapy, and/or Quantity Limits is higher than the percentage of M/S drugs subject to Prior Step Therapy, and/or Quantity Limits. UHC concluded this was due to the following contributing factors: a smaller pool of MH/SUD products to evaluate, a broader range of strengths for MH/SUD products, and an increased risk of abuse and diversion of MH/SUD products explain the variance. UHC concluded this does not indicate a parity concern, but rather is an indicator of patient safety in disbursing MH/SUD drugs.

UHC on behalf of the Plan reviewed the M/S and MH/SUD processes and noted the Plan uses the same policies and procedures to create clinical criteria and develop clinical drug policies for both M/S and MH/SUD prescription drugs. UHC also reviewed the percentage of M/S and MH/SUD prescription drugs which are subject to Step Therapy, or Quantity Limits and concluded the methodology used to determine which MH/SUD prescription drugs are subject to Step Therapy, or Quantity Limits and how Step Therapy, or Quantity Limits were applied were comparable to, and applied no more stringent than, the methodology used to determine which M/S prescription drugs were subject to Step Therapy, or Quantity Limits “in operation.”

**Retrospective Review In-Network Inpatient Non-Quantitative Treatment Limitations Analysis**  
Golden Rule Insurance  
12/01/2023**Overview**

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits, and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements – such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs – which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan Golden Rule Insurance Company (GRIC), is an affiliate entity under United Healthcare (UHC) E&I. The Plan GRIC identifies the services to which the NQTL applies (step 1). The Plan also identifies the factors used to determine whether the NQTL applies and adopts and leverages policies and criteria set forth by UHC (step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (step 4), and sets forth findings and conclusions, both “as written” and “in operation” (step 5).

**Specific NQTL**

Retrospective review is a component of the Plan’s utilization management (UM) program that helps reduce unnecessary variation in inpatient costs of healthcare services, reduction of patient risks by ensuring appropriate administration of healthcare technologies and ensure patient quality by benefit administration through use of qualified professionals. Applying retrospective review also supports appropriate utilization of the plan’s benefit package for inpatient services. The processes utilized in the Plan’s UM program is designed to achieve optimal clinical outcomes by applying objective, evidence-based internally developed clinical criteria policy, and also utilize (where applicable) externally developed nationally recognized guidelines in order to ensure best practices are encountered by the Plan’s participants and appropriate benefit administration per plan language, for purpose of protection of all stakeholders.

This document includes the following information:

- The retrospective review process for both M/S and MH/SUD services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)



**Retrospective Review In-Network Inpatient Non-Quantitative Treatment Limitations Analysis**  
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**This comparative analysis refers to the following attachments:**

- *Utilization Management Program Description (UMPD) of United Healthcare Life Insurance Company* - summarizes the philosophy, structure and standards that govern medical management, UM and utilization review responsibilities and functions
- *Certificate of Coverage (GA\_COC\_TI GEN 25 EXD)* - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *C-UM-11.00 Clinical Decision Support Tools*

## Process

For both M/S and MH/SUD services, the Plan structures inpatient retrospective review processes to be compliant with all applicable federal and state laws, as well as the applicable UM accreditation standards established by the Utilization Review Accreditation Commission (URAC).

URAC confirms the Plan's operations and policies identify appropriate turn-around times for decisions, require decision-making by appropriate personnel, and govern communication of adverse benefit determinations. In addition, retrospective review is governed at both the state and federal level, which includes consumer protections as applicable.

The Plan routinely monitors its retrospective review program performance through established committees that have quality review process and procedures, which monitor UM performance. The Plan has committees that meet on a regular basis and are overseen by a medical director.

Retrospective review is one component of the UM program that evaluates whether a benefit or service requested aligns with medical/clinical coverage criteria policies for purpose of determination of Plan coverage. The term "Medically Necessary" is used to guide retrospective review decision-making for both M/S and MH/SUD services.

### **The Plan's M/S retrospective review process consists of the following:**

Retrospective review begins after the Plan receives submission of a claim. The Plan may approve services that do not require clinical evaluation or interpretation. At the Plan's sole discretion if the case requires clinical evaluation or interpretation, the case can then be referred to either an internal Medical Director or externally contracted entity for clinical review.

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 policies, and nationally recognized guidelines. The Plan may gather more clinical information.

The clinical reviewer uses where available applicable member clinical information, coverage benefit plan documents, internal medical/clinical policies, along with utilization (where applicable) of externally developed nationally recognized guideline criteria.

Clinical reviewers employ expert opinion and experience to ensure requests align with state and federal regulations, contract language, internal medical/clinical policies, along with externally developed nationally

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recognized criteria (where applicable) from third party sources such as Interqual, MCG, American Society of Addiction Medicine (ASAM), Level of Care Utilization (LOCUS), Child and Adolescent Level of Care Utilization System (CALOCUS-CASII), and Early Childhood Service Intensity Instrument (ECSII), in the clinical case reviews for coverage determinations.

If the Plan cannot approve the services after clinical review, then the Plan communicates the adverse determination to the member and provider consistent with state, federal and accreditation requirements, including appeal rights the services will receive a medical/clinical coverage review determination based on the clinical records provided and available to the Plan.

In network inpatient depending on the provider contract, may bill the member for certain non-covered charges.

**The Plan's MH/SUD retrospective review process consists of the following:**

Retrospective review begins after the Plan receives submission of a claim. The Plan may approve services that do not require clinical evaluation or interpretation. At the Plan's sole discretion if the case requires clinical evaluation or interpretation.

For cases requiring MH/SUD specialty the Plan uses external independent contracted utilization review agencies.

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 policies, and nationally recognized guidelines. The Plan may gather more clinical information.

The external clinical reviewer as directed by the Plan uses where available applicable member clinical information, coverage benefit plan documents, internal medical/clinical policies, along with utilization (where applicable) of externally developed nationally recognized guideline criteria.

Clinical reviewers employ expert opinion and experience to ensure requests align with state and federal regulations, contract language, internal medical/clinical policies, along with externally developed nationally recognized criteria (where applicable) from third party sources such as Interqual, MCG, American Society of Addiction Medicine (ASAM), Level of Care Utilization (LOCUS), Child and Adolescent Level of Care Utilization System (CALOCUS-CASII), and Early Childhood Service Intensity Instrument (ECSII), in the clinical case reviews for coverage determinations.

If the Plan cannot approve the services after clinical review, then the Plan communicates the adverse determination to the member and provider consistent with state, federal and accreditation requirements, including appeal rights the services will receive a medical/clinical coverage review determination based on the clinical records provided and available to the Plan.

In network inpatient depending on the provider contract, may bill the member for certain non-covered charges.



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## Step 1 – NQTL and Application

*FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.*

### **Specific NQTL**

- Retrospective Review

### **Benefit Classification(s)**

- INN, Inpatient Hospital and Residential Levels of care.

### **Plan(s) at Issue**

- Golden Rule Insurance

### **Plan Terms**

*Certificate of Coverage (GA\_COC\_TI GEN 25 EXD) discusses the Plan's terms which require services to be medically necessary for coverage.*

*Utilization Management Program Description (UMPD) of United Healthcare Life Insurance Company discusses Post-Service Reviews.*

### **M/S and MH/SUD Services Subject to NQTL**

- The Plan may conduct retrospective review, and or contract external entities to conduct a review when a M/S or MH/SUD service are rendered and the Plan receives submission of a claim.

## Step 2 – Factors Used to Determine Retrospective Review Applies

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH or SUD benefits and medical or surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*

The Plan relies on the following factors to determine whether INN inpatient services are subject to retrospective review for both M/S and MH/SUD. The factors are:

- **Consistency with Clinical Criteria (Qualitative):**

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

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### **Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor**

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.*

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used designing or applying the Plan's Retrospective Review requirement to INN inpatient services. These evidentiary standards and sources apply to the following:

#### **Factor: Consistency with Clinical Criteria**

The Plan's evidentiary standards and sources apply to M/S and MH/SUD services. The Consistency with Clinical Criteria factor, evidentiary standards, and sources are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for subjecting MH/SUD INN inpatient benefits to Retrospective Review are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for subjecting M/S INN inpatient benefits to Retrospective Review "as written" and "in operation."

### **Step 4 – NQTL "As Written" and "In Operation" Comparability and Stringency Analysis**

*FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.*

### **Step 5 – Findings and Conclusions**

*FAQ 45: A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.*

#### **Findings**

The findings of the analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to subject certain MH/SUD INN inpatient services to retrospective review were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to subject certain M/S INN inpatient services to retrospective review "as written." For example, The Plan used comparable processes to conduct Retrospective Review of claims/requests for M/S and MH/SUD inpatient services. The Plan may have requested clinical

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information if necessary. The Plan approved M/S and MH/SUD claims/requests for inpatient services that met applicable clinical criteria or guidelines. The Plan issued an adverse benefit determination for M/S and MH/SUD INN provider claims/requests for inpatient services that did not meet applicable clinical criteria or guidelines.

**Conclusions**

The Plan concluded that how Retrospective Review is applied to MH/SUD INN inpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S INN inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes and operations. In reviewing the policies utilized for how the Plan conducts Retrospective Review for MH/SUD INN inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S INN inpatient services “in operation.”

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**Overview**

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits, and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements – such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs – which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan Golden Rule Insurance Company (GRIC), is an affiliate entity under United Healthcare (UHC) E&I. The Plan GRIC identifies the services to which the NQTL applies (step 1). The Plan also identifies the factors used to determine whether the NQTL applies and adopts and leverages policies and criteria set forth by UHC (step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (step 4), and sets forth findings and conclusions, both “as written” and “in operation” (step 5).

**Specific NQTL**

Retrospective review is a component of the Plan’s utilization management (UM) program that helps reduce unnecessary variation in outpatient costs of healthcare services, reduction of patient risks by ensuring appropriate administration of healthcare technologies and ensure patient quality by benefit administration through use of qualified professionals. Applying retrospective review also supports appropriate utilization of The Plan’s benefit package for outpatient services. The processes utilized in the Plan’s UM program is designed to achieve optimal clinical outcomes by applying objective, evidence-based internally developed medical/clinical criteria policies, as well as utilize (where applicable) externally developed nationally recognized criteria guidelines, in order to ensure best practices are encountered by the Plan’s participants and appropriate benefit administration per plan language, for purpose of protection of all stakeholders.

This document includes the following information:

- The retrospective review process for both M/S and MH/SUD services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

**Retrospective Review Non-Quantitative Treatment Limitations Analysis**

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**This comparative analysis refers to the following attachments:**

- *Utilization Management Program Description (UMPD) of United Healthcare Life Insurance Company* - summarizes the philosophy, structure and standards that govern medical management, UM and utilization review responsibilities and functions
- *Certificate of Coverage (GA\_COC\_TI GEN 25 EXD)* - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *C-UM-11.00 Clinical Decision Support Tools*

**Process**

For both M/S and MH/SUD services, the Plan structures outpatient retrospective review processes to be compliant with all applicable federal and state laws, as well as the applicable accreditation standards established by the Utilization Review Accreditation Commission (URAC). .

URAC confirms the Plan's operations and policies identify appropriate turn-around times for decisions, require decision-making by appropriate personnel, and govern communication of adverse benefit determinations. In addition, retrospective review is governed at both the state and federal level, which includes consumer protections.

The Plan routinely monitors its retrospective review program performance through established committees that have quality review process and procedures, which monitor UM performance. The Plan has committees that meet on a regular basis and are overseen by a medical director.

Retrospective review is one component of the UM program that evaluates whether a benefit or service requested aligns with medical/clinical coverage criteria policies, for purpose of determination of Plan coverage. The term "Medically Necessary" is used to guide retrospective review decision-making for both M/S and MH/SUD services.

**The Plan's M/S retrospective review process consists of the following:**

Retrospective review begins after the Plan receives submission of a claim. The Plan may approve services that do not require clinical evaluation or interpretation. At the Plan's sole discretion if the case requires clinical evaluation or interpretation, the case can then be referred to either an internal Medical Director or externally contracted entity for clinical review.

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 policies, and nationally recognized guidelines. The Plan may gather more clinical information.

The clinical reviewer uses where available applicable member clinical information, coverage benefit plan documents, internal medical/clinical policies, along with utilization (where applicable) of externally developed nationally recognized guideline criteria.

Clinical reviewers employ expert opinion and experience to ensure requests align with state and federal regulations, contract language, internal medical/clinical policies, along with externally developed nationally recognized criteria (where applicable) from third party sources such as Interqual, MCG, American Society of Addiction Medicine (ASAM), Level of Care Utilization (LOCUS), Child and Adolescent Level of Care

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Utilization System (CALOCUS-CASII), and Early Childhood Service Intensity Instrument (ECSII), in the clinical case reviews for coverage determinations.

If the Plan cannot approve the services after clinical review, then the Plan communicates the adverse determination to the member and provider consistent with state, federal and accreditation requirements, including appeal rights the services will receive a medical/clinical coverage review determination based on the clinical records provided and available to the Plan.

In network outpatient depending on the provider contract, may bill the member for certain non-covered charges.

**The Plan's MH/SUD retrospective review process consists of the following:**

Retrospective review begins after the Plan receives submission of a claim. The Plan may approve services that do not require clinical evaluation or interpretation. At the Plan's sole discretion if the case requires clinical evaluation or interpretation.

For cases requiring MH/SUD specialty the Plan uses external independent contracted utilization review agencies.

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 policies, and nationally recognized guidelines. The Plan may gather more clinical information.

The external clinical reviewer as directed by the Plan uses where available applicable member clinical information, coverage benefit plan documents, internal medical/clinical policies, along with utilization (where applicable) of externally developed nationally recognized guideline criteria.

Clinical reviewers employ expert opinion and experience to ensure requests align with state and federal regulations, contract language, internal medical/clinical policies, along with externally developed nationally recognized criteria (where applicable) from third party sources such as Interqual, MCG, American Society of Addiction Medicine (ASAM), Level of Care Utilization (LOCUS), Child and Adolescent Level of Care Utilization System (CALOCUS-CASII), and Early Childhood Service Intensity Instrument (ECSII), in the clinical case reviews for coverage determinations.

If the Plan cannot approve the services after clinical review, then the Plan communicates the adverse determination to the member and provider consistent with state, federal and accreditation requirements, including appeal rights the services will receive a medical/clinical coverage review determination based on the clinical records provided and available to the Plan.

In network outpatient depending on the provider contract, may bill the member for certain non-covered charges.

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## Step 1 – NQTL and Application

*FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.*

### Specific NQTL

- Retrospective Review

### Benefit Classification(s)

- INN, outpatient

### Plan(s) at Issue

- Golden Rule Insurance

### Plan Terms

*Certificate of Coverage (GA\_COC\_TI GEN 25 EXD)* discusses the Plan's terms which require services to be medically necessary for coverage.

*Utilization Management Program Description (UMPD) of United Healthcare Life Insurance Company* discusses Post-Service Reviews.

### M/S and MH/SUD Services Subject to NQTL

- The Plan may conduct retrospective review, and or contract external entities to conduct a review when a M/S or MH/SUD service are rendered and the Plan receives submission of a claim.

## Step 2 – Factors Used to Determine Retrospective Review Applies

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH or SUD benefits and medical or surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*

The Plan relies on the following factors to determine whether INN outpatient services are subject to retrospective review for both M/S and MH/SUD. The factors are:

- **Consistency with Clinical Criteria (Qualitative):**

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

## Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so.*

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*so, including an evaluation of any specific data used in the determination. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.*

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used designing or applying the Plan's Retrospective Review requirement to INN outpatient services. These evidentiary standards and sources apply to the following:

### Factor: Consistency with Clinical Criteria

The Plan's evidentiary standards and sources apply to M/S and MH/SUD services. The Consistency with Clinical Criteria factor, evidentiary standards, and sources are defined in a qualitative manner.

The factor and evidentiary standards used as the basis for subjecting MH/SUD INN outpatient benefits to Retrospective Review are comparable to, and applied no more stringently than, the factor and evidentiary standards used as the basis for subjecting M/S INN outpatient benefits to Retrospective Review "as written" and "in operation."

## Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

*FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.*

## Step 5 – Findings and Conclusions

*FAQ 45: A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.*

### Findings

The findings of the analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to subject certain MH/SUD INN outpatient services to retrospective review were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to subject certain M/S INN outpatient services to retrospective review "as written." For example, The Plan used comparable processes to conduct Retrospective Review of claims/requests for M/S and MH/SUD inpatient services. The Plan may have requested clinical information if necessary. The Plan approved M/S and MH/SUD claims/requests for outpatient services that met applicable clinical criteria or guidelines. The Plan issued an adverse benefit determination for M/S and MH/SUD INN provider claims/requests for outpatient services that did not meet applicable clinical criteria or guidelines.



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**Conclusions**

The Plan concluded that how Retrospective Review is applied to MH/SUD INN outpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S INN outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes and operations. In reviewing the policies utilized for how the Plan conducts Retrospective Review for MH/SUD INN outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S INN outpatient services “in operation.”

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## Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits, and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements – such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs – which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan Golden Rule Insurance Company (GRIC), is an affiliate entity under United Healthcare (UHC) E&I. The Plan GRIC identifies the services to which the NQTL applies (step 1). The Plan also identifies the factors used to determine whether the NQTL applies and adopts and leverages policies and criteria set forth by UHC (step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (step 4), and sets forth findings and conclusions, both “as written” and “in operation” (step 5).

### Specific NQTL

Retrospective review is a component of the Plan’s utilization management (UM) program that helps reduce unnecessary variation in costs of inpatient healthcare services, reduce patient risks by ensuring appropriate administration of healthcare technologies, and ensure patient quality by benefit administration through use of qualified professionals. Applying retrospective review also supports appropriate utilization of the plan’s benefit package. The processes utilized in the Plan’s UM programs designed to achieve optimal clinical outcomes by applying objective, evidence-based internally developed clinical criteria policies, and also utilize (where applicable) externally developed nationally recognized criteria guidelines, in order to ensure best practices are encountered by the Plan’s participants and appropriate benefit administration is applied per Plan language, for purpose of protection of all stakeholders.

This document includes the following information:

- The retrospective review process for both M/S and MH/SUD services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

**This comparative analysis refers to the following attachments:**

- *Utilization Management Program Description (UMPD) of United Healthcare Life Insurance Company -*

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summarizes the philosophy, structure and standards that govern medical management, UM and utilization review responsibilities and functions

- *Certificate of Coverage (GA\_COC\_TI GEN 25 EXD)* - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *C-UM-11.00 Clinical Decision Support Tools*

### **Process**

For both M/S and MH/SUD services, the Plan structures inpatient retrospective review processes to be compliant with all applicable federal and state laws, as well as the applicable UM accreditation standards established by the Utilization Review Accreditation Commission (URAC).

URAC confirms the Plan's retrospective review processes, operations and policies identify appropriate turn-around times for decisions, require decision-making by appropriate personnel, and govern communication of adverse benefit determinations. In addition, retrospective review is governed at both the state and federal level, which includes consumer protections as applicable.

The Plan routinely monitors its retrospective review program performance through established committees that have quality review process and procedures, which monitor UM performance. The Plan has committees that meet on a regular basis and are overseen by a medical director.

Retrospective review is one component of the UM program that evaluates whether a benefit or service requested aligns with medical/clinical coverage criteria policies for purpose of determination of Plan coverage. The term "Medically Necessary" is used to guide retrospective review decision-making for both M/S and MH/SUD services.

#### **The Plan's M/S retrospective review process consists of the following:**

Retrospective review begins after the Plan receives submission of a claim. The Plan may approve services that do not require clinical evaluation or interpretation. At the Plan's sole discretion if the case requires clinical evaluation or interpretation, the case can then be referred to either an internal Medical Director or externally contracted entity for clinical review.

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. The Plan may gather more clinical information.

The clinical reviewer uses where available applicable member clinical information, coverage benefit plan documents, internal medical/clinical policies, along with utilization (where applicable) of externally developed nationally recognized guideline criteria.

Clinical reviewers employ expert opinion and experience to ensure requests align with state and federal regulations, contract language, internal medical/clinical policies, along with externally developed nationally recognized criteria (where applicable) in the clinical case reviews for coverage determinations.

If the Plan cannot approve the services after clinical review, then the Plan communicates the adverse determination

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to the member and provider consistent with state, federal and accreditation requirements, including appeal rights. The services will receive a medical/clinical coverage review determination based on the clinical records provided and available to the Plan.

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 Plan's MH/SUD retrospective review process consists of the following:**

Retrospective review begins after the Plan receives submission of a claim. The Plan may approve services that do not require clinical evaluation or interpretation. At the Plan's sole discretion if the case requires clinical evaluation or interpretation.

For cases requiring MH/SUD specialty the Plan uses external independent contracted utilization review agencies.

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 policies, and nationally recognized guidelines. The Plan may gather more clinical information.

The external clinical reviewer as directed by the Plan uses where available applicable member clinical information, coverage benefit plan documents, internal medical/clinical policies, along with utilization (where applicable) of externally developed nationally recognized guideline criteria.

Clinical reviewers employ expert opinion and experience to ensure requests align with state and federal regulations, contract language, internal medical/clinical policies, along with externally developed nationally recognized criteria (where applicable) from third party sources such as Interqual, MCG, American Society of Addiction Medicine (ASAM), Level of Care Utilization (LOCUS), Child and Adolescent Level of Care Utilization System (CALOCUS-CASII), and Early Childhood Service Intensity Instrument (ECSII), in the clinical case reviews for coverage determinations.

If the Plan cannot approve the services after clinical review, then the Plan communicates the adverse determination to the member and provider consistent with state, federal and accreditation requirements, including appeal rights. The services will receive a medical/clinical coverage review determination based on the clinical records provided and available to the Plan.

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.

## **Step 1 – NQTL and Application**

*FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.*

### **Specific NQTL**

- Retrospective Review

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**Benefit Classification(s)**

- OON, Inpatient Hospital and Residential Levels of care.

**Plan(s) at Issue**

- *Golden Rule Insurance*

**Plan Terms**

*Certificate of Coverage (GA\_COC\_TI GEN 25 EXD)* discusses the Plan's terms which require services to be medically necessary for coverage.

*Utilization Management Program Description (UMPD) of United Healthcare Life Insurance Company* discusses Post-Service Reviews.

**M/S and MH/SUD Services Subject to NQTL**

- The Plan may conduct retrospective review, and or contract external entities to conduct a review when a M/S or MH/SUD service are rendered and the Plan is notified after submission of a claim.

**Step 2 – Factors Used to Determine Retrospective Review Applies**

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH or SUD benefits and medical or surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*

The Plan relies on the following factors to determine whether OON inpatient services are subject to retrospective review for both M/S and MH/SUD. The factors are:

- **Consistency with Clinical Criteria (Qualitative):**

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

**Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor**

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.*

Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in determining which services are subject to retrospective review:

**Factor: Consistency with Clinical Criteria** is defined as whether the application of Retrospective Review promotes optimal clinical outcomes.

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- The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:
  - Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG for M/S services, and ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services)
  - Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review
  - Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, American Psychiatric Association, etc.)

The *Medical Necessity NQTL* describes the process for determining how internally developed medical/behavioral clinical policies are developed and how externally developed third-party guidelines are reviewed and approved.

This evidentiary standard and source apply to both M/S and MH/SUD services. This standard is defined in a quantitative manner.

The factors and evidentiary standards used as the basis for subjecting MH/SUD OON inpatient benefits to retrospective review are comparable to, and applied no more stringently than, the factors and evidentiary standards used as the basis for subjecting M/S OON inpatient benefits to retrospective review "as written" and "in operation."

#### **Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis**

*FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.*

#### **Step 5 – Findings and Conclusions**

*FAQ 45: A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.*

#### **Findings**

The findings of the analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to subject MH/SUD OON inpatient services to retrospective review were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to subject M/S OON inpatient services to retrospective review “as written.” Both M/S and MH/SUD use the same factors as the basis for subjecting inpatient OON benefits to retrospective review “as written.” For example, The Plan used comparable processes to conduct Retrospective Review of claims/requests for M/S and MH/SUD inpatient services. The Plan may have requested clinical information if necessary. The Plan approved M/S and MH/SUD claims/requests for inpatient services that met applicable clinical criteria or guidelines. The Plan issued an adverse benefit determination for M/S and MH/SUD INN provider claims/requests for inpatient services that did not meet applicable clinical criteria or guidelines.

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**Conclusions**

The Plan concluded that how Retrospective Review is applied to MH/SUD OON inpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S OON inpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes and operations. In reviewing the policies utilized for how the Plan conducts Retrospective Review for MH/SUD OON inpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S OON inpatient services “in operation.”

## Overview

Pursuant to the Mental Health Parity and Addiction Equity Act (MHPAEA), the Plan must make sure that there is “parity” between mental health and substance use disorder (MH/SUD) benefits, and medical/surgical (M/S) benefits. This generally means that financial requirements and non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits cannot be more restrictive than the financial requirements and NQTLs applied to M/S benefits. The types of limits covered by MHPAEA include:

- Financial requirements – such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- NQTLs – which may limit the scope or duration of benefits for treatment under a plan or coverage.

In the NQTL analysis below, the Plan Golden Rule Insurance Company (GRIC), is an affiliate entity under United Healthcare (UHC) E&I. The Plan GRIC identifies the services to which the NQTL applies (step 1). The Plan also identifies the factors used to determine whether the NQTL applies and adopts and leverages policies and criteria set forth by UHC (step 2), as well as the evidentiary standards and sources used to define, trigger, and/or implicate each factor (step 3). The NQTL analysis provides a detailed comparative analysis that demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to M/S benefits, both “as written” and “in operation” (step 4), and sets forth findings and conclusions, both “as written” and “in operation” (step 5).

### Specific NQTL

Retrospective review is a component of the Plan’s utilization management (UM) program that helps reduce unnecessary variation in costs of outpatient healthcare services, reduce patient risks by ensuring appropriate administration of healthcare technologies, and ensure patient quality by benefit administration through use of qualified professionals. Applying retrospective review also supports appropriate utilization of the plan’s benefit package. The processes utilized in the Plan’s UM programs designed to achieve optimal clinical outcomes by applying objective, evidence-based internally developed clinical criteria policies, and also utilize (where applicable) externally developed nationally recognized criteria guidelines, in order to ensure best practices are encountered by the Plan’s participants and appropriate benefit administration is applied per Plan language, for purpose of protection of all stakeholders.

This document includes the following information:

- The retrospective review process for both M/S and MH/SUD services
- The description of the NQTL and application (Step 1)
- Factors used to determine which services are subject to the NQTL (Step 2)
- Evidentiary standards and sources used to define, trigger and/or implicate a factor (Step 3)
- NQTL “as written” and “in operation” comparability and stringency analysis (Step 4)
- Findings and conclusions (Step 5)

**This comparative analysis refers to the following attachments:**



- *Utilization Management Program Description (UMPD) of United Healthcare Life Insurance Company* - summarizes the philosophy, structure and standards that govern medical management, UM and utilization review responsibilities and functions
- *Certificate of Coverage (GA\_COC\_TI GEN 25 EXD)* - Plan document that explains covered services, terms, conditions, and limitations of the member's policy
- *C-UM-11.00 Clinical Decision Support Tools*

## Process

For both M/S and MH/SUD services, the Plan structures outpatient retrospective review processes to be compliant with all applicable federal and state laws, as well as the applicable UM accreditation standards established by the Utilization Review Accreditation Commission (URAC).

URAC confirms the Plan's retrospective review processes, operations and policies identify appropriate turn-around times for decisions, require decision-making by appropriate personnel, and govern communication of adverse benefit determinations. In addition, retrospective review is governed at both the state and federal level, which includes consumer protections as applicable.

The Plan routinely monitors its retrospective review program performance through established committees that have quality review process and procedures, which monitor UM performance. The Plan has committees that meet on a regular basis and are overseen by a medical director.

Retrospective review is one component of the UM program that evaluates whether a benefit or service requested aligns with medical/clinical coverage criteria policies for purpose of determination of Plan coverage. The term "Medically Necessary" is used to guide retrospective review decision-making for both M/S and MH/SUD services.

### **The Plan's M/S retrospective review process consists of the following:**

Retrospective review begins after the Plan receives submission of a claim. The Plan may approve services that do not require clinical evaluation or interpretation. At the Plan's sole discretion if the case requires clinical evaluation or interpretation, the case can then be referred to either an internal Medical Director or externally contracted entity for clinical review.

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. The Plan may gather more clinical information.

The clinical reviewer uses where available applicable member clinical information, coverage benefit plan documents, internal medical/clinical policies, along with utilization (where applicable) of externally developed nationally recognized guideline criteria.

Clinical reviewers employ expert opinion and experience to ensure requests align with state and federal regulations, contract language, internal medical/clinical policies, along with externally developed nationally recognized criteria (where applicable) in the clinical case reviews for coverage determinations.

If the Plan cannot approve the services after clinical review, then the Plan communicates the adverse determination to the member and provider consistent with state, federal and accreditation requirements, including appeal rights. The services will receive a medical/clinical coverage review determination based on the clinical records provided and available to the Plan.

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 Plan's MH/SUD retrospective review process consists of the following:**

Retrospective review begins after the Plan receives submission of a claim. The Plan may approve services that do not require clinical evaluation or interpretation. At the Plan's sole discretion if the case requires clinical evaluation or interpretation.

For cases requiring MH/SUD specialty the Plan uses external independent contracted utilization review agencies.

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 policies, and nationally recognized guidelines. The Plan may gather more clinical information.

The external clinical reviewer as directed by the Plan uses where available applicable member clinical information, coverage benefit plan documents, internal medical/clinical policies, along with utilization (where applicable) of externally developed nationally recognized guideline criteria.

Clinical reviewers employ expert opinion and experience to ensure requests align with state and federal regulations, contract language, internal medical/clinical policies, along with externally developed nationally recognized criteria (where applicable) from third party sources such as Interqual, MCG, American Society of Addiction Medicine (ASAM), Level of Care Utilization (LOCUS), Child and Adolescent Level of Care Utilization System (CALOCUS-CASII), and Early Childhood Service Intensity Instrument (ECSII), in the clinical case reviews for coverage determinations.

If the Plan cannot approve the services after clinical review, then the Plan communicates the adverse determination to the member and provider consistent with state, federal and accreditation requirements, including appeal rights the services will receive a medical/clinical coverage review determination based on the clinical records provided and available to the Plan.

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.

## Step 1 – NQTL and Application

*FAQ 45: A clear description of the specific NQTL, plan terms, and policies at issue. Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.*

### Specific NQTL

- Retrospective Review

### Benefit Classification(s)

- ONN, outpatient

### Plan(s) at Issue

- Golden Rule Insurance

### Plan Terms

*Certificate of Coverage (GA\_COC\_TI GEN 25 EXD)* discusses the Plan's terms which require services to be medically necessary for coverage.

*Utilization Management Program Description (UMPD) of United Healthcare Life Insurance Company* discusses Post-Service Reviews.

### M/S and MH/SUD Services Subject to NQTL

- The Plan may conduct retrospective review, and or contract external entities to conduct a review when a M/S or MH/SUD service are rendered and the Plan is notified after submission of a claim.

## Step 2 – Factors Used to Determine Retrospective Review Applies

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH or SUD benefits and medical or surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*

The Plan relies on the following factors to determine whether OON outpatient services are subject to retrospective review for both M/S and MH/SUD. The factors are:

- **Consistency with Clinical Criteria (Qualitative):**

This factor applies to M/S and MH/SUD services. Meeting Consistency with Clinical Criteria is determinative in imposing the limitation.

### Step 3 – Evidentiary Standards and Sources Used to Define, Trigger, and/or Implicate a Factor

*FAQ 45: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.*

Below are the evidentiary standards and sources used to define, trigger, and/or implicate each factor used in determining which services are subject to retrospective review:

#### **Factor: Consistency with Clinical Criteria**

These evidentiary standards and sources apply to both to M/S and MH/SUD OON outpatient services. These standards are not defined in a quantitative manner.

The factors and evidentiary standards used as the basis for subjecting MH/SUD OON outpatient benefits to retrospective review are comparable to, and applied no more stringently than, the factors and evidentiary standards used as the basis for subjecting M/S OON outpatient benefits to retrospective review "as written" and "in operation."

### Step 4 – NQTL “As Written” and “In Operation” Comparability and Stringency Analysis

*FAQ 45: The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s). If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both.*

### Step 5 – Findings and Conclusions

*FAQ 45: A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.*

#### **Findings**

The findings of the analyses confirmed the strategies, processes, factors, evidentiary standards, and source information used to subject MH/SUD OON outpatient services to retrospective review were comparable to, and applied no more stringently than, the strategies, processes, factors, evidentiary standards, and source information used to subject M/S OON outpatient services to retrospective review “as written.” Both M/S and MH/SUD use the same factors as the basis for subjecting inpatient OON benefits to retrospective review “as written.” For example, The Plan used comparable processes to conduct Retrospective Review of claims/requests for M/S and MH/SUD outpatient services. The Plan may have requested clinical information if necessary. The Plan approved M/S and MH/SUD claims/requests for outpatient services that met applicable clinical criteria or guidelines. The Plan

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issued an adverse benefit determination for M/S and MH/SUD INN provider claims/requests for inpatient services that did not meet applicable clinical criteria or guidelines.

### **Conclusions**

The Plan concluded that how Retrospective Review is applied to MH/SUD OON outpatient services was comparable to, and applied no more stringently than, how Retrospective Review is applied to M/S OON outpatient services “as written.”

The Plan reviewed the M/S and MH/SUD processes and operations. In reviewing the policies utilized for how the Plan conducts Retrospective Review for MH/SUD OON outpatient services “in operation” was comparable to, and applied no more stringently than, how the Plan conducts Retrospective Review for M/S OON outpatient services “in operation.”

## UnitedHealthcare Life Insurance Company (UHCLIC)

### Utilization Management Program

**Scope:** The UHCLIC Utilization Management (UM) Program is a comprehensive program encompassing managed care processes related to the delivery of health care services. The Utilization Management Program is compliant with all applicable state and federal mandates and holds national accreditation through the Health Utilization Management Standards of URAC. Health care service utilization review includes but is not limited to inpatient medical, surgical, and rehabilitative care in hospitals and skilled nursing facilities, home health care services, durable medical equipment and supplies and injectable medications. Mental health and substance abuse services are reviewed unless noted differently in the Utilization Review license application. The program combines pre-service review, concurrent review, post service/retrospective review. UHCLIC does not use electronic prior authorization (e-PA).

UnitedHealthcare Life Insurance Company (UHCLIC) does not have any agreements directly with clients, nor do they market services to anyone. UHCLIC functions as a UR agent and performs Medical Necessity review and Appeal review services for two subsidiary companies: Golden Rule Insurance Company and All Savers Insurance Company. The only communications sent to consumers by UHCLIC are review decision letters; they do not include any marketing information but do go out on UnitedHealthcare letterhead.

**Objectives:** The objectives of the program include but are not limited to:

- a. promote quality care for members
- b. consistently apply Utilization management and regulatory policies and procedures
- c. enhance member and provider satisfaction
- d. reduce health costs.

**Mission Statement:** The UnitedHealthcare Life Insurance Company (UHCLIC) Mission is to *help people live healthier lives* by promoting the delivery of appropriate care in the most appropriate setting at the appropriate time through the use of utilization management services. This activity results in the avoidance of unnecessary cost and risk to the member.

**Population Served:** UHCLIC performs delegated health utilization management services for affiliated companies, which may encompass concurrent, predetermination and retrospective utilization review.

**Structure:** The Medical Director, who is a licensed physician, is responsible for the clinical oversight of the Utilization Management Program.

The Medical Director provides clinical oversight of the Utilization Management operation including compliance, accreditation and the policies and procedures that govern the day-to-day program management, with the assistance of the assigned staff who operate under the direction of the Medical Director.

Registered nurses or licensed practical nurses, possessing an active unrestricted nursing license, in the United States, perform the Utilization Management reviews. They conduct initial clinical reviews that do not result in a denial for medical necessity. They also conduct ongoing clinical reviews and facilitate post hospital medical care services. Reviews may be performed on a prospective, concurrent or retrospective basis. The UR nurses work under the clinical direction of the Medical Director.

**Performance Evaluations:** The performance of Utilization Management staff is reviewed at least annually. Case files for each member of the staff are audited throughout the year by the Medical Director and presented periodically to the staff member as feedback and with action plans as applicable. Audits are conducted to

determine consistency and accuracy in rendering certification and non-certification decisions, timelines of the review process and accuracy of the technical procedure.

**Program:** Requests for health care services are evaluated through clinical review for medical necessity and appropriateness of setting. The hours of operation are 9 a.m. to 4 p.m. Central Time, Monday through Friday. A confidential voice mail service is available to take messages for any calls received during and after hours, weekends or holidays. Received communications from providers or patients are responded to within one business day of receipt of the request. A Medical Director is available during business hours to consult with the Utilization Management staff as needed. The Utilization Management Program utilizes clinical review criteria to determine medical necessity of services.

**Clinical Review Criteria:** UHCLIC adopts and leverages UHC broader corporate policies and procedures regarding the application and administration of externally developed evidenced-based nationally recognized clinical review criteria for purpose of medical necessity determinations. Criteria are applied based on the area of specialty that each guideline/criterion indicates is appropriate (e.g., InterQual, ASAM etc). Additional review criteria guidelines may be developed by UHC and adopted and leveraged by UHCLIC and are based on sound clinical evidence, state and federal mandates, and are evaluated at least annually to assure ongoing efficacy. Special circumstances may require flexibility in the application of screening criteria. Special circumstances include, but are not limited to, a person who has a disability or life-threatening illness.

**Clinical Information:** Clinical information is collected verbally via telephone, via fax or via mail. The provider and member are informed of the clinical information necessary to conduct clinical review. Clinical information is accepted from all reasonable sources and only information necessary to render a review decision is requested. Copies of medical records are not routinely requested; however, if needed for clinical review, only the section(s) of the medical record that is pertinent to the review are requested. The medical information requested is used solely for the purposes of Utilization Management, care management, and claims payment and is shared only with other departments who need access to it. If during the course of a review, a situation is identified that poses an immediate threat to the health and safety of the member, the Medical Director is notified for prompt action. All information received is retained and stored in compliance with corporate guidelines and state or federal law.

**Confidentiality:** The UM Confidentiality Policy requires that patient-specific information obtained during the review process shall be kept confidential consistent with state and federal laws and only used for utilization review or care management purposes. Patient-specific diagnoses and procedure information cannot be passed on to the group, patient or employee except as mandated by law.

Authorization to release medical information must come from the patient and will only be released to those individuals and entities that have the authority to receive such information. If the patient is a minor or unable to sign a release form, the parent, legal guardian or power of attorney must sign the form.

As a condition of employment, all Utilization Management personnel are required to sign a statement acknowledging that they understand the importance of and agree to abide by the policies and procedures set forth in the confidentiality statement. This information is reviewed and signed annually by all staff.

**Medical Necessity Review Process:** Licensed nurses perform the initial clinical review for pre-service, concurrent and/or post service/retrospective requests using clinical review criteria to determine medical necessity of health care services. All requests that cannot be certified through initial clinical review are sent to a clinical peer for determination. Only a clinical peer of the requesting provider may perform a UM review that results in the denial of payment based on medical necessity and appropriateness. The clinical peer is available during business hours to discuss review determinations with attending physicians or other ordering providers.

**Pre-service Review:** A pre-service review is conducted prior to a patient's admission, stay, or other service or course of treatment (including outpatient procedures and services). For requests involving urgent care, the determination will be made as soon as possible but in no case later than 72 hours of the request, unless state

regulations require a shorter turnaround time. If required clinical information is not provided within the 72 hours, the request will be closed due to lack of information. Once information is received, the request will be reopened, reviewed and a determination rendered within 48 hours. For requests involving non-urgent care, a determination will be rendered within 15 calendar days of receipt of request unless state regulations require a shorter turn around time. If an extension of up to 15 more calendar days is required, notification is made to the patient. If required clinical information is not received within 60 days of the request for it, the review will be closed due to lack of information. Once information is received, the request will be reopened, reviewed and a determination will be rendered within the original remaining 15 (or with extension, 30) calendar days. Once all reasonably necessary information is received, review discussion must be made and communicated to the enrollee and health care provided. A verbal notification of the pre-service determination is given to the requesting provider, followed by written notification to the patient and requesting provider of service whether approved or denied.

**Concurrent Review:** Concurrent review is conducted for ongoing inpatient facility stays. Services are reviewed for medical necessity and appropriateness of setting prior to the expiration of the initial certification. The frequency of reviews for extension is based on the complexity of the patient's condition and is not routinely conducted on a daily basis. For concurrent inpatient review, a determination is rendered within 72 hours of request. If clinical information is required to review the extension, the request is suspended to allow the provider 48 hours to supply the needed information. Once information is received, the request will be reviewed within the remaining timeframe. A verbal notification of approval is given to the requesting provider, followed by a written notification to the patient and provider at the close of the ongoing inpatient stay, unless state law requires interim approval letters to the patient.

**Post Service Review:** Post Service/Retrospective Review is conducted after the service has been rendered. Review determinations will be completed within 30 days of receipt of the claim unless an extension of up to 15 more calendar days is required and notification is made to the patient. If required clinical information is not received within 60 days of the request for it, the review will be closed due to lack of information. When the requested information is received the review is reopened, and a determination rendered within the original remaining 30 (or with an extension, 45) calendar days. Written notification of an adverse determination is provided to the insured and requesting provider.

**Automated-Only Review:** There are no, and will be no automated algorithmic determinations conducted, as such there is no standard process outlined as this is not an applicable area for the program.

**Artificial Intelligence (AI) and Machine Learning (ML) Medical Software Selection Criteria:** There are no, and will be no automated algorithmic determinations conducted, as such there is no need for AI and ML medical software, this is not an applicable area for the program.

**Certifications:** Urgent health care services that are certified will result in verbal notification to the patient and provider unless a written notification is required by the state. For non-urgent services/procedures, a verbal notification is given to the requesting provider followed by written notification to the patient and providers of service. Post claim/retrospective review adverse decisions are communicated to both provider and patient in writing. Written notification includes the date of admission or onset of services, the number of extended days or units of service, the next anticipated review date, if applicable, and the total number of days or services approved.

**Non-Certifications:** All health care service requests that cannot be certified through initial clinical review are forwarded for a peer clinical review. A clinical peer is a health professional or a physician who holds a current and unrestricted license and is in the same or similar specialty as typically manages the medical condition/procedure under review. Written notification of non-certification is sent to the patient and providers of service and contains the principal reason for the determination; applicable appeals rights; any state-specific appeal rights that may apply, the instructions for initiating a voluntary appeal of the non-certification; and the clinical rationale used to make the non-certification. For peer reviews the non-certifications are communicated to the provider by telephone. (This is not applicable to post service/retrospective reviews.) The clinical peer is



available during business hours to discuss the review determination with the attending physician or other ordering providers on a peer-to-peer basis.

**Appeal Structure:** Appeals and complaints are handled by the Appeals and Grievances (A&G) department. Any appeals or complaints that are sent to Utilization Review staff are referred to the A&G department. The E&I Operations Regulatory Adherence area is responsible for oversight of UM appeals. The Regulatory Affairs Consultant, in concert with A&G Management, is responsible to ensure appropriate application of state and federal law, and in the case of UM appeals, application of the URAC Standards. The Regulatory Affairs Consultant is supported by an A&G Supervisor who is charged with supervision of the A&G staff members involved with processing UM appeals.

Senior Appeals Representatives are non-clinical appeals specialists who act as liaisons and support the appellant through the appeals process, including providing the decision in an appeal response letter. The Senior Appeals Representatives must also apply federal, state, and URAC Standards requirements as appropriate. Appeals Intake staff is responsible for triaging correspondence and entering appeals into a tracking repository.

**Appeal Review Process:** Appeals of non-certifications may be initiated within 180 calendar days of receipt of the non-certification and can be requested verbally or in writing by the patient, patient's designee or provider. An appeal peer who was not involved in the initial non-certification and is not the subordinate of the initial reviewer completes the appeal review. The appeal peer holds an active unrestricted license to practice medicine or a health profession and is board certified, if applicable. The appeal peer is in the same profession and a similar specialty as typically manages the medical condition or treatment. The clinical information including criteria and certificate language used in the initial review and the initial reviewer's determination and clinical rationale is submitted to the appeal peer. Additional information is accepted for consideration if submitted.

**Expedited Appeal:** Expedited appeals are initiated for cases involving urgent care and are completed no later than 72 hours after the initiation of the appeal process unless state regulations require a shorter turnaround time. The appellant and provider are notified by telephone of the expedited appeal outcome followed by a written notification. If the expedited appeal decision is to uphold the adverse determination the written notification to the patient and provider includes the principal reason for the determination, the clinical rationale used in the determination, a unique identifier assigned to the initial request for certification and instructions for initiating any additional levels of appeal available.

**Standard Appeal:** Standard appeal timeframes depend on whether or not services have been received at the time of the appeal. If services have not yet been received, the standard appeal is completed within 30 calendar days of the initiation of the appeals process. If services have been received, the standard appeal is completed within 60 calendar days of the initiation of the appeals process. Timeframes may vary depending on federal or state regulations. Written notification is sent to the patient and provider informing them of the appeal determination. If the appeal determination is to uphold the non-certification, the written notification includes the principal reason for the determination, the clinical rationale used in the determination, a unique identifier assigned to the initial request for certification and instructions on any additional level of appeal available, if any.

**Records Retention and Examination:** Records shall be maintained for each review performed and each appeal received or reviewed as well as documentation sufficient to demonstrate compliance with state and federal law. Storage mechanisms for clinical and review information consist of electronic means and can be generated into any reliable format.

**Complaints:** The Appeals and Grievances department investigates, resolves and responds to complaints in a timely manner. A Quality-of-Care complaint is defined as an oral or written expression of dissatisfaction concerning any Utilization Management service, including quality issues. A complaint is not a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing the misunderstanding to the satisfaction of the inquiring party. Complaints are documented and

analyzed in order to identify trends and opportunities for improvement. Verbal or written complaints involving non-certification will follow the appeal/grievance process.

**Quality Improvement Program:** The purpose of the UM Quality Improvement (QI) Program is to monitor and evaluate the Utilization Management processes and services. The Medical Director is charged with oversight of the Utilization Management QI Program and the staff assigned to this task operate under the direction of the Medical Director. Identification of opportunities to improve the Utilization Management process is the primary goal for all staff. The process flow is analyzed for problems in staff meetings, team meetings and on an individual basis. Ideas for interventions are solicited from the staff and incorporated into action plans. The Medical Director or his/her designee submits the annual activity results to the Corporate Quality Improvement Committee (QIC). The Quality Improvement Committee provides feedback to further enhance the Utilization Management Program's activities.

**Audits of UR reviewers and outside Clinical Reviewers:** These audits evaluate compliance with timelines of the review process, accuracy of the technical procedure and compliance with state and federal regulations. These audits results are reviewed as part of the QI Committee quarterly meeting agenda. The Medical Director conducts quarterly audits of utilization reviewers. Outside clinical reviewer audits are conducted by the Medical Director to ensure consistency and accuracy in rendering certification and non-certification decisions, including but not limited to consistent and appropriate application of clinical criteria hierarchy.

**Communication Material Monitoring:** All letter templates (initial determination and appeal determination) are reviewed and updated, as applicable, to meet requirements of the current version of the URAC Health Utilization Management standards. This review is done at a minimum of every 3 years. The URAC compliant letter templates serve as the base template for all letters.

For state specific letter requirements, an Operational Regulatory Adherence staff member, on behalf of UHCLIC, monitors regulatory changes through the UnitedHealthcare National Regulatory Affairs Regulatory Change Management Policy. Regulatory changes are implemented by updating the applicable letter system (i.e Crystal Reports for initial determinations and Word for Appeals.) Letter templates that are created or edited to include state specific information requirements are submitted to State Regulators based on State filing requirements. Notification of updated template letters are provided to the appropriate staff impacted by the change(s).

UHCLIC letters are also subject to review as part of the Oversight Audit by companies who delegate to us. An annual Oversight Audit is conducted of our submission of case files/letters to the Oversight Audit SharePoint. Audit results are shared with the Quality Improvement Committee.

**Annual Evaluation of UM Program:** The Utilization Management Program is reviewed and approved at least annually by the QI Committee in the first quarterly meeting of each year. State specific UM programs are updated with those changes and updated as needed to reflect compliance with UR license renewal regulations.

#### **APPLICABLE ACCREDITATION STANDARDS:**

- URAC v8.1: CPE 2-5: Consumer Marketing and Communication Safeguards, UM 1-1: Program Structure, UM 5-2: Automated-Only Review, UM 6-1: AI and ML Medical Software Used in Utilization Review, UM 15-1: Initial Determinations

Review Date:	10/04	8/1/05	9/28/06	11/30/06	11/2/07	10/22/08	10/13/09	10/26/10	11/9/11
Revision Effective Date:	10/04	8/9/05	9/28/06	11/30/06	11/2/07	10/22/08	NR	NR	NR
Review Date:	12/24/12	6/11/13	7/31/13	11/4/14	4/28/15	1/20/16	12/7/2016	4/25/17	5/3/18
Revision Effective Date:	12/24/12	6/11/13	8/5/13	11/4/14	5/30/15	2/9/2016	NR	4/30/17	NR
Review Date:	8/17/18	9/26/18	10/9/19	11/20/19	10-15-20	9/24/21	6/23/22	9/14/22	6/22/23
Revision Effective Date:	8/17/18	9/26/18	10/9/19	11/20/19	10-15-20	9/24/21	6/23/22	NR	6/22/23
Review Date:	9/15/23								
Review Effective Date:	9/15/23								

Last Review/Update By: Heidi Socha

Approved by QI committee