HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Mental Health Parity and Addiction Equity Act Non-Quantitative Treatment Limitations
Answers to Key Questions
Sierra Health and Life Medical Necessity Model

This summary is applicable to fully insured Sierra Health and Life plans using the Medical Necessity Model.

The information provided below is based, where applicable, on the standard Sierra Health and Life Evidence of Coverage (COCs) and standard Sierra Health and Life Benefit Schedules.

Date: **April 7, 2021**

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NON-QUANTITATIVE TREATMENTS LIMITATIONS INCLUDED IN THIS SUMMARY:

Non-Quantitative Treatment Limitations	General Medical/Surgical	Mental Health/Substance Use Disorder
1) Are services subject to a medical necessity standard?	Yes, services received from both Network and Non-Network provider must meet the following definition of medical necessity: Healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance use disorder, condition disease or its symptoms, which are all of the following as determined by Sierra Health and Life or our designee, within our sole discretion. • In accordance with *Generally Accepted Standards of Medical Practice*; • Clinically appropriated, in terms of type, frequency, extent, site and duration and considered effective for the member's sickness, injury, mental illness, substance use disorder, diseased or its symptoms; • Not mainly for the member's convenience or that of the member's doctor or other health care provider; • Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member's sickness, injury, disease or symptoms. *Generally Accepted Standards of Medical Practice* are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally	Yes, services received from both Network and non-Network providers meet the following definition of medical necessity: Mental health and substance use disorder ("MH/SUD") services provided for the purpose of preventing, evaluating, diagnosing or treating a MH/SUD, or its symptoms that are all of the following as determined by Behavioral Healthcare Options ("BHO") or our designee, within our sole discretion: • In accordance with Generally Accepted Standards of Medical Practice; • Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's MH/SUD or its symptoms; • Not mainly for the member's convenience or that of the member's doctor or other health care provider; • Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member's MH/SUD, or its symptoms. *Generally Accepted Standards of Medical Practice* are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available,

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	recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. Sierra Health and Life reserves the right to consult expert opinions 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 within our sole discretion. These clinical policies (as developed by us and revised from time to time), are available to covered persons on Sierra Health and Life's member website or by calling the telephone number on the covered person's ID card. They are available to Physicians and other health care professionals on Sierra Health and Life's provider website or by calling the telephone number on the covered person's ID card.	observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. BHO reserves the right to consult expert opinions in determining whether mental health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion. BHO develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons by calling the telephone number on the Covered Person's ID card. They are available to Physicians and other health care professionals by calling the telephone number on the Covered Person's ID card.
2) How Does the Plan Detect Fraud, Waste and Abuse?	**In Network & Out of Network** The plan utilizes a comprehensive program for the detection, investigation and remediation of potential fraud, waste and abuse. The processes utilized are claims algorithms and a reporting hotline for detection, pre-payment and post-	**In Network & Out of Network** The plan utilizes a comprehensive program for the detection, investigation and remediation of potential fraud, waste and abuse. The processes utilized are claims algorithms and a reporting hotline for detection, pre-

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	payment review for investigation and recovery is conducted via claims offsets and invoicing for collection of overpaid amounts. The Fraud, Waste and Abuse processes that investigate and identify fraud though pre-payment and post-payment reviews are non-quantitative limits that may impact the scope or duration of treatment by affecting the payment of benefits to a provider or member. This limitation may occur through the denial of claims (pre-payment review) and recovery of overpaid claims (post-payment review). Pre-payment review may be applied to the claims or a provider or member for whom there is a basis to suggest irregular or inappropriate services based on the claims submitted, referral tips from the fraud hotline or other means. A pre-payment review entails review of each claim, requests for additional information to support and/or validate the claim and, if necessary, may result in denial of the claim if not substantiated. This process may be applied to any provider or member's claims without regard to the payer, the amount of claim, type of service etc. Post-payment review is conducted when an algorithm, routine claims audit, referral tips from the fraud hotline or other information suggests the need for review of a provider's billing practices and patterns after claims have previously been processed and paid. A post-payment review will involve an audit for a period that may span from six months to six years using a sampling and extrapolation methodology and	payment and post-payment review for investigation and recovery is conducted via claims offsets and invoicing for collection of overpaid amounts. The Fraud, Waste and Abuse processes that investigate and identify fraud though pre-payment and post-payment reviews are non-quantitative limits that may impact the scope or duration of treatment by affecting the payment of benefits to a provider or member. This limitation may occur through the denial of claims (pre-payment review) and recovery of overpaid claims (post-payment review). Pre-payment review may be applied to the claims or a provider or member for whom there is a basis to suggest irregular or inappropriate services based on the claims submitted, referral tips from the fraud hotline or other means. A pre-payment review entails review of each claim, requests for additional information to support and/or validate the claim and, if necessary, may result in denial of the claim if not substantiated. This process may be applied to any provider or member's claims without regard to the payer, the amount of claim, type of service etc. Post-payment review is conducted when an algorithm, routine claims audit, referral tips from the fraud hotline or other information suggests the need for review of a provider's billing practices and patterns after claims have previously been processed and paid. A post-payment review will involve an audit for a period that may span from six months to six years using a sampling and extrapolation

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	may involve any amount of claims with no specified minimum amount involved or potential recovery probability. The audit and investigation will involve review of contemporaneous treatment records as well as member and provider interviews.	methodology and may involve any amount of claims with no specified minimum amount involved or potential recovery probability. The audit and investigation will involve review of contemporaneous treatment records as well as member and provider interviews.
3) Are there Exclusions for Experimental, Investigational and Unproven Services?	Yes, services received from both Network and Non-Network providers are subject to the following exclusions: *Experimental or investigational services* are medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time a determination regarding coverage in a particular case is made, are determined to be any of the following: • Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use. • Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.) • The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial as set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight. *Unproven services* are services, including medications, which are determined not to be effective for treatment of the medical	Yes, services received from both Network and Non-Network providers are subject to the following exclusions: *Experimental or investigational services* are medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time a determination regarding coverage in a particular case is made, are determined to be any of the following: • Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use. • Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.) • The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial as set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

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	condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature. • Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.) • Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.) Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. To determine whether services are Experimental or Investigational or Unproven, the medical/surgical services are subject to Plan Terms. To determine whether a service is considered Experimental or Investigational or Unproven under the terms of the Plan, the medical/surgical reviewers use medical policies which rely on current evidence-based	*Unproven services* are services, including medications, which are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature. • Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.) • Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.) Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. To determine whether services are Experimental or Investigational or Unproven, the medical/surgical services are subject to Plan Terms. To determine whether a service is considered Experimental or Investigational or Unproven

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	medicine and criteria. To select or create the evidence-based medical policy or clinical criteria, a committee has been established and a standard process is followed to develop and/or select guidelines to administer benefits.	under the terms of the Plan, the medical/surgical reviewers use medical policies which rely on current evidence-based medicine and criteria. To select or create the evidence-based medical policy or clinical criteria, a committee has been established and a standard process is followed to develop and/or select guidelines to administer benefits.
4) Network Admission Criteria	Credentialing is a requirement for participation in the various SHL provider networks and all providers must be credentialed prior to contracting. Recredentialing is conducted every 36 months to assess and validate the providers' qualifications and to ensure providers continue to meet requirements to provide health care services to enrolled members. SHL's credentialing policies and process is in compliance with the National Committee for Quality Assurance (NCQA) credentialing standards. Types of providers credentialed by SHL include the following: Practitioners include: • Allopathic and osteopathic physicians (MDs and DOs) • Physician's assistants (PA-Cs); • Advanced practice nurses (APNs), including: o Nurse Psychotherapists;	Credentialing is a requirement for participation in the various SHL provider networks and all providers must be credentialed prior to contracting. Recredentialing is conducted every 36 months to assess and validate the providers' qualifications and to ensure providers continue to meet requirements to provide health care services to enrolled members. SHL's credentialing policies and process is in compliance with the National Committee for Quality Assurance (NCQA) credentialing standards. Types of providers credentialed by SHL include the following: Practitioners include: • Allopathic and osteopathic physicians (MDs and DOs) • Physician's assistants (PA-Cs); • Advanced practice nurses (APNs), including: o Nurse Psychotherapists;

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	A PA-C or APN preceptor must be a practitioner currently credentialed by SHL. Allied Practioners • Non-physician behavioral health practitioners: o Examples include: marriage and family therapists; professional counselors; mental health counselors; alcoholism and drug abuse practitioners. Organizational Providers: Hospitals (including inpatient rehabilitation facilities), Residential Treatment Centers, Partial hospitalization, Intensive Outpatient Programs, Skilled Nursing Facilities, Nursing homes, Free standing surgical centers, Home Health agencies, Laboratories, Comprehensive Outpatient Rehabilitation Facilities, Outpatient Physical Therapy and Speech Pathology Providers, Providers for end-stage renal disease care and Group homes and Adult Day Care centers. SHL credentialing process includes, but is not limited to the following: Completion, by the provider, of the credentialing application and submission of evidence of professional licensure, malpractice insurance, DEA and state pharmacy certificates. The application must include attestations regarding: o Reasons for any inability to perform the essential functions of the position, with or without accommodation,	A PA-C or APN preceptor must be a practitioner currently credentialed by SHL. Allied Practioners • Non-physician behavioral health practitioners: o Examples include: marriage and family therapists; professional counselors; mental health counselors; alcoholism and drug abuse practitioners. Organizational Providers: Hospitals (including inpatient rehabilitation facilities), Residential Treatment Centers, Partial hospitalization, Intensive Outpatient Programs, Skilled Nursing Facilities, Nursing homes, Free standing surgical centers, Home Health agencies, Laboratories, Comprehensive Outpatient Rehabilitation Facilities, Outpatient Physical Therapy and Speech Pathology Providers, Providers for end-stage renal disease care and Group homes and Adult Day Care centers. SHL credentialing process includes, but is not limited to the following: Completion, by the provider, of the credentialing application and submission of evidence of professional licensure, malpractice insurance, DEA and state pharmacy certificates. The application must include attestations regarding:

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	o Lack of current illegal drug use and/or sobriety (completion of Health Status Form), if applicable o History of loss of license or disciplinary activity, o Felony convictions, o Extensive work gaps, o History of loss or limitation of privileges or disciplinary activity, o History of any malpractice claim or report to the National Practitioner Database (NPDB) or Healthcare Integrity and Protection Data Bank (HIPDB), o Current malpractice insurance coverage, o Correctness and completeness of the application. o History of loss or limitations of status to participate in the Medicare, Medicaid, or Tricare programs. • Primary verification by SHL of the provider's credentials and query of appropriate monitoring agencies include, but is not limited to the following. o License: confirmation from appropriate state agency of license validity, expiration and information as to past, present or pending investigations or sanctions; o DEA certificate and/or state Pharmacy license; o Education and training: graduation from medical or professional school, completion of a residency, board certification (if applicable); o History of professional liability claims which resulted in settlements or judgments paid by or on behalf of the provider;	o Reasons for any inability to perform the essential functions of the position, with or without accommodation, o Lack of current illegal drug use and/or sobriety (completion of Health Status Form), if applicable o History of loss of license or disciplinary activity, o Felony convictions, o Extensive work gaps, o History of loss or limitation of privileges or disciplinary activity, o History of any malpractice claim or report to the National Practitioner Database (NPDB) or Healthcare Integrity and Protection Data Bank (HIPDB), o Current malpractice insurance coverage, o Correctness and completeness of the application. o History of loss or limitations of status to participate in the Medicare, Medicaid, or Tricare programs. • Primary verification by SHL of the provider's credentials and query of appropriate monitoring agencies include, but is not limited to the following. o License: confirmation from appropriate state agency of license validity, expiration and information as to past, present or pending investigations or sanctions; o DEA certificate and/or state Pharmacy license;

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	o Medicare/Medicaid Sanctions and Limitations; o Work History; o Hospital Privileges; o Health Status (Past or present chemical dependence/substance abuse); o Criminal/Felony convictions; o Non Care Complaints and Quality of Care Investigations; o Site Visit Score (If applicable); o Patient Satisfaction Survey Results; o Utilization Management; o Query of the National Practitioner Data Bank; o Query of the Medicare and Medicaid Sanction Report. The Plan's Board of Directors is responsible for the administration of the Credentialing Plan and delegates the overall responsibility for credentialing and recredentialing to the Sierra Health Services Credentialing Committee . As a delegate of UnitedHealthcare, Sierra Health Services is responsible for implementing the UnitedHealthcare Credentialing Plan. The Sierra Health Services Credentialing Committee is comprised of Participating Licensed Individual Providers (LIPs) from the network, Sierra Health and Life Medical Directors, and a designated Medical Director Chairperson; unless a different committee composition is otherwise required by applicable Credentialing Authorities. A quorum of the Sierra Health Services Credentialing Committee is required to make a Credentialing decision. A	o Education and training: graduation from medical or professional school, completion of a residency, board certification (if applicable); o History of professional liability claims which resulted in settlements or judgments paid by or on behalf of the provider; o Medicare/Medicaid Sanctions and Limitations; o Work History; o Hospital Privileges; o Health Status (Past or present chemical dependence/substance abuse); o Criminal/Felony convictions; o Non Care Complaints and Quality of Care Investigations; o Site Visit Score (If applicable); o Patient Satisfaction Survey Results; o Utilization Management; o Query of the National Practitioner Data Bank; o Query of the Medicare and Medicaid Sanction Report. The Plan's Board of Directors is responsible for the administration of the Credentialing Plan and delegates the overall responsibility for credentialing and recredentialing to the Sierra Health Services Credentialing Committee . As a delegate of UnitedHealthcare, Sierra Health Services is responsible for implementing the UnitedHealthcare Credentialing Plan. The Sierra Health Services Credentialing Committee is comprised of Participating

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	quorum requires at least five (5) voting members to be present. The Credentialing committee meets twice a month, once as a seated committee and once as an email committee. The Committee informs providers of credentialing decisions within applicable state or federally mandated timeframes.	Licensed Individual Providers (LIPs) from the network, Sierra Health and Life Medical Directors, and a designated Medical Director Chairperson; unless a different committee composition is otherwise required by applicable Credentialing Authorities. A quorum of the Sierra Health Services Credentialing Committee is required to make a Credentialing decision. A quorum requires at least five (5) voting members to be present. The Credentialing committee meets twice a month, once as a seated committee and once as an email committee. The Committee informs providers of credentialing decisions within applicable state or federally mandated timeframes.
5) What is the Basis for Provider Reimbursement?	**In Network** Reimbursement for in-network individual providers and facilities are determined through a negotiated process. During contract negotiations, the Plan applies the following factors to determine reimbursement for in-network providers for both medical/surgical (med/surg) and mental health/substance use disorder (MH/SUD) services: • Applicable CMS or other rate-setting methodology and benchmark reimbursement data for the provider type; • Member access by geography and specialty; • Impact on total medical cost relative to market and affordability;	**In Network** Reimbursement for in-network individual providers and facilities are determined through a negotiated process. During contract negotiations, the Plan applies the following factors to determine reimbursement for in-network providers for both medical/surgical (med/surg) and mental health/substance use disorder (MH/SUD) services: • Applicable CMS or other rate-setting methodology and benchmark reimbursement data for the provider type; • Member access by geography and specialty; • Impact on total medical cost relative to market and affordability;

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	• Market dynamics, including provider leverage, competitor networks, scarcity of provider type in the market, and the need for provider type in network; • Quality and efficiency; and/or • Provider type (rates may be adjusted for specialists, higher acuity facility types or non-physician provider types like physician assistants or social workers). While some variation may exist for all services, In-Network Provider Reimbursement generally is based on external rate sources for services provided by the same provider type in the same geography and the additional negotiation factors. **Out of Network** The benefit plan terms specify which reimbursement methodologies apply to the benefit plan. The reimbursement methodology generates a base payment rate for a claim. Reimbursement policies apply to the base payment rate and yield an "Allowed Amount." The amount the benefit plan pays to the provider is the Allowed Amount less any member cost- sharing requirement ("Member Responsibility") applicable to a particular type of claim.	• Market dynamics, including provider leverage, competitor networks, scarcity of provider type in the market, and the need for provider type in network; • Quality and efficiency; and/or • Provider type (rates may be adjusted for specialists, higher acuity facility types or non-physician provider types like physician assistants or social workers). While some variation may exist for all services, In-Network Provider Reimbursement generally is based on external rate sources for services provided by the same provider type in the same geography and the additional negotiation factors. **Out of Network** The benefit plan terms specify which reimbursement methodologies apply to the benefit plan. The reimbursement methodology generates a base payment rate for a claim. Reimbursement policies apply to the base payment rate and yield an "Allowed Amount." The amount the benefit plan pays to the provider is the Allowed Amount less any member cost- sharing requirement ("Member Responsibility") applicable to a particular type of claim.
6) Does the Plan Have Exclusions for Failure to Complete a	**In Network & Out of Network** The medical/surgical benefit does not include exclusions based on a failure to complete a course of treatment.	**In Network & Out of Network** The behavioral benefit does not include exclusions based on a failure to complete a course of treatment.

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Course of Treatment?		
7) Does the Plan Include Fail First Requirements (also known as step therapy protocols)?	**In Network & Out of Network** "Fail First" or "Step Therapy" programs are targeted for drug products in therapeutic classes in which several alternatives can be utilized to treat the same condition. Drugs are selected for inclusion in the program with the goal of promoting optimal drug use. Step Therapy programs require the trial of clinically appropriate, lower cost alternative(s) prior to the benefit coverage of a more expensive alternative. Based on, and consistent with, nationally recognized clinical standards, some of the plan's medical/surgical review guidelines have what may be considered to be "fail first" or "step therapy" protocols. In some instances on the pharmacy benefit, step-therapy is utilized to help promote the lower cost alternatives found on lower tiers. The full list of the guidelines (Medical & Drug Policies, Coverage Determination Guidelines, and Protocols) is available at sierrahealthandlife.com.	**In Network & Out of Network** "Fail First" or "Step Therapy" programs are targeted for drug products in therapeutic classes in which several alternatives can be utilized to treat the same condition. Drugs are selected for inclusion in the program with the goal of promoting optimal drug use. Step Therapy programs require the trial of clinically appropriate, lower cost alternative(s) prior to the benefit coverage of a more expensive alternative. Based on, and consistent with, nationally recognized clinical standards, some of the plan's medical/surgical review guidelines have what may be considered to be "fail first" or "step therapy" protocols. In some instances on the pharmacy benefit, step-therapy is utilized to help promote the lower cost alternatives found on lower tiers. The full list of the guidelines (Medical & Drug Policies, Coverage Determination Guidelines, and Protocols) is available at sierrahealthandlife.com. 1.
8) Formulary Design for Prescription Drugs	**In Network & Out of Network** The plan's Prescription Drug List (PDL) and associated management is created and maintained by the Pharmacy & Therapeutics (P&T) Committee. The national P&T Committee reviews and evaluates all NQTLs including clinical and therapeutic factors. The following are considered in the development of NQTLs for all prescription drugs: FDA	**In Network & Out of Network** The process applied by the plan for prescription drug formulary design is the same process as that used for medical/surgical prescription drugs using the same committee and work group and factors noted in the response to the left for medical/surgical prescription drugs.

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	approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant. The P&T committee assesses the prescription drug's place in therapy, and its relative safety and efficacy. The committee reviews decisions consistent with published evidence relative to these factors development by a pharmacoeconomic work group which extensively reviews medical and outcomes literature and financial models which assess the impact of cost versus potential offsets from the use of a prescription drug such as decreases in hospital stays, reduction in lab tests, or medical utilization due to side effects. The committee and work group do not utilize any factors which take into account the prescription drug's primary indication as a mental health or substance use disorder prescription drug. Such drugs are assessed under the process above without regard to their primary indication being related to mental health or substance use disorder.	The plan's Prescription Drug List (PDL) is created utilizing all medications approved by the FDA as a starting point. Certain drugs may then be excluded from the PDL coverage based on a variety of clinical, pharmacoeconomic and financial factors. These factors are also utilized to determine inclusion and tier placement on the PDL. For example, the plan excludes coverage of prescription drugs for which a therapeutic equivalent over-the-counter drug is available. This process is conducted by a national Pharmacy & Therapeutics Committee which reviews and evaluates all clinical and therapeutic factors. The committee meets no less than quarterly and assesses the medication's place in therapy, and its relative safety and efficacy. The committee reviews decisions consistent with published evidence relative to these factors developed by a pharmacoeconomic work group which extensively reviews medical and outcomes literature and financial models which assess the impact of cost versus potential offsets from the use of a prescription drug such as decreases in hospital stays, or reduction in lab tests or medical utilization due to side effects etc. The committee and work group do not utilize any factors which take into account the prescription drug's primary indication as a mental health or substance use disorder prescription drug. Such drugs are assessed under the process above without regard to their primary indication being related to mental health or substance use disorder.

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9) Are There Restrictions Based on Geographic Location?	Yes, to receive benefits, the following geographic restrictions apply: **Individual**: the SHL subscriber must reside in Clark County, Nevada. **Group:** No geographic restrictions	Yes, to receive benefits, the following geographic restrictions apply: **Individual**: the SHL subscriber must reside in Clark County, Nevada. **Group:** No geographic restrictions
10) Does the Plan Require Notification for Inpatient Admissions?	**In Network:** Yes. Facilities must provide notification of all inpatient admissions. The specific requirements for providing inpatient notification can be found within the individual hospital contracts. **Out of Network:** All inpatient services require notification.	**In Network:** Yes. Network facilities must provide notification of all inpatient admissions, including all Residential Treatment Center (RTC) admissions, partial hospitalization and intensive outpatient programs. The specific requirements for providing inpatient notification can be found within the individual hospital contracts. **Out of Network**: All inpatient services require notification.
11) Does the Plan Require Prior Authorization for Inpatient Services?	**In Network:** Yes, network providers are contractually required to obtain prior authorization for several services/procedures. A current listing of these services can be found at www.sierrahealthandlife.com (Go to Doctor/Provider, I need help with: Prior Authorization) or by calling the individual members member service number. **Out of Network:** All inpatient services require notification per the Evidence of Coverage.	**In Network:** Yes, network providers are contractually required to obtain prior authorization for several services/procedures. A current listing of these services can be found at www.sierrahealthandlife.com (Go to Doctor/Provider, I need help with: Prior Authorization) or by calling the individual members member service number. **Out of Network:** All inpatient services require notification per the Evidence of Coverage.
12) Does the Plan Conduct Concurrent Reviews for	**In Network:** Inpatient review is a component of the medical plan's utilization management activities. The Medical Director and other clinical staff review hospitalizations to detect and better manage over- and under-utilization and to	**In Network:** Inpatient review is a component of the medical plan's utilization management activities. The Medical Director and other clinical staff review hospitalizations to detect and better manage over- and

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Inpatient Services?	determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. Inpatient review also gives the plan the opportunity to contribute to decisions about discharge planning and case management. In addition, the plan may identify opportunities for quality improvement and cases that are appropriate for referral to one of our disease management programs. Reviews usually begin on the first business day following admissions. **Out of Network:** All inpatient care is reviewed concurrently for appropriate use of benefit coverage. Concurrent clinical information is required, and is used to develop a discharge plan and ensure appropriate use of the benefit, based on medical necessity.	under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines. Inpatient review also gives the plan the opportunity to contribute to decisions about discharge planning and case management. In addition, the plan may identify opportunities for quality improvement and cases that are appropriate for referral to one of our disease management or whole person care programs. Reviews usually begin on the first business day following admissions. **Out of Network:** All inpatient care is reviewed concurrently for appropriate use of benefit coverage. Concurrent clinical information is required, and is used to develop a discharge plan and ensure appropriate use of the benefit, based on medical necessity.
13) Does the Plan Conduct Retrospective Reviews for Inpatient Services?	**In Network & Out of Network** Yes, post-service, pre-claim reviews are conducted on inpatient services. Network providers follow the same process as is applied for a standard prior authorization request. A clinical coverage review will be done to determine whether the service is medically necessary and payment may be withheld if the services are determined not to have been medically necessary. Urgent services rendered without a required number will also be subject to retrospective review for medical necessity, and	**In Network & Out of Network** Yes, post-service, pre-claim reviews are conducted on inpatient services and on some outpatient procedures or services. Network providers follow the same process as is applied for a standard prior authorization request. A clinical coverage review will be done to determine whether the service is medically necessary and payment may be withheld if the services are determined not to have been medically necessary.

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	payment may be withheld if the services are determined not to have been medically necessary. Network providers/facilities may not balance bill the member/insured for any denied charges under these circumstances.	Urgent services rendered without a required prior authorization will also be subject to retrospective review for medical necessity, and payment may be withheld if the services are determined not to have been medically necessary. Network providers/facilities may not balance bill the member/insured for any denied charges under these circumstances.
14) Does the Plan Require Prior Authorization for Outpatient Services?	**In Network** The Plan requires prior authorization for some outpatient services. Upon request, even when prior authorization is not required, the facility/provider can request that the medical plan provide a medical necessity or coverage determination review of a proposed service prior to the provision of such service. This enables the facility/provider to avoid retrospective medical necessity review, which can result in full or partial denial of claims. The medical plan determines when prior authorization and other management interventions may be required by evaluating the potential administrative cost of these interventions when compared to their potential benefit. The following strategies, processes, evidentiary standards and other factors are used as part of this analysis: 1. Practice Variation/variability by: a. Level of care; b. Geographic region; c. Diagnosis; d. Provider/facility. 2. Significant drivers of cost trend.	**In Network** The Plan requires prior authorization for some outpatient services. Upon request, even when prior authorization is not required, the facility/provider can request that BHO provide a medical necessity or coverage determination review of a proposed service prior to the provision of such service. This enables the facility/provider to avoid retrospective medical necessity review, which can result in full or partial denial of claims. BHO determines when prior authorization and other management interventions may be required by evaluating the potential administrative cost of these interventions when compared to their potential benefit. The following strategies, processes, evidentiary standards and other factors are used as part of this analysis: 1. Practice Variation/variability by: a. Level of care; b. Geographic region; c. Diagnosis; d. Provider/facility. 2. Significant drivers of cost trend.

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	3. Outlier performance against established benchmarks. 4. Disproportionate Utilization. 5. Preference/System driven care: a. Preference driven; b. Supply/demand factors. 6. Gaps in Care that negatively impact cost, quality and/or utilization. 7. Outcome yield from the UM activity/Administrative cost analysis. Based on these strategies, processes, evidentiary standards and other factors the medical/surgical plan requires prior authorization for a range of planned medical/surgical services that are covered under the outpatient benefit. A benefit denial reduction may be imposed for failure to obtain a prior authorization. The amount of reduction depends on the benefit plan. Grace periods are not applicable. The member cannot be balance billed for any denied charges under these circumstances. **Out of Network** When the services on the prior authorization list are obtained from a non-network provider, the member is responsible for obtaining the prior authorization. Clinical information necessary to perform reviews is required. The member can delegate this responsibility to the non- network provider.	3. Outlier performance against established benchmarks. 4. Disproportionate Utilization. 5. Preference/System driven care: a. Preference driven; b. Supply/demand factors. 6. Gaps in Care that negatively impact cost, quality and/or utilization. 7. Outcome yield from the UM activity/Administrative cost analysis. Based on these strategies, processes, evidentiary standards and other factors the behavioral plan requires prior authorization for a small range of planned behavioral services that are covered under the outpatient benefit: • Electroconvulsive therapy (ECT) when scheduled as outpatient; • Partial hospitalization programs; • Intensive outpatient program treatment; • Psychological testing; • Transcranial Magnetic Stimulation Therapy (TMS); • Zulresso infusions for post-partum depression; and A benefit denial or reduction may be imposed for failure to obtain a prior authorization. The amount of reduction depends on the benefit plan. Grace periods are not applicable. The member cannot be balance billed for any denied charges under these circumstances. **Out of Network** When the services on the prior authorization list are obtained from a non-network provider, the member is

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	A prior authorization review involves a medical necessity review based on plan requirements and can result in a medical necessity denial. Members should notify the plan of emergent admissions within 24 hours or as soon as reasonably possible given the circumstances. If prior authorization is not obtained by the member within the required timeframe, a benefit reduction is applied to the member. The reduction percentage will vary by plan and is outlined in the Plan documents.	responsible for obtaining the prior authorization. Clinical information necessary to perform reviews is required. The member can delegate this responsibility to the non- network provider. A prior authorization review involves a medical necessity review based on plan requirements and can result in a medical necessity denial. Members should notify the plan of emergent admissions within 24 hours or as soon as reasonably possible given the circumstances.
15) Does the Plan Conduct Outlier Management & Concurrent Review for Outpatient Services?	**In Network & Out of Network** Some outpatient services are concurrently reviewed to determine if the continued course of outpatient treatment will be covered where outpatient services are approved for a defined period as well as continued or ongoing outpatient services are requested beyond the previously approved services. Outlier management algorithms are applied to outpatient services based on the following criteria: • Treatment plans ranging from 1-24+ visits, with the likelihood for treatment being medically unnecessary increasing with higher number of visits; • Treatment durations ranging from 1-365+ days, with the likelihood for treatment being medically unnecessary increasing with longer treatment durations;	**In Network & Out of Network** Some outpatient services are concurrently reviewed to determine if the continued course of outpatient treatment will be covered where outpatient services are approved for a defined period as well as continued or ongoing outpatient services are requested beyond the previously approved services. Outlier management algorithms are applied to outpatient services based on the following criteria: • Treatment plans ranging from 1-24+ visits, with the likelihood for treatment being medically unnecessary increasing with higher number of visits; • Treatment durations ranging from 1-365+ days, with the likelihood for treatment being medically unnecessary increasing with longer treatment durations;

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	• Visits including multiple units of services, with the likelihood for treatment being medically unnecessary increasing with higher number of services per visit; • Potential to bill for the same service using multiple levels of coding; • Relatively low/modest cost per service; • Variable rates of patient progress during a treatment plan; • Variable approaches to patient care among providers; • Coverage up to and including the point of maximum therapeutic benefit being attained, after which additional improvement is no longer expected, and coverage for the same services may no longer exist; • A portion of patients never having complete resolution of their condition resulting in ongoing management for a chronic condition. Based on the above criteria, the medical/surgical plan has identified the following services in the outpatient classification: • Chiropractic; • Occupational Therapy; • Physical Therapy In order to ensure members have access to services available to them through their COC/COC and the sponsor does not pay for non-covered services, a utilization review program is then applied to the identified medical/surgical services. This utilization review program has the following attributes:	• Visits including multiple units of services, with the likelihood for treatment being medically unnecessary increasing with higher number of services per visit; • Potential to bill for the same service using multiple levels of coding; • Relatively low/modest cost per service; • Variable rates of patient progress during a treatment plan; • Variable approaches to patient care among providers; • Coverage up to and including the point of maximum therapeutic benefit being attained, after which additional improvement is no longer expected, and coverage for the same services may no longer exist; • A portion of patients never having complete resolution of their condition resulting in ongoing management for a chronic condition. Outpatient MH/SUD services rendered using E/M codes are not included in this outlier program. In order to ensure members have access to services available to them through their COC/COC and the sponsor does not pay for non-covered services, a utilization review program is then applied to the identified behavioral services. This utilization review program has the following attributes: • Differentiated utilization review process based on historical provider performance;

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	• Differentiated utilization review process based on historical provider performance; • Business rules identify attributes of cases with a high likelihood for medically unnecessary services currently or in the relatively near future; • Identified cases are clinically reviewed; • In cases with apparent medically unnecessary services, peer to peer telephonic contact is initiated to make sure complete information is available; • In cases where ongoing services have been determined to be unnecessary, an adverse benefit determination is made and member/provider communication, compliant with all state and federal regulatory requirements, is issued; • Appeals process is available for adverse determination.	• Business rules identify attributes of cases with a high likelihood for medically unnecessary services currently or in the relatively near future; • Identified cases are clinically reviewed; • In cases with apparent medically unnecessary services, peer to peer telephonic contact is offered to make sure complete information is available; • In cases where ongoing services have been determined to be unnecessary, an adverse benefit determination is made and member/provider communication, compliant with all state and federal regulatory requirements, is issued; • Appeals process is available for adverse determination
16) Does the Plan Conduct Retrospective Review for Outpatient Services?	**In Network & Out of Network** Yes, post-service, pre-claim reviews are conducted on outpatient services. Network providers follow the same process as is applied for a standard prior authorization request. A clinical coverage review will be done to determine whether the service is medically necessary and payment may be withheld if the services are determined not to have been medically necessary. Urgent or emergent services rendered without a required prior authorization number will also be subject to retrospective review for medical necessity, and payment may be withheld if	**In Network & Out of Network** Yes, post-service, pre-claim reviews are conducted on outpatient services. Network providers follow the same process as is applied for a standard prior authorization request. A clinical coverage review will be done to determine whether the service is medically necessary and payment may be withheld if the services are determined not to have been medically necessary. Urgent or emergent services rendered without a required prior authorization number will also be subject to retrospective review for medical necessity, and payment

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	the services are determined not to have been medically necessary. Network providers and facilities may not balance bill the member for any denied charges under these circumstances.	may be withheld if the services are determined not to have been medically necessary. Network providers and facilities may not balance bill the member for any denied charges under these circumstances.

