Connecticut Nonquantitative Treatment Limitation "NQTL" Report

To

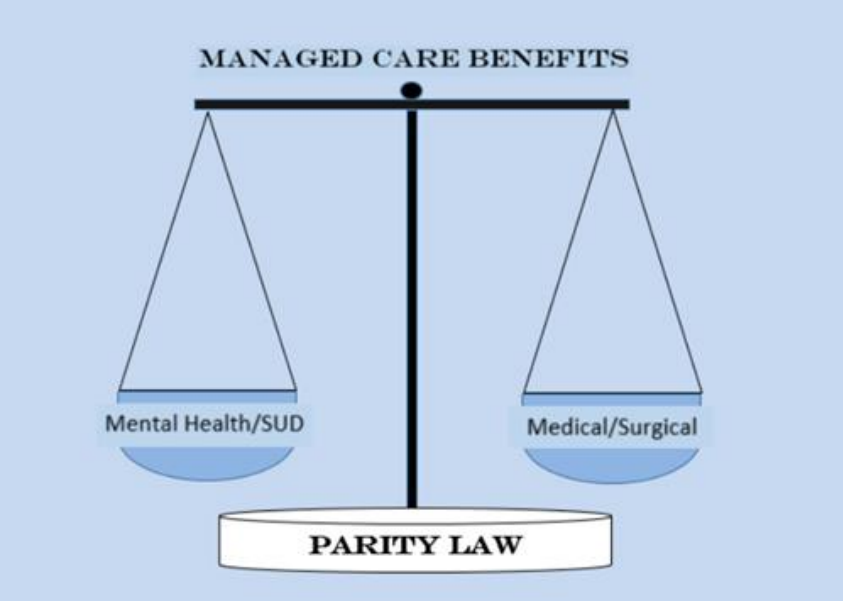
Insurance and Real Estate Committee

Presented by

Connecticut Insurance Department

Andrew N. Mais, Commissioner

April 2, 2025



Pursuant to CGS, Sec. 38a-477ee, the Connecticut Insurance Department is providing the 2025 report concerning nonquantitative treatment limitations submitted by pertinent insurers to the Commissioner ("Report").

The Report includes each NQTL report that the Insurance Commissioner received pursuant to Subsection (b) of 38a-477ee for calendar year 2024.

The data targets three (3) primary areas of disclosure:

(1) Processes used to develop and select medical necessity criteria for mental health and substance use disorder benefits and medical and surgical benefits.

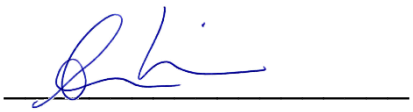
(2) A description of all medically necessary and administrative nonquantitative treatment limitations (NQTL's) applied to mental health and substance use disorder benefits and medical and surgical benefits.

(3) Documentation of every evidentiary standard supporting each medical necessity criteria used within each NQTL, full disclosure of all factors used within each NQTL and comparative analysis of the NQTL "as-written" and the NQTL "in-operation," as designed and as applied to processes for mental health and substance use disorder, demonstrating that they are comparable and being no less stringently designed and applied to the similar medical and surgical benefits. This has been enhanced to include (3) critical areas for Mental Health Parity comparative review: (1) A prospective analysis on the as-written benefit limiting standards, (2) A concurrent or operational analysis on the in-practice benefit limiting processes, and (3) A retrospective analysis on the operational outcomes of the benefit limiting impacts.

This Report evaluates Benefit Limiting practices between mental health/substance use disorder benefits and medical/surgical benefits using Three (3) Parity Analysis Checkpoints, prospective analysis on the as-written benefit limiting outcomes, concurrent or operational analysis on the in-practice benefit limiting processes, and retrospective analysis on the operational outcomes of any benefit limiting impact whenever they produce substantially disparate outcome results.

We hope you find this report informative.

Respectfully,



Andrew N. Mais
Insurance Commissioner

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Connecticut Nonquantitative Treatment Limitation Annual Report-2025

I. Introduction

Pursuant to C.G.S. Section 38a-477ee, the Connecticut Insurance Department ("the Department") hereby submits its 2025 NQTL annual Report to the General Assembly. Included are the various reports received by the Commissioner pursuant to Subsection (b) of CGS, Section 38a-477ee reflecting calendar year 2024 data.

II. Background

In 2019, the Connecticut legislature passed Public Act 19-159 (the "Act"), which, among other things, mandated that each health carrier was required to submit, not later than March 1, 2021, and annually thereafter, a report to the Commissioner, in a form and manner prescribed by the Commissioner, containing the following information for the calendar year immediately preceding:

(1) A description of the processes that such health carrier used to develop and select criteria to assess the medical necessity of (A) mental health and substance use disorder benefits, and (B) medical and surgical benefits.

(2) A description of all nonquantitative treatment limitations that such health carrier applied to (A) mental health and substance use disorder benefits, and (B) medical and surgical benefits.

(3) The results of an analysis concerning the processes, strategies, evidentiary standards and other factors that such health carrier used in developing and applying the criteria and each nonquantitative treatment limitation, provided the commissioner is not permitted to disclose such results in a manner that is likely to compromise the financial, competitive or proprietary nature of such results.

In accordance with the Act, the results of such analysis shall, at a minimum:

(A) Disclose each factor that such health carrier considered, regardless of whether such health carrier rejected such factor, in designing each nonquantitative treatment limitation and determining whether to apply such nonquantitative treatment limitation.

(B) Disclose any and all evidentiary standards, which standards may be qualitative or quantitative in nature, applied under a factor, and, if no evidentiary standard is applied under such a factor, a clear description of such factor.

(C) Provide comparative analyses, including the results of such analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the processes and strategies used to apply such nonquantitative treatment limitation, as written, to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, and the processes and strategies used to apply such nonquantitative treatment limitation, as written, to medical and surgical benefits.

(D) Provide comparative analyses, including the results of such analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, to medical and surgical benefits.

(E) Disclose information that, in the opinion of the Insurance Commissioner, is sufficient to demonstrate that such health carrier, consistent with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, as amended from time to time, and regulations adopted thereunder, applied each nonquantitative treatment limitation comparably, and not more stringently, to mental health and substance use disorder benefits, and to medical and surgical benefits. Carriers are also required to demonstrate that they have complied with 38a-488c and 38a-514c, 38a-488a and 38a-514, 38a-510 and 38a-544,

and (IV) the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Subsection (c) of CGS, Sec. 38a-477ee precludes the Commissioner from divulging the name or identity of any health carrier or entity that has contracted with such health carrier, and mandates that such name or identity shall be given confidential treatment and not be made public by the Commissioner.

In addition to our statute applicable federal law, through the enactment of the Consolidation Appropriations Act imposed additional requirements. The Consolidated Appropriations Act of 2021 was enacted on December 27, 2020 (effective 2/2021). Section 203 of Title II of Division BB of the CAA amended Mental Health Parity and Addiction Equity Act, (MHPAEA), by expressly requiring group health plans and health insurance issuers imposing NQTLs on benefits to perform, demonstrate and document a comparative analysis of the design and application of any limitation on a benefits scope or duration.

This is an important update to MHPAEA because it significantly improved benefit comparability guidance for both the industry and the regulators. All stakeholders now have clear guidance on what is required and expected to demonstrate and perform a sufficient comparative analysis on benefit limiting practices and outcomes.

III. Description of Analysis

The federal MHPAEA defines nonquantitative treatment limitations as most commonly non-numeric standards that are designed and operationally applied in the management and delivery of healthcare. It is understood and recognized that these NQTL standards ultimately result in limiting the scope of Mental Health, Substance Use Disorder and Medical/Surgical benefits. The law establishes that NQTL's are an important tool in the management of healthcare, but it also specifically requires that these NQTL's be designed and applied comparably between Mental Health, Substance Use Disorder and Medical/Surgical benefits and that the health insurers document and demonstrate this comparative analysis. The expectation is that NQTL's components, such as prior-authorization or concurrent care review practices, would be applied to Mental Health and Substance Abuse Disorder benefits comparably and no more stringently than they would be applied to Medical/Surgical benefits. Finally, the federal law points out that these benefits can maintain comparable in-practice

limiting standards that produce incongruent final operational outcomes because of justifiable clinical differences or experiences, but that these instances require an advanced comparative analysis demonstration.

This Report requires health insurers to conduct three (3) points in-time comparative benefit limiting reviews whenever they differ between similar benefit classifications within mental health/substance use disorder benefits and medical/surgical benefits: (1) A prospective analysis on all as-written benefit limiting standards, (2) A concurrent or operational analysis on all in-practice benefit limiting processes, and (3) A retrospective analysis on the operational outcomes of the benefit limiting impacts whenever actual outcome results are substantially disparate or non-comparative.

IV. Limitations of Analysis

The analysis is based on the 2024 health plan year and relies on information disclosed by the health carriers in their reports to the Insurance Department, in accordance with the Department's Bulletin MC-24A, revised November 30, 2021.

V. Key Findings

While the data is limited to what was requested and what was disclosed, there are some observations to be made. Certain health carriers provided sufficient information and supporting documentation regarding a reasoned discussion of 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 written, in operation and with the outcome results.

Overall, health carriers have continued to provide a more extensive analysis of any Mental Health / Substance Use Disorder (MH/SUD) and Medical / Surgical Benefits (Med/Surg) benefit differences. In addition, it appears that the carriers have continued to make progress in addressing provider reimbursement disparity gaps.

Based on the Department’s initial assessment of the exhibits, it was observed that there were certain instances where insufficient information and incomplete comparative analysis appears to have been provided. These areas included

pharmaceutical formulary limitation practices, participating & non-participating provider reimbursement rate methods, in-person care network access standards and prior-authorization impact analysis. The Department is following up with targeted interrogatories, to the health carriers, requiring the additional information and analysis proving comparative compliance.

The Department did identify some concerns that the Companies were not conducting comparative tests or audits on the new patient acceptance rates, or the patient wait times within their networks between similarly skilled & qualified Mental Health and Medical/Surgical providers. In addition, it appeared that the Companies did not maintain sufficient network comparability validations for mental health parity involving their provider enrollment questionnaires and self-surveying.

Also, the Department discovered that some parity compliance programs did maintain inconsistent analysis practices for certain classifications, but that these differences did not translate to any substantial outcome inequities or rise to the level of requiring administrative action.

It should be noted that insurers have maintained a high degree of cooperativeness and willingness with the Department as we work to improve and advance the effectiveness of this program.

VI. Detailed Findings

This discussion corresponds to the reports and charts attached as-Health Carrier Individual Reports-Exhibit A Submissions
The reader is encouraged to review those exhibits for full details.

Exhibit A (1)

Annual Mental Health and Substance Use Benefits Compliance Report

Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:

Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (13) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	**Medical/Surgical Benefits**
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.	Medical Necessity is defined as follows: "Medically Necessary/Medical Necessity Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization: • required to diagnose or treat an illness, injury, disease or its symptoms; • in accordance with generally accepted standards of medical practice; • clinically appropriate in terms of type, frequency, extent, site and duration; • not primarily for the convenience of the patient, Physician or other health care provider; • not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare	Medical Necessity is defined as follows: "Medically Necessary/Medical Necessity Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization: • required to diagnose or treat an illness, injury, disease or its symptoms; • in accordance with generally accepted standards of medical practice; • clinically appropriate in terms of type, frequency, extent, site and duration; • not primarily for the convenience of the patient, Physician or other health care provider; • not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare

	the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting. • rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting. In determining whether health care services, supplies, or medications are Medically Necessary, the company(ies) Medical Director or Review Organization may rely on the clinical coverage policies maintained by the company(ies) or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines." Development of Clinical Criteria The company(ies) utilizes its own internally developed coverage policies and the MCG™ Guidelines when conducting medical necessity reviews of M/S or Mental Health (MH) services, and the "The ASAM Criteria®" when conducting medical necessity reviews of Substance Use Disorder (SUD) services and technologies. As a point of clarification, the use of the various guidelines for clinical criteria/medical necessity (both external and internal) do not overlap and there is no hierarchical weight assigned to the standard, source, or guideline in any given review for clinical criteria. In other words, the company(ies) always applies MCG clinical criteria to MH services. Where MCG does not have clinical	the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting. • rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting. In determining whether health care services, supplies, or medications are Medically Necessary, the company(ies) Medical Director or Review Organization may rely on the clinical coverage policies maintained by the company(ies) or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines." Development of Clinical Criteria The company(ies) utilizes its own internally developed coverage policies and the MCG™ Guidelines when conducting medical necessity reviews of M/S or Mental Health (MH) services, and the "The ASAM Criteria®" when conducting medical necessity reviews of Substance Use Disorder (SUD) services and technologies. As a point of clarification, the use of the various guidelines for clinical criteria/medical necessity (both external and internal) do not overlap and there is no hierarchical weight assigned to the standard, source, or guideline in any given review for clinical criteria. In other words, the company(ies) always applies MCG clinical criteria to MH services. Where MCG does not have clinical

	criteria for a specific MH service, the company(ies) has developed its own clinical criteria. Where a specific company(ies) medical policy applies, that medical policy applies in whole without regard to other more general guidelines, like the ASAM Criteria® or MCG™ Guidelines as evidenced in the company(ies) Utilization Management Guidelines Policy. The review and approval of Medical Necessity clinical coverage criteria is conducted by the company(ies) Coverage Policy Unit (CPU), in partnership with the company(ies) Healthcare Medical Assessment Committee ("HMAC"). HMAC conducts evidence-based assessments of the medical literature and other sources of information pertaining to the safety and effectiveness of medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals. HMAC is composed of physicians and nurses and includes specialists from both medical and behavioral health disciplines. Internal subject matter experts include orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists cardiologists, psychologists and psychiatrists. HMAC's evidence-based medicine approach ranks the levels of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in the company(ies) "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 and evidenced in the company(ies) Medical Technology Assessment and Coverage Process for Determination of Medical Necessity Coverage Criteria Recommendations Policy (OPS-48): • Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.	criteria for a specific MH service, the company(ies) has developed its own clinical criteria. Where a specific company(ies) medical policy applies, that medical policy applies in whole without regard to other more general guidelines, like the ASAM Criteria® or MCG™ Guidelines as evidenced in the company(ies) Utilization Management Guidelines Policy. The review and approval of Medical Necessity clinical coverage criteria is conducted by the company(ies) Coverage Policy Unit (CPU), in partnership with the company(ies) Healthcare Medical Assessment Committee ("HMAC"). HMAC conducts evidence-based assessments of the medical literature and other sources of information pertaining to the safety and effectiveness of medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals. HMAC is composed of physicians and nurses and includes specialists from both medical and behavioral health disciplines. Internal subject matter experts include orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists cardiologists, psychologists and psychiatrists. HMAC's evidence-based medicine approach ranks the levels of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in the company(ies) "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 and evidenced in the company(ies) Medical Technology Assessment and Coverage Process for Determination of Medical Necessity Coverage Criteria Recommendations Policy (OPS-48): • Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs.

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	Guidelines and/or ASAM Guidelines are also shared upon request. As all services under the benefit plan are subject to the plan definition of medical necessity, this definition applies to emergency and urgent services for M/S and MH/SUD services. Since the company(ies) does not include any Prior Authorization or utilization management of emergency or urgent care services for either M/S or behavioral health services, there are no additional criteria or guidelines that are used. Factors As outlined in the company(ies) definition of medical necessity, the factors below determine when to apply the Medical Necessity NQTL. All factors are based on generally accepted standards of medical practice. These standards include: • Credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community • Physician and health care provider specialty society recommendations • The views of physicians and health care providers practicing in relevant clinical areas and • Any other relevant factor as determined by statute(s) and/or regulation(s). Factor and Definition: • FDA Approval/Clearance • As part of the review process, FDA approval or clearance, as appropriate, is necessary, but not sufficient for the company(ies) to consider a technology, drug, or biologic to be proven. FDA approval or clearance does not apply to all services (i.e., procedures). However, when FDA approval or clearance, as appropriate, is present, the company(ies) reviews English language peer-reviewed publications, as well as relevant documents by specialty societies and evidence-based review centers, such as the Agency for Healthcare Research and Quality (AHRQ). • Peer Reviewed Evidence/Publication	Guidelines and/or ASAM Guidelines are also shared upon request. As all services under the benefit plan are subject to the plan definition of medical necessity, this definition applies to emergency and urgent services for M/S and MH/SUD services. Since the company(ies) does not include any Prior Authorization or utilization management of emergency or urgent care services for either M/S or behavioral health services, there are no additional criteria or guidelines that are used. Factors As outlined in the company(ies) definition of medical necessity, the factors below determine when to apply the Medical Necessity NQTL. All factors are based on generally accepted standards of medical practice. These standards include: • Credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community • Physician and health care provider specialty society recommendations • The views of physicians and health care providers practicing in relevant clinical areas and • Any other relevant factor as determined by statute(s) and/or regulation(s). Factor and Definition: • FDA Approval/Clearance • As part of the review process, FDA approval or clearance, as appropriate, is necessary, but not sufficient for the company(ies) to consider a technology, drug, or biologic to be proven. FDA approval or clearance does not apply to all services (i.e., procedures). However, when FDA approval or clearance, as appropriate, is present, the company(ies) reviews English language peer-reviewed publications, as well as relevant documents by specialty societies and evidence-based review centers, such as the Agency for Healthcare Research and Quality (AHRQ). • Peer Reviewed Evidence/Publication

	• Demonstrated through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness. These include findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes in the federal Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), National Cancer Institute, National Academy of Sciences, Health Care Financing Administration (HCFA), Congressional Office of Technology Assessment, and any national board recognized by the NIH for the purpose of evaluating the medical value of health services. • Clinical Trials and Studies • A phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. • HTAC reviews clinical evidence on drug safety, efficacy and information from treatment guidelines from the National P&T Committee process. Sources and Evidentiary Standards The following evidentiary standards are used to evaluate the clinical appropriateness, effectiveness and safety of M/S and MH/SUD treatments and services. Factor • Food and Drug Administration clearance Sources • FDA.gov https://www.fda.gov/regulatory-information/search-fda-guidance-documents • http://www.fda.gov/RegulatoryInformation/Guidances Evidentiary Standard • FDA Safety Protocols and regulatory guidance Factor • Peer Reviewed Publication Sources	• Demonstrated through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness. These include findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes in the federal Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), National Cancer Institute, National Academy of Sciences, Health Care Financing Administration (HCFA), Congressional Office of Technology Assessment, and any national board recognized by the NIH for the purpose of evaluating the medical value of health services. • Clinical Trials and Studies • A phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. • HTAC reviews clinical evidence on drug safety, efficacy and information from treatment guidelines from the National P&T Committee process. Sources and Evidentiary Standards The following evidentiary standards are used to evaluate the clinical appropriateness, effectiveness and safety of M/S and MH/SUD treatments and services. Factor • Food and Drug Administration clearance Sources • FDA.gov https://www.fda.gov/regulatory-information/search-fda-guidance-documents • http://www.fda.gov/RegulatoryInformation/Guidances Evidentiary Standard • FDA Safety Protocols and regulatory guidance Factor • Peer Reviewed Publication Sources

	• Levels of Evidence Table adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 Specialty society references/guidelines: • PubMed® (including MEDLINE®) • Cumulative Index to Nursing & Allied Health Literature (CINAHL) Database (EBSCOHost) • ScienceDirect • Health Business Full Text (EBSCOHost) • EmBase • American Psychological Association PSYCInfo • Web of Science • Academic Search Complete (EBSCOHost) • The Council of Autism Service Providers (CASP) Evidentiary Standards: • Use of hierarchy of Levels of Scientific Evidence: ○ Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs. ○ Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also, systematic reviews and meta-analyses of non-randomized controlled trials. ○ Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also, systematic reviews and meta-analyses of observational studies. ○ Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also, systematic reviews and meta-analyses of retrospective studies. ○ Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature. Factor: • Clinical Trials & Studies	• Levels of Evidence Table adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 Specialty society references/guidelines: • PubMed® (including MEDLINE®) • Cumulative Index to Nursing & Allied Health Literature (CINAHL) Database (EBSCOHost) • ScienceDirect • Health Business Full Text (EBSCOHost) • EmBase • American Psychological Association PSYCInfo • Web of Science • Academic Search Complete (EBSCOHost) • The Council of Autism Service Providers (CASP) Evidentiary Standards: • Use of hierarchy of Levels of Scientific Evidence: ○ Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs. ○ Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also, systematic reviews and meta-analyses of non-randomized controlled trials. ○ Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also, systematic reviews and meta-analyses of observational studies. ○ Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also, systematic reviews and meta-analyses of retrospective studies. ○ Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature. Factor: • Clinical Trials & Studies Sources:

	Sources:
	• Clinicaltrials.gov
	• FDA's Role: ClinicalTrials.gov Information | FDA
	• Federally funded trial: The study of investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
	  ○ National Institutes of Health (NIH)
	  ○ Centers for Disease Control and Prevention (CDC)
	  ○ Agency for Health Care Research and Quality (AHRQ)
	  ○ Centers for Medicare and Medicaid Services (CMS)
	  ○ A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA)
	
	• A qualified non-governmental research entity identified in NIH guidelines for center support grants ANY of the following:
	  ○ Department of Defense
	  ○ Department of Veterans Affairs o Department of Energy if BOTH of the following conditions are met:
	  • study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
	  • The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
	  • The study or investigation is a drug trial that is exempt from having such an investigational new drug application
	
	Evidentiary Standards:
	• Safety Protocols
		• Clinicaltrials.gov
		• FDA's Role: ClinicalTrials.gov Information | FDA
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		  ○ Agency for Health Care Research and Quality (AHRQ)
		  ○ Centers for Medicare and Medicaid Services (CMS)
		  ○ A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA)
		
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		  ○ Department of Defense
		  ○ Department of Veterans Affairs o Department of Energy if BOTH of the following conditions are met:
		  • study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
		  • The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
		  • The study or investigation is a drug trial that is exempt from having such an investigational new drug application
		
		Evidentiary Standards:
		• Safety Protocols
		• Compliance Guidelines

	• Compliance Guidelines
	• Enforcement Activity
	• Clinical Trial phases:
	  ○ Phase I: Studies that are usually conducted with healthy volunteers and that emphasize safety. The goal is to find out what the drug's most frequent and serious adverse events are and, often, how the drug is metabolized and excreted.
	  ○ Phase II: Studies that gather preliminary data on effectiveness (whether the drug works in people who have a certain disease or condition). For example, participants receiving the drug may be compared with similar participants receiving a different treatment, usually an inactive substance (called a placebo) or a different drug. Safety continues to be evaluated, and short-term adverse events are studied.
	  ○ Phase III: Studies that gather more information about safety and effectiveness by studying different populations and different dosages and by using the drug in combination with other drugs.
	  ○ Phase IV: Studies occurring after FDA has approved a drug for marketing. These including post market requirement and commitment studies that are required of or agreed to by the sponsor. These studies gather additional information about a drug's safety, efficacy, or optimal use (National Institutes of Health [NIH], 2021)
		• Enforcement Activity
		• Clinical Trial phases:
		  ○ Phase I: Studies that are usually conducted with healthy volunteers and that emphasize safety. The goal is to find out what the drug's most frequent and serious adverse events are and, often, how the drug is metabolized and excreted.
		  ○ Phase II: Studies that gather preliminary data on effectiveness (whether the drug works in people who have a certain disease or condition). For example, participants receiving the drug may be compared with similar participants receiving a different treatment, usually an inactive substance (called a placebo) or a different drug. Safety continues to be evaluated, and short-term adverse events are studied.
		  ○ Phase III: Studies that gather more information about safety and effectiveness by studying different populations and different dosages and by using the drug in combination with other drugs.
		  ○ Phase IV: Studies occurring after FDA has approved a drug for marketing. These including post market requirement and commitment studies that are required of or agreed to by the sponsor. These studies gather additional information about a drug's safety, efficacy, or optimal use (National Institutes of Health [NIH], 2021)

In-Patient & In-Network NQTL Practices	The company(ies) applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.	The company(ies) applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.
In-Patient & Out-of-Network NQTL Practices	The company(ies) applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.	The company(ies) applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.
Out-Patient & In-Network NQTL Practices	The company(ies) applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.	The company(ies) applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.
Out-Patient & Out-of-Network NQTL Practices	The company(ies) applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.	The company(ies) applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.

Emergency Services/Benefits NQTL Practices	The company(ies) integrated medical and behavioral health plans have a single benefit for emergency room and urgent care. Accordingly, there are no differences between how coverage for M/S and MH/SUD emergency room and urgent care services.	The company(ies) integrated medical and behavioral health plans have a single benefit for emergency room and urgent care. Accordingly, there are no differences between how coverage for M/S and MH/SUD emergency room and urgent care services.
Rx Formulary Design, Management and Pharmacy Services NQTL Practices	The company(ies) does not distinguish, in writing or in operation, between M/S and MH/SUD benefits in its prescription drug formulary design for its Standard, Value, Advantage, Performance, and Legacy formularies.	The company(ies) does not distinguish, in writing or in operation, between M/S and MH/SUD benefits in its prescription drug formulary design for its Standard, Value, Advantage, Performance, and Legacy formularies.
Prior-Authorization NQTL Practices	The only distinction in utilization management practices as between M/S and MH/SUD services is the company(ies) use of a proactive Peer-To-Peer review for MH/SUD services. **Peer to Peer Review Variation** With respect to MH/SUD benefits, and in contrast to the process for performing M/S benefit reviews, the company(ies) ensures that any potential denial of MH/SUD benefits is preceded by a proactive offer to the provider of a peer-to-peer review when a request to authorize a service in the Inpatient and Outpatient All Other benefit classifications does not appear to be meeting medical necessity. The objectives of proactively seeking a peer-to-peer review is to minimize the risk of issuing a denial where, in fact, the enrollee's clinical situation warrants an approval for medically necessary care yet the provider's request may have incompletely or imprecisely stated the case for medical necessity, or, if a denial is nonetheless issued, mitigating disruption if the loss of coverage results in the enrollee moving to a different treatment type or level of care. The rendering provider is not obligated to participate in the peer-to-peer process. If they decline to participate, are not available for the review, or fail to call in to the scheduled peer-to-peer, then the Medical Director will conduct a "read only" review of the medical file, guided by the ASAM® Criteria, MCG™ and the company(ies) Clinical Coverage Policies and plan documents approved for use in care management determinations, just as they are for the M/S benefit. This process is beneficial for the enrollee and results in greater approvals and fewer appeals of medical necessity denials.	The only distinction in utilization management practices as between M/S and MH/SUD services is the company(ies) use of a proactive Peer-To-Peer review for MH/SUD services. **Peer to Peer Review Variation** With respect to MH/SUD benefits, and in contrast to the process for performing M/S benefit reviews, the company(ies) ensures that any potential denial of MH/SUD benefits is preceded by a proactive offer to the provider of a peer-to-peer review when a request to authorize a service in the Inpatient and Outpatient All Other benefit classifications does not appear to be meeting medical necessity. The objectives of proactively seeking a peer-to-peer review is to minimize the risk of issuing a denial where, in fact, the enrollee's clinical situation warrants an approval for medically necessary care yet the provider's request may have incompletely or imprecisely stated the case for medical necessity, or, if a denial is nonetheless issued, mitigating disruption if the loss of coverage results in the enrollee moving to a different treatment type or level of care. The rendering provider is not obligated to participate in the peer-to-peer process. If they decline to participate, are not available for the review, or fail to call in to the scheduled peer-to-peer, then the Medical Director will conduct a "read only" review of the medical file, guided by the ASAM® Criteria, MCG™ and the company(ies) Clinical Coverage Policies and plan documents approved for use in care management determinations, just as they are for the M/S benefit. This process is beneficial for the enrollee and results in greater approvals and fewer appeals of medical necessity denials.

	The company(ies) medical necessity review of MH/SUD services is guided by the ASAM Criteria, MCG and the company(ies) Clinical Coverage policies and plan documents approved for use in care management determinations. The company(ies) Peer-to-Peer review program is triggered when a care manager receives clinical information that does not appear to meet the ASAM Criteria, MCG and the company(ies) Clinical Coverage policies and plan documents for initial or prior authorization for level of care requested. In this instance, care managers may offer a lower level of care to ensure there is no delay or impediment to care where the medical necessity criteria is met. If that level of care is not accepted by the requesting provider (treating practitioner), the case is referred to Peer-to-peer review with a behavioral health physician reviewer. The Peer-to-Peer review is available for any coverage request for which the company(ies) anticipates issuing a denial the company(ies) incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a company(ies) clinician proactively solicit a peer-to-peer review with the rendering provider. After completing the peer-to-peer review with the rendering provider, the company(ies) Medical Director makes a decision to approve or deny the requested service, based on all of the clinical information provided. Peer-to-peer reviews that are declined by the requesting provider result in the company(ies) Medical Director making a decision to approve or deny the requested service based on the clinical information that was submitted and obtained by the company(ies) clinician. All reconsideration and appeal options are available if a case results in a denial, just as they are available for denials issues for an M/S request. If the company(ies) pro-active, volunteer Peer-to-Peer review were not applicable to MH/SUD services, and such services followed a similar process to the M/S benefit, services that were approved due to such Peer-to-Peer review, would have been much more likely to have resulted in a denial without	The company(ies) medical necessity review of MH/SUD services is guided by the ASAM Criteria, MCG and the company(ies) Clinical Coverage policies and plan documents approved for use in care management determinations. The company(ies) Peer-to-Peer review program is triggered when a care manager receives clinical information that does not appear to meet the ASAM Criteria, MCG and the company(ies) Clinical Coverage policies and plan documents for initial or prior authorization for level of care requested. In this instance, care managers may offer a lower level of care to ensure there is no delay or impediment to care where the medical necessity criteria is met. If that level of care is not accepted by the requesting provider (treating practitioner), the case is referred to Peer-to-peer review with a behavioral health physician reviewer. The Peer-to-Peer review is available for any coverage request for which the company(ies) anticipates issuing a denial the company(ies) incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a company(ies) clinician proactively solicit a peer-to-peer review with the rendering provider. After completing the peer-to-peer review with the rendering provider, the company(ies) Medical Director makes a decision to approve or deny the requested service, based on all of the clinical information provided. Peer-to-peer reviews that are declined by the requesting provider result in the company(ies) Medical Director making a decision to approve or deny the requested service based on the clinical information that was submitted and obtained by the company(ies) clinician. All reconsideration and appeal options are available if a case results in a denial, just as they are available for denials issues for an M/S request. If the company(ies) pro-active, volunteer Peer-to-Peer review were not applicable to MH/SUD services, and such services followed a similar process to the M/S benefit, services that were approved due to such Peer-to-Peer review, would have been much more likely to have resulted in a denial without

	additional information or discussion to meet clinical criteria. The provider has the right to decline the peer review and move forward retaining the same rights post-decision/denial. The company(ies) pro-active Peer-to-Peer review is more favorable to the enrollee and the rendering/requesting provide resulting in a less stringent, more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is, unless otherwise required by state law, conducted reactively, i.e., if the rendering provider outreaches to the company(ies).	additional information or discussion to meet clinical criteria. The provider has the right to decline the peer review and move forward retaining the same rights post-decision/denial. The company(ies) pro-active Peer-to-Peer review is more favorable to the enrollee and the rendering/requesting provide resulting in a less stringent, more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is, unless otherwise required by state law, conducted reactively, i.e., if the rendering provider outreaches to the company(ies).
Concurrent Review Benefit NQTL Practices	The only distinction in utilization management practices as between M/S and MH/SUD services is the company(ies) use of a proactive Peer-To-Peer review for MH/SUD services. **Peer to Peer Review Variation** With respect to MH/SUD benefits, and in contrast to the process for performing M/S benefit reviews, the company(ies) ensures that any potential denial of MH/SUD benefits is preceded by a proactive offer to the provider of a peer-to-peer review when a request to authorize a service in the Inpatient and Outpatient All Other benefit classifications does not appear to be meeting medical necessity. The objectives of proactively seeking a peer-to-peer review is to minimize the risk of issuing a denial where, in fact, the enrollee's clinical situation warrants an approval for medically necessary care yet the provider's request may have incompletely or imprecisely stated the case for medical necessity, or, if a denial is nonetheless issued, mitigating disruption if the loss of coverage results in the enrollee moving to a different treatment type or level of care. The rendering provider is not obligated to participate in the peer-to-peer process. If they decline to participate, are not available for the review, or fail to call in to the scheduled peer-to-peer, then the Medical Director will conduct a "read only" review of the medical file, guided by the ASAM® Criteria, MCG™ and the company(ies) Clinical Coverage Policies and plan documents approved for use in care management determinations, just as they are for the M/S benefit. This	The only distinction in utilization management practices as between M/S and MH/SUD services is the company(ies) use of a proactive Peer-To-Peer review for MH/SUD services. **Peer to Peer Review Variation** With respect to MH/SUD benefits, and in contrast to the process for performing M/S benefit reviews, the company(ies) ensures that any potential denial of MH/SUD benefits is preceded by a proactive offer to the provider of a peer-to-peer review when a request to authorize a service in the Inpatient and Outpatient All Other benefit classifications does not appear to be meeting medical necessity. The objectives of proactively seeking a peer-to-peer review is to minimize the risk of issuing a denial where, in fact, the enrollee's clinical situation warrants an approval for medically necessary care yet the provider's request may have incompletely or imprecisely stated the case for medical necessity, or, if a denial is nonetheless issued, mitigating disruption if the loss of coverage results in the enrollee moving to a different treatment type or level of care. The rendering provider is not obligated to participate in the peer-to-peer process. If they decline to participate, are not available for the review, or fail to call in to the scheduled peer-to-peer, then the Medical Director will conduct a "read only" review of the medical file, guided by the ASAM® Criteria, MCG™ and the company(ies) Clinical Coverage Policies and plan documents approved for use in care management determinations, just as they are for the M/S benefit. This process is beneficial for the enrollee and

	process is beneficial for the enrollee and results in greater approvals and fewer appeals of medical necessity denials. The company(ies) medical necessity review of MH/SUD services is guided by the ASAM Criteria, MCG and the company(ies) Clinical Coverage policies and plan documents approved for use in care management determinations. The company(ies) Peer-to-Peer review program is triggered when a care manager receives clinical information that does not appear to meet the ASAM Criteria, MCG and the company(ies) Clinical Coverage policies and plan documents for initial or prior authorization for level of care requested. In this instance, care managers may offer a lower level of care to ensure there is no delay or impediment to care where the medical necessity criteria is met. If that level of care is not accepted by the requesting provider (treating practitioner), the case is referred to Peer-to-peer review with a behavioral health physician reviewer. The Peer-to-Peer review is available for any coverage request for which the company(ies) anticipates issuing a denial the company(ies) incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a company(ies) clinician proactively solicit a peer-to-peer review with the rendering provider. After completing the peer-to-peer review with the rendering provider, the company(ies) Medical Director makes a decision to approve or deny the requested service, based on all of the clinical information provided. Peer-to-peer reviews that are declined by the requesting provider result in the company(ies) Medical Director making a decision to approve or deny the requested service based on the clinical information that was submitted and obtained by the company(ies) clinician. All reconsideration and appeal options are available if a case results in a denial, just as they are available for denials issues for an M/S request. If the company(ies) pro-active, volunteer Peer-to-Peer review were not applicable to MH/SUD services, and such services followed a similar process to the M/S benefit, services that	results in greater approvals and fewer appeals of medical necessity denials. The company(ies) medical necessity review of MH/SUD services is guided by the ASAM Criteria, MCG and the company(ies) Clinical Coverage policies and plan documents approved for use in care management determinations. The company(ies) Peer-to-Peer review program is triggered when a care manager receives clinical information that does not appear to meet the ASAM Criteria, MCG and the company(ies) Clinical Coverage policies and plan documents for initial or prior authorization for level of care requested. In this instance, care managers may offer a lower level of care to ensure there is no delay or impediment to care where the medical necessity criteria is met. If that level of care is not accepted by the requesting provider (treating practitioner), the case is referred to Peer-to-peer review with a behavioral health physician reviewer. The Peer-to-Peer review is available for any coverage request for which the company(ies) anticipates issuing a denial the company(ies) incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a company(ies) clinician proactively solicit a peer-to-peer review with the rendering provider. After completing the peer-to-peer review with the rendering provider, the company(ies) Medical Director makes a decision to approve or deny the requested service, based on all of the clinical information provided. Peer-to-peer reviews that are declined by the requesting provider result in the company(ies) Medical Director making a decision to approve or deny the requested service based on the clinical information that was submitted and obtained by the company(ies) clinician. All reconsideration and appeal options are available if a case results in a denial, just as they are available for denials issues for an M/S request. If the company(ies) pro-active, volunteer Peer-to-Peer review were not applicable to MH/SUD services, and such services followed a similar process to the M/S benefit, services that

	were approved due to such Peer-to-Peer review, would have been much more likely to have resulted in a denial without additional information or discussion to meet clinical criteria. The provider has the right to decline the peer review and move forward retaining the same rights post-decision/denial. The company(ies) pro-active Peer-to-Peer review is more favorable to the enrollee and the rendering/requesting provide resulting in a less stringent, more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is, unless otherwise required by state law, conducted reactively, i.e., if the rendering provider outreaches to the company(ies).	were approved due to such Peer-to-Peer review, would have been much more likely to have resulted in a denial without additional information or discussion to meet clinical criteria. The provider has the right to decline the peer review and move forward retaining the same rights post-decision/denial. The company(ies) pro-active Peer-to-Peer review is more favorable to the enrollee and the rendering/requesting provide resulting in a less stringent, more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is, unless otherwise required by state law, conducted reactively, i.e., if the rendering provider outreaches to the company(ies).
Retrospective Review Benefit NQTL Practices	The company(ies) applies the Retrospective Review NQTL comparably and no more stringently to MH/SUD benefits than to M/S benefits.	The company(ies) applies the Retrospective Review NQTL comparably and no more stringently to MH/SUD benefits than to M/S benefits.
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	The company(ies) applies Clinical Procedure Coding, Billing Coding and Process NQTL practices comparably and no more stringently to MH/SUD benefits than to M/S benefits.	The company(ies) applies Clinical Procedure Coding, Billing Coding and Process NQTL practices comparably and no more stringently to MH/SUD benefits than to M/S benefits.
Case & Medical Management NQTL Practices	Participation in case management services is not required, and an enrollee's participation in case management services does not limit the scope or duration of benefits for either MH/SUD or M/S benefits. For Medical management see peer to peer review information in Prior auth and Concurrent.	Participation in case management services is not required, and an enrollee's participation in case management services does not limit the scope or duration of benefits for either MH/SUD or M/S benefits. For Medical management see peer to peer review information in Prior auth and Concurrent.
Network Adequacy & Provider Reimbursement Rates	The company(ies) consider the composition of its current M/S network providers and MH/SUD network providers by provider type and/or specialty, in addition to census (membership) data, to ensure that the company(ies) maintain an adequate M/S provider network and an adequate MH/SUD provider network to meet the clinical needs of its customers, contracted requirements and identified client expectations as applicable "Access" is the extent to which the company(ies) has providers of an appropriate type and number distributed geographically to meet the needs of members and "availability" is defined as the timeliness within which a member can obtain services by appointment (i.e, routine appointment within 10 business days for the	The company(ies) consider the composition of its current M/S network providers and MH/SUD network providers by provider type and/or specialty, in addition to census (membership) data, to ensure that the company(ies) maintain an adequate M/S provider network and an adequate MH/SUD provider network to meet the clinical needs of its customers, contracted requirements and identified client expectations as applicable "Access" is the extent to which the company(ies) has providers of an appropriate type and number distributed geographically to meet the needs of members and "availability" is defined as the timeliness within which a member can obtain services by appointment (i.e, routine appointment within 10 business days for the initial visit, as

	initial visit, as prescribed by NCQA and 30 days for routine follow-up care, unless otherwise required by state law). The company(ies) each conduct oversight and monitoring of the adequacy of its M/S provider network(s) and MH/SUD provider network to assess whether they are meeting its internal and regulatory driven network access standards. These reviews are done twice annually for MH/SUD benefits and not less than annually for M/S providers. When access to care standards are not met, each engage in active recruitment of the relevant provider type and/or specialty at issue. The company(ies) each maintain separate but aligned policies regarding measuring access and availability of providers and services. Such aligned policies include identical population and density parameters, including an identical calculation for provider to customer ratio and defined terms related to population density including urban, suburban and rural. The company(ies) conduct annual analysis of network adequacy requirements. The company(ies) acknowledge provider types are not identical and cannot be made identical due to the inherent differences between M/S and MH/SUD provider services, credentialing and licensing requirements. The company(ies) use Quest Analytics software program to determine the distance between a participant and defined provider types and evaluate the availability of providers within the network. Availability standards are established by utilizing Federal and State standards and internal performance metrics for both the M/S and MH/SUD provider networks. The company(ies) M/S provider availability does not include facility to patient ratios while the company(ies) MH/SUD includes ratios for inpatient facilities, residential facilities and ambulatory programs and requires access to care standards for facilities within 25 miles of an urban setting, 30 miles of a suburban setting and 40 miles of a rural setting. While certain M/S providers are classified and tracked as high volume/high impact, MH/SUD does not create the same distinction	prescribed by NCQA and 30 days for routine follow-up care, unless otherwise required by state law). The company(ies) each conduct oversight and monitoring of the adequacy of its M/S provider network(s) and MH/SUD provider network to assess whether they are meeting its internal and regulatory driven network access standards. These reviews are done twice annually for MH/SUD benefits and not less than annually for M/S providers. When access to care standards are not met, each engage in active recruitment of the relevant provider type and/or specialty at issue. The company(ies) each maintain separate but aligned policies regarding measuring access and availability of providers and services. Such aligned policies include identical population and density parameters, including an identical calculation for provider to customer ratio and defined terms related to population density including urban, suburban and rural. The company(ies) conduct annual analysis of network adequacy requirements. The company(ies) acknowledge provider types are not identical and cannot be made identical due to the inherent differences between M/S and MH/SUD provider services, credentialing and licensing requirements. The company(ies) use Quest Analytics software program to determine the distance between a participant and defined provider types and evaluate the availability of providers within the network. Availability standards are established by utilizing Federal and State standards and internal performance metrics for both the M/S and MH/SUD provider networks. The company(ies) M/S provider availability does not include facility to patient ratios while the company(ies) MH/SUD includes ratios for inpatient facilities, residential facilities and ambulatory programs and requires access to care standards for facilities within 25 miles of an urban setting, 30 miles of a suburban setting and 40 miles of a rural setting. While certain M/S providers are classified and tracked as high volume/high impact, MH/SUD does not create the same distinction because all MH/SUD providers are considered high impact.

	because all MH/SUD providers are considered high impact. The company(ies) measures prescribers including MD, Nurse Practitioners, Physicians Assistants, Psychologists and Masters Level providers and each are considered high impact due to the critical importance of access. In plans without an out-of-network benefit, in the event an enrollee cannot secure a provider or appointment within a reasonable time/distance or with reasonable appointment availability the company(ies) will authorize out-of-network services at the in-network benefit level. Enrollees are able to receive assistance in locating a provider or appointment by contacting the phone number on the back of their ID card. As an additional way of ensuring meaningful access to services, the company(ies) also measures, consistent with NCQA standards, accessibility of care to MH/SUD providers annually using findings from enrollee surveys and complaints and by measuring results against the accessibility standards and metrics. The company(ies) uses the continuous quality improvement (CQI) process to identify opportunities for improvement. The company(ies) has reviewed and rendered uniform, where appropriate, its M/S and MH/SUD network adequacy policies and procedures to ensure comparability across M/S and MH/SUD providers. These policies and procedures are reviewed at least annually to ensure the continued sufficiency of the standards in meeting enrollees' needs. The company(ies) uses a combined network adequacy policy, and a similar reporting template is used for both M/S and MH/SUD benefits. Both MH/SUD and M/S negotiations are based upon provider and information availability at a single point in-time. Network adequacy standards (Network Need) is a contributing factor for both MH/SUD and M/S providers during a reimbursement negotiation. It is important to note that different providers and facilities have vastly different negotiating or so-called bargaining power. A provider's bargaining power depends on	The company(ies) measures prescribers including MD, Nurse Practitioners, Physicians Assistants, Psychologists and Masters Level providers and each are considered high impact due to the critical importance of access. In plans without an out-of-network benefit, in the event an enrollee cannot secure a provider or appointment within a reasonable time/distance or with reasonable appointment availability the company(ies) will authorize out-of-network services at the in-network benefit level. Enrollees are able to receive assistance in locating a provider or appointment by contacting the phone number on the back of their ID card. As an additional way of ensuring meaningful access to services, the company(ies) also measures, consistent with NCQA standards, accessibility of care to MH/SUD providers annually using findings from enrollee surveys and complaints and by measuring results against the accessibility standards and metrics. The company(ies) uses the continuous quality improvement (CQI) process to identify opportunities for improvement. The company(ies) has reviewed and rendered uniform, where appropriate, its M/S and MH/SUD network adequacy policies and procedures to ensure comparability across M/S and MH/SUD providers. These policies and procedures are reviewed at least annually to ensure the continued sufficiency of the standards in meeting enrollees' needs. The company(ies) uses a combined network adequacy policy, and a similar reporting template is used for both M/S and MH/SUD benefits. Both MH/SUD and M/S negotiations are based upon provider and information availability at a single point in-time. Network adequacy standards (Network Need) is a contributing factor for both MH/SUD and M/S providers during a reimbursement negotiation. It is important to note that different providers and facilities have vastly different negotiating or so-called bargaining power. A provider's bargaining power depends on

	several factors of which cannot simply be reduced to supply and demand including the provider's size (e.g., a large statewide or national hospital system vs. an individual solo practitioner); the scarcity or the "supply" of that provider type or specialty; and the reputation, name recognition, and/or quality of the provider. As expected, providers and facilities that for a variety of reasons have more bargaining power are able to negotiate higher reimbursement. The company(ies) measures accessibility of care to behavioral (prescriber and non-prescriber), PCP, and High- Impact/High-Volume SPC providers using findings from customer surveys and complaints, and by measuring results against the accessibility standards and metrics annually. The company(ies) uses the continuous quality improvement ("CQI") process to identify opportunities for improvement and when network adequacy gaps are identified and brought to the attention of the Behavioral Health Provider Operations Program Management Team (for either provider or facility). The company(ies) monitor network adequacy on at least an annual basis and creates recruitment and corrective action plans to address any deficiencies. Recruitment activity may include targeted specialties, market specific initiatives, customer notifications and network adequacy corrective actions determined during annual review as well as Quality Management analysis of provider surveys and customer complaints related to access and availability. Recruitment plans to address network adequacy are developed and modified as needed throughout the year. The company(ies) is currently implementing processes to bolster action plans to recruit MH/SUD providers in areas of need, consistent with its focus on developing robust MH/SUD provider networks. In many instances, deficiencies are a result of insufficient availability of providers/facilities. Both MH/SUD and M/S networks are held to the same 90% standard. In most instances inability to meet the 90% threshold is related to	several factors of which cannot simply be reduced to supply and demand including the provider's size (e.g., a large statewide or national hospital system vs. an individual solo practitioner); the scarcity or the "supply" of that provider type or specialty; and the reputation, name recognition, and/or quality of the provider. As expected, providers and facilities that for a variety of reasons have more bargaining power are able to negotiate higher reimbursement. The company(ies) measures accessibility of care to behavioral (prescriber and non-prescriber), PCP, and High- Impact/High-Volume SPC providers using findings from customer surveys and complaints, and by measuring results against the accessibility standards and metrics annually. The company(ies) uses the continuous quality improvement ("CQI") process to identify opportunities for improvement and when network adequacy gaps are identified and brought to the attention of the Behavioral Health Provider Operations Program Management Team (for either provider or facility). The company(ies) monitor network adequacy on at least an annual basis and creates recruitment and corrective action plans to address any deficiencies. Recruitment activity may include targeted specialties, market specific initiatives, customer notifications and network adequacy corrective actions determined during annual review as well as Quality Management analysis of provider surveys and customer complaints related to access and availability. Recruitment plans to address network adequacy are developed and modified as needed throughout the year. The company(ies) is currently implementing processes to bolster action plans to recruit MH/SUD providers in areas of need, consistent with its focus on developing robust MH/SUD provider networks. In many instances, deficiencies are a result of insufficient availability of providers/facilities. Both MH/SUD and M/S networks are held to the same 90% standard. In most instances inability to meet the 90% threshold is related to

	insufficient provider availability. Lack of providers/facilities tends to impact behavioral more than medical. The company(ies) actively recruits providers in areas where there may be access deficiencies. In some cases, not enough providers exist in a given geographic area and thus the company(ies) cannot meet a network adequacy standard due to provider unavailability. In such situations, the company(ies) takes steps to ensure that an enrollee in a plan using this network would be able to receive medically necessary services from an out of network provider, and the services would be treated as in-network for purposes of cost-sharing or other requirements. If the company(ies) identifies a network adequacy deficiency, it attempts to remediate the deficiency. The identified potential provider may decline participation in the network or may not respond to recruitment efforts. If the company(ies) identifies a non-contracted provider needed for adequacy/accessibility, it may offer higher rates than what would otherwise be standard in order to close the gap. NCQA does not prescribe goals for geo access. The company(ies) uses a 90% standard, which aligns with CMS network adequacy requirements, which require that 90% of customers have access to providers based on network adequacy access requirements for time and distance standards. **Reimbursement** Whether for initial negotiation or renegotiation, the company(ies) uses its standard in-network provider reimbursement methodology for MH/SUD and M/S providers. Network adequacy deficiencies (Network Need) is always considered when negotiating reimbursement rates. Standard reimbursement rates for inpatient and outpatient services for both M/S and MH/SUD providers are set based upon standard fee schedules, which are developed for facilities, physicians and non-physicians by state or region and reflect geographic variations within that state or region. Provider-	insufficient provider availability. Lack of providers/facilities tends to impact behavioral more than medical. The company(ies) actively recruits providers in areas where there may be access deficiencies. In some cases, not enough providers exist in a given geographic area and thus the company(ies) cannot meet a network adequacy standard due to provider unavailability. In such situations, the company(ies) takes steps to ensure that an enrollee in a plan using this network would be able to receive medically necessary services from an out of network provider, and the services would be treated as in-network for purposes of cost-sharing or other requirements. If the company(ies) identifies a network adequacy deficiency, it attempts to remediate the deficiency. The identified potential provider may decline participation in the network or may not respond to recruitment efforts. If the company(ies) identifies a non-contracted provider needed for adequacy/accessibility, it may offer higher rates than what would otherwise be standard in order to close the gap. NCQA does not prescribe goals for geo access. The company(ies) uses a 90% standard, which aligns with CMS network adequacy requirements, which require that 90% of customers have access to providers based on network adequacy access requirements for time and distance standards. **Reimbursement** Whether for initial negotiation or renegotiation, the company(ies) uses its standard in-network provider reimbursement methodology for MH/SUD and M/S providers. Network adequacy deficiencies (Network Need) is always considered when negotiating reimbursement rates. Standard reimbursement rates for inpatient and outpatient services for both M/S and MH/SUD providers are set based upon standard fee schedules, which are developed for facilities, physicians and non-physicians by state or region and reflect geographic variations within that state or region. Provider-specific fee

	specific fee schedules are developed based upon the professional or facility's negotiation request or business need, including the satisfaction of network adequacy requirements. The company(ies) preferred standard is to reimburse the same rates across all plans/products. M/S contracts have the option to pay plans differently, while BH pays the same for all plans. This approach provides more favorable rates for MH/SUD providers. For example, BH pays the same rate for a Medicare provider as it does for a commercial provider. Rates may be negotiated differently depending upon plan if requested. In determining any rate in both the M/S and MH/SUD facility agreements, the company(ies) assesses supply and demand of provider types and/or specialties based upon the same indicators including, but not limited to NCQA network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; customer satisfaction surveys; and customer complaint data. That is, the company(ies) reimbursement rate development and negotiation processes are ultimately designed to ensure achievement of its adequacy standards for MH/SUD and M/S providers, and any departure from the standard fee schedules is informed by market demand, which may include, for example, the need to maintain, or achieve, network adequacy for a provider type in a particular geographic area. **Provider Reimbursement – Outpatient** Reimbursement rates for in-network M/S and MH/SUD outpatient services are determined as follows: (1) CMS (Medicare) RVU (relative value units); (2) Ingenix data derived from practitioner charges, where available is used to fill gaps on procedure codes that do not have a Medicare rate; (3)	schedules are developed based upon the professional or facility's negotiation request or business need, including the satisfaction of network adequacy requirements. The company(ies) preferred standard is to reimburse the same rates across all plans/products. M/S contracts have the option to pay plans differently, while BH pays the same for all plans. This approach provides more favorable rates for MH/SUD providers. For example, BH pays the same rate for a Medicare provider as it does for a commercial provider. Rates may be negotiated differently depending upon plan if requested. In determining any rate in both the M/S and MH/SUD facility agreements, the company(ies) assesses supply and demand of provider types and/or specialties based upon the same indicators including, but not limited to NCQA network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; customer satisfaction surveys; and customer complaint data. That is, the company(ies) reimbursement rate development and negotiation processes are ultimately designed to ensure achievement of its adequacy standards for MH/SUD and M/S providers, and any departure from the standard fee schedules is informed by market demand, which may include, for example, the need to maintain, or achieve, network adequacy for a provider type in a particular geographic area. **Provider Reimbursement – Outpatient** Reimbursement rates for in-network M/S and MH/SUD outpatient services are determined as follows: (1) CMS (Medicare) RVU (relative value units); (2) Ingenix data derived from practitioner charges, where available is used to fill gaps on procedure codes that do not have a Medicare rate; (3)

	Clinical Lab and Pathology codes, where applicable; (4) Site of Service (SOS) (e.g. office, facility); (5) Geographical Practice Cost Index (GPCI). For both M/S and MH/SUD services where there is no CMS rate or RVU nor vendor benchmark available, the final rate for a service covered by the contract is determined to be (1) billed charges for the service; (2) negotiated discount off of billed charges for the service during the contracting process. In terms of the process by which provider rates are negotiated, for both MH/SUD and M/S providers any revisions to the standard provider contract terms and reimbursement rates for both in network facility based services and in-network outpatient services are analyzed and negotiated by either a Recruiter or Contract Negotiator, with oversight from a Contracting Director. The same standard methodologies are used for both M/S and MH/SUD rate negotiation and any substantial deviations from standard reimbursement rates must be justified and approved by more senior representatives in the respective contracting areas. All staff participating in contract negotiation are trained on internal company(ies) policies and procedures and have access to necessary tools to negotiate and develop appropriate reimbursement rates based on standard methodologies, provider-specific reimbursement requests and escalate for justification and approval any deviations. Factors assessed to determine whether to vary from the standard fee schedule are derived from, where available, Medicare rates including whether the provider experiences a high volume of utilization, the populations served, and the dynamics of the geographic market in which the provider is located (e.g. whether the provider is needed to fill or prevent an adequacy deficiency, and the competitiveness and acceptability of the requested rate). Indeed, the MH/SUD provider contracting process ensures by policy the consideration of such factors in connection with rate negotiations so as to avoid inappropriately discrepant negotiation outcomes and/or avoidable adequacy deficiencies.	Clinical Lab and Pathology codes, where applicable; (4) Site of Service (SOS) (e.g. office, facility); (5) Geographical Practice Cost Index (GPCI). For both M/S and MH/SUD services where there is no CMS rate or RVU nor vendor benchmark available, the final rate for a service covered by the contract is determined to be (1) billed charges for the service; (2) negotiated discount off of billed charges for the service during the contracting process. In terms of the process by which provider rates are negotiated, for both MH/SUD and M/S providers any revisions to the standard provider contract terms and reimbursement rates for both in network facility based services and in-network outpatient services are analyzed and negotiated by either a Recruiter or Contract Negotiator, with oversight from a Contracting Director. The same standard methodologies are used for both M/S and MH/SUD rate negotiation and any substantial deviations from standard reimbursement rates must be justified and approved by more senior representatives in the respective contracting areas. All staff participating in contract negotiation are trained on internal company(ies) policies and procedures and have access to necessary tools to negotiate and develop appropriate reimbursement rates based on standard methodologies, provider-specific reimbursement requests and escalate for justification and approval any deviations. Factors assessed to determine whether to vary from the standard fee schedule are derived from, where available, Medicare rates including whether the provider experiences a high volume of utilization, the populations served, and the dynamics of the geographic market in which the provider is located (e.g. whether the provider is needed to fill or prevent an adequacy deficiency, and the competitiveness and acceptability of the requested rate). Indeed, the MH/SUD provider contracting process ensures by policy the consideration of such factors in connection with rate negotiations so as to avoid inappropriately discrepant negotiation outcomes and/or avoidable adequacy deficiencies.

	Facility Reimbursement – Inpatient In-network facility-based services which are not reimbursed on an assigned diagnosis-related group (DRG) or case rate basis may generally be reimbursed on a per diem or discount basis. Currently, M/S has many more DRG contracts while a small minority of MH/SUD contracts are paid as DRG or case rate. Specifically, M/S paid just under 60% of admissions last year under DRGs and 20% as per-diem, and 20% as a percent of charges. MH/SUD are essentially 100% per-diem, as MH/SUD contracts do not have any significant case rates or percent of charges contracts. DRG (i.e. case rate) reimbursement rates generally do not exist for MH/SUD in-network inpatient services because unlike certain routine medical inpatient procedures (i.e. vaginal deliveries; cesarean deliveries; appendectomies, etc.), MH/SUD inpatient stays vary depending upon the unique clinical needs, circumstances and complexities of the individual patient (i.e. patient's insight or lack of insight into their illness; patient motivation to receive treatment; comorbidity, etc. Per diem reimbursement for both M/S and MH/SUD facility-based services are based upon the following factors and accompanying evidentiary standards: (1) geographic market, which may be adjusted based upon Medicare Geographical Practice Cost Index ("GPCI"); (2) type of provider and/or specialty (e.g. physician practitioner v. non-physician practitioner v. facility); (3) supply of provider type and/or specialty; (4) network need and/or demand for provider type and/or specialty; (5) Medicare reimbursement rates for codes with assigned Medicare Relative Value Unit ("RVU"); and (6) Training, experience and licensure of providers billing for professional services under the facility agreement. The company(ies) methodology and process for negotiating in-network provider reimbursements for M/S and MH/SUD services within a classification of benefits are comparable	**Facility Reimbursement – Inpatient** In-network facility-based services which are not reimbursed on an assigned diagnosis-related group (DRG) or case rate basis may generally be reimbursed on a per diem or discount basis. Currently, M/S has many more DRG contracts while a small minority of MH/SUD contracts are paid as DRG or case rate. Specifically, M/S paid just under 60% of admissions last year under DRGs and 20% as per-diem, and 20% as a percent of charges. MH/SUD are essentially 100% per-diem, as MH/SUD contracts do not have any significant case rates or percent of charges contracts. DRG (i.e. case rate) reimbursement rates generally do not exist for MH/SUD in-network inpatient services because unlike certain routine medical inpatient procedures (i.e. vaginal deliveries; cesarean deliveries; appendectomies, etc.), MH/SUD inpatient stays vary depending upon the unique clinical needs, circumstances and complexities of the individual patient (i.e. patient's insight or lack of insight into their illness; patient motivation to receive treatment; comorbidity, etc. Per diem reimbursement for both M/S and MH/SUD facility-based services are based upon the following factors and accompanying evidentiary standards: (1) geographic market, which may be adjusted based upon Medicare Geographical Practice Cost Index ("GPCI"); (2) type of provider and/or specialty (e.g. physician practitioner v. non-physician practitioner v. facility); (3) supply of provider type and/or specialty; (4) network need and/or demand for provider type and/or specialty; (5) Medicare reimbursement rates for codes with assigned Medicare Relative Value Unit ("RVU"); and (6) Training, experience and licensure of providers billing for professional services under the facility agreement. The company(ies) methodology and process for negotiating in-network provider reimbursements for M/S and MH/SUD services within a classification of benefits are comparable

	and no more stringent for MH/SUD services than for M/S services within the same classification of benefits as written. The company(ies) also follows a comparable process in determining payment rates for non-physician providers for both M/S and MH/SUD benefits. While there is variation in type of reimbursement methodology for facility reimbursement, the company(ies) Network Providers choose which methodology (DRG, Per Diem or Case Rate) will apply and the processes, factors and evidentiary standards applicable to each methodology is applied to M/S and MH/SUD providers consistently. In this process, variables including market demand, provider specialty and availability and frequency of requests for provider fee increases may result in differentials in reimbursement rates across medical/surgical and MH/SUD provider types.	and no more stringent for MH/SUD services than for M/S services within the same classification of benefits as written. The company(ies) also follows a comparable process in determining payment rates for non-physician providers for both M/S and MH/SUD benefits. While there is variation in type of reimbursement methodology for facility reimbursement, the company(ies) Network Providers choose which methodology (DRG, Per Diem or Case Rate) will apply and the processes, factors and evidentiary standards applicable to each methodology is applied to M/S and MH/SUD providers consistently. In this process, variables including market demand, provider specialty and availability and frequency of requests for provider fee increases may result in differentials in reimbursement rates across medical/surgical and MH/SUD provider types.
(STEP-5): A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.	**1. Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.** The Company(ies) has analyzed process, strategies, evidentiary standards and other factors used to apply Medical Necessity MH/SUD and M/S benefits and has determined compliance with parity requirements. The company(ies) medical necessity coverage policy development and application process is consistent between M/S and MH/SUD. The Company(ies) Coverage Policy development and application is consistent. Coverage Policies are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, Coverage Policy Unit and the impetus of new, emerging and evolving technologies. Also, the company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. The application of the IRR process across MH/SUD and M/S benefits is itself evidence of the comparability of the company(ies) diligence in monitoring the utilization management process. Further, the aforementioned IRR results for MH/SUD and M/S benefits evidence comparability and equivalent stringency in the process of performing coverage reviews; specifically, the company(ies) most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits as well as substantial agreement across reviewers who participated in the assessment. The company(ies) concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. The company(ies) applies comparable evidence-based guidelines to define established standards of effective care in both M/S and MH/SUD benefits. Consistency in policy development, process and application evidences compliance with the NQTL requirement that the medical management process be applied comparably, and no more stringently, to MH/SUD services than to M/S services. Compliance is further demonstrated through the company(ies)	

uniform definition of Medical Necessity for M/S and MH/SUD benefits. In performing the operational analysis of the application of UM, the company(ies) reviewed denial rates for both M/S and MH/SUD within each classification of benefits and for benefits subject to prior authorization, concurrent review, and retrospective review.

2. Prior-Authorization NQTL Practices

The company(ies) applies prior authorization NQTL consistently to M/S benefits and MH/SUD benefits across benefit classifications. For both in-network and out-of-network M/S and MH/SUD benefits, the company(ies) requires prior authorization of non-emergent inpatient services and certain Outpatient services. In reaching this conclusion, the company(ies) has assessed several components of its utilization management program for NQTL compliance, including the methodology for determining which services will be subject to utilization management, the process for reviewing utilization management requests, and the process for applying coverage criteria.

The process by which prior authorization is applied to M/S and MH/SUD inpatient, in-network benefits is comparable and applied no more stringently to MH/SUD inpatient benefits.

Coverage determinations of both M/S services and MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Moreover, the company(ies) methodology for determining which MH/SUD services within a classification of benefits are subject to prior authorization is comparable to, and applied no more stringently than, its methodology for determining which medical/surgical services within the same classification of benefits are subject to prior authorization.

The company(ies) methodology for determining which medical/surgical services and which MH/SUD services within a classification of benefits are subject to prior authorization, as written in policy/procedure and in operation, as well as its pre-service medical necessity review processes applied to medical/surgical services and for MH/SUD services as written and in operation, reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the same classification of benefits.

An “in operation” review of the company(ies) application of the Prior Authorization NQTL, specifically approvals and denial information, in the In-Patient, In-Network and Out-of-Network classification, Outpatient, In-Network and Out-of-Network, All Other classification for a sampling of plans revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, the company(ies) concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.

3. Concurrent Review Benefit NQTL Practices

	The company(ies) has analyzed process, strategies, evidentiary standards and other factors used to apply Concurrent review to MH/SUD and M/S benefits and has determined compliance with parity requirements. First, comparability in process is evidenced in the plan's turnaround time requirements, as well. For urgent concurrent review requests received at least twenty-four hours before expiration of the then-current approval, the company(ies) responds within twenty-four hours of receipt of the request for an extended approval for both MH/SUD and M/S benefits. Similarly, for non-urgent concurrent review requests, the company(ies) issues claim determinations for both M/S and MH/SUD services across inpatient and outpatient classifications within fifteen days of receipt of a complete claim. Second, the factors, and accompanying evidentiary standard used to determine whether prior authorization will apply to an inpatient or outpatient service pursuant to the above-described process, namely the ROI metric and cost benefit analysis, is likewise uniform for MH/SUD and M/S benefits. The company(ies) does not use different factors or evidentiary standards, or use the same factor and evidentiary standard differently, when reviewing MH/SUD and M/S benefits for continued inclusion on the prior authorization list. The company(ies) Coverage Policies are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, Coverage Policy Unit and the impetus of new, emerging and evolving technologies. Also, the company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. The application of the IRR process across MH/SUD and M/S benefits is itself evidence of the comparability of the company(ies) diligence in monitoring the utilization management process. Further, the aforementioned IRR results for MH/SUD and M/S benefits evidence comparability and equivalent stringency in the process of performing coverage reviews; specifically, the company(ies) most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits as well as substantial agreement across reviewers who participated in the assessment. Lastly, the company(ies) has assessed comparability/equivalent stringency of application of concurrent review in operation by assessing denial rates for benefits subject to concurrent review, the purpose of which is to identify potential discrepancies in how stringently the NQTL is applied in-operation to MH/SUD and M/S benefits, respectively, that warrant further scrutiny. A review of this data revealed comparable denial rates and, on average, lower concurrent review denial rates for MH/SUD benefits across the inpatient and outpatient classifications. While the outcomes of application of an NQTL are not determinative of compliance with the NQTL in-operation requirement, similar outcomes in application of concurrent review are, in conjunction with the comparable written process employed to apply concurrent review, strongly indicative of comparability and equivalent stringency across medical and MH/SUD benefits and, ultimately, therefore compliance with the NQTL requirement. **4. Network Admissions and Reimbursement**

	The company(ies) continues to invest in the breadth of the behavioral network, which has doubled since 2017 to approximately 229k mental and behavioral health care providers, includes the largest virtual network (75k) and is consistently ranked in the top behavioral health networks in local markets. This years-long process is consistent with the goal of providing access and availability through the company(ies) networks. The company(ies) assesses supply and demand of both M/S and MH/SUD provider types and/or specialties based upon the same indicators including NCQA and NAIC, and federal/state, network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; customer satisfaction surveys; customer complaint data. The conclusion of such assessments may result in an increase or decrease in the provider's reimbursement rate. Over the past several years the company(ies) has conducted a comprehensive review of its MH/SUD network admission standards, including network access standards, contracting processes and reimbursement rates applicable to Network Providers. The company(ies) behavioral health network remains open, and the company(ies) accepts all credentialed behavioral health providers who request to join the network. Any variances in contracting processes as well as a range of reimbursement rates based on percentages of Medicare RVUs as compared to M/S reimbursement rates were identified and analyzed for adherence to the NQTL requirement. The company(ies) may agree to increased reimbursement rates as necessary to meet access needs, particularly in specialty provider board certification shortage areas such as psychiatry and child and adolescent care. In connection with its ongoing NQTL compliance efforts, the company(ies) has taken proactive, additional steps to continually ensure the comparability of standards for provider admissions into the MH/SUD provider network, including reimbursement rate methodology, to ensure the processes, strategies and evidentiary standards implemented are not more stringent for MH/SUD services than M/S services. The company(ies) has aligned contracting policies and processes and rolled out a facility reimbursement strategy shifting from reactively addressing disparate outcomes between M/S and MH/SUD reimbursement rates to proactively updating reimbursement rates for facilities for which rate increases have not been requested in the past two years. As evidence of company(ies) success in establishing rates that help ensure the acquisition and retention of providers in its MH/SUD network, the facility rate renegotiation report for January 1, 2024 through December 31, 2024 documented 649 facility renegotiations, of which 620 negotiations were completed, 27 were discontinued due to the provider's non-responsiveness, 2 were discontinued due to not coming to an agreement on rates. The company(ies) has also reviewed more than 9,500 reimbursement rates for outpatient-based fee schedules. The outpatient rate negotiation report for January 1, 2024, through December 31, 2024, includes a total of 9,438 rate increases with 6,525 completed, 1,302 denied (772 due to being less than 1 year since last negotiation), 362 provider declined rates, and 1,249 were discontinued or declined due to provider non-responsiveness. Network adequacy standards for MH/SUD providers are comparable to similar M/S specialists. In most instances the behavioral network adequacy standards require a customer to travel fewer miles to see a MS/SUD specialist as compared

	to an M/S specialist, effectively making MH/SUD providers more accessible to customers as compared to medical specialists. Currently, for both M/S and MH/SUD providers, at least 90% of enrollees are required to have the designated access to meet the company(ies) network adequacy standard. Adequacy standards are not set arbitrarily but are based on State regulatory requirements. In addition to rolling out reimbursement upgrades for so-called stagnant contracts (that is, facility contracts that have not requested an increase in rates within the past 5 years and have remained at the same percentage of Medicare), facility based reimbursement is transitioning from a service level approach of negotiation to a total cost of care to address both competitiveness through the use of pricing benchmarks and market based analysis. This approach aligns with the methodology and process for updating inpatient reimbursement rates for hospitals providing M/S services. The company(ies) is currently creating a database including various benchmarking sources for the comparison of in-network rates against pricing benchmarks to assess affordability and to ensure the closure of any unsubstantiated gaps in reimbursement rates. Lastly, for new providers entering the network, the company(ies) has aligned the contracting process and has developed and implemented a standard reimbursement methodology for the negotiation of MH/SUD reimbursement rates with M/S contracting and reimbursement methodology. Such alignment includes the implementation of standard fee schedules and the implementation of established outpatient facility and practitioner fee schedules and exceptions to standard fee schedule requests in order to contract with and retain providers essential to the integrity of the MH/SUD provider network. Consistent with the NQTL requirement for comparability/stringency, the company(ies) has confirmed that standards for provider admission into the MH/SUD provider network, including credentialing, adequacy, and provider reimbursement rates for inpatient and outpatient services are comparable to, and applied no more stringently than, that of the M/S provider network as written and in operation. Put differently, company(ies) network has the ability to meet the MH/SUD services needs of our enrollees by providing reasonable access to a sufficient number of in-network providers for both inpatient and outpatient services.

Exhibit A (2)
Annual Mental Health and Substance Use Benefits Compliance Report
Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:
Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (13) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits (MH/SUD)	***Medical/Surgical Benefits (M/S)***
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S medical necessity clinical determinations are made using externally developed, evidence based clinical criteria. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S. MH/SUD medical necessity clinical determinations are made using the following criteria when applicable: American Society of Addiction Medicine (ASAM) Criteria®, 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) as well as internally developed objective, evidence-based, MH/SUD clinical policies. The MH/SUD Clinical Technology Assessment Committee (CTAC) assesses externally developed clinical criteria and develops and approves internal clinical policies for MH/SUD services. CTAC uses scientifically based clinical evidence and the Hierarchy of Clinical Evidence in its development, assessment, and approval processes. CTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective services for MH/SUD members. CTAC is comprised of, but is not limited to, 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 teams. The Clinical Quality and Operations Committee (CQOC) reviews and validates behavioral clinical policies/clinical criteria endorsed by CTAC.	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S medical necessity clinical determinations are made using externally developed, evidence based clinical criteria. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S. M/S medical necessity clinical determinations are made using Milliman Care Guidelines (MCG) criteria when applicable as well as internally developed objective, evidence-based M/S clinical policies. The M/S Medical Policy Committee assesses externally developed clinical criteria and develops and approves internal clinical policies for M/S services. The Medical Policy Committee uses scientifically based clinical evidence and the Hierarchy of Clinical Evidence in its development, assessment, and approval processes. The Medical Policy Committee conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective services for M/S members. The Medical Policy Committee is comprised of, but is not limited to, M/S 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 teams. The Medical Policy Committee reports to the Medical Management Committee.
In-Patient & In-Network NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S require authorization for in-network (INN) inpatient admissions. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S require authorization for in-network (INN) inpatient admissions. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.
In-Patient & Out-of-Network NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S require authorization for for out-of-network (OON) inpatient admissions when the plan has OON benefits. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S require authorization for for out-of-network (OON) inpatient admissions when the plan has OON benefits. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S
Out-Patient & In-Network NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S require authorization for certain in-network (INN) outpatient services. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S require authorization for certain in-network (INN) outpatient services. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S

Out-Patient & Out-of-Network NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S require authorization for certain out-of-network (OON) outpatient services. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S require authorization for certain out-of-network (OON) outpatient services. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S
Emergency Services/Benefits NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S	No distinction in any NQTL practice between MH/SUD and M/S. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S
Rx Formulary Design, Management and Pharmacy Services NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.	No distinction in any NQTL practice between MH/SUD and M/S. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.
Prior-Authorization NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S have INN and OON inpatient and outpatient services subject to prior authorization. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S have INN and OON inpatient and outpatient services subject to prior authorization. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.
Concurrent Review Benefit NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S have INN and OON inpatient and outpatient services subject to concurrent review. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S have inpatient and outpatient services subject to concurrent review. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.
Retrospective Review Benefit NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S have OON and INN inpatient and outpatient services subject to retrospective review. Any service that requires prior authorization is also eligible for retrospective review. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.	No distinction in any NQTL practice between MH/SUD and M/S. Both MH/SUD and M/S have inpatient and outpatient services subject to retrospective review. Any service that requires prior authorization is also eligible for retrospective review. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.	No distinction in any NQTL practice between MH/SUD and M/S. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.
Case & Medical Management NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S. MH/SUD and M/S do not require participation in any of its supportive case management programs and non-participation does not limit benefits or services in any way. Therefore, case management services are not a treatment limitation (NQTL). MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.	No distinction in any NQTL practice between MH/SUD and M/S. MH/SUD and M/S do not require participation in any of its supportive case management programs and non-participation does not limit benefits or services in any way. Therefore, case management services are not a treatment limitation (NQTL). MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.

Network Adequacy & Provider Reimbursement Rates	No distinction in any NQTL practice between MH/SUD and M/S for both Network Adequacy & Provider Reimburesemt Rates. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S. Both MH/SUD and M/S assess network adequacy based on access standards that are in accordance with 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), both MH/SUD and M/S consider network adequacy and access reports. Network adequacy and access reports are prepared on a regular basis and shared with network teams for recruitment purposes to ensure regulatory network access requirements are met. If MH/SUD or M/S determines it does not meet network adequacy requirements for a specialty or provider type, within set time and distance thresholds as determined by state or federal requirements, the network team will actively seek to add providers to the network in that specialty or provider type. If there is a supply gap, Plan language allows members to seek an exception and receive services from an out-of-network (OON) provider at the in-network (INN) benefit level. .	No distinction in any NQTL practice between MH/SUD and M/S for both Network Adequacy & Provider Reimburesemt Rates. MH/SUD practices are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S. Both MH/SUD and M/S assess network adequacy based on access standards that are in accordance with 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), both MH/SUD and M/S consider network adequacy and access reports. Network adequacy and access reports are prepared on a regular basis and shared with network teams for recruitment purposes to ensure regulatory network access requirements are met. If MH/SUD or M/S determines it does not meet network adequacy requirements for a specialty or provider type, within set time and distance thresholds as determined by state or federal requirements, the network team will actively seek to add providers to the network in that specialty or provider type. If there is a supply gap, Plan language allows members to seek an exception and receive services from an out-of-network (OON) provider at the in-network (INN) benefit level.
(STEP-5): *A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.*	**The Plan performed a comparative analysis and concluded the factors, evidentiary standards, and source information used to apply MH/SUD NQTLs subjected to this parity review evidenced in the Exhibit A submission are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.**	

Exhibit A (3)

Annual Mental Health and Substance Use Benefits Compliance Report

Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:

Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (13) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	*Medical/Surgical Benefits*
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.	As required by Conn. Gen. Stat. Sec. 38a-591c, the Company uses ASAM criteria for review of Mental Health/Substance Use Disorder (MH/SUD) services. **Medical Policy and Fail First** 1. Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply. Overview: This nonquantitative treatment limitation (NQTL) analysis explains how XXXXX creates its medical policies and clinical UM guidelines (collectively "medical policies"), including the medical policies that define the criteria XXXXX uses to determine what services are considered medically necessary or investigational. XXXXX also licenses MCG guidelines for review of medical, surgical and behavioral health services. MCG Guidelines are produced by an external source, independent of XXXXX, with input and information specifically from the provider community. The MCG process, and other third-party guidelines, are helpful for established procedures, but are generally not available to consider new or emerging treatments and services. XXXXX approves or modifies MCG guidelines as described below. If a state law requires XXXXX to use a different medical criteria, such as InterQual, LOCUS, CALOCUS or ASAM, then XXXXX uses those guidelines as written. Policies/Guidelines/Other Documents Describing Prior Authorization XXXXX policy and procedure documents include the following: 1. Medical Policy Formation: https://www.XXXXX.com/dam/medpolicies/XXXXX/active/policies/mp_pw_a044135.html. 2. Medical Necessity Criteria Medical Policy: https://www.XXXXX.com/dam/medpolicies/XXXXX/active/policies/mp_pw_a044145.html 3. Investigational Criteria Medical Policy: https://www.XXXXX.com/dam/medpolicies/XXXXX/active/policies/mp_pw_a044153.html Members may access any of the procedure documents and actual Medical Policies and Clinical UM Guidelines in the publicly accessible links above through XXXXX.com. Plan/Coverage Terms Regarding Prior Authorization	For Medical/Surgical services, the Company utilizes internally created medical polices and clinical guidelines and MCG. **Medical Policy and Fail First** 1. Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply. Overview: This nonquantitative treatment limitation (NQTL) analysis explains how XXXXX creates its medical policies and clinical UM guidelines (collectively "medical policies"), including the medical policies that define the criteria XXXXX uses to determine what services are considered medically necessary or investigational. XXXXX also licenses MCG guidelines for review of medical, surgical and behavioral health services. MCG Guidelines are produced by an external source, independent of XXXXX, with input and information specifically from the provider community. The MCG process, and other third-party guidelines, are helpful for established procedures, but are generally not available to consider new or emerging treatments and services. XXXXX approves or modifies MCG guidelines as described below. If a state law requires XXXXX to use a different medical criteria, such as InterQual, LOCUS, CALOCUS or ASAM, then XXXXX uses those guidelines as written. Policies/Guidelines/Other Documents Describing Prior Authorization XXXXX policy and procedure documents include the following: 1. Medical Policy Formation: https://www.XXXXX.com/dam/medpolicies/XXXXX/active/policies/mp_pw_a044135.html. 2. Medical Necessity Criteria Medical Policy: https://www.XXXXX.com/dam/medpolicies/XXXXX/active/policies/mp_pw_a044145.html 3. Investigational Criteria Medical Policy: https://www.XXXXX.com/dam/medpolicies/XXXX/active/policies/mp_pw_a044153.html Members may access any of the procedure documents and actual Medical Policies and Clinical UM Guidelines in the publicly accessible links above through XXXXX.com. Plan/Coverage Terms Regarding Prior Authorization

	Plan documents alert members that medical necessity is one aspect to determining coverage for specific services (“Getting Approval for Benefits”). The Plan Documents also provide the following information about “Medical Policy and Technology Assessment”: “XXXXX reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of XXXXX’s medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including XXXXX’s medical directors, Doctors in academic medicine and Doctors in private practice. Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.” Relevant Definitions: Investigational – Means that the procedure, treatment, supply, device, equipment, facility or drug (all services) does not meet the Company Technology Evaluation Criteria because it does not meet one or more of the following criteria: • have final approval from the appropriate government regulatory body; or • have the credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community which permits reasonable conclusions concerning the effect of the procedure, treatment, supply, device, equipment, facility or drug (all services) on health outcomes; or • be proven materially to improve the net health outcome; or • be as beneficial as any established alternative; or • show improvement outside the investigational settings. Fail first – A requirement that before a service is considered to be medically necessary, the member must have first tried and failed a different treatment. In determining whether to require fail first for a particular service or treatment, a component of Medical Policy, XXXXX is focused on member safety to ensure options with less risk or are less invasive are considered. MPTAC – Medical Policy &Technology Assessment Committee is the authorizing body for XXXXX medical policies and clinical UM guidelines including guidelines developed by MCG which serve as a basis for medical necessity determinations. The MPTAC is a multiple disciplinary group consisting of physicians external to XXXXX who are in active academic and community practice, as well as internal XXXXX medical directors. Members are from various medical and behavioral health specialties, clinical practice environments and geographic areas. All members are board certified specialists in their respective fields. OMPTA – the Office of Medical Policy & Technology Assessment, a department within XXXXX whose associates develop and maintain XXXXX medical policies and clinical utilization management (UM) guidelines, and review or propose modification to MCG guidelines, for review and approval by MPTAC. 2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits:	Plan documents alert members that medical necessity is one aspect to determining coverage for specific services (“Getting Approval for Benefits”). The Plan Documents also provide the following information about “Medical Policy and Technology Assessment”: “XXXXX reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of XXXXX’s medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including XXXXX’s medical directors, Doctors in academic medicine and Doctors in private practice. Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.” Relevant Definitions: Investigational – Means that the procedure, treatment, supply, device, equipment, facility or drug (all services) does not meet the Company Technology Evaluation Criteria because it does not meet one or more of the following criteria: • have final approval from the appropriate government regulatory body; or • have the credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community which permits reasonable conclusions concerning the effect of the procedure, treatment, supply, device, equipment, facility or drug (all services) on health outcomes; or • be proven materially to improve the net health outcome; or • be as beneficial as any established alternative; or • show improvement outside the investigational settings. Fail first – A requirement that before a service is considered to be medically necessary, the member must have first tried and failed a different treatment. In determining whether to require fail first for a particular service or treatment, a component of Medical Policy, XXXXX is focused on member safety to ensure options with less risk or are less invasive are considered. MPTAC – Medical Policy &Technology Assessment Committee is the authorizing body for XXXXX medical policies and clinical UM guidelines including guidelines developed by MCG which serve as a basis for medical necessity determinations. The MPTAC is a multiple disciplinary group consisting of physicians external to XXXXX who are in active academic and community practice, as well as internal XXXXX medical directors. Members are from various medical and behavioral health specialties, clinical practice environments and geographic areas. All members are board certified specialists in their respective fields. OMPTA – the Office of Medical Policy & Technology Assessment, a department within XXXXX whose associates develop and maintain XXXXX medical policies and clinical utilization management (UM) guidelines, and review or propose modification to MCG guidelines, for review and approval by MPTAC. 2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits:

	Factors and Evidentiary Standards In evaluating whether to develop new medical policy (MP) or clinical UM guideline (CUMG) documents or for pertinent updates to existing MP or CUMG documents, OMPTA solicits input from a variety of internal resources including actuary, analytics, behavioral health, claims processing, cost of care, health care management, legal, and program integrity. Many factors are considered when deciding whether to develop a new document and include but are not limited to why the topic is being considered, relevant scientific evidence, whether codes exist to describe the service, potential impacts to cost of care (if known), whether there are related existing XXXXX, XXX or MCG documents, regulatory information, and relevant specialty society and governmental organization information. While OMPTA does not assign more weight to any one of the factors identified above, when determining to recommend a topic to MPTAC for consideration, patient safety concerns are the primary focus of the process. In evaluating the medical necessity or investigational status of new or existing services and/or procedures the MPTAC may consider, among other things, the following factors: • Scientific data supporting the service or procedure; • Professional Associations or independent technology evaluation programs supporting the service or procedure; • Electronic literature searches supporting the service or procedure; • Effectiveness and Member Safety Related to Procedure; • The standard of care in the medical/behavioral health community; • Detailed input, especially input supported by distinctive peer reviewed medical literature. All factors are weighted and considered equally to M/S and MH/SUD benefits. All factors may not be present for each specific service; thus, the weighting would be based on the specific service or treatment being considered. As shown below, none of the factors are discriminatory as the information, evidence, sources and standards on which each factor is based is objective and not biased in a manner that discriminates against MH/SUD benefits as compared to M/S benefits. 3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits: Factors (Including Processes and Strategies) The process and criteria that MCG uses in the development of its guidelines can be found in Exhibit A. The sources and processes that MPTAC uses to create and review medical policies and clinical guidelines can be found in XXXXX medical policy ADMIN.00001 Medical Policy Formation: https://www.XXXXX.com/dam/medpolicies/XXXX/active/policies/mp_pw_a044135.html. In determining medical policy and clinical UM guidelines for services and procedures, MPTAC considers the factors noted above in conjunction with committee members' own clinical judgment informed by their education and experience. Scientific Data: MPTAC will consider current scientific data, clinical thinking and medical evidence that is peer-reviewed, published in English in a journal Indexed in the National Library of Medicine's PubMed database and uses reasonable rigorous scientific methodology. MPTAC	Factors and Evidentiary Standards In evaluating whether to develop new medical policy (MP) or clinical UM guideline (CUMG) documents or for pertinent updates to existing MP or CUMG documents, OMPTA solicits input from a variety of internal resources including actuary, analytics, behavioral health, claims processing, cost of care, health care management, legal, and program integrity. Many factors are considered when deciding whether to develop a new document and include but are not limited to why the topic is being considered, relevant scientific evidence, whether codes exist to describe the service, potential impacts to cost of care (if known), whether there are related existing XXXXX, XXX or MCG documents, regulatory information, and relevant specialty society and governmental organization information. While OMPTA does not assign more weight to any one of the factors identified above, when determining to recommend a topic to MPTAC for consideration, patient safety concerns are the primary focus of the process. In evaluating the medical necessity or investigational status of new or existing services and/or procedures the MPTAC may consider, among other things, the following factors: • Scientific data supporting the service or procedure; • Professional Associations or independent technology evaluation programs supporting the service or procedure; • Electronic literature searches supporting the service or procedure; • Effectiveness and Member Safety Related to Procedure; • The standard of care in the medical/behavioral health community; • Detailed input, especially input supported by distinctive peer reviewed medical literature. All factors are weighted and considered equally to M/S and MH/SUD benefits. All factors may not be present for each specific service; thus, the weighting would be based on the specific service or treatment being considered. As shown below, none of the factors are discriminatory as the information, evidence, sources and standards on which each factor is based is objective and not biased in a manner that discriminates against MH/SUD benefits as compared to M/S benefits. 3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits: Factors (Including Processes and Strategies) The process and criteria that MCG uses in the development of its guidelines can be found in Exhibit A. The sources and processes that MPTAC uses to create and review medical policies and clinical guidelines can be found in XXXXX medical policy ADMIN.00001 Medical Policy Formation: https://www.XXXXX.com/dam/medpolicies/XXXX/active/policies/mp_pw_a044135.html. In determining medical policy and clinical UM guidelines for services and procedures, MPTAC considers the factors noted above in conjunction with committee members' own clinical judgment informed by their education and experience. Scientific Data: MPTAC will consider current scientific data, clinical thinking and medical evidence that is peer-reviewed, published in English in a journal Indexed in the National Library of Medicine's PubMed database and uses reasonable rigorous scientific methodology. MPTAC

	does not take into consideration information such as promotional materials, product dossiers, cost effectiveness studies, white papers, review articles, abstracts, posters or presentations from medical meetings. These materials may not be subject to the same requirements as the beforementioned data and include biases not fully challenged as under the scientific method. MPTAC reviews persuasive scientific data to determine if the studies provide clinical support to recognize the service or procedure through the creation of objective, clinically based medical policy or clinical UM guidelines. MPTAC does not require a specific level of support for the service or procedure or publication in a specific journal, except as noted above. The scientific data will be considered in light of the committee's clinical judgment to determine whether the service or procedure has a material and proven net health beneficial outcome. Professional Associations or Independent Technology Evaluations Programs: MPTAC will consider the support for a specific service or procedure through publications from professional associations and independent technology evaluation programs. The materials may be published by the following: • Technology assessment entities; • Appropriate government regulatory bodies; and • Authoritative medical specialty societies and associations (e.g., American Medical Association). MPTAC considers information from the sources above to be potentially less biased and more likely subject to the rigors of the scientific method. The materials may be persuasive and can be objectively considered by committee members in determining whether the appropriate amount of research has been performed and documented to support a medical necessity determination. In reviewing such materials, while the source may be persuasive, MPTAC will objectively consider the materials in conjunction with their clinical judgment to make the overall determination. Thus, a specific quantitative evidentiary standard is not used or expected when reviewing the materials and making clinical medical necessity determinations. Effectiveness and Member Safety Related to Procedure: In general, regulatory bodies, such as the Food and Drug Administration (FDA) will opine on the safety of medical devices and other products potentially used by members after undergoing the FDA's review process. The published safety recommendation is a factor in the development of medical policy and clinical UM guidelines. However, in the event safety indications are not published by a regulatory body or a professional association, XXXXX will consider other evidence to review the effectiveness of a new/existing procedure as well as member safety to determine whether a medical policy or clinical UM guideline is necessary. The source materials for such factor includes, specific to the procedure at issue, clinical studies (and the study's methodology) available on the procedure since its introduction. MPTAC will consider whether the procedure has a level of effectiveness to outweigh any member safety concerns evidenced by known and documented side effects at the time of publication. Electronic Literature: The results of electronic literature searches are also a factor. MPTAC may consider study methodology, including but not limited to features such as randomization, blinding, clinically appropriate follow-up periods, and use of validated and objective measurements tools. MPTAC will also consider whether studies provide credible scientific evidence which permits reasonable conclusions regarding net health outcomes and clinical utility and appropriate comparisons to established alternatives. Standard of Care: MPTAC may also consider the service/procedure being reviewed as a standard of care in the medical community with supporting documentation. The supporting documentation to demonstrate a particular service or procedure has become the standard of	does not take into consideration information such as promotional materials, product dossiers, cost effectiveness studies, white papers, review articles, abstracts, posters or presentations from medical meetings. These materials may not be subject to the same requirements as the beforementioned data and include biases not fully challenged as under the scientific method. MPTAC reviews persuasive scientific data to determine if the studies provide clinical support to recognize the service or procedure through the creation of objective, clinically based medical policy or clinical UM guidelines. MPTAC does not require a specific level of support for the service or procedure or publication in a specific journal, except as noted above. The scientific data will be considered in light of the committee's clinical judgment to determine whether the service or procedure has a material and proven net health beneficial outcome. Professional Associations or Independent Technology Evaluations Programs: MPTAC will consider the support for a specific service or procedure through publications from professional associations and independent technology evaluation programs. The materials may be published by the following: • Technology assessment entities; • Appropriate government regulatory bodies; and • Authoritative medical specialty societies and associations (e.g., American Medical Association). MPTAC considers information from the sources above to be potentially less biased and more likely subject to the rigors of the scientific method. The materials may be persuasive and can be objectively considered by committee members in determining whether the appropriate amount of research has been performed and documented to support a medical necessity determination. In reviewing such materials, while the source may be persuasive, MPTAC will objectively consider the materials in conjunction with their clinical judgment to make the overall determination. Thus, a specific quantitative evidentiary standard is not used or expected when reviewing the materials and making clinical medical necessity determinations. Effectiveness and Member Safety Related to Procedure: In general, regulatory bodies, such as the Food and Drug Administration (FDA) will opine on the safety of medical devices and other products potentially used by members after undergoing the FDA's review process. The published safety recommendation is a factor in the development of medical policy and clinical UM guidelines. However, in the event safety indications are not published by a regulatory body or a professional association, XXXXX will consider other evidence to review the effectiveness of a new/existing procedure as well as member safety to determine whether a medical policy or clinical UM guideline is necessary. The source materials for such factor includes, specific to the procedure at issue, clinical studies (and the study's methodology) available on the procedure since its introduction. MPTAC will consider whether the procedure has a level of effectiveness to outweigh any member safety concerns evidenced by known and documented side effects at the time of publication. Electronic Literature: The results of electronic literature searches are also a factor. MPTAC may consider study methodology, including but not limited to features such as randomization, blinding, clinically appropriate follow-up periods, and use of validated and objective measurements tools. MPTAC will also consider whether studies provide credible scientific evidence which permits reasonable conclusions regarding net health outcomes and clinical utility and appropriate comparisons to established alternatives. Standard of Care: MPTAC may also consider the service/procedure being reviewed as a standard of care in the medical community with supporting documentation. The supporting documentation to demonstrate a particular service or procedure has become the standard of

	care may come from publications referenced above and further supported by committee members' clinical judgment. Input from current practitioners in the medical and behavioral health community may provide further evidence of the standard of care and support (or lack thereof) of the medical necessity of the service or procedure. As noted in the Medical Policy Formation process, cited previously, the above factors, sources, and standards are used by OMPTA and the MPTAC to develop medical policy and clinical UM guidelines for the medical necessity of services and procedures. MPTAC meets at least three times per year, and reviews the following: • Agenda items (e.g., new procedures or services) brought to and researched by OMPTA staff; • Every MCG guideline at least annually to determine whether to continue to use the guideline and/or whether any XXXXX-specific modifications should be proposed for review and approval by the MPTAC; • All other existing medical policies and clinical UM guidelines at least annually to identify new published peer reviewed medical studies or other evidence from authoritative sources that may influence the decision-making process of the MPTAC regarding their determination as to the medical necessity or investigational nature of the services under their consideration. Detailed Peer Input: Expert clinical opinion may be obtained from relevant specialists from within and external to XXXXX when appropriate. The process allows MPTAC access to the expertise of wide variety of specialists and subspecialists from across the United States. The input will be considered based on the credentials of the individual providing the information, and those with potential biases (e.g., paid consultants for a particular service) are considered accordingly. Medical policies/clinical UM guidelines may contain fail first requirements. When a medical policy/clinical UM guideline is created or reviewed, XXXXX primarily relies upon the inclusion criteria that was utilized to test the treatment's efficacy when determining whether to apply a fail first requirement. For example, if a service was tested and proven successful only on individuals over a certain age who had failed a different treatment for the condition, then that will be relied upon when determining when a service is medically necessary. MCG utilizes similar criteria in creating its medical policies. MPTAC decisions on the medical necessity or investigational status of services and procedures are made by a majority vote of the MPTAC voting members present. Following MPTAC review and approval, XXXXX medical policies and clinical UM guidelines are published to internal and external XXXXX websites and implemented for use by the local markets based on their local requirements. 4. Demonstration of Comparability and Stringency as Written. XXXXX uses the same processes, strategies, evidentiary standards and other factors when developing and/or approving medical policies, clinical UM guidelines, and deciding whether to apply a fail first requirement for MH/SUD and medical/surgical services. The process for adopting medical policies and clinical UM guidelines starts with a consideration of factors all deeply rooted in the clinical information available for such service. The multi-disciplinary group of professionals with both medical/surgical and mental health/substance use disorder experience review the clinical information available, regulatory	care may come from publications referenced above and further supported by committee members' clinical judgment. Input from current practitioners in the medical and behavioral health community may provide further evidence of the standard of care and support (or lack thereof) of the medical necessity of the service or procedure. As noted in the Medical Policy Formation process, cited previously, the above factors, sources, and standards are used by OMPTA and the MPTAC to develop medical policy and clinical UM guidelines for the medical necessity of services and procedures. 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The multi-disciplinary group of professionals with both medical/surgical and mental health/substance use disorder experience review the clinical information available, regulatory approvals, consult with

	approvals, consult with outside experts in the relevant specialty, as needed, and utilize their clinical judgment to make determinations about medical policy and clinical UM guidelines. MPTAC includes committee members with expertise in behavioral health to ensure that any decisions on medical policy and clinical guidelines reflect the standard of care for members with behavioral health conditions. XXXXX does not apply these processes, strategies, and evidentiary standards more stringently to MH/SUD benefits than medical/surgical benefits. For MH/SUD services, the committee has elected to adopt criteria and guidelines established by an independent, third-party organization, MCG and has only internally developed a small fraction of the amount of guidelines for MH/SUD in contrast to those applicable to M/S services. The MCG Guidelines are subject to intense peer review and regulatory scrutiny, and are also used by many provider organizations as the preferred resource to determine medical necessity for both M/S and MH/SUD services. Since 2018, XXXXX has adopted 153 new medical policies/clinical UM guidelines. All of these were medical/surgical except for the following, which apply to both medical/surgical and MH/SUD. · LAB.00044 Saliva-based Testing to Determine Drug-Metabolizer Status · LAB.00046 Testing for Biochemical Markers for Alzheimer's Disease · LAB.00048 Pain Management Biomarker Analysis · MED.00133 Ingestion Event Monitors · MED.00138 Wearable Devices for Stress Relief and Management · SURG.00158 Implantable Peripheral Nerve Stimulation Devices as a Treatment for Pain · CG-MED-91 Remote Therapeutic and Physiologic Monitoring Services · DME.00048 Virtual Reality-Assisted Therapy Systems 5. Demonstration of Comparability and Stringency In Operation Of the 153 total new medical policies/clinical UM guidelines, only 5 apply a fail first requirement, none of which address MH/SUD conditions. XXXXX medical policies and clinical UM guidelines are all available publicly at: https://www.XXXXX.com/provider/policies/clinical-guidelines/updates/. Clinical UM Guidelines are applied separately in each state and is a market determination (see Prior Authorization NQTL Comparative Analysis for additional discussion on this process). Overall, XXXXX has 232 total medical policies (219) and clinical UM guidelines (225). Some medical policies and clinical UM guidelines may apply to both M/S and MH/SUD services. Beginning in 2024, XXXXX adopted MCG for the vast majority of its behavioral health guidelines, unless a different criteria set is required by a particular state mandate. The remaining XXXXX developed criteria or XXXXX customized MCG guideline applicable for behavioral health services include: · CG -BEH 14 Intensive In-Home Behavioral Health Services · CG-BEH -15 Activity Therapy for Autism Spectrum Disorders and Rett Syndrome · CG – LAB-09 Urine Toxicology Testing · CG-SURG-120 Vagnus Nerve Stimulation, Implantable · SURG.000026 Deep Brain, Cortical, and Cerebellar Stimulation · CG-MED-37 Intensive Programs for Pediatric Feeding Disorders · CG-ANC-03 Acupuncture	outside experts in the relevant specialty, as needed, and utilize their clinical judgment to make determinations about medical policy and clinical UM guidelines. MPTAC includes committee members with expertise in behavioral health to ensure that any decisions on medical policy and clinical guidelines reflect the standard of care for members with behavioral health conditions. 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Clinical UM Guidelines are applied separately in each state and is a market determination (see Prior Authorization NQTL Comparative Analysis for additional discussion on this process). Overall, XXXXX has 232 total medical policies (219) and clinical UM guidelines (225). Some medical policies and clinical UM guidelines may apply to both M/S and MH/SUD services. 6. Findings and Conclusions. The above analysis demonstrates that: (1) the processes, strategies, evidentiary standards, and other factors used to design and apply medical policy and clinical criteria requirement to MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply medical policy and clinical criteria to M/S benefits; and (2) XXXXX complies with the relevant data requirements under the MHPAEA Final Rules. In designing the medical policy and criteria applicable to medical necessity determination, XXXXX utilizes comparable factors, sources, standards, and processes for the medical policy determination. The factors detailed above demonstrate medical policy is developed using various clinical, evidenced based and peer reviewed factors by clinical professionals in various fields, including MH/SUD. XXXXX has used these clinical factors to also adopt independent,

	· CG-SURG-17 Trigger Point Injections · CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity For MH/SUD services specifically, XXXXX does not apply any fail first requirements to inpatient stays, including residential treatment center, partial hospitalization, intensive outpatient or routine outpatient services. Transcranial Magnetic Stimulation (MCG guideline), which is FDA approved for severe treatment resistant depression in adults, is one MH/SUD service for which there is a fail first requirement. Clinical criteria and the FDA approved indication for TMS is for treatment of Major Depressive Disorder in adult patients who have failed to receive satisfactory improvement from prior antidepressant medication. Electroconvulsive Shock Therapy (ECT) (MCG guideline) is an example of a service where a member may be required to fail drug therapy, but would be eligible for the service without failing that therapy if certain conditions are met (e.g., suicidal). Other than those examples, there are no other fail first requirements on MH/SUD services. However, there are many medical/surgical services for which there may be a fail first requirement. 6. Findings and Conclusions. The above analysis demonstrates that: (1) the processes, strategies, evidentiary standards, and other factors used to design and apply medical policy and clinical criteria requirement to MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply medical policy and clinical criteria to M/S benefits; and (2) XXXXX complies with the relevant data requirements under the MHPAEA Final Rules. In designing the medical policy and criteria applicable to medical necessity determination, XXXXX utilizes comparable factors, sources, standards, and processes for the medical policy determination. The factors detailed above demonstrate medical policy is developed using various clinical, evidenced based and peer reviewed factors by clinical professionals in various fields, including MH/SUD. XXXXX has used these clinical factors to also adopt independent, clinical, evidence based third-party guidelines for usage over MH/SUD services. For example, MH/SUD services subject to review use these independent guidelines developed by clinical experts including MCG. XXXXX has also adopted MCG criteria for M/S services, but also applies its own criteria for services where third party guidelines are not available or not formally adopted following MPTAC review. To further the above, XXXXX has obtained information from MCG to support the manner in which its policies are developed. The information notes MCG is independent and supports payers, providers, and government agencies with “objective, evidence based, and unbiased content.” The criteria are developed using a clinically rigorous process, aligned with the XXXXX factors noted above. This includes published, peer reviewed literature and updated guidelines from outside sources, where possible, that is subject to review by clinically active experts. Additional evidence such as clinical judgment from the evaluating expert practitioners is also used. These clinically based factors are combined to produce guidelines that can offer comprehensive recommendations for all steps in a care plan, and are applied in a consistent manner to develop comparable M/S and MH/SUD guidelines. With respect to fail first requirements, there are very few services for which a fail first requirement applies for MH/SUD services and the rationale for why a fail first requirement exists is consistent with the medical literature and the medical community/professional	clinical, evidence based third-party guidelines for usage over MH/SUD services. For example, MH/SUD services subject to review use these independent guidelines developed by clinical experts including MCG. XXXXX has also adopted MCG criteria for M/S services, but also applies its own criteria for services where third party guidelines are not available or not formally adopted following MPTAC review. To further the above, XXXXX has obtained information from MCG to support the manner in which its policies are developed. 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With respect to fail first requirements, there are very few services for which a fail first requirement applies for MH/SUD services and the rationale for why a fail first requirement exists is consistent with the medical literature and the medical community/professional organizations. Therefore, XXXXX’s medical policy process treats MH/SUD services comparably and no more stringently than medical/surgical services.

	organizations. Therefore, XXXXX's medical policy process treats MH/SUD services comparably and no more stringently than medical/surgical services.	
In-Patient & In-Network NQTL Practices	Based on prior discussions with the DOI, Column A is reflective of the specific categories otherwise described within this as well as other NQTLs that may exist. The Company did not identify any inconsistencies or differences other than those set forth in this document. Responses below apply to Inpatient In-Network NQTLs applicable to the subcategories in this report.	Same as for MH/SUD.
In-Patient & Out-of-Network NQTL Practices	Based on prior discussions with the DOI, Column A is reflective of the specific categories otherwise described within this as well as other NQTLs that may exist. The Company did not identify any inconsistencies or differences other than those set forth in this document. It should be noted that HMO plans do not cover Out-of-Network benefits unless an out-of-network referral is approved. Responses below apply to Inpatient In-Network NQTLs applicable to the subcategories in this report.	Same as for MH/SUD.
Out-Patient & In-Network NQTL Practices	Based on prior discussions with the DOI, Column A is reflective of the specific categories otherwise described within this as well as other NQTLs that may exist. The Company did not identify any inconsistencies or differences other than those set forth in this document. Responses below apply to Outpatient In-Network NQTLs applicable to the subcategories in this report.	Same as for MH/SUD.
Out-Patient & Out-of-Network NQTL Practices	Based on prior discussions with the DOI, Column A is reflective of the specific categories otherwise described within this as well as other NQTLs that may exist. The Company did not identify any inconsistencies or differences other than those set forth in this document. Responses below apply to Outpatient Out-of-Network NQTLs applicable to the subcategories in this report.	Same as for MH/SUD.
Emergency Services/Benefits NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation. We do not do utilization review for any emergency service claims attributed to MH/SUD conditions. However, if a member is admitted, they or their provider is requested to notify us as soon as possible so we can review the number of days that are medically necessary.	Same as for MH/SUD.
Rx Formulary Design, Management and Pharmacy Services NQTL Practices - Formulary Development - Clinical Edits	There are no non-comparable inconsistencies or differences in the application, as written and in operation. The Company maintains a single committee that reviews drugs for the formulary regardless of whether the drug is used to cover medical/surgical and MH/SUD conditions. The committee includes a psychiatrist. The same review process is used to determine whether to: 1) include a drug on the formulary; 2) identify a tier for the drug to be placed in; and 3) apply prior authorization, step therapy, and quantity limits. Clinical Edits 1. Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply. This nonquantitative treatment limitation (NQTL) analysis explains how XXXXX creates its clinical edits related to prescription drugs and therapies (collectively, "prescriptions"). Clinical edits include the following: • Prior Authorization (approval for prescription is required prior to dispense) • Step Therapy (clinical guidelines to be followed to ensure appropriate drugs are tried first)	There are no non-comparable inconsistencies or differences in the application, as written and in operation. The Company maintains a single committee that reviews drugs for the formulary regardless of whether the drug is used to cover medical/surgical and MH/SUD conditions. The committee includes a psychiatrist. The same review process is used to determine whether to: 1) include a drug on the formulary; 2) identify a tier for the drug to be placed in; and 3) apply prior authorization, step therapy, and quantity limits. Clinical Edits 1. Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply. This nonquantitative treatment limitation (NQTL) analysis explains how XXXXX creates its clinical edits related to prescription drugs and therapies (collectively, "prescriptions"). Clinical edits include the following: • Prior Authorization (approval for prescription is required prior to dispense) • Step Therapy (clinical guidelines to be followed to ensure appropriate drugs are tried first)

	• Quantity Limits (safety concerns limit the amount per fill, per time period, or duration of therapy) XXXXX has contracted with XXXXX, Inc. subsidiary, XXXXX, Inc., to provide pharmacy benefit management services and develop, implement, and administer the clinical criteria and edits for prescription drugs. All clinical edits are developed to guide clinically appropriate use of drugs and therapies, and are reviewed and approved by the XXXXX Pharmacy and Therapeutics (P&T) Committee. Tiering decisions and clinical edits are developed by the Value Assessment Committee (VAC). Drug utilization review (DUR) edits can be comprised of prior authorization, step therapy, and quantity limits, and are meant to ensure clinically appropriate and safe use of medications. Members and providers may review the clinical criteria for any prescription online at: https://www.XXXXX.com/ms/pharmacyinformation/clinicalcriteria.html Here members may access those specific drugs requiring prior authorization/pre-certification, or subject to quantity limits and step therapy. Members and providers may also access formulary information (including the plan's applicable formulary listing and any edits) online at: https://www.XXXXX.com/pharmacy-information/drug-list-formulary Members may also review pharmacy coverage information within their evidence of coverage or benefit booklet. The information is typically included within the Prescription Drug Retail Pharmacy section of the schedule of benefits. Additionally, members may access plan specific prescription information through the "Price A Med" tool available online through the Sydney Application. 2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits.: • Member Impact; • Safety & Efficacy; • Regulatory Approvals; • Cost of Review; • Federal and State Mandate. Factor Weighing: Clinical considerations are considered first and foremost to ensure the clinical edits promote safe, clinically appropriate use of the drug, and prevent overutilization. Financial considerations are reviewed as a factor, but are weighted secondary to clinical concerns. 3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits: Member Impact: XXXXX considers the overall impact to the member in the event a clinical edit is imposed on the drug. The impact may include the abrasion (clinical and financial) of having to go through the prior authorization process whether for a new prescription or when obtaining a prescription following a break in usage, the requirement to complete other treatments first, or the imposition of quantity limits based on FDA labeling. Member impact volume (i.e., the number of members that will be subject to the imposition of a clinical edit) is determined by	• Quantity Limits (safety concerns limit the amount per fill, per time period, or duration of therapy) XXXXX has contracted with XXXXX, Inc. subsidiary, XXXXX, Inc., to provide pharmacy benefit management services and develop, implement, and administer the clinical criteria and edits for prescription drugs. All clinical edits are developed to guide clinically appropriate use of drugs and therapies, and are reviewed and approved by the XXXXX Pharmacy and Therapeutics (P&T) Committee. 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	historical paid claims data when applying new utilization management to an existing drug. For drugs with UM already in place, we monitor member impact through the rejection volume (i.e., the number of rejections at point of sale from the edits in place). The impact is considered in light of the clinical appropriateness of the drug at issue and the type of edit involved. There is no specific numerical threshold in place for either the member impact volume or rejection volume, but the levels will be considered in conjunction with the clinical appropriateness factors noted below. Member impact is taken into account for tiering and clinical edits as described below. Safety & Efficacy: During the evidence-based evaluation process, we determine if there is any clinically recognized and scientifically validated data supporting or demonstrating member safety concerns. We continually monitor for safety, effectiveness, and quality of care of drugs contained within our formularies. Member safety and efficacy reviews include, but not limited to the following: • Type and frequency of side effects; • Occurrence of adverse events; • Potential drug interactions; • Drug Overutilization; • Likely impact on patient adherence. The sources for safety reviews include: • FDA approved package inserts; • American Hospital Formulary Services (AHFS); • Critically and/or scientifically validated findings, information in major or peer reviewed medical publications • Recommendations of recognized expert organizations, including specialty clinical societies, academic medical centers and treatment guidelines • National Comprehensive Cancer Network (NCCN), • Clinical Pharmacology, • Truven Health Analytics Inc., DrugDex • Clinical outcomes research data; and/or • Practice pattern and utilization data. Regulatory Approvals: Federal government agencies, such as the Food and Drug Administration (“FDA”), review applications for approval for drugs and medical devices. The approval is necessary for drugs and medical devices to be sold in the United States and ultimately consumed by XXXXX members to treat their various conditions. The process ensures safe and effective drugs and medical devices are used, and provides guidance to doctors and patients on how to use the medicines. XXXXX relies on the FDA approval and guidance to determine what drugs should be covered, and whether a clinical edit should be imposed. The FDA will include this information in the FDA approved drug label and packaging insert. The label will contain a summary of the essential scientific information needed for the safe and effective use of the drug and the prescribing information, FDA approved patient labeling (Medication Guides, Patient Package Inserts, and/or Instruction for Use). (See, FDA’s Labeling Resources for Human Prescription Drugs accessed at: https://www.fda.gov/drugs/laws-acts-and-rules/fdas-labeling-resources-human-prescription-drugs) XXXXX utilizes these FDA guidelines to determine the application of quantity limits and if step therapy is required. If the FDA packaging inserts indicate a specific quantity limit, XXXXX will adopt the guideline in the insert. Cost of Review: Prior authorization (PA) data is reviewed and analyzed for trends in comparison with the costs of each claim and potential financial impact of prior authorization	number of members that will be subject to the imposition of a clinical edit) is determined by historical paid claims data when applying new utilization management to an existing drug. For drugs with UM already in place, we monitor member impact through the rejection volume (i.e., the number of rejections at point of sale from the edits in place). The impact is considered in light of the clinical appropriateness of the drug at issue and the type of edit involved. There is no specific numerical threshold in place for either the member impact volume or rejection volume, but the levels will be considered in conjunction with the clinical appropriateness factors noted below. Member impact is taken into account for tiering and clinical edits as described below. Safety & Efficacy: During the evidence-based evaluation process, we determine if there is any clinically recognized and scientifically validated data supporting or demonstrating member safety concerns. We continually monitor for safety, effectiveness, and quality of care of drugs contained within our formularies. Member safety and efficacy reviews include, but not limited to the following: • Type and frequency of side effects; • Occurrence of adverse events; • Potential drug interactions; • Drug Overutilization; • Likely impact on patient adherence. 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If the FDA packaging inserts indicate a specific quantity limit, XXXXX will adopt the guideline in the insert.

	(e.g., denials of prescriptions not deemed medically necessary) . PA data is retrieved internally from a self-service tool, which can be combined with information from rejected claims (e.g., including historic pricing and utilization). The Clinical Pharmacy Services team, including representatives from Clinical Affairs and Utilization Management, reviews the rejection volume, the percentage of rejected members that request PA review, and PA approval rates. The cost to review each claim and any savings from those claims determined to be clinically inappropriate are compared. The cost and savings calculations are measured by drug class. Those drug classes that have a prior authorization approval rate above 80% are reviewed to determine if the clinical edit is needed. Recommendations for changes are presented to the VAC committee for approval. Federal and State Mandates: In the event the federal or state government mandates coverage of specific prescription and determines the clinical edits that may be applied, XXXXX will follow these mandates. 4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits. XXXXX's pharmacy services are provided by its PBM, XXXXX. Developing the formulary is a two part process. The clinical work, which is the initial step, is done by the XXXXX Pharmacy and Therapeutics Committee ("P&T"), which meets at least quarterly. The VAC handles the second step, which includes tiering, step therapy, and clinical UM edits (e.g., prior authorization). The policies, procedures, effectiveness data, Clinical Attributes, and other factors considered by the P&T in determining its recommendations with respect to mental health and substance use disorder drugs and drug classes are comparable to, and not more stringent than, those applied to medical/surgical drugs and drug classes. P&T recommendation(s) which includes clinical designations of the comparability of products and clinical criteria are forwarded to the Value Assessment Committee (VAC) for formulary/tier assignment or formulary/tier edits. Clinical Edits on products follow similar rules as tiering decisions (the VAC tiering process is considered in the Tiering NQTL Comparative Analysis). Drugs classified as Favorable will not be subject to greater edits than those classified as Comparable, Insufficient Evidence, or Unfavorable and drugs classified as Comparable will not be subject to greater edits than those classified as Insufficient Evidence or Unfavorable. This ensures the clinical determinations based on safety and efficacy will ultimately control the ability of the VAC to impose clinical edits. For example, a drug classified as Favorable can't be subject to prior authorization if a similar drug classified as Comparable is not subject to prior authorization. VAC meetings are held at least quarterly, and a quorum (simple majority of voting members) is required for the meeting to commence. Approval is by a simple majority vote of the VAC voting members present is required. Once a simple majority of the members of the VAC agree on the formulary and/or Tier assignment for a covered product, then that approval shall be sent to the applicable delegated entity for action by each delegating entity in accordance with their applicable policies and procedures.	Cost of Review: Prior authorization (PA) data is reviewed and analyzed for trends in comparison with the costs of each claim and potential financial impact of prior authorization (e.g., denials of prescriptions not deemed medically necessary) . PA data is retrieved internally from a self-service tool, which can be combined with information from rejected claims (e.g., including historic pricing and utilization). The Clinical Pharmacy Services team, including representatives from Clinical Affairs and Utilization Management, reviews the rejection volume, the percentage of rejected members that request PA review, and PA approval rates. The cost to review each claim and any savings from those claims determined to be clinically inappropriate are compared. The cost and savings calculations are measured by drug class. Those drug classes that have a prior authorization approval rate above 80% are reviewed to determine if the clinical edit is needed. Recommendations for changes are presented to the VAC committee for approval. Federal and State Mandates: In the event the federal or state government mandates coverage of specific prescription and determines the clinical edits that may be applied, XXXXX will follow these mandates. 4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits. XXXXX's pharmacy services are provided by its PBM, XXXXX. Developing the formulary is a two part process. The clinical work, which is the initial step, is done by the XXXXX Pharmacy and Therapeutics Committee ("P&T"), which meets at least quarterly. The VAC handles the second step, which includes tiering, step therapy, and clinical UM edits (e.g., prior authorization). The policies, procedures, effectiveness data, Clinical Attributes, and other factors considered by the P&T in determining its recommendations with respect to mental health and substance use disorder drugs and drug classes are comparable to, and not more stringent than, those applied to medical/surgical drugs and drug classes. P&T recommendation(s) which includes clinical designations of the comparability of products and clinical criteria are forwarded to the Value Assessment Committee (VAC) for formulary/tier assignment or formulary/tier edits. Clinical Edits on products follow similar rules as tiering decisions (the VAC tiering process is considered in the Tiering NQTL Comparative Analysis). Drugs classified as Favorable will not be subject to greater edits than those classified as Comparable, Insufficient Evidence, or Unfavorable and drugs classified as Comparable will not be subject to greater edits than those classified as Insufficient Evidence or Unfavorable. This ensures the clinical determinations based on safety and efficacy will ultimately control the ability of the VAC to impose clinical edits. For example, a drug classified as Favorable can't be subject to prior authorization if a similar drug classified as Comparable is not subject to prior authorization. VAC meetings are held at least quarterly, and a quorum (simple majority of voting members) is required for the meeting to commence. Approval is by a simple majority vote of the VAC voting members present is required. Once a simple majority of the members of the VAC agree on the formulary and/or Tier assignment for a covered product, then that approval shall be sent to the applicable delegated entity for action by each delegating entity in accordance with their applicable policies and procedures.

	DUR Edit Process 1. General Process Through the Pharmacy & Therapeutics (P&T) process, criteria for DUR edits, (including prior authorization criteria, step therapy, quantity limit) are reviewed and approved. The P&T process consists of two interdependent committees. The first committee is the Pharmacy and Therapeutics (P&T) Committee. The second committee is the Value Assessment Committee (VAC). The Drug Utilization and Policy Review (DUPR), Hematology/Oncology, and Behavioral Health Subcommittees evaluate and make recommendations on DUR edits prior to presenting to the P&T Committee. The P&T Committee will have the opportunity to discuss, make a final recommendation, and vote on all clinical edits and subcommittee recommendations. All P&T Committee recommendations as well as substantive comments will be forwarded to the VAC for review. New products that are new formulations, strengths and/or dosage forms of an existing drug or therapeutic class of drugs or new chemical entity in an existing therapeutic class of drugs may have DUR line extension edits applied consistent with previously P&T approved DUR edit criteria for the therapeutic class. Edits will be reviewed through the P&T process during its normal course of business, including an annual review. 2. Quantity Limits Quantity limit is the maximum amount of a drug or medical supply that can be dispensed at the pharmacy at any one given time. Quantity limitations for drugs generally adhere to FDA-approved dosing guidelines and are a safeguard to prevent members from experiencing harm by exceeding the recommended dosage. When a new chemical entity, drug strength/formulation, or medical supply is announced, XXXXX may implement new quantity limits based on the FDA-approved manufacturer recommended dosage and administration schedule to enforce B26the standard benefit language in the member handbook regarding day supply. These limits may be implemented prior to P&T approval but will be brought to the P&T committee for review and approval at the next available meeting. Drug Utilization Review (DUR) line extension edits may be added. In the event that a request for a quantity limit falls in the above category, a proposal will be brought to the P&T committee for review. Additionally, requests for quantity limits that fall outside of these guidelines will also be brought to the P&T committee for review. The P&T committee will determine whether the quantity limit edit is or is not clinically appropriate, and whether or not there is a significant clinical safety component associated with it. 3. Prior Authorization Prior Authorizations are safeguards to prevent members from experiencing harm by using medications for non- Food and Drug Administration (FDA)- approved indications and/or indications that are not medically accepted. When a new chemical entity is announced, XXXXX may implement a new prior authorization based on the FDA-approved manufacturer recommended indications to enforce the standard benefit language in the member handbook regarding appropriate use. These prior authorizations may be implemented prior to P&T approval but will be brought to the Pharmacy and Therapeutics (P&T) Committee for review and approval at the next available meeting. 4. Step Therapy	DUR Edit Process 1. General Process Through the Pharmacy & Therapeutics (P&T) process, criteria for DUR edits, (including prior authorization criteria, step therapy, quantity limit) are reviewed and approved. The P&T process consists of two interdependent committees. The first committee is the Pharmacy and Therapeutics (P&T) Committee. The second committee is the Value Assessment Committee (VAC). The Drug Utilization and Policy Review (DUPR), Hematology/Oncology, and Behavioral Health Subcommittees evaluate and make recommendations on DUR edits prior to presenting to the P&T Committee. The P&T Committee will have the opportunity to discuss, make a final recommendation, and vote on all clinical edits and subcommittee recommendations. All P&T Committee recommendations as well as substantive comments will be forwarded to the VAC for review. New products that are new formulations, strengths and/or dosage forms of an existing drug or therapeutic class of drugs or new chemical entity in an existing therapeutic class of drugs may have DUR line extension edits applied consistent with previously P&T approved DUR edit criteria for the therapeutic class. Edits will be reviewed through the P&T process during its normal course of business, including an annual review. 2. Quantity Limits Quantity limit is the maximum amount of a drug or medical supply that can be dispensed at the pharmacy at any one given time. Quantity limitations for drugs generally adhere to FDA-approved dosing guidelines and are a safeguard to prevent members from experiencing harm by exceeding the recommended dosage. When a new chemical entity, drug strength/formulation, or medical supply is announced, XXXXX may implement new quantity limits based on the FDA-approved manufacturer recommended dosage and administration schedule to enforce the standard benefit language in the member handbook regarding day supply. These limits may be implemented prior to P&T approval but will be brought to the P&T committee for review and approval at the next available meeting. Drug Utilization Review (DUR) line extension edits may be added. In the event that a request for a quantity limit falls in the above category, a proposal will be brought to the P&T committee for review. Additionally, requests for quantity limits that fall outside of these guidelines will also be brought to the P&T committee for review. The P&T committee will determine whether the quantity limit edit is or is not clinically appropriate, and whether or not there is a significant clinical safety component associated with it. 3. Prior Authorization Prior Authorizations are safeguards to prevent members from experiencing harm by using medications for non- Food and Drug Administration (FDA)- approved indications and/or indications that are not medically accepted. When a new chemical entity is announced, XXXXX may implement a new prior authorization based on the FDA-approved manufacturer recommended indications to enforce the standard benefit language in the member handbook regarding appropriate use. These prior authorizations may be implemented prior to P&T approval but will be brought to the Pharmacy and Therapeutics (P&T) Committee for review and approval at the next available meeting. 4. Step Therapy

	Step therapy is used to promote the use of recognized prescribing guidelines. When a new chemical entity is announced, XXXXX may implement new step therapy guidelines in accordance with P&T approved step therapy guidelines for similar medications or class of medications. Step therapy may be implemented prior to P&T approval but will be brought to the Pharmacy and Therapeutics (P&T) Committee for review and approval at the next available meeting. Step therapy is not applied for a new medication in which a step therapy does not exist for a similar medication or class of medications. 5. Implementation The DUR edits, once approved by the P&T Committee and Health Plan, are applied to products through the XXXXX Clinical Affairs and Clinical Pharmacy Operations teams. Impacted members receive notifications of new DUR edits or changes in accordance with state and federal requirements. The edits are designed to screen each time a prescription is adjudicated electronically prior to being dispensed at point of sale through the claims processing system. The edits produce point of sale messaging to pharmacists responsible for dispensing applicable products. The message will include “informational only” notes or a rejection of the claim. The message may also include information to help resolve the situation such as a phone number for providers to contact for prior authorizations. In-Operation Comparative Analysis XXXXX reviewed the number of behavioral health drugs that are subject to quantity limits, step therapy, and prior authorization as compared to medical surgical drugs. The information is based on the National Formulary, the most commonly used formulary. The chart shows a comparison of the M/S drugs and MH/SUD drugs subject to prior authorization, step therapy, and quantity therapy. It includes a raw number total comparison as well as percentage comparison. Medical/Surgical Drugs Total drugs: 8395 M/S with PA: 1192 M/S without PA: 7203 % M/S with PA: 14.20% % M/S without PA: 85.80% % M/S PA approval rate: 73.92% Total drugs: 8395 M/S with ST: 559 M/S without ST: 7836 % M/S with PA: 6.66% % M/S without PA: 93.34% % M/S PA approval rate: 71.44% Total drugs: 8395 M/S with QL: 2560 M/S without QL: 5835 % M/S with QL: 30.49% % M/S without QL: 69.51% % M/S QL approval rate: 57.38% Mental Health/Substance Use Disorder Drugs Total drugs: 300 MH_SUD with PA: 87 MH_SUD without PA: 213 % MH_SUD with PA: 29.00% % MH_SUD without PA: 71.00% % MH_SUD PA approval rate: 91.82%	Step therapy is used to promote the use of recognized prescribing guidelines. When a new chemical entity is announced, XXXXX may implement new step therapy guidelines in accordance with P&T approved step therapy guidelines for similar medications or class of medications. Step therapy may be implemented prior to P&T approval but will be brought to the Pharmacy and Therapeutics (P&T) Committee for review and approval at the next available meeting. Step therapy is not applied for a new medication in which a step therapy does not exist for a similar medication or class of medications. 5. Implementation The DUR edits, once approved by the P&T Committee and Health Plan, are applied to products through the XXXXX Clinical Affairs and Clinical Pharmacy Operations teams. Impacted members receive notifications of new DUR edits or changes in accordance with state and federal requirements. The edits are designed to screen each time a prescription is adjudicated electronically prior to being dispensed at point of sale through the claims processing system. The edits produce point of sale messaging to pharmacists responsible for dispensing applicable products. The message will include “informational only” notes or a rejection of the claim. The message may also include information to help resolve the situation such as a phone number for providers to contact for prior authorizations. In-Operation Comparative Analysis XXXXX reviewed the number of behavioral health drugs that are subject to quantity limits, step therapy, and prior authorization as compared to medical surgical drugs. The information is based on the National Formulary, the most commonly used formulary. The chart shows a comparison of the M/S drugs and MH/SUD drugs subject to prior authorization, step therapy, and quantity therapy. It includes a raw number total comparison as well as percentage comparison. Medical/Surgical Drugs Total drugs: 8395 M/S with PA: 1192 M/S without PA: 7203 % M/S with PA: 14.20% % M/S without PA: 85.80% % M/S PA approval rate: 73.92% Total drugs: 8395 M/S with ST: 559 M/S without ST: 7836 % M/S with PA: 6.66% % M/S without PA: 93.34% % M/S PA approval rate: 71.44% Total drugs: 8395 M/S with QL: 2560 M/S without QL: 5835 % M/S with QL: 30.49% % M/S without QL: 69.51% % M/S QL approval rate: 57.38% Mental Health/Substance Use Disorder Drugs Total drugs: 300 MH_SUD with PA: 87 MH_SUD without PA: 213 % MH_SUD with PA: 29.00% % MH_SUD without PA: 71.00% % MH_SUD PA approval rate: 91.82%

Total drugs	MH_SUD with ST	MH_SUD without ST	% MH_SUD with ST	% MH_SUD without ST	% MH_HUD ST approval rate
300	86	214	28.67%	71.33%	83.63%

Total drugs	MH_SUD with QL	MH_SUD without QL	% MH_SUD with QL	% MH_SUD without QL	% MH_HUD QL approval rate
300	256	44	85.33%	14.67%	77.09%

The tables above were compiled by a Business Analyst from XXXXX's Clinical Pharmacy Services team on November 15, 2023.
The tables apply to each tier structure for the National Formulary. A higher overall percentage of MH/SUD drugs may be subject to the various clinical edits. However, the analysis demonstrates the clinical edits applied to MH/SUD drugs are approved at a higher overall rate than M/S drugs.

5. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding this NQTL on MH/SUD benefits?
Yes. MHPAEA does not mandate equality of outcomes. See, e.g., James C. v. XXXXX Blue Cross Blue Shield, 2021 U.S. Dist. LEXIS 115701, 59 (D. Utah June 21, 2021). This principle applies to the clinical edits imposed here, and disparate results do not automatically result in a parity violation. In order to determine whether a plan complies with the NQTL requirements under MHPAEA, one must examine whether "the [plan's] methodology for developing and applying reimbursement rates under the plan is comparable and applied no more stringently for MH/SUD benefits when compared to the methodology for developing and applying reimbursement rates for medical/surgical benefits under the plan." FAQS ABOUT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION AND THE 21ST CENTURY CURES ACT PART 39 (September 5, 2019), Q6., at 9.

In this instance, the same factors, sources, standards, and processes are used to develop the clinical factors and are applied comparably to MH/SUD and M/S drugs. The higher percentage of MH/SUD drugs subject to prior authorization, step therapy, and quantity limits are a reflection of the application of clinically based criteria to MH/SUD drugs. As noted above, the clinical evidence is reviewed as the first and primary step in the determination of clinical edits. The clinical evidence and regulatory approvals (e.g., FDA packaging inserts) guide the P&T and VAC decision making process related to the imposition of clinical edits to ensure member safety and clinical effectiveness is achieved. In addition, edits are applied consistently across drug classes. With fewer drug classes categorized as MH/SUD, there is a greater chance that an edit would apply to an available drug. The MH/SUD drugs included on the formulary are generally higher risk items and the clinical evidence and FDA guidelines support the imposition of these clinical edits at a higher rate than typical M/S drugs. Therefore, the Plan is not imposing an NQTL more stringently on these particular drugs, but in fact relying on objective, clinical evidence to ensure member safety and mitigate the potential negative consequences associated with these covered MH/SUD drugs. Further, the operational analysis confirms the clinical edits are not being applied to restrict access to MH/SUD drugs more stringently than M/S drugs as the MH/SUD drugs are approved at a higher rate than M/S drugs.

Total drugs	MH_SUD with ST	MH_SUD without ST	% MH_SUD with ST	% MH_SUD without ST	% MH_HUD ST approval rate
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Rx Formulary Design, Management and Pharmacy Services NQTL Practices - Formulary Designations	There are no non-comparable inconsistencies or differences in the application, as written and in operation. The Company maintains a single committee that reviews drugs for the formulary regardless of whether the drug is used to cover medical/surgical and MH/SUD conditions. The committee includes a psychiatrist. The same review process is used to determine whether to: 1) include a drug on the formulary; 2) identify a tier for the drug to be placed in; and 3) apply prior authorization, step therapy, and quantity limits. Formulary Designations 1. Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply. This nonquantitative treatment limitation (NQTL) analysis explains how XXXXX creates its drug formularies related to prescription drugs and therapies (collectively, “prescriptions”). XXXXX has contracted with XXXXX, Inc. subsidiary, XXXXX, Inc., to provide pharmacy benefit management services and develop its applicable formularies and clinical criteria for prescription drugs. All clinical criteria are developed to guide clinically appropriate use of drugs and therapies, and are reviewed and approved by the XXXXX Pharmacy and Therapeutics (P&T) Committee. Members and providers may review the clinical criteria for any prescription online at: https://www.XXXXX.com/ms/pharmacyinformation/clinicalcriteria.html Members and providers may also access formulary information (including the plan’s applicable formulary listing and any edits) online at: https://www.XXXXX.com/ms/pharmacyinformation/home.html Members may also review pharmacy coverage information within their evidence of coverage or benefit booklet. The information is typically included within the Prescription Drug Retail Pharmacy section of the schedule of benefits. 2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits: In determining the recommendation for adoption of prescriptions on the formulary and the clinical criteria used to evaluate the medical necessity of prescriptions, the P&T Committee considers the following factors: • Governmental agency approvals; • Clinical and Peer Supported Data; • Clinical effectiveness (Efficacy); • Clinical Attributes; and • Member Safety. 3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to	There are no non-comparable inconsistencies or differences in the application, as written and in operation. The Company maintains a single committee that reviews drugs for the formulary regardless of whether the drug is used to cover medical/surgical and MH/SUD conditions. The committee includes a psychiatrist. The same review process is used to determine whether to: 1) include a drug on the formulary; 2) identify a tier for the drug to be placed in; and 3) apply prior authorization, step therapy, and quantity limits. Formulary Designations 1. Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply. This nonquantitative treatment limitation (NQTL) analysis explains how XXXXX creates its drug formularies related to prescription drugs and therapies (collectively, “prescriptions”). XXXXX has contracted with XXXXX, Inc. subsidiary, XXXXX, Inc., to provide pharmacy benefit management services and develop its applicable formularies and clinical criteria for prescription drugs. All clinical criteria are developed to guide clinically appropriate use of drugs and therapies, and are reviewed and approved by the XXXXX Pharmacy and Therapeutics (P&T) Committee. Members and providers may review the clinical criteria for any prescription online at: https://www.XXXXX.com/ms/pharmacyinformation/clinicalcriteria.html Members and providers may also access formulary information (including the plan’s applicable formulary listing and any edits) online at: https://www.XXXXX.com/ms/pharmacyinformation/home.html Members may also review pharmacy coverage information within their evidence of coverage or benefit booklet. The information is typically included within the Prescription Drug Retail Pharmacy section of the schedule of benefits. 2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits: In determining the recommendation for adoption of prescriptions on the formulary and the clinical criteria used to evaluate the medical necessity of prescriptions, the P&T Committee considers the following factors: • Governmental agency approvals; • Clinical and Peer Supported Data; • Clinical effectiveness (Efficacy); • Clinical Attributes; and • Member Safety. 3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits: The P&T Committee considers multiple factors when determining the clinical criteria for the therapeutic use of drugs, insulin, products, and related supplies.

	design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits: The P&T Committee considers multiple factors when determining the clinical criteria for the therapeutic use of drugs, insulin, products, and related supplies. Governmental Agency Approvals: The Food and Drug Administration (FDA) reviews prescriptions and authorizes usage for certain indications. The FDA approved uses and package inserts are considered by the P&T Committee when evaluating the clinical effectiveness of prescriptions, adopting clinical criteria, and determining the prescription's clinical designation. Clinical and Peer Supported Data: The P&T Committee will consider a thorough review of disease state and standard of care data. The resources used include clinical practice guidelines, UpToDate, and other compendia. Clinical practice guideline recommendations are evaluated and critiqued for quality, applicability, strength of evidence and recommendations, and potential for bias and conflicts of interest. Peer supported data is also reviewed for consideration of the other factors noted below. Efficacy: Comprehensive systematic literature search is performed for all products included in therapeutic class reviews for a determination of clinical efficacy. The literature comes from various sources including: PubMed, ClinicalTrials.gov, prescribing information, clinical guidelines, manufacturer resources, and compendia (e.g., Micromedex, UpToDate, AHFS, FDA reviews). Efficacy evidence from sufficient quality trials are critically evaluated using a standardized evidence-based process, such as but not limited to: assessing generalizability, applicability to the study population to our membership, study design, potential for bias, and statistical analysis methods. Studies are rated based on the overall quality of the trial design and outcomes measured. Member Safety: A comprehensive search for safety data is also performed for all products included in therapeutic class reviews to determine member safety. A variety of resources are searched including, but not limited to: The FDA website, FDA warnings letters/postings, FDA reviews for safety communications. Member safety data is reviewed in accordance with efficacy standards. Lower quality data may be accepted as safety evidence, due to limitations in availability of safety information prior to broad availability of a drug. Member safety issues identified in this clinical data is evaluated subjectively and in conjunction with other factors. Clinical Attributes: Product attributes may be taken into consideration, especially when sufficient quality studies comparing efficacy and safety of products are lacking, or when the evidence comparing products is comparable. Products may be differentiated by clinical attributes such as but not limited to: frequency of administration, route of administration (e.g., intravenous, subcutaneous, oral, topical), clinical value of unique formulations, and whether the product is self-administered or provider administered. Factor Weighting: The clinical literature supporting each factor is graded for quality and considered in the totality of the evidence. Each factor is considered equally. 4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance	Governmental Agency Approvals: The Food and Drug Administration (FDA) reviews prescriptions and authorizes usage for certain indications. The FDA approved uses and package inserts are considered by the P&T Committee when evaluating the clinical effectiveness of prescriptions, adopting clinical criteria, and determining the prescription's clinical designation. Clinical and Peer Supported Data: The P&T Committee will consider a thorough review of disease state and standard of care data. The resources used include clinical practice guidelines, UpToDate, and other compendia. Clinical practice guideline recommendations are evaluated and critiqued for quality, applicability, strength of evidence and recommendations, and potential for bias and conflicts of interest. Peer supported data is also reviewed for consideration of the other factors noted below. Efficacy: Comprehensive systematic literature search is performed for all products included in therapeutic class reviews for a determination of clinical efficacy. The literature comes from various sources including: PubMed, ClinicalTrials.gov, prescribing information, clinical guidelines, manufacturer resources, and compendia (e.g., Micromedex, UpToDate, AHFS, FDA reviews). Efficacy evidence from sufficient quality trials are critically evaluated using a standardized evidence-based process, such as but not limited to: assessing generalizability, applicability to the study population to our membership, study design, potential for bias, and statistical analysis methods. Studies are rated based on the overall quality of the trial design and outcomes measured. Member Safety: A comprehensive search for safety data is also performed for all products included in therapeutic class reviews to determine member safety. A variety of resources are searched including, but not limited to: The FDA website, FDA warnings letters/postings, FDA reviews for safety communications. Member safety data is reviewed in accordance with efficacy standards. Lower quality data may be accepted as safety evidence, due to limitations in availability of safety information prior to broad availability of a drug. Member safety issues identified in this clinical data is evaluated subjectively and in conjunction with other factors. Clinical Attributes: Product attributes may be taken into consideration, especially when sufficient quality studies comparing efficacy and safety of products are lacking, or when the evidence comparing products is comparable. Products may be differentiated by clinical attributes such as but not limited to: frequency of administration, route of administration (e.g., intravenous, subcutaneous, oral, topical), clinical value of unique formulations, and whether the product is self-administered or provider administered. Factor Weighting: The clinical literature supporting each factor is graded for quality and considered in the totality of the evidence. Each factor is considered equally. 4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits. XXXXX's pharmacy services are provided by its PBM, XXXXX. Developing the formulary is a two-part process. The clinical work, which is the initial step, is done by the XXXXX Pharmacy and Therapeutics Committee ("P&T"), which meets at least quarterly. The VAC handles the second step, which includes tiering, step therapy, and clinical UM edits (e.g., prior authorization). The policies, procedures, effectiveness data, Clinical Attributes, and other factors considered by the P&T in determining its recommendations with respect to mental

	use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits. XXXXX's pharmacy services are provided by its PBM, XXXXX. Developing the formulary is a two-part process. The clinical work, which is the initial step, is done by the XXXXX Pharmacy and Therapeutics Committee ("P&T"), which meets at least quarterly. The VAC handles the second step, which includes tiering, step therapy, and clinical UM edits (e.g., prior authorization). The policies, procedures, effectiveness data, Clinical Attributes, and other factors considered by the P&T in determining its recommendations with respect to mental health and substance use disorder drugs and drug classes are comparable to, and not more stringent than, those applied to medical/surgical drugs and drug classes. P&T voting members come from various clinical specialties and geographic regions that adequately represent the needs of the enrollees of XXXXX and the health plans under contract with XXXXX ("Delegating Entities"). All of the P&T voting members are practicing physicians, including one psychiatrist, or pharmacists who are in good standing with XXXXX or XXXXX. In addition, voting members of the P&T are not employees of XXXXX or XXXXX. A "practicing physician or pharmacist" is an individual who has an active professional license to practice in the United States or one of its territories and either: 1) is currently practicing in the United States or one of its territories, or 2) is currently a professor at an academic medical center or school of pharmacy. Additionally, the P&T has the following: a. At least one voting member of the P&T is a practicing physician who is an expert in the care of elderly or disabled persons. b. At least two voting members of the P&T are practicing pharmacists, one of which is an expert in the care of elderly or disabled persons. The P&T may have subcommittees that address specific topics, including behavioral health (chaired by the psychiatrist that votes on the P&T), drug utilization and policy review, in order to assist the full P&T in its decision-making process. New drugs, including new uses for existing drugs, indications, and formulations are reviewed by the P&T as follows: P&T Assignment of Clinical Designation The P&T conducts its clinical review and makes a recommendation for formulary consideration to the VAC. Clinical designations will only be assigned for branded products that do not have a generic available. The applicable clinical designations and clinical criteria that the P&T may assign are as follows: Favorable The Favorable clinical designation means that, based upon the data available at the time of the review, the drug provides a better overall treatment profile for the majority of individuals taking the product as compared to other available products within the therapeutic class of drugs or other available treatment options. Designating a product Favorable relative to other drugs in a therapeutic class will be based on a review of the following criteria: • It has clinically recognized and scientifically validated data supporting or demonstrating better: o Efficacy o Safety	health and substance use disorder drugs and drug classes are comparable to, and not more stringent than, those applied to medical/surgical drugs and drug classes. P&T voting members come from various clinical specialties and geographic regions that adequately represent the needs of the enrollees of XXXXX and the health plans under contract with XXXXX ("Delegating Entities"). All of the P&T voting members are practicing physicians, including one psychiatrist, or pharmacists who are in good standing with XXXXX or XXXXX. In addition, voting members of the P&T are not employees of XXXXX or XXXXX. A "practicing physician or pharmacist" is an individual who has an active professional license to practice in the United States or one of its territories and either: 1) is currently practicing in the United States or one of its territories, or 2) is currently a professor at an academic medical center or school of pharmacy. Additionally, the P&T has the following: a. At least one voting member of the P&T is a practicing physician who is an expert in the care of elderly or disabled persons. b. At least two voting members of the P&T are practicing pharmacists, one of which is an expert in the care of elderly or disabled persons. The P&T may have subcommittees that address specific topics, including behavioral health (chaired by the psychiatrist that votes on the P&T), drug utilization and policy review, in order to assist the full P&T in its decision-making process. New drugs, including new uses for existing drugs, indications, and formulations are reviewed by the P&T as follows: P&T Assignment of Clinical Designation The P&T conducts its clinical review and makes a recommendation for formulary consideration to the VAC. Clinical designations will only be assigned for branded products that do not have a generic available. 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Comparable The Comparable clinical designation means that, based upon the data available at the time of the review, the drug provides a comparable treatment profile for the majority of individuals taking the product as compared to other available products within the therapeutic class of drugs or other available treatment options. Designating a product Comparable relative to other drugs in a therapeutic class will be based on a review of the following criteria: It has clinically recognized and scientifically validated data supporting or demonstrating comparable:

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Insufficient Evidence The Insufficient Evidence clinical designation means that, based upon the data available at the time of the review, the drug has an unclear treatment profile for the majority of individuals taking the product as compared to other available products within the therapeutic class of drugs or other available treatment options. Designating a product Insufficient Evidence relative to other drugs in a therapeutic class will be based on a review of the following criteria: There is a lack of clinically recognized and scientifically validated data supporting or demonstrating: • Efficacy • Safety • Health outcomes/effectiveness based on delegating entities' population and/or comparable data (if available) or • Clinical attribute(s) relative to comparator products. Unfavorable The Unfavorable clinical designation means that, based upon the data available at the time of the review, the drug provides an unfavorable treatment profile for the majority of individuals taking the product as compared to other available products within the therapeutic class of drugs or other available treatment options. Designating a product Unfavorable relative to other drugs in a therapeutic class will be based on a review of the following criteria: It has clinically recognized and scientifically validated data supporting or demonstrating unfavorable: • Efficacy • Safety • Health outcomes/effectiveness based on delegating entities' population and/or comparable data (if available) or • Clinical attribute(s) relative to comparator products Lack of a Comparator Product In cases where no other pharmacotherapeutic option exists, the "comparator product" listed in the clinical designations above shall become usual care. Multiple Indications for a Product	• Efficacy • Safety • Health outcomes/effectiveness based on delegating entities' population and/or comparable data (if available) or • Clinical attribute(s) relative to comparator products. Insufficient Evidence The Insufficient Evidence clinical designation means that, based upon the data available at the time of the review, the drug has an unclear treatment profile for the majority of individuals taking the product as compared to other available products within the therapeutic class of drugs or other available treatment options. Designating a product Insufficient Evidence relative to other drugs in a therapeutic class will be based on a review of the following criteria: There is a lack of clinically recognized and scientifically validated data supporting or demonstrating: • Efficacy • Safety • Health outcomes/effectiveness based on delegating entities' population and/or comparable data (if available) or • Clinical attribute(s) relative to comparator products. Unfavorable The Unfavorable clinical designation means that, based upon the data available at the time of the review, the drug provides an unfavorable treatment profile for the majority of individuals taking the product as compared to other available products within the therapeutic class of drugs or other available treatment options. Designating a product Unfavorable relative to other drugs in a therapeutic class will be based on a review of the following criteria: It has clinically recognized and scientifically validated data supporting or demonstrating unfavorable: • Efficacy • Safety • Health outcomes/effectiveness based on delegating entities' population and/or comparable data (if available) or • Clinical attribute(s) relative to comparator products Lack of a Comparator Product In cases where no other pharmacotherapeutic option exists, the "comparator product" listed in the clinical designations above shall become usual care. Multiple Indications for a Product Drugs can only receive one clinical designation. When a drug has multiple uses (indications), the clinical designation will be based on the indication for the majority of individuals using the drug. Other indications for a drug may be addressed in the clinical comments. Multiple Drug Regimens There are diseases where a treatment with a multiple drug regimen is required rather than an individual drug. These regimens will be given a clinical designation as outlined above since the entire regimen is the standard of care rather than individual drugs. The same P&T recommendation guidelines for formulary consideration to the VAC will apply to the designations of regimens. P&T Clinical Comments The P&T may also, as part of its clinical review, make substantive clinical comments about the products under review or issues pertaining to the therapy of a disease the drug(s) is/are used

	Drugs can only receive one clinical designation. When a drug has multiple uses (indications), the clinical designation will be based on the indication for the majority of individuals using the drug. Other indications for a drug may be addressed in the clinical comments. Multiple Drug Regimens There are diseases where a treatment with a multiple drug regimen is required rather than an individual drug. These regimens will be given a clinical designation as outlined above since the entire regimen is the standard of care rather than individual drugs. The same P&T recommendation guidelines for formulary consideration to the VAC will apply to the designations of regimens. P&T Clinical Comments The P&T may also, as part of its clinical review, make substantive clinical comments about the products under review or issues pertaining to the therapy of a disease the drug(s) is/are used to treat. These comments are intended to provide the VAC with additional considerations beyond the clinical designations. Clinical comments may be used by the P&T to highlight important safety, efficacy, or clinical attribute concerns. For example, clinical comments may be used to provide further detail supporting a clinical designation, to further differentiate important clinical points between products given the same clinical designation, or to emphasize key clinical concerns in the treatment of a disease state pertaining to the choice of drug therapy. Generic Drug Products While the P&T review includes generic drug products, clinical designations will not be made for these products because the tier of these products is generally based on member certificate language and/or the multisource brand policy of IngenioRx. However, the P&T may provide the VAC with clinical comments on these products that are based on safety and/or efficacy concerns. P&T Assignment of Clinical Criteria The P&T determines that, for reasons of safety and/or efficacy, Clinical Criteria are necessary to promote clinically appropriate use. The P&T shall review and approve such necessary Clinical Criteria. These would include, but not be limited to, clinical edits such as prior authorization, step therapy, quantity limitations, dose optimization, and duplicate therapy. The P&T clinical review includes, but is not limited to, the following: - Food and Drug Administration (FDA) approved uses; - FDA approved package inserts; - Critically and/or scientifically validated findings; - Information in major or peer-reviewed medical publications; - Recommendations of recognized expert organizations, including specialty clinical societies, academic medical centers and treatment guidelines; and/or - Practice pattern and utilization data. The P&T may NOT include or consider the following: - Rebates or potential rebates, or any other contractual arrangement or relationship with a pharmaceutical manufacturer; - Drug cost to the health plan, member or risk bearing entity; - Any economic cost or benefit - Benefit types and/or - Any other considerations that are not relevant to the clinical aspects of therapy.	to treat. These comments are intended to provide the VAC with additional considerations beyond the clinical designations. Clinical comments may be used by the P&T to highlight important safety, efficacy, or clinical attribute concerns. For example, clinical comments may be used to provide further detail supporting a clinical designation, to further differentiate important clinical points between products given the same clinical designation, or to emphasize key clinical concerns in the treatment of a disease state pertaining to the choice of drug therapy. Generic Drug Products While the P&T review includes generic drug products, clinical designations will not be made for these products because the tier of these products is generally based on member certificate language and/or the multisource brand policy of IngenioRx. However, the P&T may provide the VAC with clinical comments on these products that are based on safety and/or efficacy concerns. P&T Assignment of Clinical Criteria The P&T determines that, for reasons of safety and/or efficacy, Clinical Criteria are necessary to promote clinically appropriate use. The P&T shall review and approve such necessary Clinical Criteria. These would include, but not be limited to, clinical edits such as prior authorization, step therapy, quantity limitations, dose optimization, and duplicate therapy. The P&T clinical review includes, but is not limited to, the following: - Food and Drug Administration (FDA) approved uses; - FDA approved package inserts; - Critically and/or scientifically validated findings; - Information in major or peer-reviewed medical publications; - Recommendations of recognized expert organizations, including specialty clinical societies, academic medical centers and treatment guidelines; and/or - Practice pattern and utilization data. The P&T may NOT include or consider the following: - Rebates or potential rebates, or any other contractual arrangement or relationship with a pharmaceutical manufacturer; - Drug cost to the health plan, member or risk bearing entity; - Any economic cost or benefit - Benefit types and/or - Any other considerations that are not relevant to the clinical aspects of therapy. The written processes and criteria outlined above apply to all drugs/therapies including medical/surgical and mental health/substance abuse drugs. In-Operation Comparative Analysis: XXXXX applies the same factors, sources, and standards through the same process to MH/SUD and M/S pharmaceuticals. This process, applied comparably between MH/SUD and M/S prescriptions, ensures the review process, clinical designations, and formulary placement are compliant with MHPAEA. As noted previously, clinical data is used and reviewed to provide the basis for clinical designations. Formulary designations are applied consistently based on the clinical trials evaluated, and MH/SUD pharmaceuticals receive designations consistent with the review applied to both M/S and MH/SUD drugs. Drug trials for both types of

The written processes and criteria outlined above apply to all drugs/therapies including medical/surgical and mental health/substance abuse drugs.

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XXXXX applies the same factors, sources, and standards through the same process to MH/SUD and M/S pharmaceuticals. This process, applied comparably between MH/SUD and M/S prescriptions, ensures the review process, clinical designations, and formulary placement are compliant with MHPAEA. As noted previously, clinical data is used and reviewed to provide the basis for clinical designations. Formulary designations are applied consistently based on the clinical trials evaluated, and MH/SUD pharmaceuticals receive designations consistent with the review applied to both M/S and MH/SUD drugs. Drug trials for both types of pharmaceuticals are impacted by the same types of pitfalls (e.g., high drop out rates), but MH/SUD drugs ultimately suffer from higher rates of insufficient evidence designations due to the nature of the trials and subjects included. Despite this common pitfall, XXXXX continues to apply the formulary designation process comparably resulting in evidence-based formularies consisting of high-quality M/S and MH/SUD pharmaceuticals available for members. It is important to note that the clinical designation will not impact whether coverage is provided for a certain drug (i.e., insufficient evidence drugs may still be covered on the formulary), but will ultimately determine the flexibility of tiering decisions made by the VAC (i.e., drugs within a certain class with consistent designations allow for more flexibility in tiering decisions for all of the drugs in the drug class). When reviewing the tiering decisions, it is clear that the designation process is not being applied more stringently to MH/SUD drugs as a higher percentage of drugs are available on lower cost tiers. This ensures that MH/SUD drugs are accessible and on a more favorable tier for cost sharing purposes.

As noted above, to determine whether the formulary designation process results in comparable and no more stringent treatment of MH/SUD drugs than medical/surgical drugs, XXXXX analyzed the tiering. As demonstrated by the chart below, the National Formulary, which is our most used formulary, tiers a greater percentage of overall drugs used to treat a behavioral health condition in lower tiers than drugs approved by the FDA to treat medical/surgical condition. There are a total of 123,132 drugs and medical supplies (e.g., syringes) (medical surgical = 116,221 and behavioral health = 6,911) that are available to be included on the formulary.

	Tier 1	Tier 2	Tier 3	Tier 4	NonFormulary /Noncovered
Behavioral Health (Mental Health/Substance Use Disorder)	15.8%	11.0%	46.8%	4.2%	22.0%

5. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding this NQTL on MH/SUD benefits?
Yes. XXXXX utilizes the same process and procedures to determine the clinical designations for MH/SUD and M/S drugs within drug classes. The clinical designation impacts the tiering designations. A higher percentage of MH/SUD drugs reviewed are determined to be comparable or insufficient evidence. However, this doesn't impact whether a drug in a particular class is covered, but instead determines the formulary tiering possibilities. As MH/SUD drugs are more consistently designated, the VAC has greater flexibility for tiering decisions resulting in a higher percentage on lower tiers increasing overall access to MH/SUD drugs. Therefore,

pharmaceuticals are impacted by the same types of pitfalls (e.g., high drop out rates), but MH/SUD drugs ultimately suffer from higher rates of insufficient evidence designations due to the nature of the trials and subjects included. Despite this common pitfall, XXXXX continues to apply the formulary designation process comparably resulting in evidence-based formularies consisting of high-quality M/S and MH/SUD pharmaceuticals available for members. It is important to note that the clinical designation will not impact whether coverage is provided for a certain drug (i.e., insufficient evidence drugs may still be covered on the formulary), but will ultimately determine the flexibility of tiering decisions made by the VAC (i.e., drugs within a certain class with consistent designations allow for more flexibility in tiering decisions for all of the drugs in the drug class). When reviewing the tiering decisions, it is clear that the designation process is not being applied more stringently to MH/SUD drugs as a higher percentage of drugs are available on lower cost tiers. This ensures that MH/SUD drugs are accessible and on a more favorable tier for cost sharing purposes.

As noted above, to determine whether the formulary designation process results in comparable and no more stringent treatment of MH/SUD drugs than medical/surgical drugs, XXXXX analyzed the tiering. As demonstrated by the chart below, the National Formulary, which is our most used formulary, tiers a greater percentage of overall drugs used to treat a behavioral health condition in lower tiers than drugs approved by the FDA to treat medical/surgical condition. There are a total of 123,132 drugs and medical supplies (e.g., syringes) (medical surgical = 116,221 and behavioral health = 6,911) that are available to be included on the formulary.

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Non- Behavioral Health	15.8%	11.0%	46.8%	4.2%	22.0%

5. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding this NQTL on MH/SUD benefits?
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Rx Formulary Design, Management and Pharmacy Services NQTL Practices - Formulary Development - Tiering	There are no non-comparable inconsistencies or differences in the application, as written and in operation. The Company maintains a single committee that reviews drugs for the formulary regardless of whether the drug is used to cover medical/surgical and MH/SUD conditions. The committee includes a psychiatrist. The same review process is used to determine whether to: 1) include a drug on the formulary; 2) identify a tier for the drug to be placed in; and 3) apply prior authorization, step therapy, and quantity limits. Formulary Develpment - Tiering 1. Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply. This nonquantitative treatment limitation (NQTL) analysis explains how XXXXX determines its clinical drug tiers elated to prescription drugs and therapies (collectively, “prescriptions”). XXXXX has contracted with XXXXX, Inc. subsidiary, XXXXX, Inc., to provide pharmacy benefit management services and develop, implement, and administer the clinical criteria and edits for prescription drugs. All clinical edits are developed to guide clinically appropriate use of drugs and therapies, and are reviewed and approved by the XXXXX Pharmacy and Therapeutics (P&T) Committee. Tiering decisions are developed by the Value Assessment Committee (VAC). In general, drugs on the XXXXX drug list or formulary are grouped into drug tiers. The formularies are comprised of hundreds of brand name and generic medications that have been reviewed and recommended for their quality and effectiveness through the P&T process. The organization into tiers will reflect the applicable member cost share for the medications. Medications on Tier 1 have the lowest member cost share while members pay more for drugs on higher tiers. Members and providers may access formulary information (including the plan’s applicable formulary listing and any edits) online at: https://www.XXXXX.com/pharmacy-information/drug-list-formulary The formulary will indicate the prescriptions and their applicable tiers. Members may also review pharmacy coverage information within their evidence of coverage or benefit booklet. The information is typically included within the Prescription Drug Retail Pharmacy section of the schedule of benefits. Additionally, members may access plan specific prescription information through the “Price A Med” tool available online through the Sydney Application. Impacted members may also receive notices of tiering determinations in the event a prescription is moved to a higher tier or removed from the drug list/formulary. 2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits.: • Clinical aspects of the drug individually and in comparison to similar drugs; • Cost of the drug individually and in comparison to similar drugs;	Same as for MH/SUD.

	• Availability of over-the-counter options;
	• Member Impact;
	• Regulatory Approval and Timing.
	
	Factor Weighing: Clinical considerations are considered first and foremost to ensure the drugs are appropriately tiered. Financial considerations are reviewed as a factor, but are weighted secondary to clinical concerns.
	
	3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits:
	
	Clinical Aspects (ex. Safety & Efficacy): During the evidence-based evaluation process, we determine if there is any clinically recognized and scientifically validated data supporting or demonstrating member safety concerns. We continually monitor for safety, effectiveness, and quality of care of drugs contained within our formularies. Member safety and efficacy reviews include, but not limited to the following:
	• Type and frequency of side effects;
	• Occurrence of adverse events;
	• Potential drug interactions;
	• Likely impact on patient compliance.
	
	The sources for clinical reviews include:
	• Food and Drug Administration (FDA) approved uses;
	• FDA approved package inserts;
	• American Hospital Formulary Services (AHFS);
	• Critically and/or scientifically validated findings, information in major or peer reviewed medical publications, and recommendations of recognized expert organizations, including specialty clinical societies, academic medical centers and treatment guidelines;
	  ○ National Comprehensive Cancer Network (NCCN),
	  ○ Clinical Pharmacology,
	  ○ DrugPoints, and
	  ○ DrugDex,
	• Clinical outcomes research data; and/orPractice pattern and utilization data.
	
	The clinical aspects are generally considered by the P&T Committee during its “clinical designation” process. The clinical designation will ultimately provide direction on tiering decisions made by the VAC, as described in more detail below.
	
	Member Impact: XXXXX considers the overall impact to the member in the tiering determination process. The impact may include the abrasion (clinical and financial) for both the member and provider based on the drug’s tier. The impact is considered in light of the clinical appropriateness of the drug at issue, and after the clinical designation of the drug under the P&T process. Member impact is taken into account for tiering and clinical edits as described below. There is no specific threshold (number or percent of members impacted by proposed tiering changes) for evaluating the member impact on tiering proposals.	

	Over the Counter Options: Related to the member impact, the VAC will consider whether members have over the counter options in determining the appropriate tier placement. The presence or availability of suitable over the counter options weighs in favor of placing the drug in a lower tier. Generally, there is no specific threshold or standard for evaluation of over the counter options in the tiering process. The factor is minimally invoked in deference to clinical considerations. Regulatory Approvals: Federal government agencies, such as the Food and Drug Administration ("FDA"), review applications for approval for drugs and medical devices. The approval is necessary for drugs and medical devices to be sold in the United States and ultimately consumed by XXXXX members to treat their various conditions. The process ensures safe and effective drugs and medical devices are used, and provides guidance to doctors and patients on how to use the medicines. XXXXX relies on the FDA approval and guidance to determine what drugs should be covered, and whether a clinical edit should be imposed. The timing (i.e., recent approval) of the FDA's decision will be factored into the tier designation as recently approved FDA medications are generally placed on higher tiers. Cost of the Drug: Financial data related to the medications is reviewed. The source material includes rebate information, ingredient costs, copayments and cost sharing applicable for the medication. The cost is compared with other similar drugs, but is a secondary consideration in the overall tiering determination. In general, the goal is to lower the total cost of care and preference will be given to lower cost medications when deemed clinically equivalent to the other medication considered. Clinical indications are considered first before cost. 4. Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits. XXXXX's pharmacy services are provided by its PBM, XXXXX. Developing the formulary is a two part process. The clinical work, which is the initial step, is done by the XXXXX Pharmacy and Therapeutics Committee ("P&T"), which meets at least quarterly. The VAC handles the second step, which includes tiering, step therapy, and clinical UM edits (e.g., prior authorization). The policies, procedures, effectiveness data, Clinical Attributes, and other factors considered by the P&T in determining its recommendations with respect to mental health and substance use disorder drugs and drug classes are comparable to, and not more stringent than, those applied to medical/surgical drugs and drug classes. P&T recommendation(s) which includes clinical designations of the comparability of products and clinical criteria are forwarded to the Value Assessment Committee (VAC) for formulary/tier assignment or formulary/tier edits. Overview In general, Tier 1 drugs have the lowest member cost share and are typically generic drugs that offer the greatest value compared to others that treat the same conditions. Member cost share rises as each tier goes higher. Tier 2 drugs have a higher cost share than Tier 1, and include drugs such as newer, more expensive generic drugs and preferred brand drugs based on effectiveness and value. Tier 3 drugs have a higher cost share than Tier 1 and 2, and may include non-preferred brand drugs and generic drugs, and drugs recently approved by the FDA. Tiers 4 and 5 have higher cost shares and typically consist of specialty drugs.	

Tiering Process

Deciding what tier a formulary approved drug belongs on is handled by the Value Assessment Committee (“VAC”). For new drugs, the following is considered:
The VAC must make a reasonable effort to review and determine Tiering of a new FDA approved drug product (or new FDA approved indication) within 180 days of its release onto the market. For Medicare Part D, the VAC will follow CMS-mandated timeframes. For special circumstances such as high-impact medications, the chairperson may decide to call an ad hoc meeting.
Expedited review: New drugs or newly approved uses for drugs within six Medicare Part D protected clinical classes (immunosuppressant, antidepressant, antipsychotic, anticonvulsant, antiretroviral, antineoplastic) must be reviewed and a Tiering decision made within 90 days. To the extent needed, document presentation will be made at the next regular meeting to ensure compliance with CMS timelines.
For formularies that do not have a tiered copayment structure, drugs are assigned either a formulary or non-formulary status. The VAC abides by all recommended Clinical Designations and Clinical Criteria of the P&T.

Tiering Determinations:

There are three parts to the VAC review and corresponding Tier assignment. The first and second parts of the VAC review identify what MUST be considered in the review and Tiering process, and the third part of the process identifies what MAY be taken into account during the review and Tiering process. The P&T’s Clinical Designation, Clinical Comments or Clinical Criteria will be reviewed by the VAC before Tier placement is determined.

First: The VAC review and Tiering process MUST take into account the Clinical Designations made by the P&T. This means that the VAC cannot place a drug with a weaker Clinical Designation on a lower Tier than another drug with a stronger Clinical Designation; however, Insufficient Evidence and Unfavorable designations will be considered equivalent when Tiering products. The following illustrates the hierarchy:

- Drugs that are designated Favorable have the greatest clinical value. Favorable drugs have a greater clinical value than drugs designated as Comparable, Insufficient Evidence, or Unfavorable;
- Drugs that are designated Comparable have a greater clinical value than drugs designated as Insufficient Evidence or Unfavorable; and
- Drugs that are designated as Insufficient Evidence have unclear clinical value, while drugs that are designated as Unfavorable have weak clinical value.
- Drugs classified as Comparable may be placed in the same tier as drugs classified as Favorable or those classified as Insufficient Evidence or Unfavorable. However, drugs classified as Favorable cannot be placed in the same tier as drugs classified as Insufficient Evidence or Unfavorable unless a step edit is also implemented.

In addition, drugs classified as Favorable cannot be placed in a higher tier than drugs classified as Comparable and drugs classified as Comparable cannot be placed in a higher tier than drugs classified as Insufficient Evidence or Unfavorable.

	Notwithstanding the above, there are specific unique circumstances where VAC may not need to adhere to the above tiering and/or editing limitations. This may occur: 1. Only when explicitly supported by P&T in its clinical comments AND only for one of the following situations: a. When P&T has designated multiple drugs with the same active ingredient(s) which is available in different formulations/delivery methods and the different formulations/delivery methods are given the same designation by P&T; OR b. When P&T has designated in a therapeutic grouping that multiple drugs in that grouping are clinically similar, but the differentiation in the designation given by P&T is based on the formulation/delivery method and there are attributes that P&T determines may be clinically beneficial based on formulation/delivery method. 2. Federal and State laws, and the requirements of those laws take precedence over the VAC rules and when specific drugs are required for inclusion in a formulary, the Formulary regarding these drugs will follow all applicable Federal and State laws. However, such a requirement of law for inclusion of such a drug will not trigger i) a requirement that all drugs with a more favorable designation be included on the formulary ii) nor that all drugs with a more favorable designation be preferred in tiering and/or in edits. 3. For a formulary developed for use by Administrative Services Only (ASO) clients, the tier placement and edit determinations may allow selective product choice that provides flexibility and affordability. Inclusion of a drug with a lesser designation than other comparator drugs will not trigger i) a Charter requirement that all drugs with a more favorable designation be included on the formulary or preferred in edits; and ii) nor that all drugs with a more favorable designation be preferred in tiering and/or in edits. Notwithstanding the previous sentence, Insufficient evidence and Unfavorable drugs cannot be the sole drugs in a formulary category, unless all drugs in the category are Insufficient Evidence or Unfavorable. In addition, nor can Insufficient Evidence or Unfavorable drugs be favored over drugs with a Favorable Clinical Designation by formulary status, tier placement or edits. Edits that are recommended by the delegating entities and reviewed by P&T based on safety concerns (e.g., Drug-Drug interactions) will be identified for the VAC by the Clinical team. The VAC will either approve such edits or send back to the P&T for further guidance on the P&T's decision. Second: In addition to the Clinical Designations, the VAC must also take into account the member impact associated with drug Tiering and edits. The VAC must demonstrate that the member impact has been appropriately considered relative to financial factors. Accordingly, the VAC should consider the following issues before making any Tiering recommendations: • Member and provider disruption from a clinical and financial perspective; • Operational and public policy impact from a clinical and financial perspective; and • Generic and OTC availability. In general, as noted previously, there is no specific standard or threshold when determining the influence of member impact. The VAC will be provided with information demonstrating the number of members on each drug and potential impact of any proposed change. Third: The VAC review and Tiering process MAY include, but is not limited to, the following: • Clinical Comments from the P&T	

- Relevant financial information or impact on the health plan, member, group or other party at financial risk (including average wholesale price, ingredient cost, cost of care, copays, coinsurance, rebates);
- Potential provider impact or disruption;
- Market factors (including product market share, anticipated product/category growth, direct to consumer advertisement, and/or competitive environment);
- Health and economic outcomes relative to comparator products; Patent expirations, generic availability, over-the-counter availability and relative access to the drug; and

Based upon the information derived from the above review, the VAC shall assign covered products to applicable Tiers. Other than the Clinical Designation made by the P&T, it is up to the members of the VAC to determine what value and/or weight shall be assigned to the factors considered.

VAC Procedures:
VAC meetings are held at least quarterly, and a quorum (simple majority of voting members) is required for the meeting to commence. Approval is by a simple majority vote of the VAC voting members present is required. Once a simple majority of the members of the VAC agree on the formulary and/or Tier assignment for a covered product, then that approval shall be sent to the applicable delegated entity for action by each delegating entity in accordance with their applicable policies and procedures.

In-Operation Comparative Analysis
To determine whether the formulary treats behavioral health conditions no less stringently than medical/surgical conditions, XXXXX analyzed the tiering decisions for the formularies most often selected by clients. As demonstrated by the chart below, the National Formulary, which is our most used formulary, tiers a greater percentage of overall drugs used to treat a mental health conditions in lower tiers (i.e., less member cost share) than drugs approved by the FDA to treat medical/surgical condition.

National Formulary 3 Tier

Definition	Number/Percentage of drugs by therapeutic class subject to the NQTL Medical/Surgical	Mental Health/Substance Use Disorder
Total Number of drugs	8378	294

Formulary Tiering by Tier

	# of drugs	% of M/S drugs	# of drugs	% of MH/SUD drugs
Tier 1a (lowest cost share – often generic drugs)	227	2.7	8	2.7
Tier 1b (low-cost share – typically generic drugs)	1380	16.4	133	45.2
Tier 2 (higher cost share that Tier 1 – may be preferred brand drugs)	794	9.4	6	2
Tier 3 (higher cost share – non-preferred brand drugs and generic drugs)	5279	63	70	23.8

Tier 4 (highest cost share – usually specialty brand and generic drugs)	N/A	N/A	N/A	N/A
Formulary Exclusions	698	8.3	77	26

National Formulary 4 Tier

Definition	Number/Percentage of drugs by therapeutic class subject to the NQTL Medical/Surgical	Mental Health/Substance Use Disorder
Total Number of drugs	8378	294

Formulary Tiering by Tier

	# of drugs	% of M/S drugs	# of drugs	% of MH/SUD drugs
Tier 1a (lowest cost share – often generic drugs)	227	2.7	8	2.7
Tier 1b (low-cost share – typically generic drugs)	1340	15.9	132	44.9
Tier 2 (higher cost share that Tier 1 – may be preferred brand drugs)	793	9.5	6	2
Tier 3 (higher cost share – non-preferred brand drugs and generic drugs)	4825	57.5	63	21
Tier 4 (highest cost share – usually specialty brand and generic drugs)	495	5.9	8	2.7
Formulary Exclusions	698	8.3	77	26

National Formulary 5 Tier

Definition	Number/Percentage of drugs by therapeutic class subject to the NQTL Medical/Surgical	Mental Health/Substance Use Disorder
Total Number of drugs	8378	294

Formulary Tiering by Tier

Tier 1a (lowest cost share – often generic drugs)	227	2.7	8	2.7
Tier 1b (low-cost share – typically generic drugs)	1340	15.9	132	44.9
Tier 2 (higher cost share that Tier 1 – may be preferred brand drugs)	793	9.5	6	2
Tier 3 (higher cost share – non-preferred brand drugs and generic drugs)	4825	57.5	63	21
Tier 4 (highest cost share – usually specialty brand and generic drugs)	143	1.7	1	0.3
Formulary Exclusions	698	8.3	77	26

The above tiering information was provided on November 15, 2023 by a XXXXX Clinical Pharmacist on the Clinical Affairs team.

	The data above confirms the application of tiering decisions for MH/SUD are focused on clinical reasons first and foremost, and applied no more stringently to MH/SUD drugs. Overall, the total drugs on the formulary are much lower for MH/SUD than the plethora of M/S drugs available for the exponentially higher number of conditions subject to treatment. When reviewing the percentages, a much higher percentage of MH/SUD drugs are covered at a lower cost share compared to M/S drugs as indicated by the higher percentage of MH/SUD drugs in Tier 1b. This is a benefit to members seeking treatment and usage of these medications, and confirms the comparable treatment of MH/SUD drugs in the tiering process. 5. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding this NQTL on MH/SUD benefits? The P&T Committee process is focused on the clinical considerations in order to make the appropriate clinical designation for each drug. The VAC uses these clinical designations to guide their decisions on tiering, and as noted above, the clinical designations control the flexibility of the VAC in tiering similar drugs based on factors other than clinical. Regardless, the VAC applies these factors, sources, standards in the same manner for MH/SUD drugs to ultimately arrive at the tiering determinations provided above. The result is MH/SUD drugs are on lower tiers at a higher percentage than M/S drugs, a benefit for members seeking these medications as their cost share will be lower. Therefore, the process as applied and in operation confirm the plan completes the tiering decisions in a comparable manner and does not apply any factors, sources, standards, or processes more stringently to MH/SUDs drugs.	
Prior-Authorization NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation. All inpatient admissions are required to be prior authorized. For outpatient services, we apply the same factors, sources and processes for determining the services that appear on our prior authorization list. There is no prior authorization penalty applied to a MH/SUD service that is not prior authorized. 1. Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply. Overview The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply concurrent review to mental health or substance use disorder (“MH/SUD”) benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply concurrent review to medical surgical (“M/S”) benefits. Identification of the NQTL XXXXX’s fully insured policies and the plans that it administers on behalf of self-funded employers contain requirements that certain services be reviewed to ensure that they are medically necessary. The Plan Document Example details how the prior authorization process works for members. This analysis explains when XXXXX performs a prior authorization review and how XXXXX’s processes, strategies, evidentiary standards and other factors for prior authorization review comply with the NQTL requirements under MHPAEA.	There are no non-comparable inconsistencies or differences in the application, as written and in operation. All inpatient admissions are required to be prior authorized. For outpatient services, we apply the same factors, sources and processes for determining the services that appear on our prior authorization list. There is no prior authorization penalty applied to a MH/SUD service that is not prior authorized. 1. Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply. Overview The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply concurrent review to mental health or substance use disorder (“MH/SUD”) benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply concurrent review to medical surgical (“M/S”) benefits. Identification of the NQTL XXXXX’s fully insured policies and the plans that it administers on behalf of self-funded employers contain requirements that certain services be reviewed to ensure that they are medically necessary. The Plan Document Example details how the prior authorization process works for members. This analysis explains when XXXXX performs a prior authorization review and how XXXXX’s processes, strategies, evidentiary standards and other factors for prior authorization review comply with the NQTL requirements under MHPAEA.

	If a self-funded group utilizes XXXXX's standard prior authorization list, this NQTL applies to that group plan as well, although the plan language may differ. The Prior Authorization NQTL applies to medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) services as identified on the prior authorization list and within the inpatient in- network, inpatient out of network, outpatient in-network, and outpatient out of network benefit classifications. XXXXX has identified the services requiring prior authorization and their respective classifications below. Members can locate prior authorization lists online at XXXXX.com, or can call member services on the number referenced on their identification card. Plan/Coverage Terms Regarding Retrospective Review Additionally, the prior authorization process is detailed below in the Plan Document Example of the member's benefit booklet/evidence of coverage materials. Plan sponsors disseminate plan specific information and communications, including any prior authorizations lists, to their members. Providers can locate prior authorization lists online at XXXXX.com, and can check prior authorization requirements by CPT codes through the online portal. Any changes to the prior authorization list or process are also communicated to providers through monthly provider newsletter communications. The utilization management program, which includes prior authorization review, is also thoroughly outlined in each provider manual. The provider manual is accessible online at www.XXXXX.com/provider/policies/. From there, Select a State and go to the Provider Manual icon and Download the Manual. XXXXX has provided the list that reflects the standard services that require prior authorization as of January 1, 2024 and is displayed on www.XXXXX.com/provider/prior-authorization/. From there, Select a State and go to the Prior Authorization Code Lists. XXXXX is providing some clarifying definitions regarding specific terms used in this comparative analysis. Prior Authorization – A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date, including but not limited to pre-admission review, pretreatment review, Utilization Review and Case Management. Medical Policy - XXXXX medical policies are used by all plans and lines of business (unless an applicable Federal law, state law, or contract language states otherwise) for medical necessity reviews. They are developed to address experimental or investigational technologies and services where there is a significant concern regarding member safety. Clinical Utilization Management Guideline - Clinical utilization management guidelines are not always used by all plans or lines of business, but are available for adoption to review the medical necessity of services related to the guideline when the Plan performs a utilization review for the subject. They are developed to address medical necessity criteria for technologies/services where sufficient clinical evidence exists to evaluate the clinical appropriateness of the request, goal length of stay place of service, and level of care. Return on Investment – ROI is a factor used in the development of the prior authorization list. The analysis compares the medical cost savings with the cost of administering the prior authorization program. The analysis is based on historical medical management data for each procedure code, which are ultimately attributed to each Medical Policy and Clinical Utilization Management Guideline.	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	Medical Policy & Technology Assessment Committee (MPTAC) - The Medical Policy & Technology Assessment Committee (MPTAC) is a multiple disciplinary group including physicians from various medical and behavioral health specialties, clinical practice environments and geographic areas. The MPTAC consists of physicians external to Elevance Health who are in active academic and community practice, as well as internal Elevance Health medical directors. MPTAC created the medical necessity criteria within medical policy and clinical utilization management guidelines used by medical directors to determine the medical necessity of services. 2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits: • Applicable Medical Policy or Adoption of a Clinical Utilization Management Guideline over the particular service; • Appropriateness of care; • Member Safety; • Member/Provider Abrasion; • High Cost of Services; • Competitor Policies (inpatient only); • State laws, regulations, or other federal/state mandates (e.g., Medicaid contract requirements) Factor Weighting: A state or federal mandate will ultimately control whether a service is included or deleted from the prior authorization, as XXXXX will comply with the mandate despite the consideration of other factors. If a mandate is not applicable, the presence of a medical policy is weighted over the other factors. If a medical policy or clinical utilization management guideline is adopted by the local plan, the services subject to the MP or CUMG may be subject to prior authorization except where the service is considered investigational for all conditions. Member safety also outweighs the consideration of ROI or cost of care concerns during the determination of whether to adopt a CUMG. 3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits: General Overview: XXXXX conducts utilization review on services for which it has a subject matter specific medical policy or clinical UM guideline (including third-party guidelines)) and uses MCG criteria, which include goal length of stay criteria, unless a state law requires the usage of an alternative criteria (e.g., ASAM, LOCUS/CALOCUS). XXXXX also has an Administrative Medical Policy, ADMIN.00006, that provides a framework for review of services for medical necessity determinations in certain circumstances where XXXXX does not have a subject matter specific medical policy or clinical UM guideline (including third- party guidelines), such as when a service is new and XXXXX has not yet decided whether to develop policy or a guideline on point and a request for precertification has been received from a provider even though XXXXX doesn't require prior authorization. XXXXX uses MCG criteria, including those that pertain to inpatient lengths of stay, unless state law requires usage of an alternative criteria. The Medical Policy & Technology Assessment Committee (MPTAC) is the body that both approves the	Medical Policy & Technology Assessment Committee (MPTAC) - The Medical Policy & Technology Assessment Committee (MPTAC) is a multiple disciplinary group including physicians from various medical and behavioral health specialties, clinical practice environments and geographic areas. The MPTAC consists of physicians external to Elevance Health who are in active academic and community practice, as well as internal Elevance Health medical directors. MPTAC created the medical necessity criteria within medical policy and clinical utilization management guidelines used by medical directors to determine the medical necessity of services. 2. 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XXXXX also has an Administrative Medical Policy, ADMIN.00006, that provides a framework for review of services for medical necessity determinations in certain circumstances where XXXXX does not have a subject matter specific medical policy or clinical UM guideline (including third- party guidelines), such as when a service is new and XXXXX has not yet decided whether to develop policy or a guideline on point and a request for precertification has been received from a provider even though XXXXX doesn't require prior authorization. XXXXX uses MCG criteria, including those that pertain to inpatient lengths of stay, unless state law requires usage of an alternative criteria. The Medical Policy & Technology Assessment Committee (MPTAC) is the body that both approves the

	medical policies and clinical UM guidelines (and third-party guidelines, including the usage of MCG criteria). MPTAC includes a provider that specializes in behavioral health as a committee member in addition to providers in other medical and surgical specialties. Prior authorization is one type of utilization review. XXXXX reviews its prior authorization list at least semi-annually to determine whether to add or remove a service from the list. The initiation of a determination whether to add or remove a service from the prior authorization list begins with an inquiry received from a source such as: a. Post Medical Policy & Technology Assessment (MPTAC) meeting (this includes any changes to medical policy or clinical UM guidelines made by MPTAC); b. Clinical Criteria Review Team (CCRT) request; c. New diagnosis and procedure codes released by the AMA and CMS; d. Health Plan request to initiate rule change for their line of business (e.g., specific state commercial or Medicaid line of business). e. State or federal regulatory guidance. Whether a request is made or simply follows the quarterly MPTAC meeting, the determination of whether prior authorization will be required is based on the following analysis for inpatient and outpatient M/S and MH/SUD services. Inpatient Prior Authorization: XXXXX requires that all inpatient stays be prior authorized, whether for medical/surgical services or mental health/substance abuse services. Inpatient services include elective or emergency hospital admissions, transplant services, maternity stays past the 48-96 hours or a newborn staying past the mother's discharge date, skilled nursing facilities, long term care facilities (LTAC), residential treatment centers. Many surgical services on XXXXX's standard prior authorization list could be done in an inpatient or outpatient facility setting. Application of factors for Inpatient Prior Authorization Determination: • Provider/Member Abrasion – Provider/Member abrasion is a factor considered for the determination of requiring prior authorization for inpatient services. It is helpful to members to have a decision before undertaking a procedure and potentially subjecting members and providers to financial responsibility if such services, normally expensive, were reviewed retrospectively for medical necessity. The abrasion factor considers whether a member or provider would likely submit a grievance or complaint or be placed in financial hardship if the service is not prior authorized and later denied for lack of medical necessity. The abrasion factor applies equally to medical/surgical and mental health/substance use disorder services. • Competitor Plans – While lesser considered than other factors, XXXXX does consider the manner in which competitors subject services to prior authorization. Industry standards typically subject inpatient services to prior authorization requirements for medical/surgical and mental health/substance use disorder services. ○ Sources: Review of competitor plans filed in other states or available online. • Medical Policy & Clinical UM Guidelines –Inpatient procedures are subject to medical policies and clinical UM Guidelines. The services have been reviewed and criteria	medical policies and clinical UM guidelines (and third-party guidelines, including the usage of MCG criteria). MPTAC includes a provider that specializes in behavioral health as a committee member in addition to providers in other medical and surgical specialties. Prior authorization is one type of utilization review. XXXXX reviews its prior authorization list at least semi-annually to determine whether to add or remove a service from the list. 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Industry standards typically subject inpatient services to prior authorization requirements for medical/surgical and mental health/substance use disorder services. ○ Sources: Review of competitor plans filed in other states or available online. • Medical Policy & Clinical UM Guidelines –Inpatient procedures are subject to medical policies and clinical UM Guidelines. The services have been reviewed and criteria

	established based on peer reviewed information, and the member is required to satisfy the criteria before a service is ultimately approved. • State laws, federal law, program contracts – These mandates may determine the criteria ultimately required for prior authorization, and some inpatient services may be subject to specific mandates directing when prior authorization can be performed. If these are in place, they will be adhered to for medical/surgical and mental health/substance use disorder services. Outpatient Prior Authorization: Whether an outpatient M/S or MH/SUD service requires prior authorization is generally based on whether the service is subject to a medical policy or the plan has adopted a clinical utilization management guideline. Medical Policies and Clinical UM Guidelines are developed by the Medical Policy and Technology Assessment Committee (MPTAC) according to the Medical Policy Formation process outlined in ADMIN.00001 Medical Policy Formation. This process is also discussed further in XXXXX's Medical Policy and Fail First NQTL comparative analysis. MPTAC does not play any role in determining whether such service, Medical Policy or Clinical UM Guidelines, and the procedure codes under such policies and guidelines, will require prior authorization. Clinical UM Guidelines developed by MPTAC are subject to review and adoption by the Clinical Criteria Review Team (CCRT). The CCRT contains cross sectional representation of key stakeholders across the enterprise and includes the lead plan medical director, medical directors, health plan directors, reimbursement policy management and both UM and clinical operations team. The CCRT considers the following factors in determining whether to adopt the clinical UM guideline and whether such will require prior authorization: • Member Safety – Member safety is a paramount concern with all procedures, and is a factor in the determination of whether to adopt a clinical utilization management guideline. In considering member safety, the Clinical Criteria Review Team will review the clinical materials (scientific data, clinical studies, government agency analyses/approvals) to determine the risks of such procedures on members. The team may also review subsequent studies on the services and treatment following regulatory approval to determine the presence of other risks or side effects. The risks will factor into the criteria's establishment, and also be considered by the Clinical Criteria Review Team in whether such medical/surgical or mental health/substance use disorder treatment or service should require prior authorization. Ultimately, this factor will be based on the clinical judgment of the personnel on the Clinical Criteria Review Team. • Member/Provider Abrasion- Provider/Member abrasion is a factor considered for the determination of requiring prior authorization for outpatient services. It is helpful to members to have a decision before undertaking a procedure and potentially subjecting members and providers to financial responsibility if such services were reviewed retrospectively and denied for lack of medical necessity. The abrasion factor considers whether a member or provider would likely submit a grievance or complaint, or be placed in financial hardship if the service is not pre- approved and later denied for lack of medical necessity. The abrasion factor applies equally to medical/surgical and mental health/substance use disorder services.	established based on peer reviewed information, and the member is required to satisfy the criteria before a service is ultimately approved. • State laws, federal law, program contracts – These mandates may determine the criteria ultimately required for prior authorization, and some inpatient services may be subject to specific mandates directing when prior authorization can be performed. If these are in place, they will be adhered to for medical/surgical and mental health/substance use disorder services. Outpatient Prior Authorization: Whether an outpatient M/S or MH/SUD service requires prior authorization is generally based on whether the service is subject to a medical policy or the plan has adopted a clinical utilization management guideline. Medical Policies and Clinical UM Guidelines are developed by the Medical Policy and Technology Assessment Committee (MPTAC) according to the Medical Policy Formation process outlined in ADMIN.00001 Medical Policy Formation. This process is also discussed further in XXXXX's Medical Policy and Fail First NQTL comparative analysis. MPTAC does not play any role in determining whether such service, Medical Policy or Clinical UM Guidelines, and the procedure codes under such policies and guidelines, will require prior authorization. Clinical UM Guidelines developed by MPTAC are subject to review and adoption by the Clinical Criteria Review Team (CCRT). The CCRT contains cross sectional representation of key stakeholders across the enterprise and includes the lead plan medical director, medical directors, health plan directors, reimbursement policy management and both UM and clinical operations team. 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Ultimately, this factor will be based on the clinical judgment of the personnel on the Clinical Criteria Review Team. • Member/Provider Abrasion- Provider/Member abrasion is a factor considered for the determination of requiring prior authorization for outpatient services. It is helpful to members to have a decision before undertaking a procedure and potentially subjecting members and providers to financial responsibility if such services were reviewed retrospectively and denied for lack of medical necessity. The abrasion factor considers whether a member or provider would likely submit a grievance or complaint, or be placed in financial hardship if the service is not pre- approved and later denied for lack of medical necessity. The abrasion factor applies equally to medical/surgical and mental health/substance use disorder services.

	• Appropriateness of Care – Medical directors will consider whether or not the services subject to the Medical Policy or Clinical UM Guideline are subject to appropriate levels of care concerns. If so, a particular service may be subjected to prior authorization to ensure a member is receiving care at the level or form that is justified based on their presenting conditions and treatment history. XXXXX will look to regulatory approvals, such as the FDA, to determine what types of conditions the procedure/service is approved to treat and any applicable stipulations on when care should be received. • State law, regulation, contractual requirements – State law, regulations, and contractual requirements (e.g., Medicaid contractual requirements) may stipulate when prior authorization (i.e., medical management) may or may not be used for a particular service. In the event a medical policy or clinical UM guideline is being considered in a respective state, but the applicable service is subject to state mandate requiring or prohibiting prior authorization for such service, the state mandate will be followed for M/S and MH/SUD services, as applicable. • High Cost of Services – For medical/surgical services, XXXXX uses a return-on-investment analysis in consideration of the cost of services. The data analysis is performed by Business Analysts on the Finance/HealthCare Analytics team. The source for the analysis consists of: o Clinical review costs – The internal costs to XXXXX for personnel, equipment, technological systems, system upgrades and programming, and other investments necessary to complete a prior authorization review and determine the medical necessity of requested services against the criteria developed by MPTAC. o Case Data – Review of historical claims and medical management case data to determine the costs of the particular services, usage trends, and medical coding for the cases. The Financial Analytics team will analyze the data to determine the clinical review costs incurred by procedure code that is attributable to the specific medical policy or clinical utilization management guideline. Medical policies or clinical utilization management guidelines realizing savings through a length of stay consideration are not included in the analysis. Additionally, an estimate of the potential savings is projected based on the medical costs associated with each procedure code attributable to the specific medical policy or clinical utilization management guideline. The result is a ratio of the medical cost savings (e.g., savings resulting from non-payment for services deemed not medically necessary) over the clinical review costs (e.g., costs associated with performing the review). For clarity and ease of review, the team subtracts one from the quotient for those codes, clinical UM guidelines, and medical policies with a higher cost than savings. These particular codes, clinical UM guidelines and medical policies, will be referenced as a negative net ROI. If savings outweighs the clinical review costs, the ratio will presented as a positive for the Clinical Criteria Review Team consideration. The data is ultimately presented to the Clinical Criteria Review Team for consideration in the determination of whether the Medical Policy or Clinical Utilization Management Guideline, and the underlying procedure codes, should require prior authorization. Cost is one factor in the overall analysis, and will be weighed less than the other factors of appropriateness of care or member safety. The evidentiary standard for cost is a 5:1 ROI (savings to cost). If the particular Medical Policy, Clinical Utilization Management Guideline (and the underlying procedure codes)	• Appropriateness of Care – Medical directors will consider whether or not the services subject to the Medical Policy or Clinical UM Guideline are subject to appropriate levels of care concerns. If so, a particular service may be subjected to prior authorization to ensure a member is receiving care at the level or form that is justified based on their presenting conditions and treatment history. XXXXX will look to regulatory approvals, such as the FDA, to determine what types of conditions the procedure/service is approved to treat and any applicable stipulations on when care should be received. • State law, regulation, contractual requirements – State law, regulations, and contractual requirements (e.g., Medicaid contractual requirements) may stipulate when prior authorization (i.e., medical management) may or may not be used for a particular service. In the event a medical policy or clinical UM guideline is being considered in a respective state, but the applicable service is subject to state mandate requiring or prohibiting prior authorization for such service, the state mandate will be followed for M/S and MH/SUD services, as applicable. • High Cost of Services – For medical/surgical services, XXXXX uses a return-on-investment analysis in consideration of the cost of services. The data analysis is performed by Business Analysts on the Finance/HealthCare Analytics team. The source for the analysis consists of: o Clinical review costs – The internal costs to XXXXX for personnel, equipment, technological systems, system upgrades and programming, and other investments necessary to complete a prior authorization review and determine the medical necessity of requested services against the criteria developed by MPTAC. o Case Data – Review of historical claims and medical management case data to determine the costs of the particular services, usage trends, and medical coding for the cases. The Financial Analytics team will analyze the data to determine the clinical review costs incurred by procedure code that is attributable to the specific medical policy or clinical utilization management guideline. Medical policies or clinical utilization management guidelines realizing savings through a length of stay consideration are not included in the analysis. Additionally, an estimate of the potential savings is projected based on the medical costs associated with each procedure code attributable to the specific medical policy or clinical utilization management guideline. The result is a ratio of the medical cost savings (e.g., savings resulting from non-payment for services deemed not medically necessary) over the clinical review costs (e.g., costs associated with performing the review). For clarity and ease of review, the team subtracts one from the quotient for those codes, clinical UM guidelines, and medical policies with a higher cost than savings. These particular codes, clinical UM guidelines and medical policies, will be referenced as a negative net ROI. If savings outweighs the clinical review costs, the ratio will presented as a positive for the Clinical Criteria Review Team consideration. The data is ultimately presented to the Clinical Criteria Review Team for consideration in the determination of whether the Medical Policy or Clinical Utilization Management Guideline, and the underlying procedure codes, should require prior authorization. Cost is one factor in the overall analysis, and will be weighed less than the other factors of appropriateness of care or member safety. The evidentiary standard for cost is a 5:1 ROI (savings to cost). If the particular Medical Policy, Clinical Utilization Management Guideline (and the underlying procedure codes)

	has an ROI 5:1 or above, the finance team will provide a recommendation to the Clinical Criteria Review Team for inclusion on the prior authorization list. The calculations above are continuously prepared and updated throughout the year and are reported on a quarterly basis. Mental Health/Substance Use Disorder Services - Inpatient Mental Health/Substance Use Disorder Services - Inpatient Service: Inpatient Admissions (All inpatient admissions and RTC) Factor: Member/Provider Competitor Policies Abrasion Source: Inpatient admissions for all medical surgical services are required to be prior authorized, just like inpatient admissions, including residential treatment center admission, for MH/SUD services. Mental Health/Substance Use Disorder Services - Outpatient Service: Intensive Outpatient (IOP) & Partial Hospitalization (PHP) Factor: Third Party Guideline – High Cost Services, Member/Provider Abrasion Source/Standard/Description: XXXXX utilizes MCG criteria (or Partial Hospitalization (PHP) Cost Services, Member/Provider state approved criteria) for Abrasion IOP/PHP. In determining the application of prior authorization, XXXXX looks at the average length of stay based on claims data and the average per diem for each service. As a result of the calculations, the service is deemed high cost, which would likely result in member/provider abrasion if services were performed and denied retrospectively for lack of medical necessity. Service: Transcranial Magnetic Stimulation Factor: Third Party Guideline – Member Safety & Appropriateness of Care Source/Standard/Description: XXXXX utilizes MCG criteria (or state approved criteria) for this service. Due to member safety and appropriateness of care concerns, the requests for TMS are reviewed according to FDA approvals to ensure some form of medication treatment has been tried without response before using TMS for treatment of major depressive disorder. Service: Adaptive Behavioral Treatment (e.g., ABA or applied behavioral analysis) Factor: Third Party Guideline – Appropriateness of Care, Member Abrasion & High cost of services Source/Standard/Description: XXXXX has adopted a third party guideline and due to the high cost of services. The ROI analysis was above the 5:1 threshold for consideration, and member abrasion would result if services were provided (typically high volume) and later denied for lack of medical necessity. Service: Intensive Home Behavioral Therapy Factor: Clinical Guideline - Appropriateness of Care, Member Abrasion & High cost of services Source/Standard/Description: XXXXX has adopted a clinical UM guideline due to the high cost of services. The ROI analysis was well above the 5:1 threshold for consideration, and member abrasion would result if services were provided (typically high volume) and later denied for lack of medical necessity. 4. Demonstration of Comparability and Stringency as Written	has an ROI 5:1 or above, the finance team will provide a recommendation to the Clinical Criteria Review Team for inclusion on the prior authorization list. The calculations above are continuously prepared and updated throughout the year and are reported on a quarterly basis. 4. Demonstration of Comparability and Stringency as Written Prior Authorization List Development Process Overview: The following describes the process applied to determine if prior authorization is appropriate or whether an existing prior authorization should be removed. It applies to all medical/surgical outpatient services, and those listed MH/SUD services. Data Analysis is performed using data models established by the Clinical Analytics team including the cost of prior authorization. The Clinical Analytics team is led by a Director of Advanced Analytics and performs various data analysis for XXXXX. The team is comprised of data analysts with specialized training in advanced analytic techniques. The analysts have master's degrees in either mathematics, statistics, epidemiology, or data science with some having PhDs in their respective fields. Data models are based on 24 months of data with a 3 month claim lag. Reports may be requested from the appropriate Clinical Analytics team. The review occurs quarterly following the MPTAC meeting and during the annual review when all clinical guidelines and medical policies are reviewed. A Data Analyst determines if the savings meets the established 5:1 threshold, and prepares a summary and recommendation to be presented to the Clinical Criteria Review team (CCRT) to be vetted in preparation for submission for approval. The CCRT reviews recommendations and agrees to either send for review and approval or may recommend modifications based on other data points. The CCRT recommendations are submitted to the health plan's Regional Vice President (RVP) Medical Director for consideration. The RVP Medical Director will consider the recommendation amongst the additional factors noted above, and utilize their clinical judgment in determining if the clinical UM guideline should be adopted and if prior authorization is warranted based on the factors (appropriateness of care, member safety, member/provider abrasion, state mandates) considered. The RVP Medical Director has the ultimate authority to approve the adoption of a clinical UM guideline and the adoption/removal of a service from the prior authorization list. Once the initiative is approved, the XXXXX UM Rule team will assign an Initiative Owner and begin the formal implementation project. The XXXXX UM Rule team is the operational team that implements the decision to add/remove a service from the prior authorization list to ensure the systems are adjudicating claims properly and appropriate communications have been released regarding any change. The UM Rule Team does not make any clinical judgments as to whether a service should be added or removed. XXXXX will also perform prior authorization for services not on the prior authorization list when such a review is requested by the provider. The process to add/remove a service from the prior authorization list is the same for MH/SUD and M/S services. Additionally, the factors, sources, and evidentiary standards are applied

	Prior Authorization List Development Process Overview: The following describes the process applied to determine if prior authorization is appropriate or whether an existing prior authorization should be removed. It applies to all medical/surgical outpatient services, and those listed MH/SUD services. Data Analysis is performed using data models established by the Clinical Analytics team including the cost of prior authorization. The Clinical Analytics team is led by a Director of Advanced Analytics and performs various data analysis for XXXXX. The team is comprised of data analysts with specialized training in advanced analytic techniques. The analysts have master's degrees in either mathematics, statistics, epidemiology, or data science with some having PhDs in their respective fields. Data models are based on 24 months of data with a 3 month claim lag. Reports may be requested from the appropriate Clinical Analytics team. The review occurs quarterly following the MPTAC meeting and during the annual review when all clinical guidelines and medical policies are reviewed. A Data Analyst determines if the savings meets the established 5:1 threshold, and prepares a summary and recommendation to be presented to the Clinical Criteria Review team (CCRT) to be vetted in preparation for submission for approval. The CCRT reviews recommendations and agrees to either send for review and approval or may recommend modifications based on other data points. The CCRT recommendations are submitted to the health plan's Regional Vice President (RVP) Medical Director for consideration. 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The UM Rule Team does not make any clinical judgments as to whether a service should be added or removed. XXXXX will also perform prior authorization for services not on the prior authorization list when such a review is requested by the provider. The process to add/remove a service from the prior authorization list is the same for MH/SUD and M/S services. Additionally, the factors, sources, and evidentiary standards are applied comparably and no more stringently to MH/SUD services as M/S as all inpatient services are subject to prior authorization. Prior Authorization Penalty Process XXXXX's fully insured policies do not include a member penalty if prior authorization is not received. However, for medical/surgical services, if an in-network medical/surgical provider fails to obtain a prior authorization for a service on the prior authorization list, the provider's payment may be reduced and the provider is not able to balance bill the member. This reduction does	comparably and no more stringently to MH/SUD services as M/S as all inpatient services are subject to prior authorization. Prior Authorization Penalty Process XXXXX's fully insured policies do not include a member penalty if prior authorization is not received. However, for medical/surgical services, if an in-network medical/surgical provider fails to obtain a prior authorization for a service on the prior authorization list, the provider's payment may be reduced and the provider is not able to balance bill the member. This reduction does not apply to mental health and substance use disorder services/providers. Thus, XXXXX is more generous to network MH/SUD providers than medical/surgical providers. Our standard approach is to not apply a prior authorization penalty to members if a service is not prior authorized. The exceptions are as follows: • Connecticut, Georgia, New Hampshire, New York and Virginia - Standard out of Network 50% penalty in Private Exchange plans. • California Large Group - All standard PPO plans have a prior authorization penalty where member is responsible for an additional $500 copay if prior authorization is not obtained from XXXXX for non-emergency admissions to non-network providers. • Georgia, Kentucky, Ohio, Virginia, California, Connecticut, New York and Nevada - LG fully insured Private Exchange (PEX) PPO product sold through AON applies a prior authorization penalty for Out of Network services at 50% of eligible expenses up to $500; penalty does not apply to deductible and OOP maximum. Prior Authorization Process Providers can locate prior authorization lists online at XXXXX.com, and can check prior authorization requirements by CPT codes through the online portal. Any changes to the prior authorization list or process are also communicated to providers through monthly provider newsletter communications. The utilization management program, which includes prior authorization review, is also thoroughly outlined in each provider manual. The provider manual is accessible online at XXXXX.com. The actual process used is described next. Guidelines governing types of service and authorization requirements are clearly defined in the health plan precertification look up tool. XXXXX's criteria hierarchy follow state/federal criteria, medical policies, MCG (or other third part criteria), and then clinical UM Guidelines. Requests for notification and prior authorization of covered services can either be called into the health plan, called in through the provider call center, faxed to the plan or call center, or the provider may use the plan's Provider portal, Availity (https://www.availity.com/). There are multiple avenues for submission, any of which are acceptable to use. If a provider elects to utilize the fax method, forms are available online through Plan's website to aid in the submission and ensure the provider submits information critical to the service request. The use of forms is optional though and not required. The XXXXX Prior Authorization Team is available to accept requests and respond to issues from 8:30a.m. to 5:00 p.m. (EST), Monday through Friday, excluding holidays. Faxed requests received after 5:00 p.m. (EST) will be processed on the next business day. Our XXXXX call center Department is available 24 hours a day, 7 days a week for prior authorization requests. At the time of request for notification or prior authorization, the provider is required to submit information regarding the type and quantity of service being requested, as well as, the ICD-10 (diagnosis) codes, CPT (procedure) codes, HCPCS (equipment) codes, requesting provider information, servicing provider, place of service and dates of service. Additionally, clinical information (e.g., medical records) required to support the request is submitted at this time.

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At the time of request for notification or prior authorization, the provider is required to submit information regarding the type and quantity of service being requested, as well as, the ICD-10 (diagnosis) codes, CPT (procedure) codes, HCPCS (equipment) codes, requesting provider information, servicing provider, place of service and dates of service. Additionally, clinical information (e.g., medical records) required to support the request is submitted at this time. XXXXX provides forms online (XXXXX.com) that are optional for the provider to use when submitting a prior authorization request. Providers may use multiple avenues to submit a request, so the forms serve as guidelines for the type of information generally required to complete the medical necessity review or determine if such review is applicable to the service request. If the provider elects to use the electronic portal, the following information, at minimum, is required: · Member Name · Member ID	XXXXX provides forms online (XXXXX.com) that are optional for the provider to use when submitting a prior authorization request. Providers may use multiple avenues to submit a request, so the forms serve as guidelines for the type of information generally required to complete the medical necessity review or determine if such review is applicable to the service request. If the provider elects to use the electronic portal, the following information, at minimum, is required: · Member Name · Member ID · Member DOB · Payer · Request Type – Outpatient or Inpatient · Request "From" and "To" date · Rendering Provider and (if applicable) Facility NPI or Tax ID · Service Type · Place of Service · Quantity and Quantity Type (e.g., units, visits, months, days) · Level of Service · Diagnosis Code(s) · Procedure Code(s) · Clinical Documentation Attachments The Utilization Management Representative (UMR) responds to incoming phone calls, faxed requests, and portal requests, and begins the processing of notification or pre-certification requests in XXXXX's UM system utilizing the following procedure: § Verify the member's eligibility, benefit package and service history utilizing the designated step-by-step procedure. § Verify the requested service authorization requirement (no prior authorization, prior authorization) by performing a CPT/HCPCS code search in the prior authorization look up tool. § Verify if the service is a covered benefit in applicable Plan. If prior authorization is not required, the provider will be advised no prior authorization is required for the specific code requested. If the service requires prior authorization, and there is no duplicative service on file, the UMR will create a prior authorization request by entering all necessary information into the appropriate UM system and route the request queue for review by a NMM (Nurse Medical Management) for Med/Surg requests and BH Care Managers (BHCM) for MH/SUD requests. The NMM staff is composed of licensed registered nurses. BH Care Managers are non-MD level licensed behavioral health care practitioners (licensed clinical social workers, licensed marriage and family therapists, registered nurses, psychologists, licensed clinical social workers, licensed professional clinical counselor). NMM/BHCM reviews the cases requiring prior authorization using appropriate clinical hierarchy guidelines. If the request meets criteria guidelines, the NMM/BHCM will make the determination to approve and complete the request in XXXXX's UM system utilizing the designated step-by-step procedure. Written notification will be sent to the member, servicing and requesting provider within required contact timeframes. Verbal notification will also occur at the same time to the servicing provider. If the request does not meet criteria, the NMM/BHCM will route the request to the Medical Directors for review.

	· Member DOB · Payer · Request Type – Outpatient or Inpatient · Request “From” and “To” date · Rendering Provider and (if applicable) Facility NPI or Tax ID · Service Type · Place of Service · Quantity and Quantity Type (e.g., units, visits, months, days) · Level of Service · Diagnosis Code(s) · Procedure Code(s) · Clinical Documentation Attachments The Utilization Management Representative (UMR) responds to incoming phone calls, faxed requests, and portal requests, and begins the processing of notification or pre-certification requests in XXXXX’s UM system utilizing the following procedure: § Verify the member’s eligibility, benefit package and service history utilizing the designated step-by-step procedure. § Verify the requested service authorization requirement (no prior authorization, prior authorization) by performing a CPT/HCPCS code search in the prior authorization look up tool. § Verify if the service is a covered benefit in applicable Plan. 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If the request meets criteria guidelines, the NMM/BHCM will make the determination to approve and complete the request in XXXXX’s UM system utilizing the designated step-by-step procedure. Written notification will be sent to the member, servicing and requesting provider within required contact timeframes. Verbal notification will also occur at the same time to the servicing provider. If the request does not meet criteria, the NMM/BHCM will route the request to the Medical Directors for review. If the information received is insufficient to make a determination, the NMM/BHCM will instruct the provider to provide information in support of the request (clinical notes, diagnostic test results, prescriptions, etc.). If it is in the member’s best interest to extend the request timeframe, or if the member or provider requests an extension, the NMM/BHCM will send out a “14 Day Extension” letter no later than the fourteen (14) calendar days from the date of request. The NMM/BHCM will be responsible for all follow up reviews and/or MDR (Medical Director Review) referrals in reference to these requests.	If the information received is insufficient to make a determination, the NMM/BHCM will instruct the provider to provide information in support of the request (clinical notes, diagnostic test results, prescriptions, etc.). If it is in the member’s best interest to extend the request timeframe, or if the member or provider requests an extension, the NMM/BHCM will send out a “14 Day Extension” letter no later than the fourteen (14) calendar days from the date of request. The NMM/BHCM will be responsible for all follow up reviews and/or MDR (Medical Director Review) referrals in reference to these requests. If the NMM/BHCM cannot find any criteria guidelines appropriate for use in review of the requested service or if the request is for certain services that require Medical Director Review as per XXXXX guidelines, the NMM/BHCM will route the request to the Medical Director Review queue for review. If the request is forwarded to the NMM/BHCM labeled as expedited, the NMM/BHCM will route to the Medical Director queue as well as notify the Medical Director directly (phone, email, IM) to ensure review within the same business day. Requests submitted to a Medical Director will be reviewed against the applicable medical necessity criteria. The Medical Director (licensed MD level providers) determine, based on their clinical judgement and review of the materials, whether the individual meets medical necessity criteria. Peer reviews with treating physicians may be necessary in the event the materials are insufficient or additional information is required. The Medical Director will either approve or deny request based on the information available, and complete the member and provider notification within the required timeframe. The same process is used for MH/SUD and M/S service requests. Demonstration of Comparability and Stringency In Operation In Operation Analysis: The data showing the number of prior authorization reviews by line of business (fully insured or ASO, as applicable) conducted in 2024 is attached as MHPAEA NQTL Operational Data. The data shows prior authorization is not being applied more stringently to MH/SUD services than M/S. In general, with very limited exceptions, a substantially higher number of overall reviews are performed on M/S services than MH/SUD. Although a quantification of the total procedures requiring prior authorization is difficult due to the use of procedure and diagnosis codes, the listing provided above demonstrates overall that a significantly higher number of M/S services require prior authorization. Additionally, the most frequently utilized MH/SUD services (psychotherapy and outpatient therapy) are not subject to prior authorization requirements. The data also demonstrates the reviews for M/S and MH/SUD services are comparably applied resulting in similar approval and denial figures. While some MH/SUD may be higher, there is nothing to imply the overall process or requirements are being applied more stringently to MH/SUD. In many cases, the numbers of prior authorization requests are so low for MH/SUD that a handful of reviews not meeting criteria are enough to drastically change the overall percentage of approvals. However, this reflects on the limited number of cases and clinical presentation of the small number of cases instead of a more stringent application of the process overall. XXXXX has also reviewed the turnaround times for requests, and there is no measurable difference demonstrating that prior authorization requirements are being applied more stringently in the timeframe for determinations between MH/SUD and M/S requests. The

	If the NMM/BHCM cannot find any criteria guidelines appropriate for use in review of the requested service or if the request is for certain services that require Medical Director Review as per XXXXX guidelines, the NMM/BHCM will route the request to the Medical Director Review queue for review. If the request is forwarded to the NMM/BHCM labeled as expedited, the NMM/BHCM will route to the Medical Director queue as well as notify the Medical Director directly (phone, email, IM) to ensure review within the same business day. Requests submitted to a Medical Director will be reviewed against the applicable medical necessity criteria. The Medical Director (licensed MD level providers) determine, based on their clinical judgement and review of the materials, whether the individual meets medical necessity criteria. Peer reviews with treating physicians may be necessary in the event the materials are insufficient or additional information is required. The Medical Director will either approve or deny request based on the information available, and complete the member and provider notification within the required timeframe. The same process is used for MH/SUD and M/S service requests. Demonstration of Comparability and Stringency In Operation In Operation Analysis: The data showing the number of prior authorization reviews by line of business (fully insured or ASO, as applicable) conducted in 2024 is attached as MHPAEA NQTL Operational Data. The data shows prior authorization is not being applied more stringently to MH/SUD services than M/S. In general, with very limited exceptions, a substantially higher number of overall reviews are performed on M/S services than MH/SUD. 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However, this reflects on the limited number of cases and clinical presentation of the small number of cases instead of a more stringent application of the process overall. XXXXX has also reviewed the turnaround times for requests, and there is no measurable difference demonstrating that prior authorization requirements are being applied more stringently in the timeframe for determinations between MH/SUD and M/S requests. The turnaround time metrics are included in MHPAEA NQTL Operational Data. Additionally, the number of days/units approved for MH/SUD is comparable or more favorable for the multiple classifications. As demonstrated by the MHPAEA NQTL Operational Data, XXXXX does not apply these processes, strategies, evidentiary standards and other factors more stringently to MH/SUD benefits. Findings and Conclusions	turnaround time metrics are included in MHPAEA NQTL Operational Data. Additionally, the number of days/units approved for MH/SUD is comparable or more favorable for the multiple classifications. As demonstrated by the MHPAEA NQTL Operational Data, XXXXX does not apply these processes, strategies, evidentiary standards and other factors more stringently to MH/SUD benefits. Findings and Conclusions As noted above, XXXXX applies the same factors, standards, and processes to determine whether a particular M/S and MH/SUD service should be added or removed from the prior authorization list. The CCRT and the Medical Directors reviewing the services consider the same factors in making the clinical decisions of whether to add or remove a service from the prior authorization list. However, as noted above, consideration of MH/SUD, beyond an annual update, is not frequently considered in this process as relatively few MH/SUD procedures are introduced requiring changes to the prior authorization list. Therefore, the factors, standards, and sources are more often considered for M/S services. In operation, the prior authorization process is the same for each, with the critical components to the requests and supporting documentation generally being the same although tailored to the specific service subject to the request. M/S and MH/SUD providers have multiple available avenues to submit a request for prior authorization, and the usage of one particular avenue or form is not mandated. Finally, the in operation data demonstrates that XXXXX receives significantly more M/S prior authorization requests than MH/SUD, yet the percentage approval of MH/SUD service requests is often higher than M/S. MH/SUD services have a similar turnaround time in the prior authorization determination process. Lastly, based on the list above, a significantly higher number of M/S services require prior authorization. Therefore, XXXXX is within the parity requirements for MH/SUD as prior authorization is not applied more stringently to MH/SUD services than M/S services.

	As noted above, XXXXX applies the same factors, standards, and processes to determine whether a particular M/S and MH/SUD service should be added or removed from the prior authorization list. The CCRT and the Medical Directors reviewing the services consider the same factors in making the clinical decisions of whether to add or remove a service from the prior authorization list. However, as noted above, consideration of MH/SUD, beyond an annual update, is not frequently considered in this process as relatively few MH/SUD procedures are introduced requiring changes to the prior authorization list. Therefore, the factors, standards, and sources are more often considered for M/S services. In operation, the prior authorization process is the same for each, with the critical components to the requests and supporting documentation generally being the same although tailored to the specific service subject to the request. M/S and MH/SUD providers have multiple available avenues to submit a request for prior authorization, and the usage of one particular avenue or form is not mandated. Finally, the in operation data demonstrates that XXXXX receives significantly more M/S prior authorization requests than MH/SUD, yet the percentage approval of MH/SUD service requests is often higher than M/S. MH/SUD services have a similar turnaround time in the prior authorization determination process. Lastly, based on the list above, a significantly higher number of M/S services require prior authorization. Therefore, XXXXX is within the parity requirements for MH/SUD as prior authorization is not applied more stringently to MH/SUD services than M/S services.	
Concurrent Review Benefit NQTL Practices	There are no comparable inconsistencies or differences in the application, as written and in operation. The company does not initiate any concurrent reviews. Instead, the company conducts a continued stay/concurrent review when the treating provider/facility requests that the member's inpatient stay or outpatient treatment be approved for an ongoing stay in a facility or course of treatment due to the member's current medical condition. The same processes, strategies, evidentiary standards and other factors for continued stay/concurrent reviews for both MH/SUD and medical surgical benefits. Further, the company does not apply these processes, strategies, evidentiary standards and other factors more stringently to MH/SUD benefits. 1. Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply. Overview The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply concurrent review to mental health or substance use disorder ("MH/SUD") benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply concurrent review to medical surgical ("M/S") benefits. Identification of the NQTL XXXXX's fully insured policies contain requirements that certain services be reviewed to ensure that they are medically necessary. Plan/Coverage Terms Regarding Concurrent Review The Plan Document Example details how the concurrent review process works for members. Concurrent Review is defined in the plan documents as: "A utilization review of a service,	Same as for MH/SUD.

	treatment or admission for a benefit coverage determination that must be done during an ongoing stay in a Facility or course of treatment." Providers are informed of this process in the "Utilization Management" section of the Provider Manual. This analysis explains when XXXXX performs a continued stay/concurrent review and how XXXXX's processes, strategies, evidentiary standards and other factors for continued stay/concurrent review comply with the non-quantitative treatment limitation (NQTL) requirements under MHPAEA. The concurrent review NQTL applies to medical/surgical and mental health/substance use disorder services in the inpatient (in-network, out of network) and outpatient (in-network, out of network) benefit classifications. XXXXX has included some definitions used throughout the analysis: • Availity Prior Auth Portal (AVPortal): XXXXX's application on Availity web portal in submission of requests for service. (It is currently available for limited physical health providers by provider state). • Continued Stay Review: Utilization review that is conducted during a covered person's ongoing stay in a facility or course of treatment. Continued stay review includes continuation of services (Urgent Care & Extensions). • Interactive Care Reviewer (ICR): XXXXX's application inside the Availity web portal for providers to submit requests. It allows providers to electronically submit utilization review requests to XXXXX and track the status of requests. • Peer Clinical Reviewer (PCR): means a physician, nurse practitioner, doctoral-level clinical psychologists or certified addiction-medicine specialists, pharmacist, dentist, chiropractor, physical therapist professional, or doctoral-level board-certified behavioral analysts who: o Has education, training or professional experience and a current license or an administrative license; or o Is a board-certified consultant. 2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits: a. Member is inpatient or in an ongoing course of treatment. b. The provider is requesting that ongoing care be reviewed for medical necessity. c. The service is subject to prior authorization. Factor Weighting: All three of the above factors are weighted equally to determine when concurrent review is applied to M/S and MH/SUD services. 3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits: Factors (Including Processes and Strategies) XXXXX conducts a continued stay/concurrent review when the treating provider/facility requests that the member's inpatient stay or an ongoing course of outpatient treatment/stay be approved due to the member's current medical condition. XXXXX does not initiate any concurrent reviews for either MH/SUD or M/S services.	

	Member is Inpatient or in Ongoing Course of Treatment: If the member is receiving inpatient care or an ongoing course of treatment, and the previously authorized duration of treatment or number of approved visits/sessions is set to expire, the provider may request additional days of inpatient stay or additional visits/sessions to be authorized. XXXXX considers this a continued stay/concurrent review request. The only evidentiary standard used for such factor is the current course of treatment experienced by the member, and the amount of previously authorized treatment. Service is Subject to Prior Authorization: Continued stay/Concurrent Review is often performed on services that pre-service required prior authorization. In the event the days or visits authorized are set to expire, the provider can submit a request for continued stay/concurrent review in order for additional days or visits be authorized. The standards for services requiring prior authorization are separately detailed in the Prior Authorization NQTL comparative analysis. Provider Request Ongoing Care to be Reviewed for Medical Necessity: A provider may request additional services from those previously authorized or submit a request a medical necessity review for continued stay or additional treatment. There is no evidentiary standard used for this as it is completely within the provider discretion. 4. Demonstration of Comparability and Stringency as Written Continued Stay Written Process: The continued stay/concurrent review process commences when an individual member is in an ongoing inpatient stay or receiving a course of outpatient treatment and is approaching the limit of the previously authorized treatment/stay. The provider/facility can submit a request for an extension of treatment previously authorized through the Availity portal (or by phone and fax). Upon receipt, the information will be first reviewed and entered into the XXXXX Care Management System (ACMS), and ultimately reviewed by a member of the clinical team for medical necessity against the respective guideline. The clinician will perform the clinical review and may approve the request if it meets the medical necessity guideline. If it is not clear that the request meets the medical necessity guideline, the clinician will refer the request to the Peer Clinical Reviewer for a decision. Only the Peer Clinical Reviewer may deny a request. The decision is ultimately provided back to the requesting provider/facility. In some instances, a healthcare professional or non-clinical staff member may perform outreach to the provider/facility after the last approved day and inform them that a request for an extension has not been received and/or to submit the discharge date for the member. If a member is still receiving treatment, the provider/facility will be requested to submit the clinical information supporting the extension. Clinical information submitted will be reviewed by the Peer Clinical Reviewer for an ultimate decision to approve or deny the request. If information is not provided, then the non-clinical staff will document the discharge date as the day after the last approved or the denied decision date in the medical management system. The process is applied for continued stay/concurrent review of M/S and MH/SUD services. 5. Demonstration of Comparability and Stringency In Operation Continued Stay Operational Data: In performing the operational comparative analysis, XXXXX annually pulls data from the XXXXX Care Management Platform (ACMP). The data includes all continued stay/concurrent reviews performed for M/S and MH/SUD claims. First, XXXXX reviews the total amount of	

	claims subject to concurrent review. In general, XXXXX will receive more concurrent review requests for M/S services, with the exception of inpatient, out of network. XXXXX does not typically receive many outpatient concurrent reviews as they don't typically meet the factors above (e.g., member in ongoing course of treatment/stay). Thus, M/S services are typically subject to concurrent review at a higher rate than MH/SUD. When reviewing the outcomes of the reviews, MH/SUD services are typically approved at a higher rate than M/S services, with some very limited exceptions. The data is attached as MHPAEA NQTL Operational Data. 6. Findings and Conclusions As noted above, XXXXX applies the same processes, strategies, evidentiary standards and other factors for continued stay/concurrent reviews for both MH/SUD and M/S benefits. XXXXX does not apply these processes, strategies, evidentiary standards and other factors more stringently to MH/SUD benefits. Furthermore, the comparative analysis reviewing the claims subject to concurrent review demonstrates MH/SUD services are generally approved at a similar or higher rate than M/S services. Therefore, XXXXX complies with parity requirements for concurrent review in writing and in operation.	
Retrospective Review Benefit NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of retrospective review NQTL practices between medical/surgical and MH/SUD benefits. The company conducts a retrospective review when a claim is submitted and it is determined that the service is on our prior authorization list and a prior authorization was not requested. Additionally, the company will conduct a retrospective review for services for which it maintains a medical policy or clinical UM guideline and the service does not require a prior authorization. Because the company requires prior authorization of inpatient services, we expect to have very few retrospective reviews unless the provider fails to preauthorize care. In the case of outpatient services, we expect the numbers of retrospective reviews to be much higher for medical/surgical services. This is because the majority of the company's medical policies/clinical UM guidelines are for medical/surgical services. Also, a significant number of MH/SUD services are associated with outpatient office visits. XXXXX does not maintain a medical policy/clinical UM guideline for those services so no utilization management review would be performed. 1. Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply. Overview The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply concurrent review to mental health or substance use disorder ("MH/SUD") benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply concurrent review to medical surgical ("M/S") benefits. Identification of the NQTL XXXXX's fully insured policies and the plans that it administers on behalf of self-funded employers contain requirements that certain services be reviewed to ensure that they are medically necessary.	Same as for MH/SUD.

	Plan/Coverage Terms Regarding Retrospective Review The plan document example details how the retrospective/post service review process works for members. Post service review is defined in the plan documents as: “A medical necessity review of a service, treatment or admission for a benefit coverage that is conducted after the service or supply has been provided and the claim submitted to XXXXX. Post-service reviews are performed when a service, treatment or admission did not need Precertification. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.” Providers are informed of this process in the “Utilization Management” section of the Provider Manual. This analysis explains when XXXXX performs a post-service review and how XXXXX’s processes, strategies, evidentiary standards and other factors for post-service reviews comply with the NQTL requirements under MHPAEA. Post service reviews applies to medical/surgical and mental health/substance use disorder services in the inpatient (in-network, out of network) and outpatient (in-network, out of network) benefit classifications. 2. Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits: a. Does XXXXX have a medical policy or clinical utilization management (UM) guideline or third-party guideline? b. Was a prior authorization required? XXXXX does not assign more weight to any one of the factors in either area identified above. However, if a medical policy or clinical UM guideline does not exist, retrospective review will not be conducted. 3. Provide the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits: Presence of a Medical Policy or Clinical Utilization Management (UM) Guideline: The Medical Policy and Clinical Utilization Management (UM) Guidelines are developed by the Medical Policy and Technology Assessment Committee (MPTAC) or through MPTAC’s adoption of an independent third-party criteria, namely MCG. These policies and clinical utilization management guidelines are the sources to determine if retrospective review is required for a particular service, and ultimately include the criteria for determining if the service is medically necessary. The evidentiary standard for this factor is simply whether a Medical Policy or Clinical UM Guideline applies to the particular M/S and MH/SUD service. Was Prior Authorization Required: As detailed in the Prior Authorization NQTL analysis, each Plan has a team of qualified personnel that adopts or removes services on the prior authorization list. If a service is on the prior authorization list, a provider/facility should request review pre-service. In the event such request is not made and a claim is submitted post service, the service will be subject to retrospective review. The source for this factor is the adopted prior authorization list for the specific market. The standard is whether or not the	

	service is included on the applicable prior authorization list, and if the provider requested prior authorization. 4. Demonstration of Comparability and Stringency as Written Post Service Review Written Process: Medical Policies, Clinical UM Guidelines, and the Prior Authorization list are all the subject of other NQTL comparative analyses, but they are the factors determining whether retrospective review is performed on a claim in two instances. First, a provider or facility will submit a claim to XXXXX for either M/S or MH/SUD services. The claims system will automatically look to see, through claim edits, whether a pre-service review (i.e., prior authorization) is required. If prior authorization is required, the system will look to see if that was process was completed. If the prior authorization process was not completed and the health plan has in place a 100% penalty then the claim will be rejected as not authorized and sent a remittance back to the provider requesting clinical data to support the claim and ultimately for a post service clinical claim review. If the prior authorization process was not completed and a penalty is not in place, the claim will be submitted to the PSCCR team for review. When the provider/facility submits the requested clinical information, it is sent to the post service clinical claim review team for a retrospective review against the medical criteria (e.g., medical policy or clinical UM guideline) and a decision is communicated to the provider and member. A retrospective review is also performed where a medical policy or clinical UM guidelines applies to the service performed on the claim, even if prior authorization is not required. In this instance, the claims edits will look to see if the services on the claim match up with a medical policy or clinical UM guideline. If so, the claim is sent to the post service clinical claim review team for review and comparison to the medical necessity criteria within the applicable medical policy or clinical UM guideline. The written processes above apply to both M/S and MH/SUD claims. 5. Demonstration of Comparability and Stringency In Operation Post Service Review Operation Analysis: In performing the operational comparative analysis, XXXXX annually pulls data to review. The data includes all retrospective reviews performed for M/S and MH/SUD claims. First, XXXXX reviews the total amount of claims subject to retrospective review. A substantially higher amount of M/S claims are subject to retrospective, and account for a higher overall proportion of claims subject to retrospective review. Because XXXXX requires prior authorization of inpatient services, we expect to have very few retrospective reviews unless the provider fails to preauthorize care. In the case of outpatient services, we expect the numbers of retrospective reviews to be much higher for medical/surgical services. This is because the majority of XXXXX's medical policies/clinical UM guidelines are for medical/surgical services. Also, a significant number of MH/SUD services are associated with outpatient office visits. XXXXX does not maintain a medical policy/clinical UM guideline for those services so no utilization management review would be performed. Secondly, in reviewing the breakdown of M/S and MH/SUD reviews, in general, a higher proportion of MH/SUD claims are approved on retrospective review with some very limited exceptions. The comparison is provided in the attached UM Data table. 6. Findings and Conclusions As noted above, XXXXX uses the same factors, sources, standards, and process for determining when a retrospective review is performed on MH/SUD and M/S claims. Additionally, the same process to perform the retrospective review is used for MH/SUD and M/S claims. Therefore, the written processes are within parity requirements. The operational	

	data also confirms retrospective review is within parity requirements as a higher level of M/S claims are subject to retrospective review, and generally, a higher percentage of MH/SUD are approved on retrospective review. Therefore, in comparing the written process and operational data, XXXXX's retrospective review process is within mental health parity requirements.	
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation. The company relies on the same resources for coding our claims systems for the appropriate processing of claims, e.g. CMS, CPT Coding Manual, etc.	Same as for MH/SUD.
Case & Medical Management NQTL Practices	"There are no non-comparable inconsistencies or differences in the application, as written and in operation. The company relies on the requirements of state and federal law and NCQA for its processes and procedures and routinely audits its staff to ensure those requirements are followed. As noted in previous discussions, the company's case management program for M/S and MH/SUD services should not be considered a non-quantitative treatment limitation. The voluntary case management program does not limit the scope and duration of benefits. Further, the voluntary case management program is separate and distinct from the UM process."	Same as for MH/SUD.
Network Adequacy & Provider Reimbursement Rates	Based on prior discussions with the DOI, Column A is reflective of the specific categories otherwise described within this as well as other NQTLs that may exist. The Company did not identify any inconsistencies or differences other than those set forth in this document. **NETWORK ADEQUACY** 1. Description of the Network Adequacy NQTL This network adequacy NQTL analysis describes the annual assessment process for in-network practitioner access and availability to members, and how the measurements are used to determine network alterations. It further describes how XXXXX's processes, strategies, evidentiary standards, and other factors for network development comply with the NQTL requirements under MHPAEA. The NQTL applies to all medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) providers across all network benefit classifications subject to objective access and availability standards established by the NCQA, CMS, and state law. Definitions: CAHPS (Consumer Assessment of Healthcare Providers and Systems) Survey: A standardized annual survey that is used to assess the Commercial and Private Exchange patients' experiences with getting healthcare and to improve quality of care. The survey is developed and maintained by the AHRQ (Agency for Healthcare Research and Quality), a government agency. National Committee for Quality Assurance (NCQA): The NCQA is a non-profit organization promulgating health plan accreditation standards and quality measures for the health industry. The NCQA also performs accreditation reviews of health plans relied on by the industry and regulators for evidence of compliance with standards including credentialing, utilization management, and network adequacy through access and availability to care measurements. Network Adequacy: A determination of geographic and appointment access performance, realistic for the community and the delivery system. Annual quantitative assessment of	Based on prior discussions with the DOI, Column A is reflective of the specific categories otherwise described within this as well as other NQTLs that may exist. The Company did not identify any inconsistencies or differences other than those set forth in this document. **NETWORK ADEQUACY** 1. Description of the Network Adequacy NQTL This network adequacy NQTL analysis describes the annual assessment process for in-network practitioner access and availability to members, and how the measurements are used to determine network alterations. It further describes how XXXXX's processes, strategies, evidentiary standards, and other factors for network development comply with the NQTL requirements under MHPAEA. The NQTL applies to all medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) providers across all network benefit classifications subject to objective access and availability standards established by the NCQA, CMS, and state law. Definitions: CAHPS (Consumer Assessment of Healthcare Providers and Systems) Survey: A standardized annual survey that is used to assess the Commercial and Private Exchange patients' experiences with getting healthcare and to improve quality of care. The survey is developed and maintained by the AHRQ (Agency for Healthcare Research and Quality), a government agency. National Committee for Quality Assurance (NCQA): The NCQA is a non-profit organization promulgating health plan accreditation standards and quality measures for the health industry. The NCQA also performs accreditation reviews of health plans relied on by the industry and regulators for evidence of compliance with standards including credentialing, utilization management, and network adequacy through access and availability to care measurements. Network Adequacy: A determination of geographic and appointment access performance, realistic for the community and the delivery system. Annual quantitative assessment of

	membership with availability to in-network practitioners by type, within the established mileage or minutes of their residence and the access to timely appointments for those practitioners. Accreditation data is not assessed at a level of group, product or treatment criteria. Practitioner Accessibility: The extent to which members obtain timely appointments and after hours contact with medical and behavioral health care practitioners. Practitioner Availability: The extent to which members have adequate numbers and types of primary care, specialty care, and behavioral healthcare practitioner available to meet their healthcare needs. 2. Identification and Definition of the Factors and Evidentiary Standards Used to Design or Apply Network Adequacy Factors: • NCQA Accreditation Standard a. Is there an NCQA accreditation standard that applies for practitioner availability? i. If yes, the accreditation standard becomes the baseline measurement to determine compliance with network geo availability requirements for M/S and MH/SUD providers. b. Does the state have a specific practitioner availability requirement? i. If yes, the state law will supplant the base policy requirements predicated on the NCQA standards. ii. If no, the base policy requirement predicated on the NCQA standard will apply. c. Is there an NCQA accreditation standard that applies for practitioner accessibility? i. If yes, the accreditation standard becomes the baseline measurement to determine compliance with network appointment accessibility requirements for M/S and MH.SUD providers. d. Does the state have a specific practitioner accessibility requirement? i. If yes, the state law will supplant the base policy requirements predicated on the NCQA standards. ii. If no, the base policy requirement predicated on the NCQA standard will apply. • State or Federal Standards • Member Input a. Results of the various member surveys or complaints NCQA accreditation standards are the primary weighted factor in developing and determining appropriate access and availability measurement guidelines. XXXXX also relies upon standards mandated by state and federal statutes or regulations. 3. Identify the sources (including any processes, strategies, evidentiary standards) used to define the factors identified above to design the NQTL: NCQA Accreditation: XXXXX is an NCQA accredited health plan. In order to maintain the accreditation, XXXXX must establish policies and processes to measure compliance with network adequacy standards. The NCQA provides the basis for the policies and standards, and XXXXX has adopted these requirements. Sources: NCQA Accreditation Standards for Network Management (NET1-Availability of Practitioners and NET2-Accessibility of Services).	membership with availability to in-network practitioners by type, within the established mileage or minutes of their residence and the access to timely appointments for those practitioners. Accreditation data is not assessed at a level of group, product or treatment criteria. Practitioner Accessibility: The extent to which members obtain timely appointments and after hours contact with medical and behavioral health care practitioners. Practitioner Availability: The extent to which members have adequate numbers and types of primary care, specialty care, and behavioral healthcare practitioner available to meet their healthcare needs. 2. Identification and Definition of the Factors and Evidentiary Standards Used to Design or Apply Network Adequacy Factors: • NCQA Accreditation Standard a. Is there an NCQA accreditation standard that applies for practitioner availability? i. If yes, the accreditation standard becomes the baseline measurement to determine compliance with network geo availability requirements for M/S and MH/SUD providers. b. Does the state have a specific practitioner availability requirement? i. If yes, the state law will supplant the base policy requirements predicated on the NCQA standards. ii. If no, the base policy requirement predicated on the NCQA standard will apply. c. Is there an NCQA accreditation standard that applies for practitioner accessibility? i. If yes, the accreditation standard becomes the baseline measurement to determine compliance with network appointment accessibility requirements for M/S and MH.SUD providers. d. Does the state have a specific practitioner accessibility requirement? i. If yes, the state law will supplant the base policy requirements predicated on the NCQA standards. ii. If no, the base policy requirement predicated on the NCQA standard will apply. • State or Federal Standards • Member Input a. Results of the various member surveys or complaints NCQA accreditation standards are the primary weighted factor in developing and determining appropriate access and availability measurement guidelines. XXXXX also relies upon standards mandated by state and federal statutes or regulations. 3. Identify the sources (including any processes, strategies, evidentiary standards) used to define the factors identified above to design the NQTL: NCQA Accreditation: XXXXX is an NCQA accredited health plan. In order to maintain the accreditation, XXXXX must establish policies and processes to measure compliance with network adequacy standards. The NCQA provides the basis for the policies and standards, and XXXXX has adopted these requirements. Sources: NCQA Accreditation Standards for Network Management (NET1-Availability of Practitioners and NET2-Accessibility of Services).

	State and Federal Statutes: Connecticut defines network adequacy standards for its health plan. XXXXX has adopted these standards to determine network adequacy and files its network information as required by Connecticut. The established standards serve as the baseline for whether XXXXX's network is adequate to serve its members. Member and Vendor Surveys: XXXXX uses member survey results and compares with the NCQA and state law criteria analysis to perform a comprehensive review of their networks (M/S and MH/SUD providers included) to determine if the networks are meeting member expectations. Sources: • Quest Analytics SuiteTM geo access reports • Member surveys including: a. Consumer Assessment of Healthcare Providers and Systems Survey b. Enrollee Experience Survey c. Behavioral Health Member Experience Survey • Practitioner Level Access Study • Member complaints 4. Demonstration of Comparability and Stringency as Written: XXXXX is committed to a standardized process to assure that members can obtain access to practitioners for medical and behavioral health services. The processes used to evaluate Provider Availability and Provider Accessibility are the two primary methods in determining network adequacy. XXXXX Practitioner Availability Process XXXXX utilizes standard measures to annually assess members' availability to sufficient numbers and types of practitioners providing primary care, behavioral healthcare, and specialty care. The Practitioner Availability Process is reviewed annually to assess for necessary revisions as a result of changes to NCQA accreditation standards, state laws, and results of member surveys. The standards ultimately determine the input to measure and evaluate the applicable networks for numbers and types of all contracted practitioners who practice primary care, specialty care, and behavioral healthcare. NCQA standards form the basis for base policy measurements and guidelines, but state variations are included to the extent a state law diverges from the accreditation standard. The NCQA and applicable state laws define required practitioner availability guidelines and standards based on geographic availability and a membership ratio. The geographic measurement is typically the number of providers in a specific subset compared with the number of members in the same zip code for a specified amount of miles. For example, the NCQA standard for urban settings is two (2) primary care practitioners within 5 miles as noted in the graphic below. XXXXX annually measures compliance with the geographic guideline standards through Quest Analytics SuiteTM software. The results determine whether the current network meets requirements for M/S and MH/SUD providers, or if additional providers need to be added to the network to meet availability requirements. In addition, XXXXX looks at the ratio of members to a specific subset of providers in each network. The ratio goal formula is the same calculation for all M/S and MH/SUD providers. The actual quantitative goal may change based on the area, membership amounts, and number of available providers in the area, but it designed to ensure members have sufficient choices of providers. Ratios are calculated annually for each specific provider type to determine if a network satisfies adequacy requirements.	State and Federal Statutes: Connecticut defines network adequacy standards for its health plan. XXXXX has adopted these standards to determine network adequacy and files its network information as required by Connecticut. The established standards serve as the baseline for whether XXXXX's network is adequate to serve its members. Member and Vendor Surveys: XXXXX uses member survey results and compares with the NCQA and state law criteria analysis to perform a comprehensive review of their networks (M/S and MH/SUD providers included) to determine if the networks are meeting member expectations. Sources: • Quest Analytics SuiteTM geo access reports • Member surveys including: a. Consumer Assessment of Healthcare Providers and Systems Survey b. Enrollee Experience Survey c. Behavioral Health Member Experience Survey • Practitioner Level Access Study • Member complaints 4. Demonstration of Comparability and Stringency as Written: XXXXX is committed to a standardized process to assure that members can obtain access to practitioners for medical and behavioral health services. The processes used to evaluate Provider Availability and Provider Accessibility are the two primary methods in determining network adequacy. XXXXX Practitioner Availability Process XXXXX utilizes standard measures to annually assess members' availability to sufficient numbers and types of practitioners providing primary care, behavioral healthcare, and specialty care. The Practitioner Availability Process is reviewed annually to assess for necessary revisions as a result of changes to NCQA accreditation standards, state laws, and results of member surveys. The standards ultimately determine the input to measure and evaluate the applicable networks for numbers and types of all contracted practitioners who practice primary care, specialty care, and behavioral healthcare. NCQA standards form the basis for base policy measurements and guidelines, but state variations are included to the extent a state law diverges from the accreditation standard. The NCQA and applicable state laws define required practitioner availability guidelines and standards based on geographic availability and a membership ratio. The geographic measurement is typically the number of providers in a specific subset compared with the number of members in the same zip code for a specified amount of miles. For example, the NCQA standard for urban settings is two (2) primary care practitioners within 5 miles as noted in the graphic below. XXXXX annually measures compliance with the geographic guideline standards through Quest Analytics SuiteTM software. The results determine whether the current network meets requirements for M/S and MH/SUD providers, or if additional providers need to be added to the network to meet availability requirements. In addition, XXXXX looks at the ratio of members to a specific subset of providers in each network. The ratio goal formula is the same calculation for all M/S and MH/SUD providers. The actual quantitative goal may change based on the area, membership amounts, and number of available providers in the area, but it designed to ensure members have sufficient choices of providers. Ratios are calculated annually for each specific provider type to determine if a network satisfies adequacy requirements.

	XXXXX also considers other factors in the monitoring of its provider availability. First, reviews of open practice rates confirm new patient selection and availability. XXXXX has a standard goal, 90%, for open practices for each primary care practice type and behavioral health practitioners per network. XXXXX also considers member responses to multiple satisfaction, cultural surveys, and clinical complaints. The results are compared with the ratio and open practice results to determine if additional provider types are needed for a particular geographic area. Behavioral healthcare survey responses are specifically considered, and matched to XXXXX specific goals. XXXXX Practitioner Accessibility Process XXXXX also utilizes a standard process to assess members' access to timely appointments for medical and behavioral health care. Through monitoring of fulfillment of accessibility standards, network recruiting and development priorities can be adjusted to ensure adequate providers to serve members. The standard process applies to both M/S and MH/SUD providers. XXXXX uses multiple mechanisms to evaluate networks for access to primary care, specialty care, and behavioral healthcare services. Member surveys (CAHPS, Enrollee Experience Survey, BH Member Survey), a practitioner level access study (telephonic contacts to provider offices), and a review of member complaints are used to determine whether provider accessibility and wait times meets applicable NCQA standards, CMS, or state law requirements. For example, CMS establishes national goals for Enrollee Experience Survey responses related to urgent care, routine care, and specialty care access. The surveys assess accessibility of both M/S and MH/SUD providers. Responses are compared with the measurements and goals established by the NCQA standards (see below), CMS, or state law requirements, if applicable, to determine if additional network capacity is required. Both the Practitioner Availability and Practitioner Accessibility Processes are used to determine if provider networks as designed are adequate and meet the membership needs. Geographic Standards * Provider Type / Urban / Suburban / Rural MH practitioner / 2 MLT within 10 miles / 2 MLT within 25 miles / 2 MLT within 60 miles Source: Accreditation standard guidance. * Some states use the regulatory metro format as mileage or minutes variation, i.e., CO, NV and NH. Others use a common mileage, as CA and ME. Appointment Wait Times * Provider Type / Wait Times for Urgent Appointments ** / Wait Times for Routine Appointments MH practitioner / Within 48 hours / Within 10 business days - routine Within 30 calendar days – routine follow-up Source: Accreditation standard guidance. * Some states use regulatory variations, i.e., CA, CO, CT, MO, NH and VA.	XXXXX also considers other factors in the monitoring of its provider availability. First, reviews of open practice rates confirm new patient selection and availability. XXXXX has a standard goal, 90%, for open practices for each primary care practice type and behavioral health practitioners per network. XXXXX also considers member responses to multiple satisfaction, cultural surveys, and clinical complaints. The results are compared with the ratio and open practice results to determine if additional provider types are needed for a particular geographic area. Behavioral healthcare survey responses are specifically considered, and matched to XXXXX specific goals. XXXXX Practitioner Accessibility Process XXXXX also utilizes a standard process to assess members' access to timely appointments for medical and behavioral health care. Through monitoring of fulfillment of accessibility standards, network recruiting and development priorities can be adjusted to ensure adequate providers to serve members. The standard process applies to both M/S and MH/SUD providers. XXXXX uses multiple mechanisms to evaluate networks for access to primary care, specialty care, and behavioral healthcare services. Member surveys (CAHPS, Enrollee Experience Survey, BH Member Survey), a practitioner level access study (telephonic contacts to provider offices), and a review of member complaints are used to determine whether provider accessibility and wait times meets applicable NCQA standards, CMS, or state law requirements. For example, CMS establishes national goals for Enrollee Experience Survey responses related to urgent care, routine care, and specialty care access. The surveys assess accessibility of both M/S and MH/SUD providers. Responses are compared with the measurements and goals established by the NCQA standards (see below), CMS, or state law requirements, if applicable, to determine if additional network capacity is required. Both the Practitioner Availability and Practitioner Accessibility Processes are used to determine if provider networks as designed are adequate and meet the membership needs. Geographic Standards * Provider Type / Urban / Suburban / Rural Primary Care Physician / 2 practitioners within 12 miles 2 practitioners within 5 miles / 2 practitioners within 30 miles / Specialists / All members – 1 within 30 miles Source: Accreditation standard guidance. * Some states use the regulatory metro format as mileage or minutes variation, i.e., CO, NV and NH. Others use a common mileage, as CA and ME. Appointment Wait Times * Provider Type / Wait Times for Urgent Appointments ** / Wait Times for Routine Appointments Primary Care Physician / Within 24 hours Within 10 business days - routine / Within 30 calendar days – routine follow-up Specialists / Within 24 hours / Within 30 calendar days – routine

	** NCQA allows the organization to determine urgent appointment wait time standard for PCP, however, requires BH urgent at 48 hours. 5. Demonstration of Comparability and Stringency in Operation: XXXXX has reviewed and evaluated operational data for its network adequacy and to permit a comparison member access to MH/SUD providers and M/S providers. The percentage of participants and beneficiaries who can access, within a specified time and distance by county-type designation, one (or more) in-network providers who are available to accept new patients for mental health and substance use disorder and medical/surgical provider categories. Network Providers Specialty — Percentage of Participants Who Can Access Network Providers Within Geoaccess Standards Who Are Accepting New Patients Psychiatrists — 99% Psychologists — 100% LCSWs — 100% The data above demonstrates XXXXX members have comparable access to MH/SUD and M/S providers within their area that are accepting new patients. XXXXX has also separately provided geographic availability for various services (e.g., urgent, routine, regular) among various types of MH/SUD and M/S. The geographic availability report demonstrates the metrics reviewed for the provider types and plans. The plans meet the established goals at 100% for the urban, suburban, and rural districts for both M/S and MH/SUD providers. XXXXX also provided the appointment access review. The appointment access information demonstrates provider responses to vendor questions regarding the ability to obtain an appointment. XXXXX changed survey vendors for 2024, and saw a change in some of the segment results. Overall, both M/S and MH/SUD providers saw declines in appointment access rates. MH/SUD providers responded more favorably for the “Urgent” and “Routine Follow-Up" categories. MH/SUD providers responded at a lower rate for “Routine, Initial” and “Routine, Regular” categories. XXXXX has attributed the declines to the change in vendor and style of the survey. Despite the lower levels for the two categories, these alone do not demonstrate the network adequacy or standards are being applied more stringently for MH/SUD providers or services. 6. Findings and Conclusions As noted above, Practitioner Availability and Accessibility processes are assessed annually based on objective criteria developed by the NCQA for accreditation, CMS, and state law. These standards dictate requirements for M/S and MH/SUD providers. XXXXX internal metrics for other factors such as provider open practices are applied uniformly to M/S and MH/SUD. The standard process and measurements used to evaluate networks results in both M/S and MH/SUD meeting or exceeding standards in almost all measurements, and MH/SUD meeting or exceeding M/S providers in almost every category for each state. When compared, the data demonstrates the network geographic access and appointment availability are comparable for MH/SUD and M/S providers. As noted above, a high and comparable amount of MH/SUD providers are accepting new patients, and the geographic availability shows both provider types meet XXXXX’s goals at 100%. Appointment access data did change for 2024. While three	Source: Accreditation standard guidance. * Some states use regulatory variations, i.e., CA, CO, CT, MO, NH and VA. ** NCQA allows the organization to determine urgent appointment wait time standard for PCP, however, requires BH urgent at 48 hours. 5. Demonstration of Comparability and Stringency in Operation: XXXXX has reviewed and evaluated operational data for its network adequacy and to permit a comparison member access to MH/SUD providers and M/S providers. The percentage of participants and beneficiaries who can access, within a specified time and distance by county-type designation, one (or more) in-network providers who are available to accept new patients for mental health and substance use disorder and medical/surgical provider categories. Network Providers Specialty — Percentage of Participants Who Can Access Network Providers Within Geoaccess Standards Who Are Accepting New Patients Cardiologists — 100% Internists MD — 96% Endocrinologists — 100% Gastroenterologists — 98% Neurologists — 99% Pediatricians — 98% Dermatologists — 97% Podiatrists — 100% Chiropractors — 99% Occupational Therapists — 100% Physical Therapists — 100% The data above demonstrates XXXXX members have comparable access to MH/SUD and M/S providers within their area that are accepting new patients. XXXXX has also separately provided geographic availability for various services (e.g., urgent, routine, regular) among various types of MH/SUD and M/S. The geographic availability report demonstrates the metrics reviewed for the provider types and plans. The plans meet the established goals at 100% for the urban, suburban, and rural districts for both M/S and MH/SUD providers. XXXXX also provided the appointment access review. The appointment access information demonstrates provider responses to vendor questions regarding the ability to obtain an appointment. XXXXX changed survey vendors for 2024, and saw a change in some of the segment results. Overall, both M/S and MH/SUD providers saw declines in appointment access rates. XXXXX has attributed the declines to the change in vendor and style of the survey. Despite the lower levels for the two categories, these alone do not demonstrate the network adequacy or standards are being applied more stringently for MH/SUD providers or services. 6. Findings and Conclusions

	types of MH/SUD performed lower than their M/S counterparts in two categories, they generally outperformed M/S providers in two others. After taking into account the change in survey, XXXXX believes the overall data demonstrates comparability between M/S and MH/SUD. PROVIDER REIMBURSEMENT 1. Identify the NQTL: Participating Provider Fee Schedule Rates (Connecticut) Overview: This nonquantitative treatment limitation analysis focuses on how XXXXX decides the amount to pay network providers for the services they provide to our members. This nonquantitative treatment limitation analysis focuses on how XXXXX develops the standard fee schedule used to reimburse network providers for the services they provide to our members. It is applicable to network providers serving members of XXXXX's commercial health insurance exchange products. The NQTL applies to all benefit classifications where services use participating providers including inpatient in-network (M/S and MH/SUD), outpatient in-network (M/S and MH/SUD), and emergency services. The NQTL details how the standard base fee schedule is developed and used for providers reimbursed using a fee for service methodology. Although other reimbursement methodologies may be used these are the product of two-party, negotiated arrangements and are not considered as part of this comparative analysis. Providers receive reimbursement related information in their provider contracts, fee schedules, the provider manual, and newsletters. Any fee schedule changes go through a specific notification process as detailed later in the analysis. 2. Identify the factors considered in the design of the NQTL: • Product • Provider setting – office, clinic, or facility • State statute • Competitiveness of our rates • Medicare reimbursement • Education and licensure level of provider • CPT/HCPC Code being billed • Frequency with which a provider type bills a small set of specific CPT codes almost exclusively (e.g., PCPs bill E&M codes) whereby establishing a separate fee schedule for that provider type is appropriate to provide adequate and competitive reimbursement (e.g. Chiropractic, Acupuncture, Registered Dieticians, PT/OT/ST) • For new CPT codes, evaluation of whether it is a replacement of a prior code, which we would crosswalk to the prior CPT reimbursement amount, or a new CPT code. If we determine it is a new code, fees are set based on Medicare reimbursement, and guidance from the Enterprise Health Care Economics team. The following factors are considered when reviewing and making changes to the fee schedule rates: • Compliance with State & Federal network adequacy laws and regulations • Ability to attract and maintain providers in our network • Optimize medical spend • Fluctuations in CMS physician fee schedule rates XXXXX weighs most heavily the requirements to comply with state and federal laws and the ability to attract and maintain providers in its network. All other factors are weighed equally.	As noted above, Practitioner Availability and Accessibility processes are assessed annually based on objective criteria developed by the NCQA for accreditation, CMS, and state law. These standards dictate requirements for M/S and MH/SUD providers. XXXXX internal metrics for other factors such as provider open practices are applied uniformly to M/S and MH/SUD. The standard process and measurements used to evaluate networks results in both M/S and MH/SUD meeting or exceeding standards in almost all measurements, and MH/SUD meeting or exceeding M/S providers in almost every category for each state. When compared, the data demonstrates the network geographic access and appointment availability are comparable for MH/SUD and M/S providers. As noted above, a high and comparable amount of MH/SUD providers are accepting new patients, and the geographic availability shows both provider types meet XXXXX's goals at 100%. Appointment access data did change for 2024. While three types of MH/SUD performed lower than their M/S counterparts in two categories, they generally outperformed M/S providers in two others. After taking into account the change in survey, XXXXX believes the overall data demonstrates comparability between M/S and MH/SUD. PROVIDER REIMBURSEMENT 1. Identify the NQTL: Participating Provider Fee Schedule Rates (Connecticut) Overview: This nonquantitative treatment limitation analysis focuses on how XXXXX decides the amount to pay network providers for the services they provide to our members. This nonquantitative treatment limitation analysis focuses on how XXXXX develops the standard fee schedule used to reimburse network providers for the services they provide to our members. It is applicable to network providers serving members of XXXXX's commercial health insurance exchange products. The NQTL applies to all benefit classifications where services use participating providers including inpatient in-network (M/S and MH/SUD), outpatient in-network (M/S and MH/SUD), and emergency services. The NQTL details how the standard base fee schedule is developed and used for providers reimbursed using a fee for service methodology. Although other reimbursement methodologies may be used these are the product of two-party, negotiated arrangements and are not considered as part of this comparative analysis. Providers receive reimbursement related information in their provider contracts, fee schedules, the provider manual, and newsletters. Any fee schedule changes go through a specific notification process as detailed later in the analysis. 2. Identify the factors considered in the design of the NQTL: • Product • Provider setting – office, clinic, or facility • State statute • Competitiveness of our rates • Medicare reimbursement • Education and licensure level of provider • CPT/HCPC Code being billed • Frequency with which a provider type bills a small set of specific CPT codes almost exclusively (e.g., PCPs bill E&M codes) whereby establishing a separate fee schedule for that provider type is appropriate to provide adequate and competitive reimbursement (e.g. Chiropractic, Acupuncture, Registered Dieticians, PT/OT/ST) • For new CPT codes, evaluation of whether it is a replacement of a prior code, which we would crosswalk to the prior CPT reimbursement amount, or a new CPT code. If we determine

	3. Provide the evidentiary standards used for the factors identified in Step 3, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits: • Product: This refers to the type of product applicable and sold in the market (e.g., PPO, HMO, indemnity, etc.). • Provider Setting: XXXXX, consistent with Medicare, considers the provider's setting when determining the applicable reimbursement rate. The setting where the service is provided will ultimately determine if adjustments are made to the rate to consider costs associated with staff, supplies, and building maintenance. • Competitiveness of our rates – XXXXX considers whether providers of a particular type are willing to contract with us at the standard rate. In performing this review, XXXXX reviews internal feedback and complaints received from providers regarding the fee schedule reimbursement rates. XXXXX may also review publicly available transparency files to determine whether rates are competitive. There is no specific standard on how many complaints or feedback received will generate an adjustment to the fee schedule. • Medicare reimbursement - The Centers for Medicare and Medicaid Services (CMS) annually publishes the relative value unit (RVU) file through the Federal Register, which above all other factors provides a measurable standard against which XXXXX and providers can compare rates. It is a calculation to determine the value of each healthcare service organized by CPT/HCPCS code. It is produced by CMS taking into account factors such as the time and intensity of the physician's work for a particular service (work RVU), the cost of practice expenses, supplies, and office space (practice expense RVU), and the cost of malpractice insurance (malpractice RVU). RVUs are used to value a particular service against all other services. • https://www.cms.gov/medicare/physician-fee-schedule/search/overview • Education and licensure of provider - XXXXX considers the education, training, and license level of the provider in determining the applicable reimbursement rate. In general, education, training, and license level indicate the differences in time, effort, sacrifice a provider has undertaken to achieve the respective level, as well as, the complexity of the services provided, and the overall number of providers capable of performing such services. XXXXX's standard, consistent with CMS, sets rates for providers who have achieved the MD/DO level as the baseline, with non-physician practitioner adjustments for those non-MD/DO level providers (PhD., ARPNs, Masters, Bachelors, Associates, HS). • CPT/HCPCS Code being billed - CPT/HCPCS Codes determine the level of service, complexity, and duration provided. The codes and their grouping (similar services are grouped together) are considered in reimbursement rate decisions. The American Medical Association's CPT and CMS' HCPCS code listings are used in the development and adjustment of reimbursement rates. These listings and groupings of similar codes will inform rate development for new codes and any codes not subject to Medicare reimbursement. 4. Demonstration of Comparability and Stringency As Written: Annually, a reimbursement committee meets to review reimbursement rates under the various fee schedules. The reimbursement committee consists of Regional Vice President of Provider Solutions CT, Director Network Management CT, and Cost of Care Analyst Senior. The larger team of Network Management Associates also provides input once data is generated and makes recommendation to the reimbursement committee.	it is a new code, fees are set based on Medicare reimbursement, and guidance from the Enterprise Health Care Economics team. The following factors are considered when reviewing and making changes to the fee schedule rates: • Compliance with State & Federal network adequacy laws and regulations • Ability to attract and maintain providers in our network • Optimize medical spend • Fluctuations in CMS physician fee schedule rates XXXXX weighs most heavily the requirements to comply with state and federal laws and the ability to attract and maintain providers in its network. All other factors are weighed equally. 3. Provide the evidentiary standards used for the factors identified in Step 3, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits: • Product: This refers to the type of product applicable and sold in the market (e.g., PPO, HMO, indemnity, etc.). • Provider Setting: XXXXX, consistent with Medicare, considers the provider's setting when determining the applicable reimbursement rate. The setting where the service is provided will ultimately determine if adjustments are made to the rate to consider costs associated with staff, supplies, and building maintenance. • Competitiveness of our rates – XXXXX considers whether providers of a particular type are willing to contract with us at the standard rate. In performing this review, XXXXX reviews internal feedback and complaints received from providers regarding the fee schedule reimbursement rates. XXXXX may also review publicly available transparency files to determine whether rates are competitive. There is no specific standard on how many complaints or feedback received will generate an adjustment to the fee schedule. • Medicare reimbursement - The Centers for Medicare and Medicaid Services (CMS) annually publishes the relative value unit (RVU) file through the Federal Register, which above all other factors provides a measurable standard against which XXXXX and providers can compare rates. It is a calculation to determine the value of each healthcare service organized by CPT/HCPCS code. It is produced by CMS taking into account factors such as the time and intensity of the physician's work for a particular service (work RVU), the cost of practice expenses, supplies, and office space (practice expense RVU), and the cost of malpractice insurance (malpractice RVU). RVUs are used to value a particular service against all other services. • https://www.cms.gov/medicare/physician-fee-schedule/search/overview • Education and licensure of provider - XXXXX considers the education, training, and license level of the provider in determining the applicable reimbursement rate. In general, education, training, and license level indicate the differences in time, effort, sacrifice a provider has undertaken to achieve the respective level, as well as, the complexity of the services provided, and the overall number of providers capable of performing such services. XXXXX's standard, consistent with CMS, sets rates for providers who have achieved the MD/DO level as the baseline, with non-physician practitioner adjustments for those non-MD/DO level providers (PhD., ARPNs, Masters, Bachelors, Associates, HS). • CPT/HCPCS Code being billed - CPT/HCPCS Codes determine the level of service, complexity, and duration provided. The codes and their grouping (similar services are grouped together) are considered in reimbursement rate decisions. The American Medical Association's

	Data used to review rates is generally the most current twelve months of utilization . Review occurs at the type of service, specialty and geographic locations. New codes developed by CPT are reviewed and added to the correct type of service category based on recommendations from XXXXX Enterprise coders. The team reviews the CMS RVU changes relative to the specialty and type of service. All changes recommended by the team are reviewed by the reimbursement committee prior to implementation. Letters are mailed giving the required 90 days' advance written notice to impacted contracted providers. Directions to review the fee schedule samples are provided in the letter. Connecticut has a law that only permits fee schedules to be modified once a year. Providers who are not medical doctors receive compensation based on a certain percentage of the relevant fee schedule. This percentage is determined by factors such as their educational background, level of licensure, and the payment methods set forth by Medicare/Medicaid. XXXXX applies the same processes, strategies and evidentiary standards uniformly to create the rates for both mental health/substance use disorder and medical/surgical services. XXXXX's practices with respect to reimbursement rates are consistent with existing guidance regarding this NQTL. See FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 39, Q. 6-7. XXXXX does not apply "step-downs" on reimbursement rates for non-MDs more stringently to mental health/substance use disorder providers. XXXXX also takes comparable steps to ensure the adequacy of its network of mental health/substance use disorder providers, as reflected by its strong network of mental health/substance use disorder providers, which continues to expand and grow and meets all state and industry standards. 5. Demonstration of Comparability and Stringency In Operation: Providers who are not medical doctors receive compensation based on a certain percentage of the relevant fee schedule. This percentage is determined by factors such as their educational background, level of licensure, and the payment methods set forth by Medicare/Medicaid. Additionally, XXXXX has attached a spreadsheet providing a comparison of the standard fee schedule rates as of October 2024. The rate data was pulled on December 18, 2024 by a Business Change Manager in our Connecticut Provider Solutions team. The rate data provides a comparison of CPT Codes, standard fee schedule rates, and a comparison to a Medicare benchmark for various M/S and MH/SUD providers as directed by the DOL Self-Compliance Tool. Psychiatrists and MD level M/S providers receive the same reimbursement rate on the standard fee schedule. Non-MD MH/SUD providers generally receive a more favorable reimbursement rate for comparable codes. For example, psychologists receive 100% of the Medicare rate while other M/S therapists receive between 59%- 64.9% (physical therapists, occupational therapists). LCSWs also receive a higher rate and percentage of Medicare when compared to these M/S therapists. Overall, these rates for MD and Non-MD level providers indicate XXXXX is applying a comparable process to determine reimbursement rates for MH/SUD and M/S providers. Provider Type — Percentage of MD Behavioral Health Rate Behavioral Health Masters Level Provider — 75% Behavioral Health PHD Psychologists — 100%	CPT and CMS' HCPCS code listings are used in the development and adjustment of reimbursement rates. These listings and groupings of similar codes will inform rate development for new codes and any codes not subject to Medicare reimbursement. 4. Demonstration of Comparability and Stringency As Written: Annually, a reimbursement committee meets to review reimbursement rates under the various fee schedules. The reimbursement committee consists of Regional Vice President of Provider Solutions CT, Director Network Management CT, and Cost of Care Analyst Senior. The larger team of Network Management Associates also provides input once data is generated and makes recommendation to the reimbursement committee. Data used to review rates is generally the most current twelve months of utilization . Review occurs at the type of service, specialty and geographic locations. New codes developed by CPT are reviewed and added to the correct type of service category based on recommendations from XXXXX Enterprise coders. The team reviews the CMS RVU changes relative to the specialty and type of service. All changes recommended by the team are reviewed by the reimbursement committee prior to implementation. Letters are mailed giving the required 90 days' advance written notice to impacted contracted providers. Directions to review the fee schedule samples are provided in the letter. 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The rate data provides a comparison of CPT Codes, standard fee schedule rates, and a comparison to a Medicare benchmark for various M/S and MH/SUD providers as directed by the DOL Self-Compliance Tool. Psychiatrists and MD level M/S providers receive the same reimbursement rate on the standard fee schedule. Non-MD MH/SUD providers generally receive a more favorable reimbursement rate for comparable codes. For example, psychologists receive 100% of the Medicare rate while other M/S therapists receive between 59%- 64.9% (physical therapists,

	Behavioral Health APRN 85% BH MD (Psychiatrists) 100% Child Psychiatrists MD 110% 6. Findings and Conclusions MHPAEA does not require plans to pay the same reimbursement rates for medical/surgical and MH/SUD services. MHPAEA does not mandate equality of outcomes. See, e.g., James C. v. XXXXX Blue Cross Blue Shield, 2021 U.S. Dist. LEXIS 115701, *59 (D. Utah June 21, 2021). This principle applies to reimbursement rates. “MHPAEA does not require a plan or issuer to pay identical provider reimbursement rates for medical/surgical and MH/SUD providers[.]” FAQS ABOUT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION AND THE 21ST CENTURY CURES ACT PART 39 (September 5, 2019), Q6., at 10. In order to determine whether a plan complies with the NQTL requirements under MHPAEA, one must examine whether “the [plan’s] methodology for developing and applying reimbursement rates under the plan is comparable and applied no more stringently for MH/SUD benefits when compared to the methodology for developing and applying reimbursement rates for medical/surgical benefits under the plan.” Id. at 9. XXXXX’s strategy with respect to setting reimbursement rates is the same for both medical/surgical and MH/SUD services – set reimbursement rates high enough to guarantee an adequate network, but not so high that they negatively impact XXXXX’s members and unnecessarily increase the cost of care. In this instance, XXXXX uses the same factors to develop its standard fee schedules for M/S and MH/SUD providers. The operational data confirms the process is applied comparably and no more stringently for MH/SUD providers as they receive comparable or more favorable rates for similar codes. Therefore, XXXXX has concluded it is within the requirements of MHPAEA and applies the rate design and application process comparably between MH/SUD and M/S providers.	occupational therapists). LCSWs also receive a higher rate and percentage of Medicare when compared to these M/S therapists. Overall, these rates for MD and Non-MD level providers indicate XXXXX is applying a comparable process to determine reimbursement rates for MH/SUD and M/S providers. Provider Type — Percentage of MD Behavioral Health Rate Physician Assistant 85% Medical 100% APRN 85% Nurse Practitioner 85% Midwives 85% 6. Findings and Conclusions MHPAEA does not require plans to pay the same reimbursement rates for medical/surgical and MH/SUD services. MHPAEA does not mandate equality of outcomes. See, e.g., James C. v. XXXXX Blue Cross Blue Shield, 2021 U.S. Dist. LEXIS 115701, *59 (D. Utah June 21, 2021). This principle applies to reimbursement rates. “MHPAEA does not require a plan or issuer to pay identical provider reimbursement rates for medical/surgical and MH/SUD providers[.]” FAQS ABOUT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION AND THE 21ST CENTURY CURES ACT PART 39 (September 5, 2019), Q6., at 10. In order to determine whether a plan complies with the NQTL requirements under MHPAEA, one must examine whether “the [plan’s] methodology for developing and applying reimbursement rates under the plan is comparable and applied no more stringently for MH/SUD benefits when compared to the methodology for developing and applying reimbursement rates for medical/surgical benefits under the plan.” Id. at 9. XXXXX’s strategy with respect to setting reimbursement rates is the same for both medical/surgical and MH/SUD services – set reimbursement rates high enough to guarantee an adequate network, but not so high that they negatively impact XXXXX’s members and unnecessarily increase the cost of care. In this instance, XXXXX uses the same factors to develop its standard fee schedules for M/S and MH/SUD providers. The operational data confirms the process is applied comparably and no more stringently for MH/SUD providers as they receive comparable or more favorable rates for similar codes. Therefore, XXXXX has concluded it is within the requirements of MHPAEA and applies the rate design and application process comparably between MH/SUD and M/S providers.
(STEP-5): *A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.*	The company did not identify any areas of concern with respect to its NQTL analysis. As noted above, we do have one area of disparity within the source of the medical policies used to review cases for medical necessity. The company is required by law to use ASAM for medical necessity reviews, so that disparity is compliant with MHPAEA. Therefore, the company is compliant with respect to the above NQTLs.	

Exhibit A (4)

Annual Mental Health and Substance Use Benefits Compliance Report

Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:

Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (13) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	*Medical/Surgical Benefits*
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of medical necessity criteria between medical/surgical and MH/SUD (while different medical necessity tools may be used; for example, LOCUS and Milliman, they're both nationally recognized tools for developing medical necessity criteria for the treatment of MH/SUD and Medical/Surgical benefits). Plan Terms and/or Description of NQTL: According to the standard language of XXXXX's benefit plans, "medically necessary" or "medical necessity" means: "Health care services or supplies that prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms, and that are all of the following, as determined by us within our 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 your illness, injury or disease • Not primarily for your convenience, the convenience of your [physician], or other health care [provider] • Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury or disease 'Generally accepted standards of medical practice' mean: • Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and • Following the standards set forth in our clinical policies and applying clinical judgment" These elements are incorporated into the following guidelines utilized by XXXXX's clinicians in making medical necessity determinations: • XXXXX® Clinical Policy Bulletins (www.XXXXX.com/health-care-professionals/clinical-policy-bulletins.html) • MCG Health care guidelines® (www.mcg.com/care-guidelines/care-guidelines/) • National Comprehensive Cancer Network treatment guidelines (www.nccn.org/guidelines/category_1) • American Society of Addiction Medicine (ASAM) Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd Edition (www.XXXXX.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html) • XXXXX's Applied Behavioral Analysis (ABA) Medical Necessity Guide (www.XXXXX.com/health-care-professionals/patient-care-programs/locat-aba□guidelines.html) • Level of Care Utilization System for Psychiatric and Addictive Services (LOCUS) (www.XXXXX.com/health-care-professionals/patient-care□programs/locat-aba-guidelines.html)	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences in the application, as written and in operation, of medical necessity criteria between medical/surgical and MH/SUD (while different medical necessity tools may be used; for example, LOCUS and Milliman, they're both nationally recognized tools for developing medical necessity criteria for the treatment of MH/SUD and medical/surgical benefits).

	• Child Adolescent Level of Care Utilization System for Psychiatric and Addictive Services/ Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) (www.XXXXX.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html) Fully insured plans in a state that mandates a different definition of medical necessity are administered in accordance with the state's requirements. M/S services NQTL applies to: All inpatient, outpatient, and emergency care services MH/SUD services NQTL applies to: All inpatient, outpatient, and emergency care services Factors used in designing the NQTL: XXXXX's Clinical Policy Council (CPC) follows a standard process to develop and/or approve medical necessity criteria for MH/SUD and M/S services. As detailed in the XXXXX Clinical Policy Council Charter, the factors the CPC considers are: • The technology must have final approval from the appropriate governmental regulatory bodies. • The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. • The technology must improve the net health outcome. • The technology must be as beneficial as any established alternatives. • The improvement must be attainable outside the investigational settings. No formula is used for weighting these factors. CPC members apply their clinical training and expertise in evaluating them Sources: Processes, strategies and/or evidentiary standards used to design and apply the NQTL Strategy: Medical necessity determinations rely upon the clinical reviewers' exercise of their clinical judgment based on their training and experience, guided by clinical criteria adopted by the Clinical Policy Council, and informed by the member's clinical presentation, to determine whether to authorize coverage. Sources and Evidentiary Standards: • Evidence in the peer-reviewed published medical literature • Evidence-based consensus statements • Expert opinions of healthcare providers • Evidence-based guidelines from nationally recognized professional healthcare organizations and public health agencies • Technology assessments and structured evidence reviews • Clinical training, experience and judgment of XXXXX's clinical reviewers Process: XXXXX's Chief Medical Officer (CMO) and by delegation, the Vice President for Clinical Policy, is charged with whether medical services, drugs and devices are considered experimental, cosmetic, or medically necessary. The XXXXX Clinical Policy Council provides guidance and advice to the CMO or designee on specific clinical topics under review for coverage (see XXXXX Clinical Policy Council Charter). The voting members of the CPC are pharmacists and medical directors from the Medical Policy and Operations (MPO) department, National Accounts department, Behavioral Health department, Clinical	

	Pharmacy department and regional Patient Management units (see the Appendix to UM NQTLs for the complete XXXXX Clinical Policy Council composition). The CPC applies the factors, sources and evidentiary standards identified above to develop (in the case of XXXXX® Clinical Policy Bulletins) or approve (in the case of clinical guidelines published by third parties) evidence-based guidelines that are used by XXXXX's clinicians to evaluate the medical necessity of a service, drug or device. The CPC has approved the Clinical Policy Bulletins to be used by XXXXX's clinicians in making medical necessity determinations: XXXXX® Clinical Policy Bulletins (CPBs) (MH/SUD and M/S) XXXXX CPBs are developed and approved by the CPC based on the factors, sources and evidentiary standards listed above. Both new and revised CPBs undergo a comprehensive review process entailing review by the CPC and external practicing clinicians, and approval by XXXXX's Chief Medical Officer or designee. In developing a CPB, for each technology selected for evaluation the CPC conducts a comprehensive search of the peer-reviewed published medical literature indexed in the National Library of Medicine PubMed Database, assesses the regulatory status of the technology, reviews relevant evidence-based clinical practice guidelines and related documents indexed in the Agency for Healthcare Research and Quality (AHRQ) National Guideline Clearinghouse Database, and reviews relevant technology assessments indexed in the National Library of Medicine's Health Services/Technology Assessment Text (HSTAT) Database. The opinions of relevant experts are obtained where that would be informative. Once approved, new or revised CPBs are published on XXXXX's public websites within 60 days. CPBs are reviewed annually unless relevant new medical literature, guidelines, regulatory actions, or other information warrants more frequent review. Each time a CPB is updated, a comprehensive search of the peer-reviewed published medical literature is performed to determine if there is a change in the experimental and investigational status or medical necessity of the technology. If the CPC determines that new evidence or other information has emerged to warrant consideration of a change in our clinical policy, a revised CPB is prepared. If no new evidence has emerged that would warrant a change in position, the CPB may be updated with additional supporting background information and references. Each revised and updated CPB is submitted to the CPC for review and approval. MCG Health Care Guidelines® (M/S) XXXXX uses the most current evidence-based care guidelines published by MCG Health to guide clinicians in making medically necessary level of care determinations for M/S services. The decision to use MCG was made in 2002. ASAM (MH/SUD) XXXXX uses the criteria published by the American Society of Addiction Medicine (ASAM), 3rd Edition, to guide clinicians in evaluating the medical necessity of levels and types of care for substance use disorders. ASAM criteria are generally accepted, national standards for SUD treatment decisions and are recognized as such by many courts and regulators. XXXXX has been using ASAM criteria for over 20 years. Some states, notably New York and New	

	Jersey, require state-specific SUD level of care criteria. In those states, XXXXX uses the criteria required by law. LOCUS and CALOCUS/CASII (MH/SUD) XXXXX uses the most current versions of LOCUS and CALOCUS/CASII, which are recognized nationally as a generally accepted standard of care tool, to guide clinicians in making medically necessary level of care determinations for mental health services. The Level of Care Utilization System (LOCUS) assessment was developed by the American Association of Community Psychiatrists (AACP) in 1996 to help determine the mental health care resource intensity needs of adults. CALOCUS was developed by the American Association of Community Psychiatrists in collaboration with the American Association of Child and Adolescent Psychiatry to help determine the mental health care resource intensity needs of children and adolescents. The decision to adopt LOCUS and CALOCUS was made in 2021 by XXXXX's Chief Psychiatric Officer, in consultation with Behavioral Health (BH) Senior Medical Director (MD) and other members of the BH Clinical Operations leadership team, after consideration of other tools. XXXXX's National Quality Advisory Committee (NQAC - a committee that includes external members and participating providers) and National Quality Oversight Committee (NQOC) approved the decision. Comparability and Stringency Analysis: Show if the processes, strategies, evidentiary standards and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation As Written: XXXXX applies the same strategy, Certificate of Coverage definition of "medical necessity", and factors/sources/process to determine medical necessity for both MH/SUD and M/S services. The XXXXX Clinical Policy Bulletins and third-party clinical guidelines used by clinicians to make MH/SUD and M/S medical necessity determinations are developed and adopted by the same Clinical Policy Council pursuant to its written charter. This satisfies the as-written comparability and stringency tests. In Operation: Reviewing denial rates for precertification, concurrent review and retrospective review decisions provides a way to compare how XXXXX determines medical necessity for MH/SUD and M/S services in operation. Denial Rates for MH/SUD and M/S medical necessity reviews: We examined the medical necessity denials for in-network and out-of-network services subject to precertification, concurrent review or retrospective review for XXXXX's national, fully insured book of business in 2022. This analysis concluded that determinations made on the basis of medical necessity are performed comparably, and not more stringently, on MH/SUD services compared to M/S services. Data is available upon request. Summary of Conclusions: The factors and sources used to determine medical necessity are comparable, and not more stringent, for MH/SUD benefits both in writing and in operation. Referenced Policies and Documents: • XXXXX Clinical Policy Council Composition (see Appendix to UM NQTLs)	

	• XXXXX Clinical Policy Council Charter • XXXXX® Clinical Policy Bulletins (www.XXXXX.com/health-care-professionals/clinical-policy-bulletins.html) • MCG Health care guidelines® (www.mcg.com/care-guidelines/care-guidelines/) • National Comprehensive Cancer Network treatment guidelines (www.nccn.org/guidelines/category_1) • American Society of Addiction Medicine (ASAM) Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition (www.XXXXX.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html) • XXXXX's Applied Behavioral Analysis (ABA) Medical Necessity Guide (www.XXXXX.com/health-care-professionals/patient-care-programs/locat-aba□guidelines.html) • Level of Care Utilization System for Psychiatric and Addictive Services (LOCUS) (www.XXXXX.com/health-care-professionals/patient-care□programs/locat-aba-guidelines.html) • Child Adolescent Level of Care Utilization System for Psychiatric and Addictive Services/ Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) (www.XXXXX.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html) • UM Denial & TAT_2023_FI_Final.xlsx Form language: COC: Medically necessary, medical necessity The medical necessity requirements are in the Glossary section, where we define "medically necessary, medical necessity." That is where we also explain what our medical directors or a physician they assign consider when determining if a service is medically necessary. Important note: We cover medically necessary, sex-specific covered services regardless of identified gender. Medically necessary, medical necessity Health care services or supplies that prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms, and that are all of the following, as determined by us within our 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 your illness, injury or disease • Not primarily for your convenience, the convenience of your [physician], or other health care [provider] • Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury or disease 'Generally accepted standards of medical practice' mean: • Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and • Following the standards set forth in our clinical policies and applying clinical judgment" Important note: We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is experimental or investigational. They are subject to change. You can find these bulletins and other information at https://www.XXXXX.com/health-care-professionals/clinical-policy-bulletins.html. You can also contact us. See the Contact us section for how. SOB: No reference	

In-Patient & In-Network NQTL Practices	The description in column A reflects a benefit classification, as such NQTLs that apply to this benefit classification are: Prior Authorization/Precertification, Concurrent Review, Retrospective Review, Medical Necessity Criteria, Sequenced Treatment, Participating Provider Reimbursement, Participating Facility Reimbursement, Network Adequacy, and Provider Admission Standards - Credentialing. There are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.
In-Patient & Out-of-Network NQTL Practices	The description in column A reflects a benefit classification, as such NQTLs that apply to this benefit classification are: Prior Authorization/Precertification, Concurrent Review, Retrospective Review, Medical Necessity Criteria, Sequenced Treatment, Non-Participating Provider Reimbursement There are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.
Out-Patient & In-Network NQTL Practices	The description in column A reflects a benefit classification which the Plan subclassifies as Outpatient-Office Visit and Outpatient-All Other. NQTLs that apply to the Outpatient-Office Visit benefit classification are: Medical Necessity Criteria, Participating Provider Reimbursement, Participating Facility Reimbursement, Network Adequacy, and Provider Admission Standards - Credentialing. NQTLs that apply to the Outpatient-All Other Benefit classification are: Prior Authorization/Precertification, Concurrent Review, Retrospective Review, Medical Necessity Criteria, Sequenced Treatment, Treatment Plan Requirement, Participating Provider Reimbursement, Participating Facility Reimbursement, Network Adequacy, and Provider Admission Standards - Credentialing. There are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.
Out-Patient & Out-of-Network NQTL Practices	The description in column A reflects a benefit classification which the Plan subclassifies as Outpatient-Office Visit and Outpatient-All Other. NQTLs that apply to the Outpatient-Office Visit benefit classification are: Medical Necessity Criteria and Non-Participating Provider Reimbursement. NQTLs that apply to the Outpatient-All Other Benefit classification are: Prior Authorization/Precertification, Concurrent Review, Retrospective Review, Medical Necessity Criteria, Sequenced Treatment, Treatment Plan Requirement and Non-Participating Provider Reimbursement. There are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.
Emergency Services/Benefits NQTL Practices	The description in column A reflects a benefit classification, as such NQTLs that apply to this benefit classification are: Prior authorization/Precertification, Retrospective Review, Medical Necessity Criteria, Participating Provider Reimbursement, Participating Facility Reimbursement, Non-Participating Provider Reimbursement, Network Adequacy, and Provider Admission Standards - Credentialing There are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.
Rx Formulary Design, Management and Pharmacy Services NQTL Practices	The practices to apply limits to Rx Formulary Design, Management and Pharmacy Services they are not different for Mental Health & Substance Use Disorder Benefits when compared to Medical/Surgical Benefits. A comprehensive report Non-Quantitative Treatment Limits for Rx Formulary Design, Management and Pharmacy Services is available upon request.	See the Mental Health & Substance Use Disorder Benefit response. The same factors are considered, evidentiary standards used to apply the factors, processes in the development, and implementation strategies, applied to drugs used in MH/SUD conditions as for drugs used in medical/surgical conditions.
Prior-Authorization NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of prior authorization - in-network NQTL practices between medical/surgical and MH/SUD. Plan Terms and/or Description of NQTL: Precertification is a utilization review service performed by licensed healthcare professionals before inpatient admissions, select ambulatory procedures and	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences in the application, as written and in operation, of medical necessity criteria between medical/surgical and MH/SUD (while different medical necessity tools may be used; for example, LOCUS and Milliman, they're both nationally

	outpatient services under the Outpatient-All Other classification, to determine medical necessity and appropriateness of treatment. The member's certificate of coverage identifies whether precertification is required and what the consequences are of failing to obtain precertification. For in-network benefits, precertification applies to: • Services on the XXXXX Participating Provider Precertification List, • Services on the XXXXX Behavioral Health Precertification List, and • Services that require precertification under the terms of the member's plan (typically applicable to self-insured plans). It is the participating provider's responsibility to seek precertification. The XXXXX Participating Provider Precertification List and XXXXX Behavioral Health Precertification List are referred to collectively as the National Precertification List (NPL). The NPL in effect as of the date of this document is included in the Appendix to UM NQTLs. It is subject to change. The most current version is publicly available at www.XXXXX.com/health-care-professionals/precertification/precertification-lists.html. For out-of-network benefits, precertification applies to the services listed in the member's certificate of coverage, referred to in this document as the Member Precertification List (MPL). It is the member's responsibility to seek precertification. In-Network Services Subject to Precertification Medical/Surgical (M/S) services NQTL applies to: INN Inpatient: All inpatient admissions including hospital at home, skilled nursing facilities and rehabilitation facilities (except hospice and maternity/newborn stays within the standard length of stay) INN Outpatient-All Other: Too numerous to list -- see the Participating Provider Precertification List at the Appendix to UM NQTLs Mental Health and Substance Use Disorder (MH/SUD) services NQTL applies to: INN Inpatient: All inpatient admissions including residential treatment facilities INN Outpatient-All Other: • Applied Behavioral Analysis (ABA) for Autism Spectrum Disorder • Transcranial Magnetic Stimulation • Partial Hospitalization (PHP) • Gender Affirmation Surgery (These are also listed in the Appendix to UM NQTLs) Factors: Factors used in designing the NQTL Factors for Adding a Service to the NPL: All services must meet one or more of the following three criteria to be added to the NPL:	recognized tools for developing medical necessity criteria for the treatment of MH/SUD and medical/surgical benefits).

	a. Cost – Cost of treatment is satisfied when the average paid Medicare rate is at least $150 for the service being considered (based on XXXXX's national paid Medicare claims experience) b. High cost growth (projected or actual) – Whether, based on internal XXXXX claims data, the per member per month expense for the services increased more than 10% in the most recent two-year period compared to an initial year baseline. (For example, if the 2020 per member per month (PMPM)=$1.00, the 2021 PMPM=$2.00, and the 2022 PMPM=$3.00, then that would be a 200% trend increase over the two-year period. This is calculated by subtracting the 2020 PMPM from the 2022 PMPM and then dividing by the 2020 PMPM.) c. Variability in cost and practice – Internal claims data demonstrates that there is greater than three-fold variability in cost per unit, overall length of treatment, or overall number of services per treatment for the procedure, service, device, or therapy in the most recent 12-month period In addition, a forecasted ROI of at least 3:1 is expected. ROI refers to health care cost expense savings related to denials of non-medically necessary care divided by administrative costs. There are two variables in the ROI calculation: (i) gross dollar amount of claims costs saved through appropriate denials of coverage for that service, and (ii) gross dollar amount of costs to administer precertification for that service. ROI is calculated by dividing (i) by (ii). The 3:1 ROI threshold has been utilized by XXXXX for many years to assess whether potential cost-containment initiatives warrant implementing and is deemed appropriate for purposes of adding, retaining or removing services, drugs and devices on the NPL. A service may be added to the NPL if it does not have a forecasted ROI of at least 3:1 but one or more of the three criteria above are met. Extenuating Factors: The NPL Committee may add a service that does not meet the above criteria, based on the following Extenuating Factors: • Patient safety - considers whether precertification can minimize potential harm to a member, particularly for life changing procedures that are irreversible post-surgery. • Clinical quality control - refers to ensuring a provider and proposed treatment are qualified and appropriate so that the possibility of adverse outcomes is reduced. • Marked variation in provider utilization patterns - refers to there being a significant range providers' utilization of the service, drug or device, suggesting that some of the utilization may be unnecessary. • Incorrect utilization - refers to the potential that a given service, drug or device is not appropriate for the member's condition. • Application of Clinical Policy Bulletin (CPB) requirements - refers to the opportunity to make determinations required under XXXXX's CPBs and other clinical policies pertaining to the experimental/investigational nature of a service, appropriate use of new/changing technology, step therapy, or site of service. • Standards of industry practice - refers to what other health insurers and administrators have decided to be appropriate in terms of precertification.	

	There are no fixed quantitative standards for the above factors; rather, they are evaluated in comparison to other services in the same benefit classification. Factors for Retaining a Service on the NPL: • ROI 3:1 or greater – retain • ROI 2 to 2.9:1 – consider Extenuating Factors • ROI </= 1.9:1 and not integral to NPL Group/Category (example, breast reduction code may independently have a low ROI, but it is part of a procedure group for which precertification is required) – consider Extenuating Factors While ROI is the primary factor in deciding whether to retain a service on the NPL, it is not an absolute determinant. The NPL Committee may also consider the factors for adding a service to the NPL and/or any Extenuating Factors. There are no fixed quantitative standards for the factors; rather, they are evaluated in comparison to other services in the same benefit classification. Sources: Processes, strategies and/or evidentiary standards used to design and apply the NQTL Process for Developing the National Precertification List (NPL): The NPL is used by participating providers to identify which MH/SUD and M/S services require precertification for INN coverage. The NPL Committee is responsible for determining which services to add, retain or remove from the NPL. It comprises clinicians and other subject matter experts representing both MH/SUD and M/S expertise. See Appendix to UM NQTLs for the NPL Committee composition. Proposed additions or changes to the NPL are submitted to the NPL Committee. The Committee considers the factors listed above and decides whether to add or remove the service. Also, the Committee annually reviews services on the NPL to decide whether to retain or remove them. Any factors and Extenuating Factors relied upon in making the decision must be documented; this allows for validation that they are being applied comparably, and not more stringently, to MH/SUD services. The process is comprehensively described in the NPL Committee Policy & Procedure. Evidentiary Standards for Developing the NPL: • Medicare rates • Internal claims database analysis • Internal analysis of administrative costs • Clinical guidelines and standards of practice. (These depend on the service under consideration and would include, by way of example, the most currently available versions of CMS Coverage Determinations and Medicare Benefit Policy Manual, MCG Health guidelines, National Comprehensive Cancer Network (NCCN) guidelines, American Society of Addiction Medicine (ASAM) Criteria, CALOCUS/LOCUS guidelines, and XXXXX Clinical Policy Bulletins.) Process and Standards for Performing Precertification: XXXXX's processes for precertifying services that are on the NPL are designed in accordance with National Committee for Quality Assurance (NCQA) utilization management standards for Health Plan Accreditation and Managed Behavioral Health Organization accreditation, and applicable state and federal law. In brief, precertification requests and supporting documentation are reviewed by clinical support staff who are not licensed health care providers. They can make coverage	

	approvals that do not require clinical review, and administrative denials (due to member's lack of eligibility or benefit plan exclusions, for example). Coverage decisions that require clinical review are performed by licensed clinicians who are Registered Nurses (RNs), licensed clinical social workers (LSCWs) or physicians. If a licensed clinician is unable to approve coverage, the clinician refers the request to a Medical Director who is a physician or to a consulting psychiatrist/ psychologist/ board certified behavior analyst-doctoral (BCBA-D) for further review and action. Consulting psychiatrists/psychologists/BCBA-D use the available clinical information to approve a coverage request or, when unable to approve, make a level of care or service recommendation and forward the recommendation to the Medical Director or the designated psychologist/BCBA-D for issuance of the coverage determination. The licensed clinician or Medical Director draws upon his or her training and expertise in applying the applicable clinical review criteria to the request. (See XXXXX's Medical Necessity NQTL Comparative Analysis for more information about clinical review criteria.) The precertification determination is made and communicated to the provider/member according to the established timeframes for urgent or non-urgent requests. In some circumstances the treating provider may have a peer-to-peer consultation with a physician. These processes are described in detail in these XXXXX National Clinical Services policies and procedures: • NCS 100 Precertification Policy & Procedure • NCS 503 Medical Review Policy & Procedure • NCS 504 Timeliness Standards for Coverage Decisions and Notification Policy • NCS 505 Denial of Coverage Policy and Notification • NCS 506 Peer-to-Peer Review Policy • NCS 510 Internal Quality Review Policy Comparability and Stringency Analysis: Show if the processes, strategies, evidentiary standards and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation. As Written: The same factors and sources, and the same National Precertification List Policy and Procedure, apply to MH/SUD and M/S benefits in deciding which services to add to, retain or remove from the National Precertification list. The same factors and sources, and the same National Clinical Services Policies and Procedures, apply to handling precertification requests for MH/SUD and M/S benefits. Thus, as written this NQTL is applied comparably, and not more stringently, to MH/SUD benefits. In Operation: The following measures are used to assess comparability and stringency: Evaluation of determinations adding to or removing MH/SUD and M/S services from the NPL: Precertification is required for all inpatient admissions for both MH/SUD and M/S services. (The exceptions for hospice and short maternity/newborn stays are not significant enough to suggest a parity concern.) Precertification is not required for any MH/SUD or M/S Outpatient-Office Visits. As for Outpatient-All Other benefits, there are only 4 MH/SUD services in that classification subject to precertification compared to approximately 34 categories of M/S services, and no new MH/SUD services have been added to the NPL in the past 5 years (since the framework for inclusion on the NPL was formalized). In the NPL Committee's 2022 annual retention review, no MH/SUD or M/S services that met the ROI were removed from the NPL. For services that did not meet the ROI, two M/S services were retained on the NPL due to clinical quality control concerns (kyphectomy) and marked variation in utilization patterns (motorized scooters), and one MH/SUD service was retained on the list due to clinical quality control concerns (partial hospitalization). From this information it is clear that the factors and sources used to add to, retain or remove a service from the NPL are comparable, and not more stringent, for MH/SUD services. Denial Rates and turnaround times for INN MH/SUD and M/S precertifications: We compared data from INN precertification decisions for services on the NPL for XXXXX's fully insured book of business in 2023. This analysis	

concluded that precertification is applied comparably, and not more stringently, to MH/SUD services compared to M/S services. Data is available upon request.

Internal Quality Reviews and Inter-Rater Reliability assessments: The IQR/IRR process described in NCS 510 Internal Quality Review Policy & Procedure provides a way to evaluate whether utilization review of MH/SUD and M/S services is performed comparably, and not more stringently for MH/SUD, in operation. In that process, Medical Directors and Utilization Management Clinicians are audited for accuracy and consistency in their application of utilization management criteria. Corrective actions are taken if an individual's results do not meet the goal of 90%. Corrective action plans and appropriate monitoring are also established for business areas with a final score below the target of 95%. The IQR and IRR results for both Behavioral Health and Medical clinicians and Medical Directors show that the audits were performed as required and the overall goals met. Some Behavioral Health and Medical individual clinicians and business areas fell below the goal and were identified for corrective actions should they continue to score below the goal. These IQR/IRR reports show that utilization review is performed comparably, and not more stringently, for MH/SUD services. (The detailed results of the IQR and IRR reviews are available upon request.)

Summary of Conclusions: The factors and sources used in determining what INN services are subject to precertification, and in handling precertification requests, are comparable, and
not more stringent, for MH/SUD benefits both in writing and in operation.
Referenced Policies and Documents:
• National Precertification List (NPL) (see Appendix), publicly available at www.XXXXX.com/health-care□professionals/precertification/precertification-lists.html
• NPL Committee Composition (see Appendix)
• National Precertification List Policy & Procedure
• NCS 100 Precertification Policy & Procedure
• NCS 503 Medical Review Policy & Procedure
• NCS 504 Timeliness Standards for Coverage Decisions and Notification Policy
• NCS 505 Denial of Coverage Policy and Notification
• NCS 506 Peer-to-Peer Review Policy
• NCS 510 Internal Quality Review Policy
• UM Denial & TAT_2023_FI_Final.xlsx
• 1Q-2Q23, 3Q-4Q23 BH IQR-IRR Analysis
• 2023 Medical IQR Report
• 2023 Medical IRR Report

Plan Language:
COC:
Precertification
You need pre-approval from us for some covered services. Pre-approval is also called precertification.
In-network
Your network physician is responsible for obtaining any necessary precertification before you get the care. Network providers cannot bill you if they fail to ask us for precertification. But if your physician requests precertification and we deny it, and you still choose to get the care, you will have to pay for it yourself.

Timeframes for precertification are listed below. For emergency services, precertification is not required, but you should notify us as shown. To obtain precertification, contact us. You, your physician or the facility must call us within these timelines:

Type of care / Timeframe
Non-emergency admission - Call at least [7 days] before the date you are scheduled to be admitted

	Emergency admission - Call within [24 hours] or as soon as reasonably possible after you have been admitted Urgent admission - Call before you are scheduled to be admitted Outpatient non-emergency medical services - Call at least [7 days] before the care is provided, or the treatment or procedure is scheduled. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or injury. We will tell you and your physician in writing of the precertification decision, where required by state law. An approval is valid for [30-180 days] as long as you remain enrolled in the plan. For an inpatient stay in a facility, we will tell you, your physician and the facility about your precertified length of stay. If your physician recommends that you stay longer, the extra days will need to be precertified. You, your physician, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. We will tell you and your physician in writing of an approval or denial of the extra days. If you or your provider request precertification and we don't approve coverage, we will tell you why and explain how you or your provider may request review of our decision. See the Complaints, claim decisions [and appeal procedures] section. Sometimes you or your provider may want us to review a service that doesn't require precertification before you get care. This is called a predetermination, and it is different from precertification. Predetermination means that you or your provider requests the pre-service clinical review of a service that does not require precertification. Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You can find the bulletins and other information at https://www.XXXXX.com/health-care-professionals/clinical-policy-bulletins.html Certain prescription drugs are covered under the medical plan when they are given to you by your doctor or health care facility. The following precertification information applies to these prescription drugs: • For certain drugs, your provider needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are medically necessary. Step therapy is a type of precertification where you must try one or more prerequisite drugs before a step therapy drug is covered. A 'prerequisite' is something that is required before something else. Prerequisite drugs are FDA-approved, may cost less and treat the same condition. If you don't try the prerequisite drugs first, the step therapy drug may not be covered. However, if you are in a pain management program, this requirement will not apply. Step therapy will not be required for any prescribed drug for longer than 30 days. At the end of the 30 day period, your physician or PCP may feel the use of the step therapy provision is ineffective and prescribe a different medication. For a covered FDA approved drug for cancer treatment of stage IV metastatic cancer you will not be required to follow step therapy precertification if your prescriber deems step therapy clinically ineffective for you and obtains a medical exception. This also includes drugs for the treatment of schizophrenia, major depressive disorder or bipolar disorder, as defined in the most recent edition of Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association. SOB: No reference	

Concurrent Review Benefit NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of concurrent review benefit NQTL benefit practices between medical/surgical and MH/SUD. Plan Terms and/or Description of NQTL: Concurrent review is performed by licensed healthcare professionals to review the medical necessity of a patient's care while in the hospital or while undergoing outpatient treatment, for dates of service beyond the initial precertification authorization. The purpose is to determine medical necessity and appropriateness of treatment, assess appropriateness of level of care and treatment setting, determine benefits and eligibility, identify the patient's discharge and continuing care plan, and identify and refer potential quality of care and patient safety concerns for additional review. Concurrent review is performed on all inpatient admissions and outpatient services that are subject to precertification and entail an ongoing course of treatment. (See the Prior Authorization NQTL Comparative Analysis for information about precertification.) M/S services NQTL applies to: All inpatient admissions that extend beyond the initial precertification (refer to Prior Authorization NQTL Comparative Analysis) MH/SUD services NQTL applies to: All inpatient admissions and outpatient services subject to precertification that entail an ongoing course of treatment (refer to Prior Authorization NQTL Comparative Analysis) Factors: Factors used in designing the NQTL The factors used in determining what services are subject to precertification and, by extension, to concurrent review, are described in XXXXX's Prior Authorization NQTL Comparative Analysis. In addition, for Outpatient-All Other services, the inability of a service to be managed through quantitative treatment limits is a factor in whether it is subject to concurrent review. The factors used in determining how concurrent review is performed are: • National Committee for Quality Assurance (NCQA) utilization management standards for Health Plan Accreditation and Managed Behavioral Health Organization accreditation • Applicable state and federal law Sources: Processes, strategies and/or evidentiary standards used to design and apply the NQTL. The processes and evidentiary standards used in determining what services are subject to precertification and, therefore, to concurrent review, are described in XXXXX's Prior Authorization NQTL Comparative Analysis. Evidentiary Standards for Performing Concurrent Review: XXXXX's concurrent review processes are designed in accordance with National Committee for Quality Assurance (NCQA) utilization management standards for Health Plan Accreditation and Managed Behavioral Health Organization accreditation, and applicable state and federal law. Strategy for Performing Concurrent Review: For both MH/SUD and M/S services, the guiding strategy behind concurrent review relies upon the clinical reviewers' exercise of their clinical judgment, guided by clinical criteria, to determine whether to authorize coverage for additional units of care. They rely upon their training and experience, informed by the member's medical history, clinician progress	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences in the application, as written and in operation, of concurrent review benefit NQTL benefit practices between medical/surgical and MH/SUD.

notes and discharge plans, to assess “severity” and “complexity” (as those terms are used within XXXXX’s National Clinical Services policies and procedures and clinical guidelines).

Process for Performing Concurrent Review:
Concurrent review is initiated before the authorized coverage period under the initial precertification or previous concurrent review expires. Updated information about the patient’s condition, progress and treatment/discharge plan is obtained from the provider. Concurrent reviews are performed by licensed clinicians who are RNs, licensed behavioral health clinicians. The licensed clinician may approve coverage for additional units of care or, if unable to approve coverage, will refer the case to a Medical Director who is a physician or to a consultant psychiatrist/ psychologist/ board certified behavior analyst-doctoral (BCBA-D) for further review and action. Consultant psychiatrists/ psychologists/ BCBA-Ds use the available clinical information to approve a coverage request or, when unable to approve, make a level of care or service recommendation and forward the recommendation to the Medical Director or the designated psychologist/BCBA-D for issuance of the coverage determination. The licensed clinician or Medical Director draws upon his or her training and expertise in applying the applicable clinical review criteria to the request. (See XXXXX’s Medical Necessity NQTL Comparative Analysis for more information about clinical review criteria.) The concurrent review determination is made and communicated to the provider/member according to the established timeframes for urgent or non-urgent requests. In some circumstances the treating provider may have a peer-to-peer consultation with a physician.
These processes are described in detail in these XXXXX National Clinical Services policies and procedures:
• NCS 200 Concurrent Review and Discharge Planning Policy & Procedure
• NCS 503 Medical Review Policy & Procedure
• NCS 504 Timeliness Standards for Coverage Decisions and Notification Policy
• NCS 505 Denial of Coverage Policy and Notification
• NCS 506 Peer-to-Peer Review Policy
• NCS 510 Internal Quality Review Policy

Comparability and Stringency Analysis:
Show if the processes, strategies, evidentiary standards and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation

As Written: The same factors and sources apply to MH/SUD and M/S benefits in deciding which services are subject to precertification and, by extension, to concurrent review. The same factors and sources, and the same National Clinical Services Policies and Procedures, apply to handling concurrent review requests for MH/SUD and M/S benefits. Thus, as written this NQTL is applied comparably, and not more stringently, to MH/SUD benefits.

In Operation: The following measures are used to assess comparability and stringency:

Denial Rates and turnaround times for INN and OON MH/SUD and M/S concurrent reviews: The below data reflect INN and OON concurrent review decisions for services on the NPL and/or MPL for XXXXX’s fully insured book of business in 2023. (See UM Denial & TAT_2023_FI_Final.xlsx.)

Internal Quality Reviews and Inter-Rater Reliability assessments: The IQR/IRR process described in NCS 510 Internal Quality Review Policy & Procedure provides a way to evaluate whether utilization review of MH/SUD and M/S services is performed comparably, and not more stringently for MH/SUD, in operation. In that process, Medical Directors and Utilization Management Clinicians are audited for accuracy and consistency in their application of utilization management criteria. Corrective actions are taken if the results do not meet the goal of 90%. Corrective action plans and appropriate monitoring are also established for business areas with a final score below the target of 95%. The IQR and IRR results for both Behavioral Health and Medical clinicians and Medical Directors show that the audits were performed as required and the overall goals met. Some Behavioral Health and Medical individual clinicians and business areas fell below the goal and were identified for corrective actions should they continue to score below the goal. These IQR/IRR reports show that

	utilization review is performed comparably, and not more stringently, for MH/SUD services. (The detailed results of the IQR and IRR reviews are contained in the following reports:1Q-2Q23, 3Q-4Q23 BH IQR-IRR Analysis; 2023 Medical IQR Report; 2023 Medical IRR Report.) Summary of Conclusions: The factors and sources used in determining what services are subject to precertification (and by extension, to concurrent review), and in performing concurrent reviews, are comparable, and not more stringent, for MH/SUD benefits both in writing and in operation. Referenced Policies and Documents: • National Precertification List (NPL) (see Appendix), publicly available at www.XXXXX.com/health-care□professionals/precertification/precertification-lists.html. • NPL Committee Composition (see Appendix) • National Precertification List Policy & Procedure • NCS 200 Concurrent Review and Discharge Planning Policy & Procedure • NCS 503 Medical Review Policy & Procedure • NCS 504 Timeliness Standards for Coverage Decisions and Notification Policy • NCS 505 Denial of Coverage Policy and Notification • NCS 506 Peer-to-Peer Review Policy • NCS 510 Internal Quality Review Policy • UM Denial & TAT_2023_FI_Final.xlsx • 1Q-2Q23, 3Q-4Q23 BH IQR-IRR Analysis • 2023 Medical IQR Report • 2023 Medical IRR Report Plan language: COC: Concurrent care claim extension A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a hospital stay or adding a number of visits to a [provider]. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hour] for an urgent request. You may receive the decision for a non-urgent request within 7 days, which may be extended once for up to 5 calendar days for a concurrent review, or a one-time extension of up to 15 days for a retrospective, non-urgent request. Concurrent care claim reduction or termination A concurrent care claim reduction or termination occur when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us [or an external review organization if the situation is eligible for external review]. During this continuation period, you are still responsible for your share of the costs, such as copayments, coinsurance and deductibles that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period. SOB: No reference	
Retrospective Review Benefit NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of retrospective review benefit NQTL benefit practices between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences in the application, as written and in operation, of

	Plan Terms and/or Description of NQTL: Retrospective review is a utilization review service performed by licensed healthcare professionals to determine coverage after treatment has been given. The intent is to determine medical necessity, appropriateness of treatment, and benefits and eligibility. For OON services, XXXXX performs retrospective review on OON Inpatient services that were not precertified and OON Outpatient All-Other services that are on the member precertification list and were not precertified. For INN services, XXXXX performs retrospective review in the following limited circumstances: when an INN psychiatric hospital or other MH/SUD or M/S facility that is not a Hospital or Children's Hospital failed to precertify or give timely notice of inpatient admission; when required by state law or XXXXX's contract with a facility; when provider precertification requirements are waived due to a state or federal disaster declaration; or when there is a valid reason for failure to precertify or give timely notice (e.g., member was unable to provide insurance information at the time). For Emergency services, XXXXX performs retrospective review on M/S and MH/SUD services where the diagnosis code signifies a condition that potentially was not an "emergency" under the federal "prudent layperson" standard. M/S services NQTL applies to: All OON M/S inpatient services, and all outpatient-all other services on the Member Precertification List, that were not precertified. INN inpatient services when provided by a facility (other than a hospital or children's hospital) that failed to precertify or give timely notice of admission. "Emergency" M/S services on the Non-Emergent ER Diagnosis List MH/SUD services NQTL applies to: All OON MH/SUD inpatient services, and outpatient-all other services on the Member Precertification List, that were not precertified. INN inpatient services when provided by a psychiatric hospital or facility (other than a hospital or children's hospital) that failed to precertify or give timely notice of admission. "Emergency" MH/SUD services on the Non-Emergent ER Diagnosis List Factors: Factors used in designing the NQTL The factors used in determining what services are subject to retrospective review are: • National Participating Provider Precertification List (NPL) for INN services; Member Precertification List (MPL) for OON services (see XXXXX's Prior Authorization NQTL Comparative Analysis for more information) • Terms of XXXXX's contracts with INN providers • State and federal laws pertaining to waiver of INN provider precertification requirements • Federal law defining "prudent layperson" standard for emergency services • ICD10 and DSM-V coding descriptions The factors used in determining how retrospective review is performed are: • National Committee for Quality Assurance (NCQA) utilization management standards for Health Plan Accreditation and Managed Behavioral Health Organization accreditation • Applicable state and federal law	retrospective review benefit NQTL benefit practices between medical/surgical and MH/SUD.

Sources:
Processes, strategies and/or evidentiary standards used to design and apply the NQTL
Some of the processes and evidentiary standards used in determining what services are subject to retrospective review are described in XXXXX's Prior Authorization NQTL Comparative Analysis. Additionally, XXXXX reviews its contracts with participating facility providers and monitors state and federal laws and disaster declarations to determine when the standard obligation for the provider to give timely notice of an admission must be waived; when the obligation to give timely notice of an admission is waived, then XXXXX will perform retrospective review instead of imposing a payment penalty on the participating provider. Regarding the list of non-emergent diagnosis codes that trigger a retrospective review of "emergency" services, that list is maintained by XXXXX's Payment Policy and Coding Committee (PPCC). The composition of the Committee is described in the Appendix. The Medical Directors on the PPCC review ICD10 and DSM-V coding descriptions and apply their clinical training, experience and judgment to assess whether the symptoms would typically cause a "prudent layperson" (as that term is defined in federal law) to believe emergency care was needed.

Evidentiary Standards for Performing Retrospective Review:
The evidentiary standards/sources for XXXXX's retrospective review processes are National Committee for Quality Assurance (NCQA) utilization management standards for Health Plan Accreditation and Managed Behavioral Health Organization accreditation, applicable state and federal law.

Strategy for Performing Retrospective Review:
For both MH/SUD and M/S services, the guiding strategy behind retrospective review relies upon the clinical reviewers' exercise of their clinical judgment based on their training and experience, guided by clinical criteria and informed by the member's medical history, to determine whether to approve coverage for care already provided.

Process for Performing Retrospective Review:
Retrospective review is performed after services have already been provided. It is done by licensed clinicians who are RNs, licensed behavioral health clinicians. The licensed clinician may approve coverage or, if unable to approve coverage, will refer the case to a Medical Director who is a physician or to a consultant psychiatrist/ psychologist/ board certified behavior analyst-doctoral (BCBA-D) for further review and action. Consultant psychiatrists/ psychologists/ BCBA-Ds use the available clinical information to approve a coverage request or, when unable to approve, make a level of care or service recommendation and forward the recommendation to the Medical Director or the designated psychologist/BCBA-D for issuance of the coverage determination. The licensed clinician or Medical Director draws upon his or her training and expertise in applying the applicable clinical review criteria to the request. (See XXXXX's Medical Necessity NQTL Comparative Analysis for more information about clinical review criteria.) For retrospective reviews of non-emergent diagnosis codes, a Medical Director reviews the available clinical information and applies his or her clinical training, experience and judgment to evaluate whether a "prudent layperson" (as that term is used under applicable law) would have believed emergency care was required. The retrospective review determination is made and communicated to the provider/member according to the established timeframes. In some circumstances the treating provider may have a peer-to-peer consultation with a physician. These processes are described in detail in these XXXXX National Clinical Services policies and procedures:
• NCS 300 Retrospective Review Policy & Procedure
• NCS 503 Medical Review Policy & Procedure
• NCS 504 Timeliness Standards for Coverage Decisions and Notification Policy
• NCS 505-01 Denial of Coverage Policy and Notification
• NCS 506 Peer-to-Peer Review Policy
• NCS 510 Internal Quality Review Policy

Comparability and Stringency Analysis:

	Show if the processes, strategies, evidentiary standards and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation As Written: The same factors and sources, and the same National Clinical Services Policies and Procedures, apply to handling retrospective review requests for MH/SUD and M/S benefits. Regarding “emergency” services that are subject to retrospective review, of the 1589 diagnosis codes that trigger retrospective review, only 80 (5%) are for MH/SUD conditions. Thus, as written this NQTL is applied comparably, and not more stringently, to MH/SUD benefits. In Operation: The following measures are used to assess comparability and stringency: Denial Rates for INN and OON MH/SUD and M/S retrospective reviews: We examined the retrospective review denials of INN and OON benefits for XXXXX's national, fully insured book of business in 2022. This analysis concluded that retrospective review is performed comparably, and not more stringently, on MH/SUD services compared to M/S services. Data is available upon request. Internal Quality Reviews and Inter-Rater Reliability assessments: The IQR/IRR process described in NCS 510 Internal Quality Review Policy & Procedure provides a way to evaluate whether utilization review of MH/SUD and M/S services is performed comparably, and not more stringently for MH/SUD, in operation. In that process, Medical Directors and Utilization Management Clinicians are audited for accuracy and consistency in their application of utilization management criteria. Corrective actions are taken if the results do not meet the goal of 90%. Corrective action plans and appropriate monitoring are also established for business areas with a final score below the target of 95%. The IQR and IRR results for both Behavioral Health and Medical clinicians and Medical Directors show that the audits were performed as required and the overall goals met. Some Behavioral Health and Medical individual clinicians and business areas fell below the goal and were identified for corrective actions should they continue to score below the goal. These IQR/IRR reports show that utilization review is performed comparably, and not more stringently, for MH/SUD services. (The detailed results of the IQR and IRR reviews are contained in the following reports:1Q-2Q23, 3Q-4Q23 BH IQR-IRR Analysis; 2023 Medical IQR Report; 2023 Medical IRR Report.) Summary of Conclusions: The factors and sources used in determining what services are subject to retrospective review, and in performing retrospective reviews, are comparable, and not more stringent, for MH/SUD benefits both in writing and in operation. Referenced Policies and Documents: • Non-Emergent ER Diagnosis List_effective 09012023.pdf • Payment Policy and Coding Committee Composition (see Appendix) • NCS 300 Retrospective Review Policy • NCS 503 Medical Review Policy & Procedure • NCS 504 Timeliness Standards for Coverage Decisions and Notification Policy • NCS 505-01 Denial of Coverage Policy and Notification • NCS 506 Peer-to-Peer Review Policy • NCS 510 Internal Quality Review Policy • UM Denial & TAT_2023_FI_Final.xlsx • ER Retro Review Denial_2023_FI_Final.xlsx• 1Q-2Q23, 3Q-4Q23 BH IQR-IRR Analysis • 2023 Medical IQR Report • 2023 Medical IRR Report Plan Language: COC & SOB: No reference	

Clinical Procedure Coding, Billing Coding and Process NQTL Practices	There are no clinical automated claims edits/policies applied to MH/SUD benefits. Therefore, a NQTL analysis is not required. There are no non-comparable inconsistencies or differences in the application, as written and in operation, of clinical procedure coding, billing coding and process practices between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences in the application, as written and in operation, of clinical procedure coding, billing coding and process practices between medical/surgical and MH/SUD.
Case & Medical Management NQTL Practices	This entire section is not applicable. NQTLs are “treatment limitations” that are not numerical in nature but otherwise may limit the scope or duration of MH/SUD benefits. Case Management is a voluntary service to our members. There are no adverse consequences to the member if a member decides not to enroll or use information provided during case management. These are provided to help high risk members and those who support them to improve management of health conditions as well as improve impact on functioning and overall health. We outline in our Behavioral Health Case Management Program Policy NCS 415 (available upon request), “Eligible members have the right to participate or decline participation.” If a member decided not to participate in the case management program, or does not complete the care plan, benefits are not excluded or denied.	This entire section is not applicable. NQTLs are “treatment limitations” that are not numerical in nature but otherwise may limit the scope or duration of MH/SUD benefits. Case Management is a voluntary service to our members. There are no adverse consequences to the member if a member decides not to enroll or use information provided during case management. These are provided to help high risk members and those who support them to improve management of health conditions as well as improve impact on functioning and overall health. We outline in our Behavioral Health Case Management Program Policy NCS 415 (available upon request), “Eligible members have the right to participate or decline participation.” If a member decided not to participate in the case management program, or does not complete the care plan, benefits are not excluded or denied.
Participating Provider Reimbursement - Professionals NQTL	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of participating provider reimbursement - professionals NQTL practices between medical/surgical and MH/SUD. Plan Terms and/or Description of NQTL: This NQTL is implemented by the plan’s definition of Negotiated Charge, which is the amount a network provider has agreed to accept or that we have agreed to pay them or a third-party vendor (including any administrative fee in the amount paid). M/S services NQTL applies to: Applies to all M/S benefits delivered in-network MH/SUD services NQTL applies to: Applies to all MH/SUD benefits delivered in-network Factors: Factors used in designing the NQTL The following factors are used to establish the XXXXX Market Fee Schedule (“AMFS”), which is the preferred fee schedule for MH/SUD and M/S network providers. AMFS rates are established at the market level by the Medical and Behavioral Health (BH) network teams in collaboration with XXXXX’s Medical Economics Unit (MEU). When a provider does not accept the AMFS, the AMFS is used as a starting point for contract negotiations. Provider type: Provider type refers to the provider’s licensure type (e.g., MD, DO, LCSW, RN). Service type: Service type is a factor that bases reimbursement on the billing codes submitted by a provider (e.g., initial assessments are generally reimbursed at a higher rate than follow-up appointments). Service types are identified by CPT and HCPCS codes. Index rates: The Resource Based Relative Value System (RBRVS) payment methodology developed by the Centers for Medicare and Medicaid Services (CMS) is used as a benchmark in developing the AMFS and contracting with providers for	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences in the application, as written and in operation, of participating provider reimbursement - professionals NQTL practices between medical/surgical and MH/SUD.

	the Negotiated Charges. CMS, in consultation with the American Medical Association, assigns Relative Value Units (RVUs) to service codes to reflect the physician or other provider work involved, practice expense and liability insurance each service code entails. CMS applies a conversion factor to the RVU and an adjustment for the geographic area to calculate the resulting RBRVS rate. Where there is no RBRVS rate, the rate from Optum (a third party) is used; where there is no Optum rate, the Developed XXXXX Rate Table (“DART”) rate is used, which is 80% of the average allowed amount. Market dynamics: The local networks establish their own AMFS rates to take into consideration the unique characteristics of that market including supply and demand, the carrier’s market penetration compared to other carriers and networks, and any other relevant characteristics specific to that market. When contracting with a given provider, additional factors may enter into consideration: Unit Cost Trend Target: This refers to the percentage of unit cost by which the network determines it can adjust overall M/S and MH/SUD rates when refreshing them. Plans establish unit cost trend targets for provider contract rates so they can estimate future health care costs in order to set appropriate premiums. The trend target is a baseline in which to begin the negotiations with providers. The network teams still negotiate with providers as needed to maintain an adequate network even if that means their overall trend target is exceeded. To establish the trend target, XXXXX’s Medical Economics Unit (MEU) performs analyses of utilization, current network rates, estimated competitor unit cost trends, and the provider contracts up for renewal that year to create unit cost increase targets for the network teams to aim for when contracting with network providers. MEU uses an XXXXX tool called pModel to do these analyses. Unit cost trend targets are set at an overall market level, not at the level of individual providers (except that the trend target for the Behavioral Health network is set at the national level). Each network team is charged with contracting with providers in a way that allows them to achieve the overall trend target for their market. If they agree on a rate with one provider that’s below the unit cost trend target, they then have leeway to agree on a rate that’s higher with another provider, and vice versa. Separate trend targets are established for M/S and standalone MH/SUD providers because the network teams responsible for contracting with MH/SUD providers are different. The network teams are responsible for tracking to their given trend target as they contract with providers. As provider contracts are finalized in the course of the year, the pModel is updated with the newly-agreed rates to monitor whether the market is on track to meet the target or whether there will be a variance from it. Provider leverage: AKA bargaining power. This is generally a function of the relative scarcity of the provider’s specialty or area of focus, member needs for that specialty/focus, whether the provider group is a large system or practice group that includes numerous specialties, plan sponsor demand, the provider’s participation with other payors, and any other factors that dictate a provider’s ability to negotiate a rate higher than AMFS, as well as the number of members the carrier is able to drive to the provider. Sources: Processes, strategies and/or evidentiary standards used to design and apply the NQTL Strategy: Achieve total health care cost rates that are competitive with the total health care cost rates for similar products issued by third parties in the market so as to achieve premium pricing required to compete effectively and drive membership growth. Process: 1. Develop the AMFS rates.	

	a. XXXXX's Medical Economics Unit (MEU) identifies the CMS RBRVS rates for the service codes and proposes the AMFS rates as a percentage of the CMS rates. (Variations: Where there is no CMS rate for a code, the Optum rate is used; where there is no Optum rate, the DART rate is used. Also, a network may choose to use a flat rate instead of a percentage of CMS rates for some services.) MEU communicates the preliminary rates to network management. b. XXXXX's Behavioral Health (BH) and local market network management in collaboration with MEU adjusts those preliminary rates up or down (or makes no adjustment) based on the network's analysis of market dynamics. Codes are classified as Medical class (most commonly billed by Medical professionals but may also be billed by BH professionals) or BH class (most commonly billed by BH professionals though could also be billed by Medical professionals). For new CPT/HCPC codes released by the American Medical Association, BH network will classify them as BH class or Medical class and decide if specialty tiering is to be applied. AMFS for BH class codes will be set at a percentage of then–available Medicare/GAP rates (percentage to be based on BH network's direction). AMFS for BH providers billing Medical class codes will be at least the then-current Medical class. For BH class codes, AMFS is determined utilizing the following hierarchy of sources: CMS RBRVS, GAP supplied by Optum 360, DART rates, historical pricing if no other source is available, or rates recommended by national workgroups and medical directors (may be used even if Medicare-based pricing sources are available). For Medical class codes, the BH AMFS rate is set at or above the Medical AMFS rates. This results in the final AMFS rates. c. For service types that are billed both by MH/SUD and M/S providers, after the rate for M/S providers is determined the rate for the same service for MH/SUD providers is set at or above that rate. d. For both MH/SUD and M/S providers, rates are tiered based on provider type/level of training: - Doctors (MDs) (MH/SUD and M/S) & Clinical Psychologists receive 100% of the rate. - Nurse Practitioners, Physician Assistants and Certified Nurse Specialist (MH/SUD and M/S) receives 85% of the new rate. - Drug and Alcohol Counselor, Licensed Professional Counselor, Marriage and Family Therapist, Pastoral Counselor, Social Worker receive 75% of the new rate. - Audiologist, Registered Dietician, Genetic Counselor, Massage Therapist, Nutritionist, Respiratory Therapist receive 75% of the new rate. This is consistent with CMS methodology -- see Medicare Claims Processing Manual Chapter 12, available at https://www.cms.gov/regulations□and-guidance/guidance/manuals/downloads/clm104c12.pdf. For example, see section 110, which indicates Medicare pays physician assistants 80% of the lesser of the actual charge or 85% of what a physician would be paid for the same service, and section 150, which indicates Medicare pays 75% of the physician fee schedule for clinical social worker services.) 2. Update the AMFS rates periodically. The frequency varies by market. a. To refresh the AMFS rates for M/S services, and MH/SUD services that are not also billable by M/S providers, MEU indexes the rates against CMS rates and adjusts the rates for various service code ranges to maintain cost neutrality. BH and local market network management collaborate with MEU to make adjustments based on their understanding of market dynamics. b. To refresh the AMFS rates for MH/SUD providers for the service codes that can also be billed by M/S providers, those rates are compared to the M/S AMFS rates to develop the AMFS rates for MH/SUD providers. That process works as follows: The Medical and BH network and MEU personnel agree on when the AMFS rates will be refreshed for a given market. After the Medical network finalizes the refreshed rates for the codes shared with MH/SUD providers, those rates are communicated to BH network personnel. BH network personnel, supported by MEU, compare the refreshed rates to the existing rates for MH/SUD providers. BH class codes are set at % of Medicare to achieve overall market budget neutral. If the refreshed M/S rate is higher, the BH network will adopt the M/S rate or a rate that is higher (but not lower) than the M/S rate. The refreshed MH/SUD rates are effective at the same time as the refreshed M/S rates. MH/SUD rates can also be refreshed apart from Medical's rate refresh, which occurs when the American Medical Association releases new CPT4® codes for MH/SUD	

services or when the BH network team observes that the volume of nonstandard rates in provider contracts has increased due to provider demand for
higher reimbursement.

For more detail about steps 1 and 2, refer to the AMFS Rate Development P&P for Non-Facility Providers.

3. Use the AMFS rates as the basis for contracting with providers.
a. When seeking to contract with a new provider, the contract negotiator proposes the AMFS rates as the Negotiated Charges. If the provider agrees, then the AMFS rates become the Negotiated Charges. If the provider does not agree to AMFS, the contract negotiator offers adjustments to the rates in light of the Unit Cost Trend Target, until the parties agree on the final Negotiated Charges. Provider Leverage is the key factor in determining whether and by how much the final Negotiated Charges differ from the proposed rates. (Variation: Whereas AMFS is the preferred basis for contract with providers, it is possible that a different percentage of AMFS or an alternate methodology may be agreed upon, either for some or all service codes. The parties may agree to lower rates for some services but higher rates for others).
b. When the AMFS is refreshed, the refreshed rates are communicated to network providers at least 90 days before they take effect, and according to whether the provider's contract permits rate changes. Providers may seek to negotiate the changes, and the unit cost trend target and provider leverage determine whether the parties will agree to the refreshed AMFS rates as the new Negotiated Charges or negotiate something different.

Evidentiary Standards: The evidentiary standard for index rates used in setting the AMFS rates is the CMS Resource Based Relative Value Scale (RBRVS) payment system. Those CMS rates are used as an index when developing rates for new service codes, as well as when refreshing M/S rates and rates for services that can be billed for both MH/SUD and M/S providers. When there is no RBRVS rate for a service code, the Optum rate is the standard used. When there is no Optum rate, the DART rate is the standard used.

Comparability and Stringency Analysis:
Show if the processes, strategies, evidentiary standards and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation

There are two main steps for setting network provider reimbursement, which are the same for MH/SUD and M/S services: (1) developing and refreshing the AMFS rates which are the baseline for contracting with providers; and (2) contracting with providers. Below is the comparability and stringency analysis for each step.

Even though the Plan's factors, processes and evidentiary standards for developing and maintaining the AMFS for MH/SUD rates are not more stringent
than for M/S rates, the final Negotiated Charges resulting from contract negotiations may not reflect identical or more favorable MH/SUD rates in every
instance. Provider groups and individual providers are free to negotiate rates different from the fee schedules, and the bargaining power they bring to such
negotiations may result in Negotiated Charges that are different from the AMFS rates. According to DOL, HHS and Treasury, "[u]nder this analysis, the
focus is not on whether the final result is the same for MH/SUD benefits as for medical/surgical benefits, but rather on whether the underlying processes,
strategies, evidentiary standards, and other factors are in parity" (see FAQs part 45, April 2, 2021, at https://www.dol.gov/sites/dolgov/files/EBSA/about□ebsa/our-activities/resource-center/faqs/aca-part-45.pdf).

Summary of Conclusions:
In summary, the factors, processes, strategies and evidentiary standards used to reimburse MH/SUD network providers are comparable to, and are applied no more stringently than, for M/S providers, both as written and in operation.

	Referenced Policies and Documents: • AMFS Rate Development P&P for Non-Facility Providers • 1Q24_AMFS_TX Shared Codes.xlsx Plan language: COC: Negotiated charge For health coverage: This is the amount a network [provider] has agreed to accept or that we have agreed to pay them or a third party vendor (including any administrative fee in the amount paid). Surprise bill There may be times when you unknowingly receive services or don't consent to receive services from an out-of-network [provider], even when you try to stay in the network for your covered services. You may get a bill at the out-of-network rate that you didn't expect. This is called a surprise bill. Some providers are part of XXXXX's network for some XXXXX plans but are not considered [network] providers for your plan. For those providers, the negotiated charge is the amount that provider has agreed to accept for rendering services or providing prescription drugs to members of your plan. We may enter into arrangements with network providers or others related to: • The coordination of care for members • Improving clinical outcomes and efficiencies Some of these arrangements are called: • Value-based contracting • Risk sharing • Accountable care arrangements These arrangements will not change the negotiated charge under this plan. For prescription drug services: When you get a prescription drug, we have agreed to this amount for the prescription or paid this amount to the network pharmacy or third party vendor that provided it. The negotiated charge may include a rebate, additional service or risk charges and administrative fees. It may include additional amounts paid to or received from third parties under price guarantees. SOB: No reference	
Participating Provider Reimbursement - Facilities NQTL	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of participating provider reimbursement - facilities NQTL practices between medical/surgical and MH/SUD. Plan Terms and/or Description of NQTL: This NQTL is implemented by the plan's definition of Negotiated Charge, which is the amount a network provider has agreed to accept or that we have agreed to pay them or a third-party vendor (including any administrative fee in the amount paid). M/S services NQTL applies to: Applies to all M/S benefits delivered in-network MH/SUD services NQTL applies to: Applies to all MH/SUD benefits delivered in-network	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences in the application, as written and in operation, of participating facility reimbursement NQTL practices between medical/surgical and MH/SUD.

	Factors: Factors used in designing the NQTL The factors on which Negotiated Charges are based are: Provider type: Type of facility (inpatient hospital, ambulatory surgery center, etc.) Scope and complexity of services: range of practice specialties, levels of care and settings offered by the facility Service type: Service type is a factor that bases reimbursement on the billing codes submitted by a provider (e.g., initial assessments are generally reimbursed at a higher rate than follow-up appointments). Service types are identified by CPT and HCPC codes. For facility-based providers, type of service also refers to inpatient or outpatient. Index rates: Medicare DRGs and Medicare RVRBS rates Competitive data: Refers to what competitors pay the facility for the same services, to the extent that can be determined from information publicly available through state and federal All Payor Claims Databases. Also includes consultants' analyses of XXXXX's discount position in the market compared to other carriers, and what XXXXX pays other facilities. Market dynamics: The local networks establish their own reimbursement strategies to take into consideration the unique characteristics of that market including supply and demand, the carrier's market penetration compared to other carriers and networks, and any other relevant characteristics specific to that market. When contracting with a given provider, additional factors may enter into consideration: Unit Cost Trend Target: This refers to the percentage of unit cost by which the network determines it can adjust overall M/S and MH/SUD rates when refreshing them. Plans establish unit cost trend targets for provider contract rates so they can estimate future health care costs in order to set appropriate premiums. The trend target is a baseline in which to begin the negotiations with providers. the network teams still negotiate with providers as needed to maintain an adequate network even if that means their overall trend target is exceeded. To establish the trend target, XXXXX's Medical Economics Unit (MEU) performs analyses of utilization, current network rates, estimated competitor unit cost trends, and the provider contracts up for renewal that year to create unit cost increase targets for the network teams to aim for when contracting with network providers. MEU uses an XXXXX tool called pModel to do these analyses. Unit cost trend targets are set at an overall market level, not at the level of individual providers (except that the trend target for the Behavioral Health network is set at the national level). Each network team is charged with contracting with providers in a way that allows them to achieve the overall trend target for their market. If they agree on a rate with one provider that's below the unit cost trend target, they then have leeway to agree on a rate that's higher with another provider, and vice versa. Separate trend targets are established for M/S and standalone MH/SUD providers because the network teams responsible for contracting with MH/SUD providers are different. The network teams are responsible for tracking to their given trend target as they contract with providers. As provider contracts are finalized in the course of the year, the pModel is updated with the newly-agreed rates to monitor whether the market is on track to meet the target or whether there will be a variance from it. Provider leverage: AKA bargaining power. This is generally a function of the relative scarcity of the facility's licensure type and services provided, member needs for that type of facility, whether the facility is part of a large system and/or includes numerous practice specialties, plan sponsor demand, the facility's participation with other payors, and any other factors that dictate a facility's ability to negotiate higher reimbursement, as well as the number of members the	

	carrier is able to drive to the facility. Sources: Processes, strategies and/or evidentiary standards used to design and apply the NQTL Strategy: Achieve total health care cost rates that are competitive with the total health care cost rates for similar products issued by third parties in the market so as to achieve premium pricing required to compete effectively and drive membership growth. Process: Behavioral Health (BH) and local market network management and the Medical Economics Unit (MEU) examine what XXXXX pays other facilities in the area and what competitive data reveals regarding what competitors are paying (though BH network does not currently use competitive data). The provider type, scope and complexity of the services, and service types are considered, along with market dynamics. Based on this, a proposed reimbursement methodology and set of rates are offered to the facility. For M/S facilities there is no standard or preferred proposed reimbursement methodology (e.g., per diem, fee for service, DRG, % of charges) or set of rates when contracting with a new facility. For MH/SUD facilities the standard proposed reimbursement methodology is per diem. Rates for MH/SUD service codes that can also be billed by M/S facility-based professionals are set at or above the rate established for M/S providers. After the contract negotiator proposes contract terms and reimbursement rates, the provider may accept them or seek to negotiate. The contract negotiator may offer adjustments to the rates in light of the Unit Cost Trend Target, until the parties agree on the final Negotiated Charges. Provider Leverage is the key factor in determining whether and by how much the final Negotiated Charges differ from the proposed rates. Evidentiary Standards Index rates are referred to when developing rates for services that are paid according to a Medicare DRG or fee for service (AMFS) methodology. Comparability and Stringency Analysis: Show if the processes, strategies, evidentiary standards and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation The factors, strategy, processes and evidentiary standards for determining reimbursement for MH/SUD facility-based providers are comparable to M/S facility-based providers, inasmuch as the Negotiated Charges are ultimately subject to individualized negotiations between XXXXX and the facility. Notwithstanding the comparable processes, most MH/SUD facilities are paid on a per diem basis, whereas M/S facilities are paid by a wide variety of reimbursement methodologies including DRGs, per diem, percent of Medicare and percent of billed charges. This difference is due to the fact that Medicare DRGs are not available for MH/SUD services. Also, the structures and scope of services of MH/SUD facilities are simpler than those of M/S facilities which often have multiple specialties and locations and provide a wide range of service types; multiple reimbursement methodologies are therefore more common within a single M/S facility contract. A comparison of Negotiated Charge amounts between facilities that are paid using different reimbursement methodology(ies) such as DRG versus per diem, and for different services, is not possible because they are too disparate to allow comparison. Nevertheless, there are some professional services that can be billed by both MH/SUD and M/S facility-based providers, and under some facility contracts those may be reimbursed on a fee for service bases using AMFS. For those shared codes, the AMFS rates are higher for MH/SUD providers than M/S providers. This is demonstrated by reviewing AMFS rates for shared codes in a sample market in this case Dallas, TX 1Q24 (see 1Q24_AMFS_TX Shared Codes.xlsx).	

	Even though XXXXX's factors, processes and evidentiary standards for developing and maintaining the AMFS for MH/SUD rates are comparable and not more stringent than for M/S rates, the final Negotiated Charges will not reflect identical or more favorable MH/SUD rates in every instance. Providers are free to negotiate rates different from the proposed fee schedule, and their bargaining power may result in Negotiated Charges that are different from the AMFS rates. According to DOL, HHS and Treasury, "[u]nder this analysis, the focus is not on whether the final result is the same for MH/SUD benefits as for medical/surgical benefits, but rather on whether the underlying processes, strategies, evidentiary standards, and other factors are in parity" (see FAQs part 45, April 2, 2021, at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf). Summary of Conclusions: In summary, the factors, processes, strategies and evidentiary standards used to reimburse MH/SUD network facilities are comparable to, and are applied no more stringently than, for M/S providers, both as written and in operation. Referenced Policies and Documents: • 1Q24_AMFS_TX Shared Codes.xlsx Plan language: COC: Negotiated charge For health coverage: This is the amount a network [provider] has agreed to accept or that we have agreed to pay them or a third party vendor (including any administrative fee in the amount paid). Surprise Bill There may be times when you unknowingly receive services or don't consent to receive services from an out-of-network [provider], even when you try to stay in the network for your covered services. You may get a bill at the out-of-network rate that you didn't expect. This is called a surprise bill. We may enter into arrangements with network providers or others related to: • The coordination of care for members • Improving clinical outcomes and efficiencies Some of these arrangements are called: • Value-based contracting • Risk sharing • Accountable care arrangements These arrangements will not change the negotiated charge under this plan. For prescription drug services: When you get a prescription drug, we have agreed to this amount for the prescription or paid this amount to the network pharmacy or third party vendor that provided it. The negotiated charge may include a rebate, additional service or risk charges and administrative fees. It may include additional amounts paid to or received from third parties under price guarantees.] SOB: No reference	
Non-Participating Provider Reimbursement NQTL	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of non-participating provider reimbursement NQTL practices between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences in the application, as written and in operation, of

	Plan Terms and/or Description of NQTL: This NQTL is implemented by the Recognized Charge, (previously referred to as the Allowable Amount), which is the amount of an out-of-network provider's charge that is eligible for coverage according to the method defined in the Certificate (typically a specified percentile of prevailing charges or a percentage of Medicare rates). The method for determining the Recognized Charge for a given plan is always the same for MH/SUD and M/S providers. The Recognized Charge depends on the geographic area where members get the service or supply. M/S services NQTL applies to: Applies to all M/S benefits delivered out of network MH/SUD services NQTL applies to: Applies to all MH/SUD benefits delivered out of network Factors: Factors used in designing the NQTL Single-case contract: XXXXX negotiates with the provider at the time of precertification to agree on a rate before services are provided; if a rate is agreed upon, the member cannot be balance billed. National Advantage Program (NAP) rate: XXXXX contracts with providers directly or through vendors to provide services to members at a reduced rate, while not being in-network providers. NAP providers are not permitted to balance bill members. NAP is not available when the member pays the provider up front. Plan's standard OON rate: The Plan's standard OON rate is specified in the plan documents. It is generally a percentage of the CMS rates or a specified percentile of the prevailing charges. Facility Charge Review: XXXXX determines the recognized charged based on cost-to-charge ratios the facilities report to the government. Includes a patient advocacy process in which XXXXX negotiates with the provider to accept the charges and not balance bill the patient. If the provider agrees, the member is not balance billed. Ad hoc post-service negotiations: Negotiations are done with the provider after services are provided. If this results in an agreed-upon rate, the provider cannot balance bill the member. Non-par reasonable rate: 125% of Medicare rate for professional services and 200% of Medicare rate for facility services. Default rate: 50% of billed charges. State and federal law: State and federal laws prescribe how plans must reimburse OON providers for emergency services or when the member did not voluntarily use OON benefits. Sources: Processes, strategies and/or evidentiary standards used to design and apply the NQTL Strategy XXXXX compensates OON providers based on the terms of the member's plan, at the lesser of the billed charges or the recognized charge. The recognized charge is determined by a standard rate hierarchy that is the same for both MH/SUD and M/S. Process The Plan applies the following rate hierarchy to determine the recognized charge for OON claims. If one step is unsuccessful in producing a rate, the claim continues to the next step in the hierarchy until it is successfully priced.	non-participating provider reimbursement NQTL practices between medical/surgical and MH/SUD.

First tier: single-case contracting (pre-service negotiation)
Second tier: National Advantage Program (NAP) rate
Third tier: the Plan's standard OON rate*
Fourth tier: Facility Charge Review (for facility claims only)
Fifth tier: Ad hoc post-service negotiations
Sixth tier: Non-par reasonable rate
Seventh tier: Default rate

* Where the plan's OON rate is based on Medicare, all MH/SUD providers are paid at 100%. Where reimbursement is based on the Plan's standard OON rate then payment is tiered according to provider licensure:

	M/S	MH/SUD
100%	Doctors	Doctors Clinical Psychologists
85%	Nurse Practitioners Physician Assistants Certified Nurse Midwives Clinical Nurse Specialists (e.g., Nurse Practitioner or Registered Nurse)	Nurse Practitioners Physician Assistants Psychiatric Nurse Drug and Alcohol Counselor Licensed Professional Counselor Marriage and Family Counselor Pastoral Counselor Psychological Examiner Social Worker
75%	Audiologists Registered Dieticians Genetic Counselors Massage Therapists Nutritionists Respiratory Therapists	N/A

For emergency and other involuntary OON services, applicable state and/or federal law is applied to determine the allowed amount and protect the member from balance billing.

Evidentiary Standards
CMS Medicare rates or the FAIR Health prevailing charges database are the benchmarks used to determine the Plan's standard OON rate. Medicare rates are also the standard for the Non-par reasonable rate. CMS' National Correct Coding Initiative (NCCI) and similar external materials about billing and coding practices, as well as generally accepted standards of medical practice, are also standards used to determine whether an OON bill is appropriately coded.

Comparability and Stringency Analysis:
Show if the processes, strategies, evidentiary standards and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation

As written: The factors, strategy, process and evidentiary standards are comparable as written, and not more stringent for MH/SUD services, inasmuch as the plan's method for determining the recognized charge for OON services is the same for

M/S and MH/SUD providers, and the same OON rate hierarchy tiers apply to MH/SUD and M/S claims. As for the payment tiers according to provider licensure type, the fact that there is a 75% tier for M/S providers whereas no MH/SUD providers are paid at 75% (even where their licensure requirements are comparable) shows that the recognized charge is more favorable to members, not less, for OON MH/SUD services.

In operation: Reviewing average OON reimbursement rates provides a way to compare how XXXXX reimburses services from non-participating M/S and MH/SUD providers in operation.

Average recognized charges for M/S and MH/SUD physicians compared to Medicare: The below data reflect the average recognized charges for OON physicians by CPT code for XXXXX's national, fully insured book of business in 2023. The CPT codes selected are for the four most frequently billed shared codes, meaning codes that may be billed by both MH/SUD and M/S providers. The M/S Physician averages are inclusive of both primary care and specialist M/S physician types. The MH/SUD Physician averages are for psychiatrists, which is the only MH/SUD physician type. The Medicare column is included for reference; these Medicare allowed rates are based on the CMS National Average for nonparticipating, unassigned claims.

Average recognized charges for nonparticipating office-based providers:

Service Code	M/S Physician		MH/SUD Physician (Psychiatrist)		Medicare 4Q23
	Avg. Allowed	Units Billed	Avg. Allowed	Units Billed	
99203	$220.81	5,854	$143.12	41	$123.28
99204	$282.27	2,064	$283.11	92	$182.88
99213	$163.11	13,607	$161.19	13,867	$ 99.22
99214	$217.68	7,567	$193.59	402	$140.31

The average recognized charges for all M/S and MH/SUD services are higher than the Medicare allowed rate for a self-pay patient. Of these codes, 99213 (established patient office visit, 20-29 minutes) was most frequently billed by OON psychiatrists. The average reimbursement for MH/SUD was $161.19, compared to $163.11 for M/S physicians for this code.
The code with the greatest difference between M/S and MH/SUD, 99203 (new patient office visit, 30-44 minutes) was only billed 41 times for OON psychiatrist claims, whereas it was billed 5,854 times for OON M/S physician claims. With so few MH/SUD units billed, the average is skewed by the
particular claims and reimbursement methodology used. In contrast, the larger data sets are more representative of the overall average reimbursement arrangements (NAP, prevailing charges or percentage of Medicare, single case contracting, etc.) as well as geographic distribution. Although prevailing charges and a percentage of the Medicare allowed rate will be the same for each CPT code for both M/S and MH/SUD providers, each will vary based on geographic area. The average allowed amounts for CPT codes 99204 and 99213 billed by MH/SUD physicians are within 1% of the M/S amount. The average allowed amounts for CPT codes 99203 and 99214 billed by MH/SUD physicians are within a higher percentage but this is a result of fewer claims billed for these codes. Though the outcomes are mixed, the underlying methodology is the same for M/S and MH/SUD, and the outcome is weighted by the particular methodology in place for the claims billed.

Summary of Conclusions:
In summary, the factors, processes, strategies and evidentiary standards used to reimburse OON MH/SUD providers are comparable to, and are applied no more stringently than, for OON M/S providers, both as written and in operation.

Referenced Policies and Documents:
• 2023 OP Provider Reimbursement National Bob.xlsb

Plan Language:

COC:
Allowable amount
This is the amount of an out-of-network provider's charge that is eligible for coverage. You are responsible for all charges above this amount. The allowable amount depends on the geographic area where you get the service or supply . Allowable amount doesn't apply to involuntary services. These are services or supplies that are:

- Provided at a network facility by an out-of-network provider
- Not available from a network provider
- An emergency service

The table below shows the method for calculating the allowable amount for specific services or supplies:

Service or supply:	Allowable amount is based on:
• Professional services and other services or supplies not mentioned below	Reasonable amount rate 50%-400% of Medicare allowed rate
• Services of hospitals and other facilities	Reasonable amount rate 50%-400% of Medicare allowed rate
• Prescription drugs	50%-200% of average wholesale price (AWP)
• Prescription drugs for gene-based, cellular and other innovative therapies (GCIT)	50%-200% of average wholesale price (AWP)

Important note:
See Special terms used, below, for a description of what the allowable amount is based on.
If the provider bills less than the amount calculated using a method above, the allowable amount is what the provider bills.

If your ID card displays the National Advantage Program (NAP) logo, your cost share may be lower when you get care from a NAP provider. These are out-of-network providers and third party vendors who have contracts with us but are not network providers. When you get care from a NAP provider, your out-of-network cost share applies.

Special terms used:

- Our out-of-network rates (AONR) are our standard rates used to begin contract talks with providers in a specific geographic area. For areas where we don't maintain AONR, we use 50%-400% of the Medicare allowed rates.
- Average wholesale price (AWP) is the current average wholesale price of a prescription drug as listed in the Facts & Comparisons®, Medi-Span daily price updates or any other similar publication we choose to use.
- Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility provider's estimated costs for the service and leave the provider with a reasonable profit.

This means for:

* Hospitals and other facilities that report costs or cost to charge ratios to The Centers for Medicare & Medicaid Services (CMS), the FCR rate is based on what the facilities report to CMS
* Facilities that don't report costs or cost to charge ratios to CMS, the FCR rate is based on a statewide average of these facilities

We may adjust the formula as needed to maintain the reasonableness of the allowable amount. For example, we may make an adjustment if we determine that in a state the charges of a specific type of facility are much higher than charges of facilities that report to CMS.

- Geographic area is normally based using the first three digits of a zip code. If we believe we need more data for a particular service or supply, we may base rates on a wider geographic area such as the entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees without taking into account adjustments for specific provider performance. We update our system with these when revised within

30-180 days of receiving them from CMS. If Medicare doesn't have a rate, we use one or more of the items below to determine the rate for a service or supply:

* The method CMS uses to set Medicare rates
* How much other providers charge or accept as payment
* How much work it takes to perform a service
* Other things as needed to decide what rate is reasonable

We may make the following exceptions:

* For inpatient services, our rate may exclude amounts CMS allows for operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) programs
* Our rate may exclude other payments that CMS may make directly to hospitals or other providers and backdated adjustments
* For anesthesia, our rate may be at least 100%-350% of the rate CMS establishes
* For lab, our rate may be 5%-75% of the rate CMS establishes
* For DME, our rate may be 25%-75% of the rate CMS establishes
* For medications that are paid as a medical benefit instead of a pharmacy benefit, our rate may be 50%-100% of the rates CMS establishes.

When the allowable amount is based on a percentage of the Medicare allowed rate, it is not affected by adjustments or incentives given to providers under Medicare programs.

• Prevailing charge rate is the 50th-95th percentile value reported in a database prepared by FAIR Health®, a non-profit company. FAIR Health may change these periodically. We update our systems within 30-180 days of receiving them from FAIR Health. If the database becomes unavailable, we may substitute a different, comparable database. If the alternate data source doesn't contain a value for a service or supply, we will base the allowable amount on the Medicare allowed rate.

Reasonable amount rate means your plan has established a rate amount as follows:

Service or supply:	Reasonable amount is:
Professional services	50th-95th percentile value reported in a database prepared by Fair Health
Inpatient and outpatient hospital charges	50%-500% of Medicare allowed rate The FCR rate What the provider bills
Inpatient and outpatient charges that are not from a hospital	50%-500% of Medicare allowed rate The FCR rate What the provider bills

Our reimbursement policies

We have the right to apply our reimbursement policies to all out-of-network services including involuntary services. This may affect the allowable amount. When we do this, we consider:

• The length and difficulty of a service
• Whether additional expenses are needed, when multiple procedures are billed at the same time
• Whether an assistant surgeon is needed
• If follow up care is included
• Whether other conditions change or make a service unique
• Whether any of the services described by a claim line are part of or related to the primary service provided, when a charge includes more than one claim line
• The educational level, licensure or length of training of the provider

	We base our reimbursement policies on our review of: • CMS National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and aren't appropriate • Generally accepted standards of medical and dental practice • The views of physicians and dentists practicing in relevant clinical areas We use commercial software to administer some of these policies. Policies may differ for professional services and facility services. SOB: No Reference	
Network Adequacy NQTL	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of non-participating provider reimbursement NQTL practices between medical/surgical and MH/SUD. Plan Terms and/or Description of NQTL: XXXXX maintains sufficient numbers and types of MH/SUD and M/S providers in its network and monitors how effectively this network meets the needs and preferences of its membership. XXXXX establishes mechanisms to ensure access to appointments for MH/SUD and M/S services. M/S services NQTL applies to: Applies to all M/S benefits delivered in-network MH/SUD services NQTL applies to: Applies to all MH/SUD benefits delivered in-network Factors: Factors used in designing the NQTL • State network availability and accessibility standards (where applicable) • Default network availability and accessibility standards (aka "XXXXX's NCQA standards") Definitions: Network availability refers to the extent to which practitioners of the appropriate type and number are geographically distributed to meet the needs of members. Network accessibility refers to members' ability to receive timely care from network providers (that is, to schedule an appointment). Sources: Processes, strategies and/or evidentiary standards used to design and apply the NQTL XXXXX's strategy in having network adequacy standards is to ensure a sufficient number of network providers are available within a reasonable distance to provide covered services to members within a reasonable time, and to comply with state law and NCQA accreditation requirements. The evidentiary standards and processes for developing and maintaining the network adequacy standards for MH/SUD and M/S providers are found in state law (where applicable) and NCQA accreditation requirements. XXXXX's default network availability and accessibility standards are developed and monitored in accordance with NCQA's requirements (specifically, NCQA's HPA standards NET 1—AVAILABILITY OF PRACTITIONERS and NET 2—ACCESSIBILITY OF SERVICES and MBHO standards QI 3-AVAILABILITY OF PRACTITIONERS and QI 4-ACCESSIBILITY OF SERVICES). XXXXX, which has NCQA accreditation as a Health Plan and a Managed Behavioral Healthcare Organization, has submitted these standards to NCQA which has accepted them as part of XXXXX's accreditation.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences in the application, as written and in operation, of network adequacy NQTL practices between medical/surgical and MH/SUD.

	In the application of the network availability and accessibility standards, XXXXX applies the most stringent of the applicable Federal, State, or XXXXX standard. Network availability and accessibility standards for MH/SUD and M/S providers are established and monitored pursuant to written policies applicable to both provider types. (See XXXXX policies QM 07, QM 10 and QM 87.) Network adequacy for both provider types is overseen by the National Quality Oversight Committee (NQOC). Refer to the Appendix to Network Adequacy NQTL for committee composition. For M/S, the NCQA HP Accreditation team performs a qualitative and quantitative analysis by product line using network adequacy data, which includes member complaints/grievances and appeals, accessibility, availability, out of network requests, and member experience data (CAHPS or member experience survey). For MH/SUD, the NCQA MBHO Accreditation team performs separate qualitative and quantitative analyses by product line for Availability, Accessibility, and Member Experience. The Behavioral Health Member Experience Analysis includes member complaints/grievances and appeals, out of network requests, and member experience survey data. Using those analyses, the following data is reviewed to identify barriers and opportunities for improvement which the local market network management (for M/S) and BH (Behavioral Health) network management for (MH/SUD) is responsible for addressing. • Requests for OON services. • Network adequacy complaints, grievances and appeals at or in excess of .01 per thousand member months and volume greater than five* trigger an additional review. Network availability standards express the minimum goal for number and geographic location of providers. XXXXX maintains an open panel for new MH/SUD providers to request participation in the network, even when the standard is met in a given state or market. This is not the case in every market for M/S providers. * Complaint threshold effective 01/01/2024 Comparability and Stringency Analysis: Show if the processes, strategies, evidentiary standards and other factors used for MH/SUD are comparable to, and no more stringent than, those for M/S, as written and in operation The factors, strategy, processes and evidentiary standards for maintaining and monitoring network adequacy are comparable for MH/SUD and M/S providers. This does not, however, mean the actual metrics are identical for various kinds of MH/SUD and M/S providers. State laws vary in the type of standard they apply (numerical or time-and-distance or both) and what the actual standards are. As Written: XXXXX maintains uniform network adequacy policies and practices that are equally applicable to MH/SUD and M/S (see XXXXX policies QM 07, QM 10 and QM 87). In operation: Availability: The 2023 annual network availability reports to NQOC for MH/SUD and M/S providers show a range of results in meeting the various network availability standards. (See 2023 PPO Medical Availability Analysis and 2023 BH Availability Analysis.) For example, in 2023 XXXXX's commercial PPO (non-Medicare) M/S network met or exceeded 100% of the numeric provider-to-member ratio measures. The M/S network met or exceeded 92.8% of the geographic measures. As for the commercial PPO MH/SUD network, in 2023 it met or exceeded 98.6% of the numeric	

	provider-to□member ratio measures. It met or exceeded the 85.7% of the geographic measures. For both the MH/SUD and M/S networks, the reports also propose corrective actions to fill network gaps. These corrective actions are at least as strong for MH/SUD providers as M/S providers. The locations where MH/SUD network availability did not meet standards are generally sparsely populated, and the availability of outpatient MH/SUD services on an in-network basis through XXXXX's contracted telemedicine providers mitigates those network gaps. Accessibility: The 2023 annual network accessibility reports to NQOC for MH/SUD and M/S providers show mixed results in meeting the various network accessibility standards (after-hours availability, wait times for routine and follow-up appointments, etc.), with both MH/SUD and M/S providers meeting standards in some areas and not meeting them in others. (See 2023 PPO Medical Accessibility Analysis and 2023 BH Accessibility Analysis.) For both the MH/SUD and M/S networks, the reports also propose corrective actions where standards were not met. These corrective actions are at least as strong for MH/SUD providers as M/S providers. According to DOL, HHS and Treasury, "[u]nder this analysis, the focus is not on whether the final result is the same for MH/SUD benefits as for medical/surgical benefits, but rather on whether the underlying processes, strategies, evidentiary standards, and other factors are in parity" (see FAQs part 45, April 2, 2021, at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf). Summary of Conclusions: In summary, the factors, processes, strategies and evidentiary standards used to determine network adequacy for MH/SUD providers are comparable to, and are applied no more stringently than, for M/S providers, both as written and in operation. Referenced Policies and Documents: • QM 07 – Member Access to Practitioners and Member Services • QM 10 – Provider Availability Standards • QM 87 – Assessment of Network Adequacy Policy and Procedure • 2023 PPO Medical Availability Analysis • 2023 BH Availability Analysis • 2023 PPO Medical Accessibility Analysis • 2023 BH Accessibility Analysis Plan Language: COC & SOB: No Reference	
(STEP-5): *A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.*	The Plan has confirmed that the criteria for all Medical/Surgical and MH/SUD procedures, services, devices and therapies demonstrate that a consistent methodology for determining which services will be subject to NQTLs, in policy and practice, is comparably and no more stringently applied with respect to MH/SUD benefits than those applied to Medical/Surgical benefits.	

Exhibit A (5a)

Annual Mental Health and Substance Use Benefits Compliance Report

Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:

Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (13) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	*Medical/Surgical Benefits*
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.	Step 1 The Plan covers MH/SUD services/technologies (e.g., services, interventions, devices, medically administered MH/SUD drugs, etc.) that are medically necessary. Medical necessity refers to the principle that healthcare services, technologies and treatments should be in accordance with generally accepted standards of medical practice, appropriate for the member's disorder, disease, or symptoms, cost-effective, and essential for diagnosing, preventing, or treating a medical condition. The concept of medical necessity takes into account the best interests of the patient and the evidence-based standards of medical practice. It helps ensure that healthcare resources are allocated efficiently and that patients receive appropriate care based on their medical needs. The Plan makes medical necessity clinical coverage determinations using externally developed, evidence-based clinical criteria (also known as medical necessity criteria) such as American Society of Addiction Medicine (ASAM) Criteria® , 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 as well as internally developed objective, evidence-based, medical/behavioral clinical policies. Application of medical necessity criteria is integral to the utilization management (UM) processes of a medical necessity clinical coverage benefit determination. The Plan publishes its medical necessity criteria, which are available through the plan's website, and upon request. This document includes the following information: • Process for developing and approving medical necessity criteria for MH/SUD services and technologies • Description of the NQTL and application (Step 1) • Factors used to determine which services and technologies 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)	Step 1 The Plan covers M/S services/technologies (e.g., services, interventions, devices, medically administered M/S drugs, etc.) that are medically necessary. Medical necessity refers to the principle that healthcare services, technologies and treatments should be in accordance with generally accepted standards of medical practice, appropriate for the member's disorder, disease, or symptoms, cost-effective, and essential for diagnosing, preventing, or treating a medical condition. The concept of medical necessity takes into account the best interests of the patient and the evidence-based standards of medical practice. It helps ensure that healthcare resources are allocated efficiently and that patients receive appropriate care based on their medical needs. The Plan makes medical necessity clinical coverage determinations using externally developed, evidence-based clinical criteria (also known as medical necessity criteria) such as InterQual and MCG, guidelines as well as internally developed objective, evidence-based, medical clinical policies. Application of medical necessity criteria is integral to the utilization management (UM) processes of a medical necessity clinical coverage benefit determination. The Plan publishes its medical necessity criteria, which are available through the Plan's website and upon request. This document includes the following information: • Process for developing and approving medical necessity criteria for M/S services and technologies • Description of the NQTL and application (Step 1) • Factors used to determine which services and technologies 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) The Plan concludes that the methodologies used to develop and approve medical necessity criteria and medical clinical policies for M/S and MH/SUD services and technologies are comparable and applied no more stringently for MH/SUD both "as written" and "in operation." M/S has a UM program descriptions that are the foundation for the objectives and guidelines of the Plan's UM strategy. Medical necessity criteria or medical clinical policies are not included in the UM program descriptions.

	The Plan concludes that the methodologies used to develop and approve medical necessity criteria and medical/behavioral clinical policies for M/S and MH/SUD services and technologies are comparable and applied no more stringently for MH/SUD both “as written” and “in operation.” MH/SUD have UM program descriptions that are the foundation for the objectives and guidelines of the Plan’s UM strategy. Medical necessity criteria or medical/behavioral clinical policies are not included in the UM program descriptions. The Plan develops internal, objective, evidence-based, clinical policies and approves third-party, externally developed medical necessity criteria. Where available, MH/SUD use externally developed evidence-based medical necessity criteria (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII) when making clinical coverage determinations. When MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical/behavioral clinical policies are used when making medical necessity clinical coverage determinations. All MH/SUD internally developed medical and behavioral clinical policies are reviewed at least annually. The MH/SUD Clinical Criteria Development/Selection and Application Policy outline the processes to ensure medical necessity criteria are developed consistently. The Clinical Quality and Operations Committee (CQOC) assesses and approves the use of externally developed clinical criteria for MH/SUD services. CQOC uses scientifically based, clinical evidence and the Behavioral Health Hierarchy of Clinical Evidence in its assessment and approval processes. CQOC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services for members. The CQOC is comprised of representatives from sub-committees, representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair must be an executive leader, board certified in psychiatry or psychiatric subspecialty, and a licensed physician. Additionally, CQOC reviews the prior authorization list, and considers the factors and evidentiary standards when applying UM. The CQOC develops and approves behavioral clinical policies for MH/SUD services when externally developed criteria are not available. CQOC uses scientifically based clinical evidence and the Behavioral Health Hierarchy of Clinical Evidence in its development and approval processes. CQOC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services for members. The Clinical Technology Assessment Committee (CTAC) is a sub-committee of CQOC and is responsible for reviewing new or evolving technologies and then developing and maintaining evidence-based behavioral clinical policies for behavioral health technologies. CTAC’s purpose is to make determinations regarding technologies that may or may not be experimental, investigational, or unproven (EIU). CTAC members include behavioral health medical directors, senior leaders of clinical operations,	The Plan develops internal, objective, evidence-based, clinical policies and approves third-party, externally developed medical necessity criteria. Where available, M/S uses externally developed evidence-based medical necessity criteria (e.g., InterQual, MCG) when making clinical coverage determinations. When M/S technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical clinical policies are used when making medical necessity clinical coverage determinations. All M/S internally developed medical clinical policies are reviewed at least annually. The M/S Clinical Review Criteria Operational Policy outline the processes to ensure medical necessity criteria are developed consistently. The Medical Technology Assessment Committee (MTAC) assesses externally developed clinical criteria for M/S services and technologies. MTAC uses scientifically based, clinical evidence and the Hierarchy of Clinical Evidence in its assessment and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services and technologies for members. MTAC is comprised of, but not limited to, medical directors with diverse medical and surgical specialties and sub-specialties, representatives from business segments, legal services, consumer affairs, medical policy development and operations teams, benefit interpretation team, and other guests, as needed. MTAC voting members include medical directors with the following specialties (note that some doctors have multiple specialties): • Plastic Surgery • Internal Medicine (x7) • Medical Oncology • Thoracic and Cardiothoracic Vascular Surgery (x2) • Preventative Medicine • Pediatrics • Diagnostic Radiology and Vascular/Interventional Radiology • Ophthalmology • Physical Medicine & Rehabilitation Pain Medicine • Family Practice • Emergency Medicine As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization, Concurrent Review, and Retrospective Review processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State

	research and development, clinical review, legal, compliance, and policy. CTAC voting members include six psychiatrists and one licensed independent social worker (LISW), plus two co-chairs, both of whom are psychiatrists. CTAC obtains approval of its determinations from the CQOC. When assessing the safety efficacy, and appropriateness of services/technologies used to treat MH/SUD conditions, CQOC and CTAC first look for scientifically based clinical evidence and peer reviewed literature. In addition, the committees will look for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled trials and cohort studies. In addition, CTAC (for EIU) and CQOC will also look for systematic reviews and meta-analyses, large prospective trials, cross-sectional studies, retrospective studies, surveillance studies, case reviews/case series, anecdotal/editorial statements, and professional opinions. In the absence of any strong and compelling scientific evidence, CQOC (and CTAC for potential EIU technologies) assesses services and technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs. CQOC (and CTAC for potential EIU technologies) will not deem a service or technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies. The CQOC reviews and validates behavioral clinical policies endorsed by CTAC. If CQOC determines that any behavioral clinical policies are not appropriately supported by clinical evidence, then CQOC refers the behavioral clinical policy back to CTAC. Internally developed medical and behavioral clinical policies are publicly available online. MH/SUD clinical reviewers follow an established process of reviewing state/federal laws and regulations, followed by Plan documents when making medical necessity coverage benefit determinations. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. Where available, MH/SUD use externally developed evidence-based medical necessity criteria (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII) when making medical necessity coverage benefit determinations. When MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical/behavioral clinical policies are used when making medical necessity clinical coverage determinations. There is no duplication between internally and externally developed medical necessity criteria. This means that there are either externally developed medical necessity criteria available or there are internally developed behavioral clinical policies available. MH/SUD clinical reviewers do not have to make a choice between using internal or external medical necessity criteria. Second level, or peer review, medical necessity coverage benefit determinations include clinical judgment. The MH/SUD Management of Behavioral Health Benefits Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians	• Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. MTAC reports to the UMPC. The Plan uses the following standard process to develop and approve internal medical necessity criteria: The Plan uses committees to assess technologies and conduct a thorough review of scientifically based clinical evidence and peer-reviewed literature in accordance with the Hierarchies of Clinical Evidence to develop medical clinical policies that apply to the technologies. MTAC develops and approves medical clinical policies for M/S services and technologies when externally developed criteria are not available. MTAC uses scientifically based clinical evidence and the Hierarchy of Clinical Evidence in its development and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services and technologies for members. When assessing the safety, efficacy, and appropriateness of the services/technologies used to treat M/S conditions, MTAC first looks for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled, trials and cohort studies. In addition, MTAC will look for multi-site observational studies and single site observational studies. In the absence of any strong and compelling scientific evidence, MTAC assesses technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD). MTAC will not deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies. As of April 1, 2023, UMPC began reviewing and validating the medical clinical policies endorsed by MTAC. If UMPC determines that any medical clinical policies are not appropriately supported by clinical evidence, then UMPC refers the medical clinical policy back to MTAC. Internally developed medical clinical policies are publicly available online. The Plan uses the following standard process to apply medical necessity criteria: M/S clinical reviewers follow an established process of reviewing state/federal laws and regulations, followed by Plan documents when making medical necessity coverage benefit determinations. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. Where available, M/S uses externally developed evidence-based medical necessity criteria (e.g., InterQual, MCG,) when making medical necessity coverage benefit determinations. When M/S technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical clinical policies are used when making

	use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical/behavioral clinical policies. Step 2 The M/S Factors are the same as MH/SUD. Step 3 Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in developing or approving medical necessity criteria. Factor – MH/SUD Committee Considerations, including clinical efficacy, safety of the service or technology, and appropriateness of the proposed service or technology when developing and approving behavioral clinical policies and medical necessity criteria • Clinical Effectiveness - Is a characteristic of care that is in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines as determined by internal medical experts. Clinically appropriate care is more likely to be effective • Patient Safety - As defined by the World Health Organization as “the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum. • Appropriateness of the Proposed Service or Technology - The service or technology is suitable for the member’s clinical presentation and the expected health benefits from the medical service or technology are clinically significant and exceed the expected natural history of recovery and the expected health risks by a sufficient margin The Plan’s evidentiary standard and sources that define and/or trigger the M/S and MH/SUD Committee Considerations factor: • The Plan uses scientifically based clinical evidence and the Behavioral Health Hierarchies of Clinical Evidence to determine which MH/SUD services or technologies are safe and effective and, therefore, eligible for benefit coverage. The Hierarchies of Clinical Evidence detail the hierarchy of clinical evidence that is preferred when assessing which health services or technologies are safe and effective. To be deemed safe and effective, a health service or technology only has to have evidence in at least one category. o MH/SUD assesses evidence from the following when developing or approving behavioral clinical policies/medical necessity criteria: • Scientifically based clinical evidence • Peer-reviewed literature • Behavioral Health Hierarchy of Clinical Evidence • In the absence of strong and compelling scientific evidence, behavioral clinical policies/clinical criteria may be based upon: • National consensus statements • Publications by recognized authorities such as government sources and/or professional societies • ASAM Criteria, LOCUS, CALOCUS-CASII, and ECSII (for review of external medical necessity criteria) Note: Anecdotal/editorial statements and professional opinions are only used to support adoption of behavioral clinical policies /clinical criteria when no other source is available. These evidentiary standards and sources apply for the following:	medical necessity clinical coverage determinations. There is no duplication between internally and externally developed medical necessity criteria. This means that there are either externally developed medical necessity criteria available or there are internally developed medical clinical policies available. M/S clinical reviewers do not have to make a choice between using internal or external medical necessity criteria. Second level, or peer review, medical necessity coverage benefit determinations include clinical judgment. The M/S Peer Clinical Review Operational outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member’s specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical clinical policies. Step 2 The M/S Factors are the same as MH/SUD. Step 3 Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in developing or approving medical necessity criteria. Factor – M/S Committee Considerations, including clinical efficacy, safety of the service or technology, and appropriateness of the proposed service or technology when developing and approving medical clinical policies and medical necessity criteria • Clinical Effectiveness - Is a characteristic of care that is in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines as determined by internal medical experts. Clinically appropriate care is more likely to be effective • Patient Safety - As defined by the World Health Organization as “the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum. • Appropriateness of the Proposed Service or Technology - The service or technology is suitable for the member’s clinical presentation and the expected health benefits from the medical service or technology are clinically significant and exceed the expected natural history of recovery and the expected health risks by a sufficient margin The Plan’s evidentiary standard and sources that define and/or trigger the M/S Committee Considerations factor: • The Plan uses scientifically based clinical evidence and the Hierarchy of Clinical Evidence to determine which M/S services or technologies are safe and effective and, therefore, eligible for benefit coverage. The Hierarchies of Clinical Evidence detail the hierarchy of clinical evidence that is preferred when assessing which health services or technologies are safe and effective. To be deemed safe and effective, a health service or technology only has to have evidence in at least one category. o M/S assesses evidence from the following when developing or approving medical clinical policies/medical necessity criteria: • Scientifically based clinical evidence • Peer-reviewed literature • Hierarchy of Clinical Evidence • In the absence of strong and compelling scientific evidence, medical policies may be based upon: o National guidelines and consensus statements

	• All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM These evidentiary standards and sources are defined in a qualitative manner. Step 4 As Written The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information MH/SUD uses to • develop internal, objective, evidence-based, behavioral clinical policies and • approve third-party, externally developed clinical criteria • to the strategies, processes, factors, evidentiary standards, and source information M/S uses to: • develop internal, objective, evidence-based, medical clinical policies and • approve third-party, externally developed clinical criteria for use in UM clinical coverage determinations and found they were comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information used by M/S “as written.” National internal committees evaluate the applicable factors and standards described in Steps 2 and 3 when developing and approving Medical Necessity criteria. Review of Factor and Evidentiary Standards When developing and approving behavioral clinical policies/medical necessity criteria, MH/SUD committees consider clinical efficacy, safety, and appropriateness of the proposed services or technologies. The MH/SUD Behavioral Health Hierarchies of Clinical Evidence are comparable. MH/SUD use the following categories of sources • Well-designed evidence-based studies • Observational studies • Case studies • Consensus statements • Clinical and professional opinion papers Review of Operational Policies and Procedures The Plan reviewed the following MH/SUD operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes. MH/SUD • Behavioral Health Hierarchy of Clinical Evidence o The purpose of this document is to outline the hierarchy of clinical evidence that is used to determine which MH/SUD health services or technologies are safe and effective and, therefore, eligible for benefit coverage. In developing the hierarchy, MH/SUD uses scientifically based clinical evidence to identify safe and effective health services or technologies for members • CTAC Charter o CTAC is responsible for reviewing new or evolving technologies and then developing and maintaining evidence-based behavioral clinical policies for behavioral health technologies • CQOC Charter	o CMS NCDs o 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, e.g., American College of Physicians (ACP), The Society for Post-Acute and Long-Term Care Medicine (AMDA), American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), American College of Cardiology (ACC), etc. • InterQual or MCG (for review of external medical necessity criteria) Note: Anecdotal/editorial statements and professional opinions are only used to support adoption of behavioral clinical policies /clinical criteria when no other source is available. These evidentiary standards and sources apply for the following: • All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM These evidentiary standards and sources are defined in a qualitative manner. Step 4 As Written The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information M/S uses to • develop internal, objective, evidence-based, behavioral clinical policies and • approve third-party, externally developed clinical criteria • to the strategies, processes, factors, evidentiary standards, and source information M/S uses to: • develop internal, objective, evidence-based, medical clinical policies and • approve third-party, externally developed clinical criteria for use in UM clinical coverage determinations and found they were comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information used by M/S “as written.” National internal committees evaluate the applicable factors and standards described in Steps 2 and 3 when developing and approving Medical Necessity criteria. Review of Factor and Evidentiary Standards When developing and approving medical clinical policies/medical necessity criteria, M/S committees consider clinical efficacy, safety, and appropriateness of the proposed services or technologies. The M/S Hierarchy of Clinical Evidence uses the following categories of sources: • Well-designed evidence-based studies • Observational studies • Case studies • Consensus statements • Clinical and professional opinion papers Review of Operational Policies and Procedures The Plan reviewed the following M/S operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes. M/S

	o The role and purpose of the CQOC is to review and approve externally developed medical necessity criteria, develop behavioral clinical policies when externally developed criteria is not available, and to review and validate CTAC's assessment of EIU technologies • Management of Behavioral Health Benefits o The purpose of this policy is to describe the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and ensure that members receive appropriate, high quality behavioral health services or technologies in a timely manner • Clinical Criteria Development Selection and Application Policy o This document addresses MH/SUD selection, development, and use of clinical criteria in making benefit determinations. MH/SUD uses written clinical criteria consistent with National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) requirements and applicable laws and regulations o MH/SUD selects and uses clinical criteria that are consistent with generally accepted standards of care, including objective criteria that are based on sound clinical evidence. MH/SUD uses the criteria to make standardized coverage determinations and to inform discussions about evidence-based practices and discharge planning Where available, both MH/SUD use externally developed evidence-based medical necessity criteria (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII) when making clinical coverage determinations. When MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, behavioral clinical policies are used when making medical necessity clinical coverage determinations. CQOC (and CTAC for EIU) develop internal clinical policies only. CQOC review and approve externally developed medical necessity criteria. In either case, a comparable process is followed. In some cases, the Plan is obligated by State regulations to use certain externally developed medical necessity criteria. The committees assess the clinical efficacy, safety, and appropriateness of the proposed services or technologies used for the treatment of health care conditions based upon the scientific evidence. CTAC's technology assessment process for MH/SUD potential EIU technologies, including the Behavioral Health Hierarchy of Clinical Evidence, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S technologies including the M/S Hierarchy of Clinical Evidence. Additionally, CQOC's assessment process for MH/SUD services, including the Behavioral Health Hierarchy of Clinical Evidence, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S services including the M/S Hierarchy of Clinical Evidence. All MH/SUD behavioral clinical policies are reviewed at least annually. Review of processes to review externally developed medical necessity criteria The CQOC assesses externally developed clinical criteria for MH/SUD services. CQOC uses scientifically based clinical evidence and the Behavioral Health Hierarchy of Clinical Evidence in its development, assessment, and approval processes. CQOC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services for members.	• Hierarchy of Clinical Evidence o The purpose of this document is to outline the hierarchy of clinical evidence that is used to determine which M/S health services or technologies are safe and effective and, therefore, eligible for benefit coverage. In developing the hierarchy, M/S uses scientifically based clinical evidence to identify safe and effective health services or technologies for members. • Applying Benefit Plan and Review Criteria Standard Operating Procedure o This standard operating procedure outlines the hierarchy of authorities to be reviewed (i.e., state/federal laws and regulations followed by Benefit Plan criteria) when making clinical coverage determinations • Utilization Management Program Committee Charter o This document summarizes the philosophy, structure and standards that govern medical management, utilization management and utilization review responsibilities and functions • Clinical Review Criteria Operational Policy o The purpose of this operational policy is to document that M/S will use evidence-based clinical review criteria to support clinical review decisions for UM programs, and to ensure that the clinical review process is applied consistently Where available, M/S use externally developed evidence-based medical necessity criteria (e.g., InterQual, MCG) when making clinical coverage determinations. When M/S technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical clinical policies are used when making medical necessity clinical coverage determinations. MTAC develop internal clinical policies only. MTAC review and approve externally developed medical necessity criteria. In either case, a comparable process is followed. In some cases, the Plan is obligated by State regulations to use certain externally developed medical necessity criteria. The committees assess the clinical efficacy, safety, and appropriateness of the proposed services or technologies used for the treatment of health care conditions based upon the scientific evidence. CTAC's technology assessment process for MH/SUD potential EIU technologies, including the Behavioral Health Hierarchy of Clinical Evidence, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S technologies including the M/S Hierarchy of Clinical Evidence. Additionally, CQOC's assessment process for MH/SUD services, including the Behavioral Health Hierarchy of Clinical Evidence, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S services including the M/S Hierarchy of Clinical Evidence. All M/S medical clinical policies are reviewed at least annually. Review of processes to review externally developed medical necessity criteria A standard and comparable process is followed to review externally developed, third party medical necessity criteria. The MTAC assesses externally developed clinical criteria for M/S services or technologies. MTAC uses scientifically based, clinical evidence and the Hierarchy of Clinical Evidence in its assessment and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services or technologies for members. M/S committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services or technologies to approve medical clinical policies.

	MH/SUD committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services or technologies to approve medical/behavioral clinical policies. MH/SUD committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors. ASAM Criteria, LOCUS, CALOCUS-CASII, and ECSII are widely recognized as best-in-class externally developed medical necessity criteria sources. The MH/SUD external medical necessity criteria is developed by nationally recognized organizations. The MH/SUD medical necessity criteria sets apply to specific clinical conditions and do not overlap. Review of processes to develop and approve internal medical necessity criteria CQOC (and CTAC for EIU technologies) develops and approves behavioral clinical policies for MH/SUD services and technologies. CQOC/CTAC uses scientifically based clinical evidence and the Behavioral Health Hierarchy of Clinical Evidence in its development, assessment, and approval processes. CQOC/CTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services and technologies for members. When assessing services and technologies used to treat MH/SUD conditions, CQOC/CTAC first look for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled, trials and cohort studies. CQOC/CTAC will also look for systematic reviews and meta-analyses, large prospective trials, cross-sectional studies, retrospective studies, surveillance studies, case reviews/case series, anecdotal/editorial statements, and professional opinions. In the absence of any strong and compelling scientific evidence, CQOC/CTAC assess services and technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs. Neither CQOC nor CTAC will deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies. MH/SUD committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services and technologies to develop or approve behavioral clinical policies. Review of Medical Necessity Processes MH/SUD clinical reviewers follow a hierarchy of authority when making medical necessity determinations. MH/SUD clinical reviewers follow the established process of reviewing state/federal laws and regulations, followed by Plan documents when making clinical coverage benefit determinations (see enclosed MH/SUD Clinical Criteria Development Selection and Application Policy). Internally developed clinical policies or externally developed third party medical necessity criteria are then reviewed. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. As there is no duplication between internally and externally developed medical necessity criteria, MH/SUD clinical reviewers do not have to make a choice between using internal or external medical necessity criteria.	M/S committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors. The Plan uses InterQual medical necessity criteria for M/S services or technologies because InterQual monitors more than 3,000 guidelines, guideline issuers and medical societies for newly published medical literature, and an independent clinical review panel drawn from more than 1,000 experts provides authoritative peer review. The M/S medical necessity criteria sets apply to specific clinical conditions and do not overlap. Review of processes to develop and approve internal medical necessity criteria MTAC develops and approves medical clinical policies for M/S services or technologies. MTAC uses scientifically based clinical evidence and the Hierarchy of Clinical Evidence in its development, assessment, and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services or technologies for members. In the absence of any strong and compelling scientific evidence, MTAC assess services and technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs. MTAC will deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies. M/S and committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services and technologies to develop or approve medical clinical policies. Review of Medical Necessity Processes M/S clinical reviewers follow a hierarchy of authority when making medical necessity determinations. M/S clinical reviewers follow the established process of reviewing state/federal laws and regulations, followed by Plan documents when making clinical coverage benefit determinations (see enclosed M/S Applying Benefit Plan and Review Criteria Standard Operating Procedure). Internally developed clinical policies or externally developed third party medical necessity criteria are then reviewed. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. As there is no duplication between internally and externally developed medical necessity criteria, M/S clinical reviewers do not have to make a choice between using internal or external medical necessity criteria. The Plan generally assesses the appropriate application of its medical necessity criteria in operation by comparing the results of its mandatory M/S Inter-Rater Reliability (IRR) assessment outcomes. In Operation The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information MH/SUD uses to • develop internal, objective, evidence-based, behavioral clinical policies and

	The Plan generally assesses the appropriate application of its medical necessity criteria in operation by comparing the results of its mandatory MH/SUD Inter-Rater Reliability (IRR) assessment outcomes. In Operation The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information MH/SUD uses to • develop internal, objective, evidence-based, behavioral clinical policies and • approve third-party, externally developed clinical criteria to the strategies, processes, factors, evidentiary standards Review of Factor and Evidentiary Standards When reviewing and developing medical/behavioral clinical policies and medical necessity criteria, MH/SUD committees both consider clinical efficacy, safety, and appropriateness of the proposed services and technologies. The Behavioral Health Hierarchies of Clinical Evidence are comparable. The factors and evidentiary standards were applied to MH/SUD services and technologies comparably and not more stringently to MH/SUD services than to M/S services and technologies “in operation.” Review of Operational Policies and Procedures The Plan reviewed MH/SUD operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes. The MH/SUD Clinical Criteria Development/Selection and Application Policy outline the processes to ensure medical necessity criteria are developed consistently. Second level, or peer review, determinations include clinical judgment; the MH/SUD Management of Behavioral Health Benefits Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member’s specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal behavioral clinical policies. Further, review of the committee charters confirms that both committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors. Review of process to develop and approve medical necessity criteria The strategy for developing and approving medical necessity criteria is comparable for both M/S and MH/SUD and applied no more stringently to MH/SUD services and technologies. The Plan conducted a review of the MH/SUD processes to confirm comparability. The review focused on the following aspects of the process for MH/SUD: • The committees follow standard processes outlined in their respective charters and apply their respective Hierarchies of Clinical Evidence when developing, assessing, and approving medical/behavioral clinical policies and medical necessity criteria. o CQOC reviewed and approved the use of third-party externally developed medical necessity criteria and developed new behavioral clinical policies when external criteria were not available. - CTAC developed behavioral clinical policies for EIU. o CQOC reviewed and approved EIU behavioral clinical policies developed by CTAC	• approve third-party, externally developed clinical criteria to the strategies, processes, factors, evidentiary standards, and source information M/S uses to: • develop internal, objective, evidence-based, medical clinical policies and • approve third-party, externally developed clinical criteria for use in UM clinical coverage determinations and found they were comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information used by M/S “in operation.” Review of Factor and Evidentiary Standards When reviewing and developing medical/behavioral clinical policies and medical necessity criteria, M/S committees both consider clinical efficacy, safety, and appropriateness of the proposed services and technologies. The MS Hierarchies of Clinical Evidence are comparable. The factors and evidentiary standards were applied to M/S and MH/SUD services and technologies comparably and not more stringently to MH/SUD services than to M/S services and technologies “in operation.” Review of Operational Policies and Procedures The Plan reviewed M/S operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes. The M/S Clinical Review Criteria Operational Policy outline the processes to ensure medical necessity criteria are developed consistently. Second level, or peer review, determinations include clinical judgment; the M/S Peer Clinical Review Operational Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member’s specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical clinical policies. Further, review of the committee charters confirms that both committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors. Review of process to develop and approve medical necessity criteria The strategy for developing and approving medical necessity criteria is comparable for both M/S and MH/SUD and applied no more stringently to MH/SUD services and technologies. The Plan conducted a review of the M/S processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD: • The committees follow standard processes outlined in their respective charters and apply their respective Hierarchies of Clinical Evidence when developing, assessing, and approving medical/behavioral clinical policies and medical necessity criteria. o MTAC reviewed and approved the use of third-party externally developed medical necessity criteria and developed new medical clinical policies when external criteria were not available • UMPC reviewed and validated the MTAC assessment and approval of medical necessity criteria. • If UMPC determine that any internally developed medical/behavioral clinical policies are not appropriately supported by clinical evidence, then UMPC refer the medical necessity criteria back to MTAC. Review of Use of Medical Necessity Criteria M/S utilize medical and behavioral clinical policies and medical necessity criteria when making medical necessity clinical coverage benefit determinations related to M/S services and

	• If CQOC determine that any internally developed medical/behavioral clinical policies are not appropriately supported by clinical evidence, then CQOC refer the medical necessity criteria back to CTAC. Review of Use of Medical Necessity Criteria MH/SUD utilize medical and behavioral clinical policies and medical necessity criteria when making medical necessity clinical coverage benefit determinations related to MH/SUD services and technologies. All MH/SUD clinical staff and peer reviewers who make clinical coverage benefit determinations utilizing medical and behavioral clinical policies and medical necessity criteria are required to participate in an IRR assessment to ensure clinical policies and medical necessity criteria are applied in a consistent and appropriate manner “in operation.” Clinical staff are required to achieve a passing score of at least 90%. The IRR assessment process identifies areas of improvement for clinical staff who do not achieve a passing score and additional training is provided on the use and application of the relevant policies. If necessary, remediation planning, and training will be directed by a supervisor/manager. Second level, or peer review, medical necessity benefit coverage determinations include clinical judgment. The MH/SUD Management of Behavioral Health Benefits Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member’s specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical/behavioral clinical policies.	technologies. All M/S clinical staff and peer reviewers who make clinical coverage benefit determinations utilizing medical and behavioral clinical policies and medical necessity criteria are required to participate in an IRR assessment to ensure clinical policies and medical necessity criteria are applied in a consistent and appropriate manner “in operation.” Clinical staff are required to achieve a passing score of at least 90%. The IRR assessment process identifies areas of improvement for clinical staff who do not achieve a passing score and additional training is provided on the use and application of the relevant policies. If necessary, remediation planning, and training will be directed by a supervisor/manager. Second level, or peer review, medical necessity benefit coverage determinations include clinical judgment. The M/S Peer Clinical Review Operational Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member’s specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical/behavioral clinical policies.
In-Patient & In-Network NQTL Practices	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.
In-Patient & Out-of-Network NQTL Practices	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy

	Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.	Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.
Out-Patient & In-Network NQTL Practices	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.
Out-Patient & Out-of-Network NQTL Practices	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.
Emergency Services/Benefits NQTL Practices	Prior Authorization, Concurrent Review and Retrospective Review are not performed on MH/SUD Emergency services. Emergency services for MH/SUD, as defined by the prudent layperson standard (and as defined by the state), are covered without medical necessity.	Prior Authorization and Concurrent Review are not performed on M/S Emergency services. Emergency services for M/S, as defined by the prudent layperson standard (and as defined by the state), are covered without medical necessity.

Rx Formulary Design, Management and Pharmacy Services NQTL Practices	**Prescription Drug List (PDL) Design** Step 1 There are no differences in how the NQTL procedure is generally applied Step 2 There are no differences in the factors Step 3 There are no differences in the evidentiary standards and sources Step 4 The Pharmacy & Therapeutics (P&T) Committee assesses a MH/SUD 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. For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop clinical policies through a single P&T Committee. The Plan reviewed the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis 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 2023). The Plan 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 2023: • January 2023 o 56.5% of MH/SUD drugs are on Tiers 1 and 2 • May 2023 o 56.5% of MH/SUD drugs are on Tiers 1 and 2 • September 2023 o 56.3% of MH/SUD drugs are on Tiers 1 and 2 These evaluations were based on the Advantage PDL, which is the most commonly used PDL. Prescription Drug Prior Authorization / Step Therapy / Quantity Limits For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop MH/SUD drug policies through a single Pharmacy & Therapeutics (P&T) Committee. The findings of the prescription drug prior authorization or step therapy outcomes analysis for each Plan (see data below) indicated the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for MH/SUD prescription drugs were comparable to the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for M/S prescription drugs. Data is for (January, May, and September 2023). The Plan notes that the U.S. Department of	**Prescription Drug List (PDL) Design** Step 1 There are no differences in how the NQTL procedure is generally applied. Step 2 There are no differences in the factors. Step 3 There are no differences in the evidentiary standards and sources. Step 4 The Pharmacy & Therapeutics (P&T) Committee assesses a M/S 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. For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop clinical policies through a single P&T Committee. The Plan reviewed the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis. 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 2023). The Plan also notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance. • January 2023 o 56.5% of MH/SUD drugs are on Tiers 1 and 2 o 52.3% of M/S drugs are on Tiers 1 and 2 • May 2023 o 56.5% of MH/SUD drugs are on Tiers 1 and 2 o 52.0% of M/S drugs are on Tiers 1 and 2 • September 2023 o 56.3% of MH/SUD drugs are on Tiers 1 and 2 o 52.5% of M/S drugs are on Tiers 1 and 2 Prescription Drug Prior Authorization / Step Therapy / Quantity Limits For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop M/S drug policies through a single Pharmacy & Therapeutics (P&T) Committee. The findings of the prescription drug prior authorization or step therapy outcomes analysis for each Plan (see data below) indicated the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for MH/SUD prescription drugs were comparable to the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for M/S prescription drugs. Data is for (January, May, and September

	Labor has indicated generally that outcomes data are not dispositive of parity compliance. The following are results of each analysis in 2023: • January 2023 – 33.7% (165) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits • May 2023 – 33.7% (165) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits • September 2023 – 34.0% (166) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits All analysis and material documentation is available upon request.	2023). 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 2023 • January 2023 – 38.5% (1,575) of M/S drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits • May 2023 – 39.3% (1,618) of M/S drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits • September 2023 – 40.1% (1,657) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits"
Prior-Authorization NQTL Practices	**In-Network Inpatient** Step 1 The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. The Plan requires INN providers and facilities to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., Schedule of Benefits). The INN provider's submission of a request (notification) triggers the inpatient Prior Authorization process. INN providers may submit Prior Authorization requests through the secure provider portal (Home (providerexpress.com)) by telephone, or by fax (where required). Providers communicate basic information to create a case. As outlined in the National Network Manual, inpatient behavioral health services require an initial Prior Authorization or notification in advance of the service. As described in the Management of Behavioral Health Benefits Policy, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve coverage requests that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to initial clinical reviewers. First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.). Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and	**In-Network Inpatient** Step 1 The Plan requires INN facilities and providers to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., Schedule of Benefits). The INN provider's submission of a request (notification) triggers the Prior Authorization process. INN providers can submit Prior Authorization requests through the secure provider portal, their connected electronic medical record, by telephone, or by fax (where required). Members may submit Prior Authorization requests by telephone, fax, or mail, in accordance with Plan requirements. Providers and members communicate basic information to create a case. As outlined in the Provider Administrative Guide, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated. The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff will also approve a coverage request if the facility's contract does not allow for clinical reviews. Requests that are submitted through the secure provider portal may also be approved based on the benefit plan coverage criteria, member diagnosis, and the clinical information submitted. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer coverage requests that they cannot approve or administratively deny to initial clinical reviewers. First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met or may access clinical

	history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review. Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information. Platinum Designation. The Plan offers a Platinum Designation program to MH/SUD facilities based on facilities' quantitative practice patterns (effectiveness and efficiency benchmarks). The Platinum Designation program's effectiveness and efficiency benchmarks include targeted 30- and 90-day readmission rates, 7- and 30-day follow up after hospitalization, outlier length of stay, and outlier behavioral health episode spend. INN MH/SUD facilities that meet the Platinum Designation are required to notify the Plan of admissions and provide member information. The Plan covers the first 8 to 21 days of a stay depending on the specific level of care without review. The Plan evaluates INN MH/SUD facilities performance annually as described in the National Network Manual. Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria, 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. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate. MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing	information in the provider's electronic medical record (EMR) if the provider has given the Plan access. The clinical reviewer may approve cases that meet applicable clinical criteria. Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination and appeal rights and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and use clinical criteria from third-party sources such as InterQual or MCG guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate. M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

	score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as warranted. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews UM program outcomes, including inpatient Prior Authorization outcomes, to confirm overall utilization is appropriate. The CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the Clinical Quality & Operations Committee must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law where applicable. List of MH/SUD Services Subject to NQTL • MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment Step 2 The Plan confirmed that the MH/SUD and M/S factors are the same. MH/SUD does not use any other factors other than those shared with M/S in determining the services that are subject to Prior Authorization, specifically Clinical Appropriateness and Value. For MH/SUD, meeting Clinical Appropriateness and Value is determinative in imposing the limitation. For MH/SUD, a service must meet both the Clinical Appropriateness and Value factors to be subject to Prior Authorization. This makes the limitation more difficult to impose for MH/SUD services. Step 3 For MH/SUD services, meeting Clinical Appropriateness and Value is determinative in imposing the limitation. For MH/SUD, a service must meet both the Clinical	The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. Per the M/S policy entitled Performance Assessment and Incentives, at no time are initial clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable. List of M/S Services Subject to NQTL • The Plan publishes the INN services subject to Prior Authorization on the provider portals. • Arthroplasty • Bariatric Surgery • Breast Reconstruction (non-mastectomy) • Cerebral Seizure Monitoring – Inpatient Video EEG • Chemotherapy Services • Clinical Trials • Congenital Heart Disease • Cosmetic and Reconstructive Procedures • End-stage renal disease (ESRD) dialysis services • Foot Surgery • Gender Dysphoria Treatment • Hysterectomy • Inpatient admissions – post-acute services • Orthognathic Surgery

	Appropriateness and Value factors to be subject to prior authorization. This makes the limitation more difficult to impose for MH/SUD services. MH/SUD does not use any other factors other than those shared with M/S in determining the services that are subject to prior authorization, specifically Clinical Appropriateness and Value. Step 4 • Timeframe to Submit. The Administrative Guide (for M/S) and National Network Manual (for MH/SUD) were reviewed for notification timeframes. The timeframes for the provider or member to notify of an inpatient admission were reviewed and determined that MH/SUD was comparable and no more stringent. o MH/SUD: As outlined in National Network Manual, MH/SUD requires notification within one business day after an inpatient admission to a facility unless a longer period is required by contract or state-specific requirements. - Unplanned or emergency services are not subject to Prior Authorization. • Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA). o MH/SUD is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors. Outcomes Data reviewed for comparability INN inpatient medical necessity approval and denial rates and appeals outcomes data from 1/1/2024 – 12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD INN inpatient cases from 1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for Plans 1, 2 and 3. MH/SUD INN IP Cases Plan 1 Administrative Denial Rate - 0% (0 out of 15 cases) Clinical Denial Rate – 6.67% (1 out of 15 cases) Plan 2 Administrative Denial Rate - 0% (0 out of 10 cases) Clinical Denial Rate - 10% (1 out of 10 cases) Plan 3 Administrative Denial Rate - 0% (0 out of 79 cases) Clinical Denial Rate - 1.25% (1 out of 79 cases) All analysis and material documentation is available upon request. **Out-of-Network Inpatient**	• Sleep Apnea Procedures and Surgeries • Spinal Surgery • Transplant • Ventricular Assist Devices Step 2 The Plan confirmed that the MH/SUD and M/S factors are the same. For M/S services, meeting Clinical Appropriateness or Value is required to impose the limitation. Step 3 For M/S services, meeting Clinical Appropriateness or Value is required to impose the limitation. Step 4 • Timeframe to Submit. The Administrative Guide (for M/S) and The timeframes for the provider or member to notify of an inpatient admission were reviewed and determined that MH/SUD was comparable and no more stringent. o M/S: As outlined in the Administrative Guide, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated. • Review of Staff Qualifications. For M/S clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA). o M/S is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by Medical Directors. Outcomes Data reviewed for comparability INN inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2024 – 12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD INN inpatient cases from 01/01/2024 -12/31/2024 to support an analysis of clinical outcomes data for Plans 1, 2 and 3. M/S INN IP Cases Plan 1 Administrative Denial Rate - 0% (0 out of 143 cases) Clinical Denial Rate – 10.49% (15 out of 143 cases) Plan 2 Administrative Denial Rate - 0% (0 out of 20 cases) Clinical Denial Rate – 5% (1 out of 20 cases) Plan 3 Administrative Denial Rate – 1.61% (5 out of 111 cases) Clinical Denial Rate – 16.72% (52 out of 111 cases) All analysis and material documentation is available upon request.

	Step 1 The Plan delegates management of MH/SUD inpatient services, including Prior Authorization, to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. Members are responsible for ensuring Prior Authorization is obtained by the OON provider administering the service. The OON provider must provide clinical information on the member's behalf. The member's benefit plan document (i.e., Schedule of Benefits) identifies the services for which the member is responsible for ensuring Prior Authorization is obtained. As outlined in the Plan document, OON providers must submit the Prior Authorization request before inpatient MH/SUD services are received. OON provider's submission of a request (notification) triggers the Prior Authorization process. OON providers may submit Prior Authorization requests on behalf of the member by phone or by fax (where required). Members or providers communicate basic information to create a case. As described in the Management of Behavioral Health Benefits Policy, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve coverage requests that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers. First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.). Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review. Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., the admission is not medically necessary and is not approved), then the Plan timely	**Out-of-Network Inpatient** Step 1 Members are responsible for obtaining Prior Authorization for services rendered by OON providers. The member's benefit plan document (i.e., Schedule of Benefits) identifies the services for which the member is responsible for obtaining Prior Authorization and the required timeframe(s). The member or OON provider's submission of a request (notification) triggers the Prior Authorization process. Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. OON providers may submit Prior Authorization requests on behalf of the member by phone, online or by fax (where required). Members or providers communicate basic information to create a case. The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to clinical reviewers. First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria. Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Adverse Benefit Determination. For M/S an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria

	communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information. Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria, 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. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Prior Authorization determinations are appropriate. MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews UM program outcomes, including inpatient Prior Authorization outcomes, to confirm overall utilization is appropriate. The CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the Clinical Quality & Operations Committee must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician.	and member clinical information and are recorded as administrative denials when member benefits are exhausted. Modified coverage requests that are approved are recorded as partial denials. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and use clinical criteria from third-party sources such as InterQual or MCG guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate. M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed.

	Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law where applicable. List of MH/SUD Services Subject to NQTL • MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment Step 2 For MH/SUD, meeting Clinical Appropriateness and Value is determinative in imposing the limitation. For MH/SUD, a service must meet both the Clinical Appropriateness and Value factors to be subject to Prior Authorization. This makes the limitation more difficult to impose for MH/SUD services. MH/SUD does not use any other factors other than those shared with M/S in determining the services that are subject to Prior Authorization, specifically Clinical Appropriateness and Value. Step 3 For MH/SUD, meeting Clinical Appropriateness and Value is determinative in imposing the limitation. For MH/SUD, a service must meet both the Clinical Appropriateness and Value factors to be subject to Prior Authorization. This makes the limitation more difficult to impose for MH/SUD services. MH/SUD does not use any other factors other than those shared with M/S in determining the services that are subject to Prior Authorization, specifically Clinical Appropriateness and Value. Step 4 • Timeframe to Submit. The timeframes for the member or OON provider on behalf of the member to submit the Prior Authorization request were reviewed and it was determined that MH/SUD was no more stringent. o MH/SUD: Per the member's Plan documents, the Prior Authorization should be requested before OON services are received. - Unplanned or emergency services are not subject to Prior Authorization • Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA). o MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors.	Per the M/S policy entitled, Performance Assessment and Incentives, at no time are initial or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable. List of M/S Services Subject to NQTL • Addendum A, attached, lists the M/S and MH/SUD OON outpatient service categories subject to Prior Authorization. Prior Authorization is one component of the UM program that evaluates whether a benefit or service is medically necessary. Plan 1 • Congenital Heart Disease (CHD) Surgeries (Large Group only) • Gender Dysphoria - Surgical Treatment (Large Group only) • Habilitative Services (Large Group only) • Hospice Care • Hospital inpatient care - all scheduled admissions [and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery and stays for Complications of Pregnancy exceeding 96 hours for a cesarean section delivery. (Small Group only) • Hospital - Inpatient Stay (Large Group only) • Obesity - Weight Loss Surgery • Pregnancy - Maternity Services - Inpatient Stay more than 48 hours following a normal vaginal delivery, or more than 96 hours for a cesarean section delivery (Large Group only) • Reconstructive Procedures - Admissions • Skilled Nursing Facility/Inpatient Rehabilitation Facility Services • Spine and Joint Surgeries (Large Group only) • Temporomandibular Joint (TMJ) Services • Transplantation Services - Admission Plan 2 • Congenital Heart Disease (CHD) Surgeries (Large Group only) • Gender Dysphoria - Surgical Treatment (Large Group only) • Habilitative Services (Large Group only) • Hospice Care • Hospital inpatient care - all scheduled admissions [and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery and stays for Complications of Pregnancy exceeding 96 hours for a cesarean section delivery. (Small Group) • Hospital - Inpatient Stay (Large Group only) • Obesity - Weight Loss Surgery • Pregnancy - Maternity Services - Inpatient Stay more than 48 hours following a normal vaginal delivery, or more than 96 hours for a cesarean section delivery (Large Group only) • Reconstructive Procedures - Admissions • Skilled Nursing Facility/Inpatient Rehabilitation Facility Services • Spine and Joint Surgeries (Large Group only) • Temporomandibular Joint (TMJ) Services • Transplantation Services – Admission

	Outcomes Data reviewed for comparability OON inpatient medical necessity approval and denial rates and appeals outcomes data from 1/1/2024 -12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD OON inpatient cases from 1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for Plans 1, 2 and 3. MH/SUD OON IP Cases Plan 1 Administrative Denial Rate - 0% (0 out of 17 cases) Clinical Denial Rate - 0% (0 out of 13 cases) Plan 2 Administrative Denial Rate - 0% (0 out of 4 cases) Clinical Denial Rate - 0% (0 out of 7 cases) Plan 3 Administrative Denial Rate – 9.3% (4 out of 43 cases) Clinical Denial Rate - 0% (0 out of 43 cases) All analysis and material documentation is available upon request **In-Network Outpatient** Step 1 The Plan delegates management of MH/SUD outpatient services, including Prior Authorization, to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. The Plan requires INN providers to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., Schedule of Benefits). INN providers may submit Prior Authorization requests through the secure provider portal (Home (providerexpress.com) by telephone, or by fax (where required). Providers and members communicate basic information to create a case. As outlined in the National Network Manual, most routine outpatient behavioral health services do not require an initial pre-authorization or notification in advance of the service. The INN provider's submission of a request (notification) triggers the Prior Authorization process. As described in the Management of Behavioral Health Benefits Policy, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers.	Plan 3 • Hospice Care • Hospital Inpatient Care • Obesity Surgery • Orthodontia • Reconstructive Procedures • Skilled Nursing Facility and Inpatient Rehabilitation Facility Services • Temporomandibular Joint (TMJ) Services • Transplants • Ventricular assist device implantation Step 2 For M/S, meeting Clinical Appropriateness or Value is determinative in imposing the limitation. While the Value factor is considered for M/S, it is not determinative in imposing the limitation. A service category meeting just the Clinical Appropriateness factor can be subjected to Prior Authorization. Step 3 For M/S, meeting Clinical Appropriateness or Value is determinative in imposing the limitation. While the Value factor is considered for M/S, it is not determinative in imposing the limitation. A service category meeting just the Clinical Appropriateness factor can be subjected to Prior Authorization. Step 4 • Timeframe to Submit. The timeframes for the member or OON provider on behalf of the member to submit the Prior Authorization request were reviewed and it was determined that MH/SUD was no more stringent. o M/S – Per the member's Plan documents, the timeframes vary depending upon the services requested from as soon as possible to six months prior to the OON service. • Review of Staff Qualifications For M/S, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA). o M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse determinations are made by Medical Directors. Outcomes Data reviewed for comparability OON inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2024 – 12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of M/S and MH/SUD OON outpatient cases from 1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for Plans 1, 2 and 3. M/S OON IP Cases Plan 1 Administrative Denial Rate – 0% (0 out of 7 cases) Clinical Denial Rate – 0% (0 out of 7 cases)

	First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.). Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria. Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements, before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., the number of treatments are not authorized), then the Plan timely communicates the adverse benefit determination including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information. Intensive Outpatient Program (IOP) Practice Management. The Plan identifies INN MH/SUD IOP facilities and clinics that demonstrate effective performance based on readmission rates, lengths of stay, and post-discharge outcomes for inclusion in Practice Management. INN MH/SUD facilities or clinics that meet these performance criteria do not have to obtain Prior Authorization for IOP services. Instead, the facilities submit claims post-service, which the Plan pays. Platinum Designation. The Plan offers a Platinum Designation program to MH/SUD providers based on facilities' quantitative practice patterns (effectiveness and efficiency benchmarks). The Platinum Designation program's effectiveness and efficiency benchmarks include targeted 30- and 90-day readmission rates, 7- and 30-day follow up after hospitalization, outlier length of stay, and outlier behavioral health episode spend. INN MH/SUD facilities that meet the Platinum Designation are required to notify the Plan of admissions to Partial Hospitalization Program (PHP) and provide member information. The Plan covers the first 17 days of admission to PHP without review. Facilities notify the Plan if additional days are needed. The Plan evaluates INN MH/SUD facilities' performance annually as described in the National Network Manual.	Plan 2 Administrative Denial Rate - 0% (0 out of 0 cases) Clinical Denial Rate – 0% (0 out of 0 cases) Plan 3 Administrative Denial Rate – 8% 2 out of 25 cases) Clinical Denial Rate – 24% (6 out of 25 cases) All analysis and material documentation is available upon request. **In-Network Outpatient** Step 1 The Plan requires INN providers to submit a Prior Authorization request for services on the Prior Authorization list prior to rendering the service. There may be some INN benefits for which the member is responsible for obtaining Prior Authorization. These are identified in the member's benefit plan document (i.e., Schedule of Benefits). The INN provider's submission of a request (notification) triggers the Prior Authorization process. INN providers may submit Prior Authorization requests through the secure provider portal, their connected electronic medical record, by telephone, or by fax (where required). Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. Providers and members communicate basic information to create a case. As outlined in the Provider Administrative Guide, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated. The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Requests that are submitted through the secure provider portal may also be approved based on the benefit plan coverage criteria, member diagnosis, and the clinical information submitted. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers for medical necessity review. First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria. Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or

	Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria, 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. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate. MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Prior Authorization outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law where applicable. List of MH/SUD Services Subject to NQTL • Partial Hospitalization (PHP)/Day Treatment/ High Intensity Outpatient • Intensive Outpatient (IOP)	mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Adverse Benefit Determination. For M/S an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based, medical clinical policies or use clinical criteria from third-party sources such as InterQual or MCG guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate. M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the

	• Psychological Testing • Applied Behavior Analysis (ABA) • Transcranial Magnetic Stimulation (TMS) Step 2 Factor – Clinical Appropriateness For MH/SUD, meeting Clinical Appropriateness and Value and/or is determinative in imposing the limitation. For MH/SUD, a service must meet the Clinical Appropriateness and Value and/or Variation factors to be subject to Prior Authorization. This makes the limitation more difficult to impose for MH/SUD services. MH/SUD does not use any other factors other than those shared with M/S in determining the services that are subject to Prior Authorization, specifically Clinical Appropriateness and Value and/or Variation. Step 3 Factor – Clinical Appropriateness • The Plan's evidentiary standards and sources for the Clinical Appropriateness factor are: o Clinical criteria from nationally recognized, third-party sources (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines) o Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Psychiatric Association, etc.) • The sources that define and/or trigger the Clinical Appropriateness factor: o Clinical Technology Assessment Committee (CTAC) review o Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Psychiatric Association, etc.) For MH/SUD, meeting Clinical Appropriateness and Value and/or Variation is determinative in imposing the limitation. For MH/SUD, a service must meet the Clinical Appropriateness and Value and/or Variation factors to be subject to Prior Authorization. This makes the limitation more difficult to impose for MH/SUD services. MH/SUD does not use any other factors other than those shared with M/S in determining the services that are subject to Prior Authorization, specifically Clinical Appropriateness and Value. Factor – Patient Safety • The Plan's evidentiary standards that define and/or trigger the Patient Safety factor: o Clinical criteria from nationally recognized third-party sources (e.g., ASAM, LOCUS, CALOCUS-CASII and ECSII guidelines) o Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Psychiatric Association, etc.) • The Plan's sources used to define the Patient Safety factor: o Clinical criteria from nationally recognized third-party sources (e.g., ASAM, LOCUS, CALOCUS-CASII and ECSII guidelines)	M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. Per the M/S policy entitled, Performance Assessment and Incentives, at no time are initial or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable. List of M/S Services Subject to NQTL • The Plan publishes the INN services subject to Prior Authorization on the provider portals • Arthroplasty • Arthroscopy • Bariatric Surgery • Bone Growth Stimulator • Breast Reconstruction (non-mastectomy) • Cancer Supportive Care • Cardiology • Cardiovascular • Cartilage Implants • Chemotherapy Services • Clinical Trials • Cochlear and Other Auditory Implants • Congenital Heart Disease • Continuous Glucose Monitor • Cosmetic and Reconstructive Procedures • Durable Medical Equipment (DME) over $1,000 • End-Stage Renal Disease (ESRD) Dialysis Services • Foot Surgery • Functional Endoscopic Sinus Surgery (FESS) • Gastroenterology Endoscopy (GI) • Gender Dysphoria Treatment • Genetic and Molecular Testing to Include BRCA Gene Testing

	o Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Psychiatric Association, etc.) For MH/SUD, meeting Clinical Appropriateness and Value and/or Variation is determinative in imposing the limitation. For MH/SUD, a service must meet the Clinical Appropriateness and Value and/or Variation factors to be subject to Prior Authorization. This makes the limitation more difficult to impose for MH/SUD services. MH/SUD does not use any other factors other than those shared with M/S in determining the services that are subject to Prior Authorization, specifically Clinical Appropriateness and Value. Step 4 • Timeframe to Submit. The timeframes for the provider or member to submit the Prior Authorization request were reviewed and it was determined that MH/SUD was comparable and no more stringent. o MH/SUD: As outlined in the National Network Manual, MH/SUD indicates that prior authorization, when required, should occur prior to the delivery of certain non-routine outpatient services. - Unplanned or emergency services are not subject to prior authorization. • Review of Staff Qualifications. For MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA). o MH/SUD is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Outcomes Data reviewed for comparability INN outpatient medical necessity approval and denial rates and appeals outcomes data from 1/1/2024 -12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. The findings of a comparative analysis for each Plan product (see data below) indicated the Prior Authorization process for MH/SUD INN outpatient services was comparable to the Prior Authorization process for INN M/S outpatient services. There is an insufficient number of MH/SUD INN outpatient cases from 1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for Plan 2. MH/SUD INN OP Cases Plan 1 Administrative Denial Rate - 0% (0 out of 157 cases) Clinical Denial Rate - 1.27% (2 out of 157 cases) Plan 2 Administrative Denial Rate - 0% (0 out of 83 cases) Clinical Denial Rate - 0% (0 out of 83 cases)	• Home Health Care – Non-nutritional • Hysterectomy - Outpatient Procedures • Infertility • Injectable Medications • MR-guided Focused Ultrasound (MRgFUS) to Treat Uterine Fibroid • Non-Emergency Air Transport • Orthognathic Surgery • Orthotics over $1,000 • Pain Management and Injection • Potentially Unproven Services (including experimental/investigational and/or linked services) • Prostate Procedures • Prosthetics over $1,000 • Radiation Therapy • Radiology • Rhinoplasty • Sinuplasty • Site of Service – Office-based Program • Site of Service – Outpatient Hospital • Site of Service – Outpatient Hospital Expansion • Sleep Apnea Procedures and Surgeries • Sleep Studies • Spinal Cord Stimulators • Spinal Surgery • Stimulators – Not Related to Spine • Therapeutic Radiopharmaceuticals • Transplant • Vein Procedures Step 2 For M/S, meeting Clinical Appropriateness is determinative in imposing the limitation. While the Value and Variation factors are considered for M/S, they are not determinative in imposing the limitation. A service category meeting just the Clinical Appropriateness factor can be subjected to Prior Authorization. Step 3 Factor – Clinical Appropriateness • The Plan's evidentiary standards and sources for the Clinical Appropriateness factor are: o Objective, evidence-based clinical criteria from nationally recognized third-party sources (e.g., InterQual or MCG for M/S services. o Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.) • The sources that define and/or trigger the Clinical Appropriateness factor: o Medical Technology and Assessment Committee (MTAC) review o Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.)

	Plan 3 Administrative Denial Rate - 1.90% (8 out of 420 cases) Clinical Denial Rate - 2.86% (12 out of 420 cases) All analysis and material documentation is available upon request. **Out-of-Network Outpatient** Step 1 The Plan delegates management of MH/SUD outpatient services, including Prior Authorization to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. Members are responsible for ensuring Prior Authorization is obtained by the OON provider administering the service. The OON provider must provide clinical information on the member's behalf. The member's benefit plan document (i.e., Schedule of Benefits) identifies the services for which the member is responsible for ensuring Prior Authorization is obtained. As outlined in the Plan document, OON providers must submit the Prior Authorization request before outpatient MH/SUD services are received. OON providers may submit Prior Authorization requests on behalf of the member by telephone, online (for certain services) or by fax (where required). Providers communicate basic information to create a case. OON provider's submission of a request (notification) triggers the Prior Authorization process. As described in the Management of Behavioral Health Benefits Policy, the Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may administratively deny coverage when member benefits are exhausted. Non-clinical staff may approve coverage requests that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve or administratively deny to the initial clinical reviewers. First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.). Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether a service is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request additional clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services. The clinical reviewer may approve cases that meet applicable clinical criteria. Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an	Factor – Patient Safety • The Plan's evidentiary standards that define and/or trigger the Patient Safety factor: o Professional judgment of members of the Utilization Management Program Committee o Clinical criteria from nationally recognized third-party sources (e.g., InterQual for M/S services services) o Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.) • The Plan's sources used to define the Patient Safety factor: o Professional judgment of members of the Utilization Management Program Committee o Clinical criteria from nationally recognized third-party sources (e.g., InterQual for M/S services). o Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.) Step 4 • Timeframe to Submit. The timeframes for the provider or member to submit the Prior Authorization request were reviewed and it was determined that MH/SUD was comparable and no more stringent. o M/S: As outlined in the Provider Administrative Guide, providers must submit prior authorization requests with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated. - Unplanned or emergency admissions are not subject to Prior Authorization. • Determinations and Non-Clinical Reviews, First Level Clinical Reviews, and Second Level/Peer Clinical Reviews. For M/S outpatient Prior Authorization, non-clinical staff may approve cases that do not require clinical evaluation or interpretation. Non-clinical staff may administratively deny cases when member benefits are exhausted/excluded. M/S INN outpatient cases that are submitted through the provider portal may also be approved based on the member diagnosis and the clinical information submitted. • Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA). o M/S is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by a physician or other appropriate health care professionals. Outcomes Data reviewed for comparability INN outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2024 – 12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. The findings of a comparative analysis for each Plan product (see data below) indicated the Prior Authorization process for MH/SUD INN outpatient services was comparable to the Prior Authorization process for INN M/S outpatient services.

	adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors or psychologists) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination (e.g., number of treatments are not authorized), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity clinical coverage determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third-party sources such as American Society of Addiction Medicine (ASAM) Criteria, 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. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate. MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Prior Authorization outcomes, to	There is an insufficient number of MH/SUD INN outpatient cases from 1/1/2024 -12/31/2024 to support an analysis of clinical outcomes data for Plan 2. M/S INN OP Cases Plan 1 Administrative Denial Rate - 0.48% (73 out of 15,062 cases) Clinical Denial Rate – 18.92% (2,849 out of 15,062 cases) Plan 2 Administrative Denial Rate - 0.37% (5 out of 1,335 cases) Clinical Denial Rate - 17.43% (238 out of 1,335 cases) Plan 3 Administrative Denial Rate - 0.66% (99 out of 18,879 cases) Clinical Denial Rate - 9.24% (1,745 out of 18,879 cases) All analysis and material documentation is available upon request. **Out-of-Network Outpatient** Step 1 Members are responsible for obtaining Prior Authorization for services rendered by OON providers. The member's benefit plan document (i.e., Schedule of Benefits) identifies the services for which the member is responsible for obtaining Prior Authorization and the required timeframe(s). The member or OON provider's submission of a request (notification) triggers the Prior Authorization process. Members may submit Prior Authorization requests by phone, fax, or mail, in accordance with Plan requirements. OON providers may submit Prior Authorization requests on behalf of the member by phone, online or by fax (where required). Members or providers communicate basic information to create a case. The Plan confirms receipt of the Prior Authorization request. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. Non-clinical staff review cases to ensure availability of accurate and thorough case information. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff may administratively deny coverage when a member's benefits are exhausted. Non-clinical staff refer cases that they cannot approve or administratively deny to clinical reviewers. First Level Clinical Review/Initial Review. Clinical reviewers (nurses) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. The clinical reviewer can approve cases that meet applicable clinical criteria.

	confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law where applicable. List of MH/SUD Services Subject to NQTL • Intensive Outpatient (IOP) • Partial Hospitalization (PHP)/Day Treatment/ High Intensity Outpatient • Psychological Testing • Applied Behavior Analysis (ABA) • Transcranial Magnetic Stimulation (TMS) Step 2 For MH/SUD, meeting Clinical Appropriateness and Value and/or is determinative in imposing the limitation. For MH/SUD, a service must meet the Clinical Appropriateness and Value and/or Variation factors to be subject to Prior Authorization. This makes the limitation more difficult to impose for MH/SUD services. MH/SUD does not use any other factors other than those shared with M/S in determining the services that are subject to Prior Authorization, specifically Clinical Appropriateness and Value and/or Variation. Step 3 The evidentiary standards for the Clinical Appropriateness factor are: • Objective, evidence-based clinical criteria from nationally recognized third-party sources (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services): o ASAM Criteria are criteria developed by the American Society of Addiction Medicine used to make determinations for substance-related disorder benefits. o LOCUS is a standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make determinations and placement decisions for adults ages 18 and older. o CALOCUS-CASII is a standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry and the American Association of Community Psychiatrists used to make determinations and to provide level of service intensity recommendations for children and adolescents ages 6-18. o ECSII is a standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry used to make determinations and to provide level of service intensity recommendations for children ages 0-5.	Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer issues an adverse benefit determination, then the Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Adverse Benefit Determination. For M/S an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when member benefits are exhausted. Modified coverage requests that are approved are recorded as partial denials. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and use clinical criteria from third-party sources such as InterQual or MCG guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Prior Authorization determinations are appropriate. M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Prior Authorization performance through its clinical performance oversight functions. Outcomes are monitored against timeliness compliance, performance guarantees, and for potential trends, including overall utilization. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the

	• Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., American Psychiatric Association, etc.) The sources that define and/or trigger the Clinical Appropriateness factor: • Clinical Quality and Operations Committee (CQOC) review o The MH/SUD CQOC determines whether services should be added to, removed from, or remain on the prior authorization list through its evaluation of objective, evidence-based clinical criteria. - MH/SUD CQOC is comprised of representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair must be an executive leader, board certified in psychiatry or psychiatric subspecialty, and a licensed physician. • Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., American Psychiatric Association, etc.) For MH/SUD, meeting Clinical Appropriateness and Value and/or Variation is determinative in imposing the limitation. For MH/SUD, a service must meet the Clinical Appropriateness and Value and/or Variation factors to be subject to Prior Authorization. This makes the limitation more difficult to impose for MH/SUD services. Step 4 • Timeframe to Submit. The timeframes for the member, or OON provider on behalf of the member, to submit the Prior Authorization request were reviewed and it was determined that MH/SUD was no more stringent. o MH/SUD: Per the member's Plan documents, the Prior Authorization should be requested before OON services are received. - Unplanned or emergency services are not subject to Prior Authorization • Review of Staff Qualifications. For MH/SUD, clinical staff qualifications align with the type of clinical review and with state, federal, and accreditation requirements (NCQA). o MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by medical directors or psychologists. Outcomes Data reviewed for comparability OON outpatient medical necessity approval and denial rates and appeals outcomes data from 1/1/2024 -12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD OON outpatient cases from 1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for OHP. There is an insufficient number of MH/SUD OON outpatient cases from 1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for Plans 2 and 3. MH/SUD OON OP Cases	M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. Per the M/S policy entitled, Performance Assessment and Incentives, at no time are initial or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable. List of M/S Services Subject to NQTL • Addendum A, attached, lists the M/S OON outpatient service categories subject to Prior Authorization. Prior Authorization is one component of the UM program that evaluates whether a benefit or service is medically necessary. Plan 1: • Ambulance Services - Non-Emergency Air Ambulance • Cellular and Gene Therapy (Large Group) • Clinical Trials • Diabetes Equipment (Small Group) • Diabetes Services (Large Group) • Durable Medical Equipment (DME), Orthotics and Supplies • Fertility Preservation for Iatrogenic Infertility (Large Group) • Formulas/Specialized Foods (Small Group) • Gender Dysphoria - Non-Surgical Treatment (Large Group) • Genetic Testing – Including BRCA (Small Group) • Habilitative Services – Outpatient Therapies (Large Group) • Hearing Aids • Home Health Care • Infertility Services • Lab, X-Ray and Diagnostic • Major Diagnostic and Imaging • Orthodontia (Small Group) • Pain Management (Small Group)

	Plan 1 Administrative Denial Rate - 0.88% (1 out of 113 cases) Clinical Denial Rate - 1.77% (2 out of 113 cases) Plan 2 Administrative Denial Rate - 0% (0 out of 69 cases) Clinical Denial Rate - 2.90% (2 out of 69 cases) Plan 3 Administrative Denial Rate - 9.09% (3 out of 33 cases) Clinical Denial Rate - 9.09% (3 out of 33 cases) All analysis and material documentation is available upon request.	• Pharmaceutical Products • Pregnancy - Maternity Services (Large Group) • Preimplantation Genetic Testing (PGT) and Related Services (Large Group) • Preventive Care Services – Breast Pump • Prosthetic Devices • Reconstructive Procedures • Rehabilitation Services - Outpatient Therapy and Manipulative Treatment • Scopic Procedures • Spine and Joint Surgeries (Large Group) • Surgery – Outpatient • Temporomandibular Joint (TMJ) Services • Therapeutic Treatments (Large Group) Plan 2 • Ambulance Services - Non-Emergency Air Ambulance • Cellular and Gene Therapy (Large Group) • Clinical Trials • Diabetes Equipment (Small Group) • Diabetes Services (Large Group) • Durable Medical Equipment (DME), Orthotics and Supplies • Fertility Preservation for Iatrogenic Infertility (Large Group) • Formulas/Specialized Foods (Small Group) • Genetic Testing – Including BCRA (Small Group) • Habilitative Services – Outpatient Therapies (Large Group) • Hearing Aids • Home Health Care • Infertility Services • Lab, X-Ray and Diagnostic • Major Diagnostic and Imaging • Orthodontia (Small Group) • Pain Management (Small Group) • Pharmaceutical Products • Pregnancy - Maternity Services (Large Group) • Preimplantation Genetic Testing (PGT) and Related Services (Large Group) • Preventive Care Services – Breast Pump • Prosthetic Devices • Reconstructive Procedures • Rehabilitation Services - Outpatient Therapy and Manipulative Treatment • Scopic Procedures • Spine and Joint Surgeries (Large Group) • Surgery – Outpatient • Temporomandibular Joint (TMJ) Services • Therapeutic Treatments • Ventricular Assist Device Implantation Plan 3 • Ambulance Services - Non-Emergency Air Ambulance • Breast Pumps • Clinical Trials

		• Diabetes Equipment • Durable Medical Equipment (DME) • Formulas/specialized foods • Genetic Testing – BRCA • Genetic Testing, including BRCA genetic testing • Hearing Aids • Home Health Care • Infertility Services • Lab, X-Ray and Diagnostics • Lab, X-Ray and Major Diagnostics • Orthodontia • Pain management • Pharmaceutical Products – IV infusions only • Prosthetic Devices • Reconstructive Procedures • Rehabilitation Services and Chiropractic Treatment • Scopic Procedures • Surgery – Outpatient • Temporomandibular Joint (TMJ) Services • Therapeutics Step 2 For M/S, meeting Clinical Appropriateness is determinative in imposing the limitation. While the Value and Variation factors are considered for M/S, they are not determinative in imposing the limitation. A service category meeting just the Clinical Appropriateness factor can be subjected to Prior Authorization. Step 3 Factor – Clinical Appropriateness is defined as those outpatient services that are determined by internal medical experts to be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. Clinically appropriate services promote optimal clinical outcomes. The evidentiary standards for the Clinical Appropriateness factor are: • Objective, evidence-based clinical criteria from nationally recognized third-party sources (e.g., InterQual or MCG for M/S services) • Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.) The sources that define and/or trigger the Clinical Appropriateness factor: • Medical Technology and Assessment Committee (MTAC) review • Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.) For M/S, meeting Clinical Appropriateness is determinative in imposing the limitation. While the Value and Variation factors are considered for M/S, they are not determinative in imposing the limitation. A service category meeting just the Clinical Appropriateness factor can be subjected to Prior Authorization.

		Factor - Patient Safety is defined as “the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum by the World Health Organization. • The Plan’s evidentiary standards that define and/or trigger the Patient Safety factor: o Professional judgment of members of the Utilization Management Program Committee o Clinical criteria from nationally recognized third-party sources (e.g., InterQual for M/S services) o Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.) • The Plan’s sources used to define the Patient Safety factor: o Professional judgment of members of the Utilization Management Program Committee o Clinical criteria from nationally recognized third-party sources (e.g., InterQual for M/S services) o Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.) Step 4 • Timeframe to Submit. The timeframes for the member, or OON provider on behalf of the member, to submit the Prior Authorization request were reviewed and it was determined that MH/SUD was no more stringent. o M/S: Per the member’s Plan documents, the timeframes vary depending upon the services requested from as soon as possible to six months prior to the OON service - Unplanned or emergency services are not subject to Prior Authorization • Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and with state, federal, and accreditation requirements (NCQA). o M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse determinations are made by a physician or other appropriate health care professionals. Outcomes Data reviewed for comparability OON outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2024 – 12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of M/S and MH/SUD OON outpatient cases from 1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for Plans 2 and 3. Plan 1 Administrative Denial Rate – 1.59% (8 out of 565 cases) Clinical Denial Rate - 22.48% (127 out of 565 cases) Plan 2 Administrative Denial Rate - 25% (7 out of 28 cases) Clinical Denial Rate – 14.29% (4 out of 28 cases) Plan 3 Administrative Denial Rate – 0.61% (48 out of 11,046 cases) Clinical Denial Rate – 11.10% (1,226 out of 11,046 cases) All analysis and material documentation is available upon request.

Concurrent Review Benefit NQTL Practices	**In-Network Inpatient** Step 1 The Plan delegates management of MH/SUD inpatient services, including Concurrent Review, to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. Initial Concurrent Review. All INN inpatient admissions are subject to the Concurrent Review process. The Plan requires INN providers and facilities to timely notify the Plan of MH/SUD inpatient admissions. INN facilities must notify the Plan within one business day after an admission unless a longer period is required by contract or state-specific requirements. Provider notification triggers the inpatient Concurrent Review process. Providers notify the Plan of the need for additional days/services by telephone. As described in the Management of Behavioral Health Benefits Policy, upon receipt of admission notification, non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to initial clinical reviewers. First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.). Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review. Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of	**In-Network Inpatient** Step 1 Initial Concurrent Review. The Plan requires INN facilities and providers to timely notify the Plan (e.g., within 24 hours) of an unplanned (e.g., urgent/emergent) inpatient admission. Provider notification triggers the inpatient Concurrent Review process. Providers can notify the Plan through the secure provider portal, their connected electronic medical record, by telephone, or by fax (where required). The Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff will also approve a coverage request if the facility's contract does not allow for clinical reviews. Non-clinical staff refer coverage requests that they cannot approve to initial clinical reviewers. First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met or may access clinical information in the provider's electronic medical record (EMR) if the provider has given the Plan access. The clinical reviewer may approve the admission based on their review. Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., Medical Director) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan timely communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials.

	a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information. Ongoing Concurrent Review. INN providers may request coverage for additional days by contacting the Plan prior to the expiration of the last covered day of an approved MH/SUD inpatient admission. The Plan's INN MH/SUD general acute care facilities are reimbursed on a per diem basis. The Plan conducts ongoing Concurrent Review for INN MH/SUD admissions depending on the applicable clinical criteria and the member's clinical presentation. Upon receipt of a request for coverage of additional days, the Plan reviews the medical necessity of inpatient admissions. Clinical reviewers and peer clinical reviewers follow the initial Concurrent Review process. Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria, 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. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure inpatient Concurrent Review determinations are appropriate. MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as warranted. The Plan routinely monitors Concurrent Review program performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews UM program outcomes, including inpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the Clinical Quality & Operations	Ongoing Concurrent Review. INN M/S facilities may request coverage of additional days prior to the expiration of the last day of an approved inpatient admission. The Plan conducts ongoing Concurrent Reviews for additional days for approved inpatient M/S admissions as follows: • General acute care facilities reimbursed on a per diem basis: every two days • General acute care facilities reimbursed on a diagnosis related group (DRG) basis: when the inpatient admission meets the number of days stated in the provider participation agreement • Skilled Nursing Facility (SNF) admissions: initial Concurrent Review at day three and then weekly. Subsequent reviews may be sooner if clinically appropriate • Acute Inpatient Rehab (AIR) admissions: initial Concurrent Review at day five and then weekly. Subsequent reviews may be sooner if clinically appropriate • Long Term Acute Care Hospital (LTACH) admissions: initial Concurrent Review at day 14 and then weekly The Plan follows the initial Concurrent Review clinical review process when conducting ongoing Concurrent Reviews. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and clinical criteria from third party sources such as InterQual or MCG guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Concurrent Review determinations are appropriate. M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within the 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer

	Committee must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law, where applicable List of services subject to NQTL - OHI, OHP, and UHIC: • MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment Step 2 There are no differences in the factors used Step 3 There are no differences in the standards and sources used Step 4 • Timeframe to Submit. The timeframe for the provider or member to submit the inpatient notification was reviewed and it was determined that MH/SUD was no more stringent. o INN MH/SUD facilities must notify the Plan within one business day after an admission unless a longer period is required by contract or state-specific requirements. • Determinations and Non-clinical Reviews, First Level Clinical Reviews, and Second Level Peer Clinical Reviews. o For MH/SUD, non-clinical staff refer coverage requests that they cannot approve to clinical reviewers. Clinical reviewers (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required. • Adverse Benefit Determinations and Peer-to-Peer Conversations. INN inpatient MH/SUD facilities and providers are offered the opportunity to discuss a potential adverse benefit determination before an adverse determination is issued. This process allows INN inpatient MH/SUD facilities and providers the opportunity to provide additional information and/or modify their request prior to an adverse benefit determination being issued	• Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable. List of M/S and MH/SUD Services Subject to NQTL • All unplanned M/S inpatient admissions are subject to initial Concurrent Review • All M/S inpatient admissions are subject to ongoing Concurrent Review if coverage of additional days is requested after initial Concurrent Review approved days expire Step 2 There are no differences in the factors used. Step 3 There are no differences in the standards and sources used. Step 4 • Timeframe to Submit. The Administrative Guide (for M/S) was reviewed for notification timeframes. The timeframe for the provider or member to notify of an admission was reviewed and determined that MH/SUD was comparable and no more stringent. o INN M/S facilities must notify the Plan within 24-hours for week-day admissions, unless otherwise indicated. • Determinations and Non-clinical Reviews, First Level Clinical Reviews, and Second Level Peer Clinical Reviews. o For M/S, non-clinical staff may approve requests for coverage of cases in scenarios where the Plan identified applicable clinical criteria always indicate that an inpatient level of care is medically necessary. Non-clinical staff refer coverage requests that they cannot approve to clinical reviewers. Clinical reviewers determine whether the inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. If the case cannot be approved by the clinical reviewer, it is referred to a peer (physician) clinical reviewer. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required.

	o An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted/excluded. • Review of Staff Qualifications o MH/SUD is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. • Clinical Criteria. For MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based behavioral clinical policies and use clinical criteria from third party sources such as ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines. Outcomes Data reviewed for comparability INN inpatient medical necessity approval and denial rates and appeals outcomes data from 1/1/2024 -12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of M/S and MH/SUD INN inpatient cases from 1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for Plan 2. MH/SUD INN IP Cases Plan 1 Administrative Denial Rate - 0% (0 out of 123 cases) Clinical Denial Rate - 0.81% (1 out of 123 cases) Plan 2 Administrative Denial Rate - 0% (0 out of 69 cases) Clinical Denial Rate - 1.45% (1 out of 69 cases) Plan 3 Administrative Denial Rate - 0% (0 out of 272 cases) Clinical Denial Rate – 0.37% (1 out of 272 cases) All analysis and material documentation is available upon request. **Out-of-Network Inpatient** Step 1 The Plan delegates management of MH/SUD inpatient services, including Concurrent Review its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. Initial Concurrent Review. All OON inpatient admissions are subject to the Concurrent Review process. The Plan requires that members ensure that OON providers and facilities timely notify the Plan of inpatient admissions. Notification triggers the inpatient	• Adverse Benefit Determinations and Peer-to-Peer Conversations. o INN inpatient M/S services - The Plan offers INN M/S facilities and providers the opportunity to discuss adverse benefit determinations after the adverse benefit determination is issued. Only M/S peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations for coverage of M/S inpatient services. - For M/S, an adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted/excluded. • Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA). o M/S is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by Medical Directors. • Clinical Criteria. For M/S, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical clinical policies and use clinical criteria from third party sources such as InterQual and MCG. Outcomes Data reviewed for comparability INN inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2024 – 12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of M/S and MH/SUD INN inpatient cases from 1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for Plan 2. M/S INN IP Cases Plan 1 Administrative Denial Rate - 0% (0 out of 353 cases) Clinical Denial Rate – 22.38% (79 out of 353 cases) Plan 2 Administrative Denial Rate - 0% (0 out of 44 cases) Clinical Denial Rate – 29.55% (13 out of 44 cases) Plan 3 Administrative Denial Rate - 0.16% (2 out of 1,237 cases) Clinical Denial Rate – 23.69% (293 out of 1,237 cases) All analysis and material documentation is available upon request. **Out-of-Network Inpatient** Step 1 Initial Concurrent Review. Members are required to ensure that OON facilities and providers timely notify the Plan (e.g., within 24 hours) of an unplanned (e.g., urgent/emergent) inpatient admission. Notification triggers the inpatient Concurrent Review process. OON facilities can notify the Plan by telephone or fax (where required).

	Concurrent Review process. Providers notify the Plan of the need for additional days/services by telephone. As described in the Management of Behavioral Health Benefits Policy, upon receipt of admission notification, non-clinical staff confirm member eligibility and benefit coverage. Non-clinical staff may approve cases that do not require clinical evaluation or interpretation based on the member's diagnosis and the clinical information submitted by providers. Non-clinical staff refer cases that they cannot approve to initial clinical reviewers. First Level Clinical Review/Initial Review. Clinical decisions are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.). Clinical reviewers consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for certification, related diagnostic results, and history of related treatment and services to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review. Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. The requesting provider is offered the opportunity to discuss the case with the peer clinical reviewer, consistent with state, federal, and accreditation requirements before an adverse benefit determination is issued. Only qualified peer clinical reviewers (e.g., Medical Directors) can issue adverse benefit determinations. Peer clinical reviewers apply clinical criteria to member clinical information to determine coverage for an inpatient admission. If the requesting provider fails to complete the peer-to-peer discussion, the peer clinical reviewer makes a determination based on the information available. If a peer clinical reviewer issues an adverse benefit determination, (e.g., the admission is not medically necessary and is not approved), then the Plan timely communicates the adverse benefit determination, including appeal rights, to the member and provider consistent with applicable state, federal, and accreditation requirements. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as a clinical denial when it is based on clinical criteria and member clinical information. Ongoing Concurrent Review. OON providers may request coverage for additional days by contacting the Plan prior to expiration of the last covered day of an approved MH/SUD inpatient admission. The Plan's OON MH/SUD general acute care facilities are reimbursed on a per diem basis. The Plan conducts ongoing Concurrent Review for OON MH/SUD admissions depending on the applicable clinical criteria and the member's clinical presentation. Upon receipt of a request for coverage of additional days, the Plan reviews the medical necessity of inpatient admissions. Clinical reviewers and peer clinical reviewers follow the initial Concurrent Review process.	The Plan confirms receipt of the Concurrent Review request. Non-clinical staff confirm member eligibility and benefit coverage upon receipt of the notification. Non-clinical staff may approve coverage requests in scenarios where the member's plan documents allow and if a clinical review is not required. Non-clinical staff refer coverage requests that they cannot approve to initial clinical reviewers. First Level Clinical Review/Initial Review. Clinical reviewers (nurses or physicians) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether the inpatient admission is medically necessary by reviewing the member's clinical information, the applicable clinical criteria or guidelines, and the Plan benefit terms. Clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs to determine whether the applicable clinical criteria are met. The clinical reviewer may approve the admission based on their review. Second Level Clinical Review/Peer Review. The initial clinical reviewer refers cases to a second level/peer clinical reviewer if the case cannot be approved. Peer clinical reviewers (physician or mid-level practitioner) consult clinical criteria when making clinical coverage benefit determinations. Peer clinical reviewers may request more clinical information including, but not limited to, office or facility medical records, consultations, rehabilitation evaluations, clinical exams, diagnosis, history of the presenting problems, description of treatment or services being requested for authorization, related diagnostic results, history of related treatment and services, and photographs. Only qualified peer clinical reviewers (e.g., Medical Director) can issue adverse benefit determinations. The peer clinical reviewer reviews applicable member clinical information, benefit plan documents, and clinical criteria in the case review. If a peer clinical reviewer issues an adverse benefit determination, then the Plan timely communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Modified coverage requests that are approved are recorded as partial denials. Ongoing Concurrent Review. OON M/S facilities may request coverage of additional days prior to the expiration of the last day of an approved inpatient admission. The Plan conducts ongoing Concurrent Reviews for additional days for approved inpatient M/S admissions as follows: • General acute care facilities reimbursed on a per diem basis: every two days • General acute care facilities reimbursed on a diagnosis related group (DRG) basis: when the inpatient admission meets the number of days stated in the provider participation agreement • Skilled Nursing Facility (SNF) admissions: initial Concurrent Review at day three and then weekly. Subsequent reviews may be sooner if clinically appropriate

	Clinical Criteria. Initial clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria, 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. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure inpatient Concurrent Review determinations are appropriate. MH/SUD monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual IRR assessment. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, the reviewer enters a remediation period and is required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as warranted. The Plan routinely monitors Concurrent Review program performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews UM program outcomes, including inpatient Concurrent Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the Clinical Quality & Operations Committee must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, NCQA UM standards, and state law, where applicable. List of services subject to NQTL	• Acute Inpatient Rehab (AIR) admissions: initial Concurrent Review at day five and then weekly. Subsequent reviews may be sooner if clinically appropriate • Long Term Acute Care Hospital (LTACH) admissions: initial Concurrent Review at day 14 and then weekly The Plan follows the initial Concurrent Review clinical review process when conducting ongoing Concurrent Reviews. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies and clinical criteria from third party sources such as InterQual or MCG guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Concurrent Review determinations are appropriate. M/S monitors clinical reviewer and peer clinical reviewer application of clinical criteria through an annual inter-rater reliability (IRR) assessment that is provided by InterQual. Clinical reviewers and peer clinical reviewers are required to pass the IRR assessment with a score of 90% or better through three attempts. After a second failed IRR assessment, staff enter a remediation period and are required to review all cases with a supervisor for 30 days, or until 90% is achieved on the assessment. If the clinical reviewer achieves a passing score within 30-day period, supervisors review a minimum of one case per week for the remainder of the 30-day period. The Plan also conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Concurrent Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation

	• MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment Step 2 There are no differences in the factors used Step 3 There are no differences in the standards and sources used Step 4 • Determinations and Non-Clinical Reviews, First Level Clinical Reviews, and Second Level Peer Clinical Reviews. o For MH/SUD, non-clinical staff refer coverage requests that they cannot approve to clinical reviewers. Clinical reviewers (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) consult clinical criteria when making clinical coverage benefit determinations. Clinical reviewers determine whether an inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. The clinical reviewer refers cases to a peer clinical reviewer for a peer-to-peer discussion if the case cannot be approved. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required. • Adverse Benefit Determinations and Peer-to-Peer Conversations. OON inpatient MH/SUD facilities and providers are offered the opportunity to discuss a potential adverse benefit determination before an adverse determination is issued. This process allows OON inpatient MH/SUD facilities and providers the opportunity to provide additional information and/or modify their request prior to an adverse benefit determination being issued. o An adverse benefit determination is recorded as a clinical denial when it is based on clinical criteria and member clinical information and is recorded as an administrative denial when member benefits are exhausted/excluded. • Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA). o MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors. • Clinical Criteria. For MH/SUD, clinical reviewers and peer clinical reviewers' base determinations on objective, evidence-based medical/behavioral clinical policies and use clinical criteria from third party sources such as, ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines. Outcomes Data reviewed for comparability	One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, NCQA UM standards, and state law where applicable. List of M/S and MH/SUD Services Subject to NQTL • All unplanned M/S and MH/SUD inpatient admissions are subject to initial Concurrent Review • All M/S and MH/SUD inpatient admissions are subject to ongoing Concurrent Review if coverage of additional days is requested after initial Concurrent Review approved days expire Step 2 There are no differences in the factors used. Step 3 There are no differences in the standards and sources used. Step 4 • Determinations and Nonclinical Reviews, First Level Clinical Reviews, and Second Level Peer Clinical Reviews. o For M/S, non-clinical staff may approve requests for coverage of cases in scenarios where the Plan identified applicable clinical criteria always indicate that an inpatient level of care is medically necessary. Non-clinical staff refer coverage requests that they cannot approve to clinical reviewers. Clinical reviewers (nurses) determine whether the inpatient admission is medically necessary. The clinical reviewer may approve the admission based on their review. If the case cannot be approved by the clinical reviewer, it is referred to a peer (physician) clinical reviewer. Only qualified peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations. Peer-to-peer discussions are offered as required. • Adverse Benefit Determinations and Peer-to-Peer Conversations. The Plan offers OON M/S facilities and providers the opportunity to discuss adverse benefit determinations after the adverse benefit determination is issued. Only M/S peer clinical reviewers (e.g., Medical Directors) may issue adverse benefit determinations for coverage of M/S inpatient services (M/S: Peer Clinical Review). o An adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded. Modified coverage requests that are approved are recorded as partial denials. • Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state, federal, and accreditation requirements (NCQA). o M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., nurses, physicians, etc.) and all adverse benefit determinations are made by Medical Directors.

	OON inpatient medical necessity approval and denial rates and appeals outcomes data from1/1/2024 -12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of M/S and MH/SUD OON inpatient cases from from1/1/2024 -12/31/2024 to support an analysis of clinical outcomes data for Plans 1, 2 and 3. MH/SUD OON IP Cases Plan 1 Administrative Denial Rate - 0% (0 out of 61 cases) Clinical Denial Rate – 6.56% (4 out of 61 cases) Plan 2 Administrative Denial Rate - 0% (0 out of 24 cases) Clinical Denial Rate - 0% (0 out of 24 cases) Plan 3 Administrative Denial Rate - 0% (0 out of 30 cases) Clinical Denial Rate - 0% (0 out of 30 cases) All analysis and material documentation is available upon request. **In-Network Outpatient** Step 1 The Plan structures outpatient Concurrent Review 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 the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted. The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. Concurrent Review of MH/SUD outpatient services consists of the following: The Plan reclassifies MH/SUD outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services. Refer to the INN outpatient Prior Authorization NQTL for a description of the process, factors, evidentiary standards, and comparability of processes "in writing" and "in operation."	• Clinical Criteria. For M/, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical clinical policies and use clinical criteria from third party sources such as InterQual and MCG. Outcomes Data reviewed for comparability OON inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2024 – 12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD OON inpatient cases from 01/01/2024 -12/31/2024 to support an analysis of clinical outcomes data for Plan 1, Plan 2 and Plan 3. M/S OON IP Cases Plan 1 Administrative Denial Rate - 0% (0 of 1 cases) Clinical Denial Rate - 0% (0 out of 1 cases) Plan 2 Administrative Denial Rate - 0 cases Clinical Denial Rate - 0 cases Plan 3 Administrative Denial Rate - 0% (0 out of 6 cases) Clinical Denial Rate - 0% (0 of 6 cases) All analysis and material documentation is available upon request. **In-Network Outpatient** Step 1 The Plan structures outpatient Concurrent Review 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 the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted. The Plan requires INN M/S providers to timely request coverage of additional units of service or extensions of time for services previously approved in Prior Authorization. The Plan reclassifies M/S and MH/SUD outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services. Refer to the INN outpatient Prior Authorization NQTL for a description of the process, factors, evidentiary standards, and comparability of processes "in writing" and "in operation." **Out-of-Network Outpatient**

	Out-of-Network Outpatient Step 1 The Plan structures outpatient Concurrent Review 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 the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted. The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. Concurrent Review of MH/SUD outpatient services consists of the following: The Plan reclassifies MH/SUD outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services. Refer to the OON outpatient Prior Authorization NQTL for a description of the process, factors, evidentiary standards, and comparability of processes "in writing" and "in operation."	Step 1 The Plan structures outpatient Concurrent Review 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 the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted. The Plan requires members, or OON M/S providers on the member's behalf, to timely request coverage of additional units of service or extensions of time for services previously approved in Prior Authorization. The Plan reclassifies M/S and MH/SUD outpatient Concurrent Review coverage requests as preservice/Prior Authorization requests consistent with NCQA UM standards. The Plan follows the outpatient Prior Authorization process for these requests and uses the outpatient Prior Authorization process to review requests for coverage of additional units of service or extensions of time for previously approved services. Refer to the OON outpatient Prior Authorization NQTL for a description of the process, factors, evidentiary standards, and comparability of processes "in writing" and "in operation."
Retrospective Review Benefit NQTL Practices	**In-Network Inpatient** Step 1 The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. MH/SUD claims/requests for inpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for requests or claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) reviews the claim to determine if the inpatient admission billed meets clinical criteria for coverage based on application of objective, evidence-based, clinical criteria, or nationally	**In-Network Inpatient** Step 1 Retrospective Review for certain inpatient services begins after the Plan receives claims or notification of inpatient admission post discharge from an INN facility. The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services EIU, or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the inpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (e.g., Medical Directors).

	recognized guidelines. Clinical reviewers either approve requests for payment or refer requests to peer clinical reviewers (Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that an admission was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria, 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. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Retrospective Review determinations are appropriate. The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty, and a licensed physician.	Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual or MCG guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate. The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity

	Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable. List of MH/SUD Services Subject to NQTL • MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment Step 2 There are no differences in the factors used Step 3 • The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor: o Clinical criteria from nationally recognized, third-party sources (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services) o Clinical Technology Assessment Committee (CTAC) review o Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Psychiatric Association, etc.) Step 4 • Timeframe to submit. National Network Manual (for MH/SUD) were reviewed for requirements related to timeliness of notification to the Plan and it was determined that MH/SUD was no more stringent. o For MH/SUD, facilities have 180 days after the service is rendered to request a Retrospective Review • Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements. o MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. • Clinical Criteria. For MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines.	• Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable. List of M/S and MH/SUD Services Subject to NQTL • Services that have not previously been reviewed in Prior Authorization or Concurrent Review • M/S Claims that are denied, if requested by an INN facility • Services where the service or procedure codes do not match a diagnosis code • EIU services • Services that are subject to benefit limits/exclusions • Codes identified by the Plan as subject to Retrospective Review • Please see the file M/S Retrospective Review Codes for the list of M/S codes that may be subject to Retrospective Review Step 2 There are no differences in the factors used. Step 3 • The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor: o Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG) o Medical Technology and Assessment Committee (MTAC) review o Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.) Step 4 • Timeframe to submit. The Administrative Guide (for M/S) was reviewed for requirements related to timeliness of notification to the Plan and it was determined that MH/SUD was no more stringent. o For M/S, facilities must request the Retrospective Review within the requirements outlined in their provider contract • Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state and federal requirements. o M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses, physicians) and all adverse benefit determinations are made by a physician or other appropriate health care professionals.

	The Plan subjected claims/requests for M/S and MH/SUD inpatient admissions to Retrospective Review that were not reviewed in the Prior Authorization or Concurrent Review process. Outcomes data reviewed for comparability INN inpatient medical necessity approval and denial rates and appeals outcomes data from 1/1/2024 -12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD INN inpatient cases from 1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for Plans 1, 2 and 3. MH/SUD INN IP Cases Plan 1 Administrative Denial Rate - 0% (0 out of 11 cases) Clinical Denial Rate - 18.18% (1 out of 11 cases) Plan 2 Administrative Denial Rate - 0% (0 out of 6 cases) Clinical Denial Rate - 16.67% (1 out of 6 cases) Plan 3 Administrative Denial Rate - 0% (0 out of 16 cases) Clinical Denial Rate - 0% (0 out of 16 cases) All analysis and material documentation is available upon request. **Out-of-Network Inpatient** Step 1 The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. MH/SUD claims/requests for inpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes, or if services are EIU. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for requests or claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) review the claim to determine if the inpatient admission billed meets clinical criteria for coverage	• Clinical Criteria. For M/S, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual and MCG. The Plan subjected claims/requests for M/S and MH/SUD inpatient admissions to Retrospective Review that were not reviewed in the Prior Authorization or Concurrent Review process. Additionally, M/S claims/requests for inpatient services submitted by INN providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits/exclusions. Claims/requests for inpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU. Outcomes data reviewed for comparability INN inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2023 – 12/31/2023 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD INN inpatient cases from 01/01/2023 -12/31/2023 to support an analysis of clinical outcomes data for Plan 1, Plan 2, and Plan 3. M/S INN IP Cases Plan 1 Administrative Denial Rate - 76.6% (144 out of 188 cases) Clinical Denial Rate - 4.26% (8 out of 144 cases) Plan 2 Administrative Denial Rate - 83.33% (20 out of 24 cases) Clinical Denial Rate - 0% (0 out of 24 cases) Plan 3 Administrative Denial Rate - 57.85% (383 out of 662 cases) Clinical Denial Rate - 6.95% (46 out of 662 cases) All analysis and material documentation is available upon request. **Out-of-Network Inpatient** Step 1 Retrospective Review for certain inpatient services begins after the Plan receives claims or notification of an inpatient admission post discharge from an OON facility. The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services EIU, or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission.

	based on application of objective, evidence-based, clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that an admission was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim. The OON provider may bill non-reimbursable charges to the member. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria, 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. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Retrospective Review determinations are appropriate. The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider	Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, cases are referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the inpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual or MCG Guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate. The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair)

	experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable. List of MH/SUD Services Subject to NQTL • MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment Step 2 There are no differences in the factors used Step 3 • The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor: o Clinical criteria from nationally recognized, third-party sources (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services) o Clinical Technology Assessment Committee (CTAC) review o Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Psychiatric Association, etc.) Step 4 • Timeframe to submit. The timeframe for the member to submit the Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent. o For MH/SUD, members have 180 days after the service is rendered to request a Retrospective Review • Notification of Decisions to Providers and Members. The Plan notifies MH/SUD OON facilities and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state and federal requirements. • Review of Staff Qualifications. For MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements. o MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors.	• Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable. M/S Services Subject to NQTL • Services that have not previously been reviewed in Prior Authorization or Concurrent Review • Services where the service or procedure codes do not match a diagnosis code • EIU services • Services that are subject to benefit limits/exclusions • Codes identified by the Plan as subject to Retrospective Review • Please see the file M/S Retrospective Review Codes for the list of M/S codes that may be subject to Retrospective Review Step 2 There are no differences in the factors used. Step 3 • The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor: o Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG) o Medical Technology and Assessment Committee (MTAC) review o Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.) Step 4 • Timeframe to submit. The timeframe for the member to submit the Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent. o For M/S, members must notify the Plan within timely filing requirements

	• Clinical Criteria. For MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines. Outcomes data reviewed for comparability OON inpatient medical necessity approval and denial rates and appeals outcomes data from 1/1/2024 -12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD OON inpatient cases from 1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for Plans 1, 2, 3. MH/SUD OON IP Cases Plan 1 Administrative Denial Rate - 0% (0 out of 9 cases) Clinical Denial Rate - 33.33% (3 out of 9 cases) Plan 2 Administrative Denial Rate - 0% (0 out of 6 cases) Clinical Denial Rate – 33.33% (2 out of 6 cases) Plan 3 Administrative Denial Rate - 0% (0 out of 2 cases) Clinical Denial Rate - 50% (1 out of 2 cases) All analysis and material documentation is available upon request. **In-Network Outpatient** Step 1 The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. MH/SUD claims/requests for outpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) reviews the request or claim to determine if the outpatient service meets clinical criteria for	• Notification of Decisions to Providers and Members. The Plan notifies M/S OON facilities and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state and federal requirements. • Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state and federal requirements. o M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses, physicians) and all adverse benefit determinations are made by a physician or other appropriate health care professionals. • Clinical Criteria. For M/S, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual and MCG. Outcomes data used for comparability OON inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2024 – 12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of M/S and MH/SUD OON inpatient cases from 1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for Plans 1, 2 and 3. M/S OON IP Cases Plan 1 Administrative Denial Rate - 0% (0 out of 3 cases) Clinical Denial Rate – 66.67% (2 out of 3 cases) Plan 2 Administrative Denial Rate - 0 cases Clinical Denial Rate - 0 cases Plan 3 Administrative Denial Rate - 0% (0 out of 5 cases) Clinical Denial Rate - 20% (1 out of 5 cases) All analysis and material documentation is available upon request. **In-Network Outpatient** Step 1 Retrospective Review for certain outpatient services begins after the Plan receives claims from INN providers. The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are EIU, or if the services are subject to benefit limits/exclusion. The Plan also conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission. INN providers may also request Retrospective Review of outpatient claims that are denied.

	coverage based on application of objective, evidence-based clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors or psychologists). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination is issued. The Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies, or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria, 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. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Retrospective Review determinations are appropriate. The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an	Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (physician or nurse) reviews the claim to determine if the outpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual or MCG guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate. The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the

	executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable. List of MH/SUD Services Subject to NQTL - OHI, OHP, and UHIC: • Partial Hospitalization (PHP)/Day Treatment/ High Intensity Outpatient • Intensive Outpatient (IOP) • Psychological Testing • Applied Behavior Analysis (ABA) • Transcranial Magnetic Stimulation (TMS) Step 2 There are no differences in the factors used Step 3 • The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor: o Clinical criteria from nationally recognized, third-party sources (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services) o Clinical Technology Assessment Committee (CTAC) and review o Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Psychiatric Association, etc.) Step 4 • Timeframe to submit. National Network Manual (for MH/SUD) were reviewed for requirements relating to timeliness of notification to the Plan and it was determined MH/SUD was no more stringent. o For MH/SUD, providers have 180 days after the service is rendered to request a Retrospective Review • Review of Staff Qualifications. For MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements. o MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Outcomes data reviewed for comparability INN outpatient medical necessity approval and denial rates and appeals outcomes data from 1/1/2024 -12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.	M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements and state law where applicable. List of M/S Services Subject to NQTL • Services that have not previously been reviewed in Prior Authorization or Concurrent Review • Claims that are denied, if requested by INN provider • Services where the service or procedure codes do not match a diagnosis code • EIU services • Services that are subject to benefit limits/exclusions • Codes identified by the Plan as subject to Retrospective Review o Please see the file M/S Retrospective Review Codes for the list of M/S codes that may be subject to Retrospective Review Step 2 There are no differences in the factors used. Step 3 • The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor: o Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG) o Medical Technology and Assessment Committee (MTAC) review o Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.) Step 4

	There is an insufficient number of MH/SUD INN outpatient cases from 1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for Plans 1, 2 and 3. MH/SUD INN OP Cases Plan 1 Administrative Denial Rate - 0% (0 out of 4 cases) Clinical Denial Rate - 0% (0 out of 4 cases) Plan 2 Administrative Denial Rate - 0% (0 out of 2 cases) Clinical Denial Rate - 0% (0 out of 2 cases) Plan 3 Administrative Denial Rate - 0% (0 out of 16 cases) Clinical Denial Rate - 12.50% (2 out of 16 cases) All analysis and material documentation is available upon request. Out-of-Network Outpatient Step 1 The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. MH/SUD claims/requests for outpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) reviews the request or claim to determine if the outpatient service meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors or psychologists). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination is issued. The Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer	• Timeframe to submit. The Administrative Guide (for M/S) was reviewed for requirements relating to timeliness of notification to the Plan and it was determined MH/SUD was no more stringent. o For M/S, providers must request the Retrospective Review within the requirements outlined in their provider contract • Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state and federal requirements. o M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses) and all adverse benefit determinations are made by a physician or other appropriate health care professionals. • Clinical Criteria. For M/S, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual and MCG. Outcomes data reviewed for comparability INN outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2024 – 12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD INN outpatient cases from 1/1/2024 -12/31/2024 to support an analysis of clinical outcomes data for Plan 1 and 3. There is an insufficient number of M/S and MH/SUD INN outpatient cases from 1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for Plan 2. M/S INN OP Cases Plan 1 Administrative Denial Rate - 0% (0 out of 680 cases) Clinical Denial Rate – 15.61% (103 out of 680 cases) Plan 2 Administrative Denial Rate - 0% (0 out of 55 cases) Clinical Denial Rate – 14.55% (8 out of 55 cases) Plan 3 Administrative Denial Rate – 0.22% (6 out of 1,836 cases) Clinical Denial Rate – 22.82% (419 out of 1,836 cases) All analysis and material documentation is available upon request. **Out-of-Network Outpatient** Step 1 Retrospective Review for certain outpatient services begins after the Plan receives claims from OON providers. The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are EIU, or if the

	conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim. The OON provider may bill non-reimbursable charges to the member. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies, or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria, 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. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Retrospective Review determinations are appropriate. The Plan conducts monthly quality audits of individual non-clinical staff clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.	services are subject to benefit limits/exclusion. The Plan also conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the outpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. The OON provider may bill non-reimbursable charges to the member. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual or MCG guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate. The Plan conducts end-to- end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated.

	MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable. List of MH/SUD Services Subject to NQTL - • Partial Hospitalization (PHP)/Day Treatment/ High Intensity Outpatient • Intensive Outpatient (IOP) • Psychological Testing • Applied Behavior Analysis (ABA) • Transcranial Magnetic Stimulation (TMS) Step 2 There are no differences in the factors used Step 3 • The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor: o Clinical criteria from nationally recognized, third-party sources (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services) o Clinical Technology Assessment Committee (CTAC) review o Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Psychiatric Association, etc.) Step 4 • Timeframe to submit. The timeframe for the member to submit a Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent. o For MH/SUD, members have 180 days after the service is rendered to request a Retrospective Review • Review of Staff Qualifications. For MH/SUD, clinical staff qualifications align with the type of clinical review and state, and federal requirements. o MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. • Clinical Criteria. For MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines. Outcomes data for comparability OON outpatient medical necessity approval and denial rates and appeals outcomes data from1/1/2024 -12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD OON outpatient cases from 1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for plan 1, plan 2, and plan 3.	The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements and state law where applicable. List of M/S and MH/SUD Services Subject to NQTL • Services that have not previously been reviewed in Prior Authorization or Concurrent Review • Services where the service or procedure codes do not match a diagnosis code • EIU services • Services that are subject to benefit limits • Codes identified by the Plan as subject to Retrospective Review o Please see the file M/S Retrospective Review Codes for the list of M/S codes that may be subject to Retrospective Review Step 2 There are no differences in the factors used. Step 3 • The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor: o Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG) o Medical Technology and Assessment Committee (MTAC) review

	MH/SUD OON OP Cases Plan 1 Administrative Denial Rate - 0% (0 out of 5 cases) Clinical Denial Rate - 20% (1 out of 5 cases) Plan 2 Administrative Denial Rate - 0% (0 out of 1 case) Clinical Denial Rate - 0% (0 out of 1 case) Plan 3 Administrative Denial Rate - 0% (0 out of 3 cases Clinical Denial Rate - 0% (0 out of 3 cases) All analysis and material documentation is available upon request.	o Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.) Step 4 • Timeframe to submit. The timeframe for the member to submit the Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent. o For M/S, members must notify the Plan within timely filing requirements • Notification of Decisions to Providers and Members. The Plan notifies M/S OON facilities and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state and federal requirements. • Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state and federal requirements. o M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses, physicians) and all adverse benefit determinations are made by a physician or other appropriate health care professionals. • Clinical Criteria. For M/S, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual and MCG. Outcomes data reviewed for comparability OON outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2024 – 12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD OON outpatient cases from from1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for Plans 1 and 3. There is an insufficient number of MS and MH/SUD OON outpatient cases from from1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for Plan 2. M/S OON OP Cases Plan 1 Administrative Denial Rate - 0% (0 out of 189 cases) Clinical Denial Rate – 55.56% (105 out of 189 cases) Plan 2 Administrative Denial Rate – 0 cases Clinical Denial Rate - 0 cases Plan 3 Administrative Denial Rate – 2.36% (2 out of 127 cases) Clinical Denial Rate – 17.32% (22 out of 127 cases) All analysis and material documentation is available upon request.

Clinical Procedure Coding, Billing Coding and Process NQTL Practices	There are no differences in clinical procedure coding, billing coding and process NQTL practices that limit benefits within the similarly mapped classification when compared between medical/surgical and mental health/substance use disorder.	There are no differences in clinical procedure coding, billing coding and process NQTL practices that limit benefits within the similarly mapped classification when compared between medical/surgical and mental health/substance use disorder.
Case & Medical Management NQTL Practices	Medical Case Management is a collaborative process between a member, that member's treating providers, and the Plan to improve the member's functional health and well-being and support the member's recovery. Such programs seek to achieve this goal by proactively engaging members before their health declines and helping them avoid escalation to higher levels of care (for example inpatient hospitalization). Case management is a voluntary member-facing program that does not include coverage determinations. Medical Case Management does not modify or influence a benefit determination. Case Managers do not make or recommend medical necessity determinations, do not direct treatment, or place treatment limitations based on program participation or lack thereof.	Medical Case Management is a collaborative process between a member, that member's treating providers, and the Plan to improve the member's functional health and well-being and support the member's recovery. Such programs seek to achieve this goal by proactively engaging members before their health declines and helping them avoid escalation to higher levels of care (for example inpatient hospitalization). Case management is a voluntary member-facing program that does not include coverage determinations. Medical Case Management does not modify or influence a benefit determination. Case Managers do not make or recommend medical necessity determinations, do not direct treatment, or place treatment limitations based on program participation or lack thereof.
Network Adequacy & Provider Reimbursement Rates	Step 1 For MH/SUD, the Plan conducts 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 MH/SUD provider specialties. 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 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 Oversite 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. Step 2 There are no differences in the factors used Step 3 There are no differences in the standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis. **Provider Reimbursement - Professional** Step 1 For MH/SUD providers, the Plan uses a comparable process to negotiate and establish reimbursement rate(s) for INN professional services. The Plan delegates negotiation of reimbursement rates for MH/SUD providers to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. Key steps in the INN professional services reimbursement negotiation process for MH/SUD services include:	Step 1 For M/S, the Plan conducts 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 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. Step 2 There are no differences in the factors used. Step 3 There are no differences in the standards and sources used. Step 4 There are no differences in the ""As Written"" and ""In Operation"" analysis. All analysis and material documentation is available upon request. **Provider Reimbursement - Professional** Step 1 For M/S providers, the Plan uses a comparable process to negotiate and establish reimbursement rate(s) for INN professional services. Key steps in the INN professional services reimbursement negotiation process for both M/S and MH/SUD services include: • The provider submits a completed application to the Plan to be included in the Plan's provider network • Based on the above, the Plan offers a contract and reimbursement rate package to the provider for the services/programs the provider intends to offer

	• The provider submits a completed application to the Plan to be included in the Plan's provider network • Based on the above, the Plan offers a contract and reimbursement rate package to the provider for the services/programs the provider intends to offer • If the provider rejects the contract proposal, the Plan may negotiate with the provider using the factors described Detailed process for the INN professional services reimbursement negotiation: For MH/SUD professionals, the Plan follows a comparable process. The Plan starts with the CMS national physician fee schedule rate for the service type and practitioner type at issue and then determines the percentage of CMS reimbursement based upon CMS locality fee schedules and the factors, evidentiary standards, and sources described in Steps 2 and 3 below. The Plan maintains five (5) internally developed standard fee schedules based on the CMS national physician fee schedule rates and the CMS geography-specific rates for the provider's area. Individual or group MH/SUD care providers are assigned to one of these standardized fee schedules based on their geographic location. For MH/SUD professional providers, the Plan uses CMS annual national RVUs and other data to determine whether routine, non-negotiation-based adjustments to the fee schedules may be necessary. If an RVU is not available for a particular code, the Plan uses other sources such as the FairHealth Medicare Gap Fill Database and then market research to determine an appropriate rate. Providers already in the network may also negotiate for non-routine adjustments upon contract renewal or changing market circumstances. For MH/SUD professional providers, the fee schedule rates are negotiable, and the Plan assesses the market dynamic factors listed in Step 2 to reach agreement with providers. Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis **Provider Reimbursement - Facility** Step 1 Negotiation For MH/SUD facilities, the Plan uses a substantially similar process to negotiate and establish reimbursement rates for INN facility services. The Plan delegates negotiation of reimbursement rates for MH/SUD facility providers to it's delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. Key steps in the INN facility reimbursement negotiation process for MH/SUD services include:	• If the provider rejects the contract proposal, the Plan may negotiate with the provider using the factors described Detailed process for the INN professional services reimbursement negotiation: For M/S professionals, the Plan contracts for services using standardized reimbursement templates. These templates are organized by Medicare carrier locality and reflect 100% of Geographic Practice Cost Indices (GPCI)-adjusted Centers for Medicare & Medicaid Services (CMS) reimbursement for a given rate year. The Plan uses the following fee sources to create these templates: • CMS Resource Based Relative Value Scale (RBRVS) is determined by calculating the CMS relative value units (RVU): o The CMS RVU for a given service or procedure is derived using the following mathematical formula: (work RVU x work GPCI) + (PE RVU x PE GPCI) + (MP RVU x MP GPCI) x CF. This is also referred to as the CMS benchmark rate o Definitions: - Work = Provider work reflects the provider's work when performing a procedure or service including provider's technical skills, physical effort, mental effort and judgment, stress related to patient risk, and the amount of time required to perform the service or procedure - PE = Provider Expense reflects the costs for medical supplies, office supplies, clinical and administrative staff, and pro rata costs of building space, utilities, medical equipment, and office equipment - MP = Malpractice Insurance expense reflects the cost of professional liability insurance based on an estimate of the relative risk associated with procedure or service CF = Conversion Factor GPCI = Geographic Practice Cost Indices • Applicable CMS RVU • FAIR Health Medicare GapFill PLUS database • CMS Clinical Lab Fee Schedule • CMS DMEPOS (Durable Medical Equipment, Prosthetics/Orthotics, and Supplies) Fee Schedule • CMS ASP (Average Sales Pricing) and RJ Health ASP (for drug pricing) • CMS Ambulance Fee Schedule • RBRVS (for codes not priced by CMS) M/S providers only • CMS Carrier Priced Fees (for codes referred to the local carrier for pricing) • Within these templates, Current Procedural Technology (CPT), Healthcare Common Procedure Coding System (HCPCS) codes are organized into 54 type of service categories: o Evaluation & Management – 4 categories o Surgery – 15 categories o Radiology – 10 categories o Laboratory/Pathology – 3 categories o Medicine – 10 categories o Obstetrics – 1 category o Immunizations/Injectables – 5 categories o DME & Supplies – 5 categories o Ambulance – 1 category This standardized structure enables the Plan to tailor fee schedules around specific CPT/HCPCS codes, generally the highest volume codes, billed by different types of providers. Thus, the fee schedules are not specialty-specific; but instead based on the codes most likely to be billed by a particular provider.

	• The facility submits a completed application to the Plan to be included in the Plan's provider network • The Plan reviews the facility reimbursement proposal • Based on the above, the Plan 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 the Plan provider network submit a reimbursement proposal to the Plan. The Plan 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. The Plan does not apply defined formulae to establish base rates or standard fee schedules. 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. The Plan does not apply defined formulae to establish base rates or standard fee schedules. 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 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.	Before creating a new fee schedule for a negotiation, the Plan determines if there is an existing fee schedule that will meet the needs of the negotiation; for example, if the negotiation is with a primary care group in Bridgeport, the Plan would look to find other primary care group fee schedules for that geographic locality that included the relevant codes. If no existing fee schedule fits the factual scenario, then the creation of a new fee schedule will be approved. The Plan does not maintain designated "go-out" or "base rate" fee schedules for M/S services. Rather, the Plan begins with the standardized structure described here and then negotiates a percentage of CMS reimbursement with providers for the service categories listed above, applying the factors described in Step 2 and evidentiary sources described in Step 3 below. Any CPT/HCPCS codes not reflected in the fee schedule templates are paid at a negotiated percentage of charges. Step 2 There are no differences in the factors used. Step 3 There are no differences in the evidentiary standards and sources used. Step 4 There are no differences in the ""As Written"" and ""In Operation"" analysis. All analysis and material documentation is available upon request. **Provider Reimbursement - Facility** Step 1 Negotiation For both M/S facilities, the Plan uses a substantially similar process to negotiate and establish reimbursement rates for INN facility services. Key steps in the INN facility reimbursement negotiation process for M/S services include: • The facility submits a completed application to the Plan to be included in the Plan's provider network • The Plan reviews the facility reimbursement proposal • Based on the above, the Plan 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 the Plan provider network submit a reimbursement proposal to the Plan. The Plan 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 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. M/S 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.

	Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "as written" and "in operation" analysis All analysis and material documentation is available upon request. All analysis and material documentation is available upon request. **OON Reimbursement - Inpatient/Outpatient** Step 1 There are no differences in how the NQTL procedure is generally applied Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis All analysis and material documentation is available upon request. **OON Reimbursement - Emergency** Step 1 There are no differences in how the NQTL procedure is generally applied Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis All analysis and material documentation is available upon request.	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 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 • 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. 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: • 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. Step 2 There are no differences in the factors used. Step 3 There are no differences in the evidentiary standards and sources used.

		Step 4 There are no differences in the ""as written"" and ""in operation"" analysis. All analysis and material documentation is available upon request." **OON Reimbursement - Inpatient/Outpatient** Step 1 There are no differences in how the NQTL procedure is generally applied Step 2 There are no differences in the factors used. Step 3 There are no differences in the evidentiary standards and sources used. Step 4 There are no differences in the ""As Written"" and ""In Operation"" analysis All analysis and material documentation is available upon request." **OON Reimbursement - Emergency** Step 1 There are no differences in how the NQTL procedure is generally applied Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis All analysis and material documentation is available upon request.
(STEP-5): *A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.*	The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information for the NQTLs. The findings of the comparative analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used by MH/SUD were comparable to, and applied no more stringently than the strategies, processes, factors, evidentiary standards, and source information used by M/S both “as written” and "in operation." The Plan concluded the methodologies used by MH/SUD were comparable to, and applied no more stringently than, the methodologies used by M/S.	

Exhibit A (5b)

Annual Mental Health and Substance Use Benefits Compliance Report

Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:

Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (13) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	*Medical/Surgical Benefits*
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.	Step 1 The Plan covers MH/SUD services/technologies (e.g., services, interventions, devices, medically administered MH/SUD drugs, etc.) that are medically necessary. Medical necessity refers to the principle that healthcare services, technologies and treatments should be in accordance with generally accepted standards of medical practice, appropriate for the member's disorder, disease, or symptoms, cost-effective, and essential for diagnosing, preventing, or treating a medical condition. The concept of medical necessity takes into account the best interests of the patient and the evidence-based standards of medical practice. It helps ensure that healthcare resources are allocated efficiently and that patients receive appropriate care based on their medical needs. The Plan makes medical necessity clinical coverage determinations using externally developed, evidence-based clinical criteria (also known as medical necessity criteria) such as American Society of Addiction Medicine (ASAM) Criteria® , 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 as well as internally developed objective, evidence-based, medical/behavioral clinical policies. Application of medical necessity criteria is integral to the utilization management (UM) processes of a medical necessity clinical coverage benefit determination. The Plan publishes its medical necessity criteria, which are available through the plan's website, and upon request. This document includes the following information: • Process for developing and approving medical necessity criteria for MH/SUD services and technologies • Description of the NQTL and application (Step 1) • Factors used to determine which services and technologies 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)	Step 1 The Plan covers M/S services/technologies (e.g., services, interventions, devices, medically administered M/S drugs, etc.) that are medically necessary. Medical necessity refers to the principle that healthcare services, technologies and treatments should be in accordance with generally accepted standards of medical practice, appropriate for the member's disorder, disease, or symptoms, cost-effective, and essential for diagnosing, preventing, or treating a medical condition. The concept of medical necessity takes into account the best interests of the patient and the evidence-based standards of medical practice. It helps ensure that healthcare resources are allocated efficiently and that patients receive appropriate care based on their medical needs. The Plan makes medical necessity clinical coverage determinations using externally developed, evidence-based clinical criteria (also known as medical necessity criteria) such as InterQual and MCG, guidelines as well as internally developed objective, evidence-based, medical clinical policies. Application of medical necessity criteria is integral to the utilization management (UM) processes of a medical necessity clinical coverage benefit determination. The Plan publishes its medical necessity criteria, which are available through the Plan's website and upon request. This document includes the following information: • Process for developing and approving medical necessity criteria for M/S services and technologies • Description of the NQTL and application (Step 1) • Factors used to determine which services and technologies 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) The Plan concludes that the methodologies used to develop and approve medical necessity criteria and medical clinical policies for M/S and MH/SUD services and technologies are comparable and applied no more stringently for MH/SUD both "as written" and "in operation." M/S has a UM program descriptions that are the foundation for the objectives and guidelines of the Plan's UM strategy. Medical necessity criteria or medical clinical policies are not included in the UM program descriptions.

	The Plan concludes that the methodologies used to develop and approve medical necessity criteria and medical/behavioral clinical policies for M/S and MH/SUD services and technologies are comparable and applied no more stringently for MH/SUD both “as written” and “in operation.” MH/SUD have UM program descriptions that are the foundation for the objectives and guidelines of the Plan’s UM strategy. Medical necessity criteria or medical/behavioral clinical policies are not included in the UM program descriptions. The Plan develops internal, objective, evidence-based, clinical policies and approves third-party, externally developed medical necessity criteria. Where available, MH/SUD use externally developed evidence-based medical necessity criteria (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII) when making clinical coverage determinations. When MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical/behavioral clinical policies are used when making medical necessity clinical coverage determinations. All MH/SUD internally developed medical and behavioral clinical policies are reviewed at least annually. The MH/SUD Clinical Criteria Development/Selection and Application Policy outline the processes to ensure medical necessity criteria are developed consistently. The Clinical Quality and Operations Committee (CQOC) assesses and approves the use of externally developed clinical criteria for MH/SUD services. CQOC uses scientifically based, clinical evidence and the Behavioral Health Hierarchy of Clinical Evidence in its assessment and approval processes. CQOC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services for members. The CQOC is comprised of representatives from sub-committees, representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair must be an executive leader, board certified in psychiatry or psychiatric subspecialty, and a licensed physician. Additionally, CQOC reviews the prior authorization list, and considers the factors and evidentiary standards when applying UM. The CQOC develops and approves behavioral clinical policies for MH/SUD services when externally developed criteria are not available. CQOC uses scientifically based clinical evidence and the Behavioral Health Hierarchy of Clinical Evidence in its development and approval processes. CQOC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services for members. The Clinical Technology Assessment Committee (CTAC) is a sub-committee of CQOC and is responsible for reviewing new or evolving technologies and then developing and maintaining evidence-based behavioral clinical policies for behavioral health technologies. CTAC’s purpose is to make determinations regarding technologies that may or may not be experimental, investigational, or unproven (EIU). CTAC members include behavioral health medical directors, senior leaders of clinical operations, research and development, clinical review, legal, compliance, and policy. CTAC voting members include six psychiatrists and	The Plan develops internal, objective, evidence-based, clinical policies and approves third-party, externally developed medical necessity criteria. Where available, M/S uses externally developed evidence-based medical necessity criteria (e.g., InterQual, MCG) when making clinical coverage determinations. When M/S technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical clinical policies are used when making medical necessity clinical coverage determinations. All M/S internally developed medical clinical policies are reviewed at least annually. The M/S Clinical Review Criteria Operational Policy outline the processes to ensure medical necessity criteria are developed consistently. The Medical Technology Assessment Committee (MTAC) assesses externally developed clinical criteria for M/S services and technologies. MTAC uses scientifically based, clinical evidence and the Hierarchy of Clinical Evidence in its assessment and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services and technologies for members. MTAC is comprised of, but not limited to, medical directors with diverse medical and surgical specialties and sub-specialties, representatives from business segments, legal services, consumer affairs, medical policy development and operations teams, benefit interpretation team, and other guests, as needed. MTAC voting members include medical directors with the following specialties (note that some doctors have multiple specialties): • Plastic Surgery • Internal Medicine (x7) • Medical Oncology • Thoracic and Cardiothoracic Vascular Surgery (x2) • Preventative Medicine • Pediatrics • Diagnostic Radiology and Vascular/Interventional Radiology • Ophthalmology • Physical Medicine & Rehabilitation Pain Medicine • Family Practice • Emergency Medicine As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization, Concurrent Review, and Retrospective Review processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State

	one licensed independent social worker (LISW), plus two co-chairs, both of whom are psychiatrists. CTAC obtains approval of its determinations from the CQOC. When assessing the safety efficacy, and appropriateness of services/technologies used to treat MH/SUD conditions, CQOC and CTAC first look for scientifically based clinical evidence and peer reviewed literature. In addition, the committees will look for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled trials and cohort studies. In addition, CTAC (for EIU) and CQOC will also look for systematic reviews and meta-analyses, large prospective trials, cross-sectional studies, retrospective studies, surveillance studies, case reviews/case series, anecdotal/editorial statements, and professional opinions. In the absence of any strong and compelling scientific evidence, CQOC (and CTAC for potential EIU technologies) assesses services and technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs. CQOC (and CTAC for potential EIU technologies) will not deem a service or technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies. The CQOC reviews and validates behavioral clinical policies endorsed by CTAC. If CQOC determines that any behavioral clinical policies are not appropriately supported by clinical evidence, then CQOC refers the behavioral clinical policy back to CTAC. Internally developed medical and behavioral clinical policies are publicly available online. MH/SUD clinical reviewers follow an established process of reviewing state/federal laws and regulations, followed by Plan documents when making medical necessity coverage benefit determinations. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. Where available, MH/SUD use externally developed evidence-based medical necessity criteria (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII) when making medical necessity coverage benefit determinations. When MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical/behavioral clinical policies are used when making medical necessity clinical coverage determinations. There is no duplication between internally and externally developed medical necessity criteria. This means that there are either externally developed medical necessity criteria available or there are internally developed behavioral clinical policies available. MH/SUD clinical reviewers do not have to make a choice between using internal or external medical necessity criteria. Second level, or peer review, medical necessity coverage benefit determinations include clinical judgment. The MH/SUD Management of Behavioral Health Benefits Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member’s specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition	• Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. MTAC reports to the UMPC. The Plan uses the following standard process to develop and approve internal medical necessity criteria: The Plan uses committees to assess technologies and conduct a thorough review of scientifically based clinical evidence and peer-reviewed literature in accordance with the Hierarchies of Clinical Evidence to develop medical clinical policies that apply to the technologies. MTAC develops and approves medical clinical policies for M/S services and technologies when externally developed criteria are not available. MTAC uses scientifically based clinical evidence and the Hierarchy of Clinical Evidence in its development and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services and technologies for members. When assessing the safety, efficacy, and appropriateness of the services/technologies used to treat M/S conditions, MTAC first looks for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled, trials and cohort studies. In addition, MTAC will look for multi-site observational studies and single site observational studies. In the absence of any strong and compelling scientific evidence, MTAC assesses technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCD). MTAC will not deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies. As of April 1, 2023, UMPC began reviewing and validating the medical clinical policies endorsed by MTAC. If UMPC determines that any medical clinical policies are not appropriately supported by clinical evidence, then UMPC refers the medical clinical policy back to MTAC. Internally developed medical clinical policies are publicly available online. The Plan uses the following standard process to apply medical necessity criteria: M/S clinical reviewers follow an established process of reviewing state/federal laws and regulations, followed by Plan documents when making medical necessity coverage benefit determinations. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. Where available, M/S uses externally developed evidence-based medical necessity criteria (e.g., InterQual, MCG,) when making medical necessity coverage benefit determinations. When M/S technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical clinical policies are used when making medical necessity clinical coverage determinations. There is no duplication between internally and externally developed medical necessity criteria. This

	meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical/behavioral clinical policies. Step 2 The M/S Factors are the same as MH/SUD. Step 3 Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in developing or approving medical necessity criteria. Factor – MH/SUD Committee Considerations, including clinical efficacy, safety of the service or technology, and appropriateness of the proposed service or technology when developing and approving behavioral clinical policies and medical necessity criteria • Clinical Effectiveness - Is a characteristic of care that is in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines as determined by internal medical experts. Clinically appropriate care is more likely to be effective • Patient Safety - As defined by the World Health Organization as “the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum. • Appropriateness of the Proposed Service or Technology - The service or technology is suitable for the member’s clinical presentation and the expected health benefits from the medical service or technology are clinically significant and exceed the expected natural history of recovery and the expected health risks by a sufficient margin The Plan’s evidentiary standard and sources that define and/or trigger the M/S and MH/SUD Committee Considerations factor: • The Plan uses scientifically based clinical evidence and the Behavioral Health Hierarchies of Clinical Evidence to determine which MH/SUD services or technologies are safe and effective and, therefore, eligible for benefit coverage. The Hierarchies of Clinical Evidence detail the hierarchy of clinical evidence that is preferred when assessing which health services or technologies are safe and effective. To be deemed safe and effective, a health service or technology only has to have evidence in at least one category. o MH/SUD assesses evidence from the following when developing or approving behavioral clinical policies/medical necessity criteria: • Scientifically based clinical evidence • Peer-reviewed literature • Behavioral Health Hierarchy of Clinical Evidence • In the absence of strong and compelling scientific evidence, behavioral clinical policies/clinical criteria may be based upon: • National consensus statements • Publications by recognized authorities such as government sources and/or professional societies • ASAM Criteria, LOCUS, CALOCUS-CASII, and ECSII (for review of external medical necessity criteria) Note: Anecdotal/editorial statements and professional opinions are only used to support adoption of behavioral clinical policies /clinical criteria when no other source is available. These evidentiary standards and sources apply for the following: • All MH/SUD INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM	means that there are either externally developed medical necessity criteria available or there are internally developed medical clinical policies available. M/S clinical reviewers do not have to make a choice between using internal or external medical necessity criteria. Second level, or peer review, medical necessity coverage benefit determinations include clinical judgment. The M/S Peer Clinical Review Operational outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member’s specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical clinical policies. Step 2 The M/S Factors are the same as MH/SUD. Step 3 Below are the evidentiary standards and sources used to define, trigger, and/or implicate the factor used in developing or approving medical necessity criteria. Factor – M/S Committee Considerations, including clinical efficacy, safety of the service or technology, and appropriateness of the proposed service or technology when developing and approving medical clinical policies and medical necessity criteria • Clinical Effectiveness - Is a characteristic of care that is in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines as determined by internal medical experts. Clinically appropriate care is more likely to be effective • Patient Safety - As defined by the World Health Organization as “the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum. • Appropriateness of the Proposed Service or Technology - The service or technology is suitable for the member’s clinical presentation and the expected health benefits from the medical service or technology are clinically significant and exceed the expected natural history of recovery and the expected health risks by a sufficient margin The Plan’s evidentiary standard and sources that define and/or trigger the M/S Committee Considerations factor: • The Plan uses scientifically based clinical evidence and the Hierarchy of Clinical Evidence to determine which M/S services or technologies are safe and effective and, therefore, eligible for benefit coverage. The Hierarchies of Clinical Evidence detail the hierarchy of clinical evidence that is preferred when assessing which health services or technologies are safe and effective. To be deemed safe and effective, a health service or technology only has to have evidence in at least one category. o M/S assesses evidence from the following when developing or approving medical clinical policies/medical necessity criteria: • Scientifically based clinical evidence • Peer-reviewed literature • Hierarchy of Clinical Evidence • In the absence of strong and compelling scientific evidence, medical policies may be based upon: o National guidelines and consensus statements o CMS NCDs

	These evidentiary standards and sources are defined in a qualitative manner. Step 4 As Written The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information MH/SUD uses to • develop internal, objective, evidence-based, behavioral clinical policies and • approve third-party, externally developed clinical criteria • to the strategies, processes, factors, evidentiary standards, and source information M/S uses to: • develop internal, objective, evidence-based, medical clinical policies and • approve third-party, externally developed clinical criteria for use in UM clinical coverage determinations and found they were comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information used by M/S “as written.” National internal committees evaluate the applicable factors and standards described in Steps 2 and 3 when developing and approving Medical Necessity criteria. Review of Factor and Evidentiary Standards When developing and approving behavioral clinical policies/medical necessity criteria, MH/SUD committees consider clinical efficacy, safety, and appropriateness of the proposed services or technologies. The MH/SUD Behavioral Health Hierarchies of Clinical Evidence are comparable. MH/SUD use the following categories of sources • Well-designed evidence-based studies • Observational studies • Case studies • Consensus statements • Clinical and professional opinion papers Review of Operational Policies and Procedures The Plan reviewed the following MH/SUD operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes. MH/SUD • Behavioral Health Hierarchy of Clinical Evidence o The purpose of this document is to outline the hierarchy of clinical evidence that is used to determine which MH/SUD health services or technologies are safe and effective and, therefore, eligible for benefit coverage. In developing the hierarchy, MH/SUD uses scientifically based clinical evidence to identify safe and effective health services or technologies for members • CTAC Charter o CTAC is responsible for reviewing new or evolving technologies and then developing and maintaining evidence-based behavioral clinical policies for behavioral health technologies • CQOC Charter o The role and purpose of the CQOC is to review and approve externally developed medical necessity criteria, develop behavioral clinical policies when externally developed criteria is not available, and to review and validate CTAC’s assessment of EIU technologies • Management of Behavioral Health Benefits	o 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, e.g., American College of Physicians (ACP), The Society for Post-Acute and Long-Term Care Medicine (AMDA), American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), American College of Cardiology (ACC), etc. • InterQual or MCG (for review of external medical necessity criteria) Note: Anecdotal/editorial statements and professional opinions are only used to support adoption of behavioral clinical policies /clinical criteria when no other source is available. These evidentiary standards and sources apply for the following: • All M/S INN inpatient, OON inpatient, INN outpatient, and OON outpatient services and technologies subject to UM These evidentiary standards and sources are defined in a qualitative manner. Step 4 As Written The Plan conducted a comparative analysis of the strategies, processes, factor, evidentiary standards, and source information M/S uses to • develop internal, objective, evidence-based, behavioral clinical policies and • approve third-party, externally developed clinical criteria • to the strategies, processes, factors, evidentiary standards, and source information M/S uses to: • develop internal, objective, evidence-based, medical clinical policies and • approve third-party, externally developed clinical criteria for use in UM clinical coverage determinations and found they were comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information used by M/S “as written.” National internal committees evaluate the applicable factors and standards described in Steps 2 and 3 when developing and approving Medical Necessity criteria. Review of Factor and Evidentiary Standards When developing and approving medical clinical policies/medical necessity criteria, M/S committees consider clinical efficacy, safety, and appropriateness of the proposed services or technologies. The M/S Hierarchy of Clinical Evidence uses the following categories of sources: • Well-designed evidence-based studies • Observational studies • Case studies • Consensus statements • Clinical and professional opinion papers Review of Operational Policies and Procedures The Plan reviewed the following M/S operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes. M/S • Hierarchy of Clinical Evidence o The purpose of this document is to outline the hierarchy of clinical evidence that is used to determine which M/S health services or technologies are safe and effective and, therefore, eligible

	o The purpose of this policy is to describe the mechanisms and processes designed to promote consistency in the management of behavioral health benefits and ensure that members receive appropriate, high quality behavioral health services or technologies in a timely manner • Clinical Criteria Development Selection and Application Policy o This document addresses MH/SUD selection, development, and use of clinical criteria in making benefit determinations. MH/SUD uses written clinical criteria consistent with National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) requirements and applicable laws and regulations o MH/SUD selects and uses clinical criteria that are consistent with generally accepted standards of care, including objective criteria that are based on sound clinical evidence. MH/SUD uses the criteria to make standardized coverage determinations and to inform discussions about evidence-based practices and discharge planning Where available, both MH/SUD use externally developed evidence-based medical necessity criteria (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII) when making clinical coverage determinations. When MH/SUD technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, behavioral clinical policies are used when making medical necessity clinical coverage determinations. CQOC (and CTAC for EIU) develop internal clinical policies only. CQOC review and approve externally developed medical necessity criteria. In either case, a comparable process is followed. In some cases, the Plan is obligated by State regulations to use certain externally developed medical necessity criteria. The committees assess the clinical efficacy, safety, and appropriateness of the proposed services or technologies used for the treatment of health care conditions based upon the scientific evidence. CTAC's technology assessment process for MH/SUD potential EIU technologies, including the Behavioral Health Hierarchy of Clinical Evidence, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S technologies including the M/S Hierarchy of Clinical Evidence. Additionally, CQOC's assessment process for MH/SUD services, including the Behavioral Health Hierarchy of Clinical Evidence, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S services including the M/S Hierarchy of Clinical Evidence. All MH/SUD behavioral clinical policies are reviewed at least annually. Review of processes to review externally developed medical necessity criteria The CQOC assesses externally developed clinical criteria for MH/SUD services. CQOC uses scientifically based clinical evidence and the Behavioral Health Hierarchy of Clinical Evidence in its development, assessment, and approval processes. CQOC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services for members. MH/SUD committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services or technologies to approve medical/behavioral clinical policies. MH/SUD committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors.	for benefit coverage. In developing the hierarchy, M/S uses scientifically based clinical evidence to identify safe and effective health services or technologies for members. • Applying Benefit Plan and Review Criteria Standard Operating Procedure o This standard operating procedure outlines the hierarchy of authorities to be reviewed (i.e., state/federal laws and regulations followed by Benefit Plan criteria) when making clinical coverage determinations • Utilization Management Program Committee Charter o This document summarizes the philosophy, structure and standards that govern medical management, utilization management and utilization review responsibilities and functions • Clinical Review Criteria Operational Policy o The purpose of this operational policy is to document that M/S will use evidence-based clinical review criteria to support clinical review decisions for UM programs, and to ensure that the clinical review process is applied consistently Where available, M/S use externally developed evidence-based medical necessity criteria (e.g., InterQual, MCG) when making clinical coverage determinations. When M/S technologies (e.g., services, interventions, devices, medically administered drugs, etc.) fall outside the scope of externally developed medical necessity criteria, internally developed, evidence-based, medical clinical policies are used when making medical necessity clinical coverage determinations. MTAC develop internal clinical policies only. MTAC review and approve externally developed medical necessity criteria. In either case, a comparable process is followed. In some cases, the Plan is obligated by State regulations to use certain externally developed medical necessity criteria. The committees assess the clinical efficacy, safety, and appropriateness of the proposed services or technologies used for the treatment of health care conditions based upon the scientific evidence. CTAC's technology assessment process for MH/SUD potential EIU technologies, including the Behavioral Health Hierarchy of Clinical Evidence, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S technologies including the M/S Hierarchy of Clinical Evidence. Additionally, CQOC's assessment process for MH/SUD services, including the Behavioral Health Hierarchy of Clinical Evidence, is comparable to, and applied no more stringently than, MTAC's assessment process for M/S services including the M/S Hierarchy of Clinical Evidence. All M/S medical clinical policies are reviewed at least annually. Review of processes to review externally developed medical necessity criteria A standard and comparable process is followed to review externally developed, third party medical necessity criteria. The MTAC assesses externally developed clinical criteria for M/S services or technologies. MTAC uses scientifically based, clinical evidence and the Hierarchy of Clinical Evidence in its assessment and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services or technologies for members. M/S committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services or technologies to approve medical clinical policies. M/S committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors.

	ASAM Criteria, LOCUS, CALOCUS-CASII, and ECSII are widely recognized as best-in-class externally developed medical necessity criteria sources. The MH/SUD external medical necessity criteria is developed by nationally recognized organizations. The MH/SUD medical necessity criteria sets apply to specific clinical conditions and do not overlap. Review of processes to develop and approve internal medical necessity criteria CQOC (and CTAC for EIU technologies) develops and approves behavioral clinical policies for MH/SUD services and technologies. CQOC/CTAC uses scientifically based clinical evidence and the Behavioral Health Hierarchy of Clinical Evidence in its development, assessment, and approval processes. CQOC/CTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective MH/SUD services and technologies for members. When assessing services and technologies used to treat MH/SUD conditions, CQOC/CTAC first look for any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled, trials and cohort studies. CQOC/CTAC will also look for systematic reviews and meta-analyses, large prospective trials, cross-sectional studies, retrospective studies, surveillance studies, case reviews/case series, anecdotal/editorial statements, and professional opinions. In the absence of any strong and compelling scientific evidence, CQOC/CTAC assess services and technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs. Neither CQOC nor CTAC will deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies. MH/SUD committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services and technologies to develop or approve behavioral clinical policies. Review of Medical Necessity Processes MH/SUD clinical reviewers follow a hierarchy of authority when making medical necessity determinations. MH/SUD clinical reviewers follow the established process of reviewing state/federal laws and regulations, followed by Plan documents when making clinical coverage benefit determinations (see enclosed MH/SUD Clinical Criteria Development Selection and Application Policy). Internally developed clinical policies or externally developed third party medical necessity criteria are then reviewed. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. As there is no duplication between internally and externally developed medical necessity criteria, MH/SUD clinical reviewers do not have to make a choice between using internal or external medical necessity criteria. The Plan generally assesses the appropriate application of its medical necessity criteria in operation by comparing the results of its mandatory MH/SUD Inter-Rater Reliability (IRR) assessment outcomes. In Operation The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information MH/SUD uses to	The Plan uses InterQual medical necessity criteria for M/S services or technologies because InterQual monitors more than 3,000 guidelines, guideline issuers and medical societies for newly published medical literature, and an independent clinical review panel drawn from more than 1,000 experts provides authoritative peer review. The M/S medical necessity criteria sets apply to specific clinical conditions and do not overlap. Review of processes to develop and approve internal medical necessity criteria MTAC develops and approves medical clinical policies for M/S services or technologies. MTAC uses scientifically based clinical evidence and the Hierarchy of Clinical Evidence in its development, assessment, and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective M/S services or technologies for members. In the absence of any strong and compelling scientific evidence, MTAC assess services and technologies by looking for any national consensus statements and/or publications by recognized authorities such as clinical position papers published by professional specialty societies and CMS NCDs. MTAC will deem a technology unproven solely based on a lack of randomized controlled trials, particularly for new and emerging technologies. M/S and committees use comparable evidentiary standards and sources to evaluate clinical efficacy, safety, and appropriateness of the proposed services and technologies to develop or approve medical clinical policies. Review of Medical Necessity Processes M/S clinical reviewers follow a hierarchy of authority when making medical necessity determinations. M/S clinical reviewers follow the established process of reviewing state/federal laws and regulations, followed by Plan documents when making clinical coverage benefit determinations (see enclosed M/S Applying Benefit Plan and Review Criteria Standard Operating Procedure). Internally developed clinical policies or externally developed third party medical necessity criteria are then reviewed. The criteria chosen for review are based on the treatment type, diagnosis, and services requested. As there is no duplication between internally and externally developed medical necessity criteria, M/S clinical reviewers do not have to make a choice between using internal or external medical necessity criteria. The Plan generally assesses the appropriate application of its medical necessity criteria in operation by comparing the results of its mandatory M/S Inter-Rater Reliability (IRR) assessment outcomes. In Operation The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information MH/SUD uses to • develop internal, objective, evidence-based, behavioral clinical policies and • approve third-party, externally developed clinical criteria to the strategies, processes, factors, evidentiary standards, and source information M/S uses to: • develop internal, objective, evidence-based, medical clinical policies and

	• develop internal, objective, evidence-based, behavioral clinical policies and • approve third-party, externally developed clinical criteria to the strategies, processes, factors, evidentiary standards Review of Factor and Evidentiary Standards When reviewing and developing medical/behavioral clinical policies and medical necessity criteria, MH/SUD committees both consider clinical efficacy, safety, and appropriateness of the proposed services and technologies. The Behavioral Health Hierarchies of Clinical Evidence are comparable. The factors and evidentiary standards were applied to MH/SUD services and technologies comparably and not more stringently to MH/SUD services than to M/S services and technologies "in operation." Review of Operational Policies and Procedures The Plan reviewed MH/SUD operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes. The MH/SUD Clinical Criteria Development/Selection and Application Policy outline the processes to ensure medical necessity criteria are developed consistently. Second level, or peer review, determinations include clinical judgment; the MH/SUD Management of Behavioral Health Benefits Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal behavioral clinical policies. Further, review of the committee charters confirms that both committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors. Review of process to develop and approve medical necessity criteria The strategy for developing and approving medical necessity criteria is comparable for both M/S and MH/SUD and applied no more stringently to MH/SUD services and technologies. The Plan conducted a review of the MH/SUD processes to confirm comparability. The review focused on the following aspects of the process for MH/SUD: • The committees follow standard processes outlined in their respective charters and apply their respective Hierarchies of Clinical Evidence when developing, assessing, and approving medical/behavioral clinical policies and medical necessity criteria. o CQOC reviewed and approved the use of third-party externally developed medical necessity criteria and developed new behavioral clinical policies when external criteria were not available. - CTAC developed behavioral clinical policies for EIU. o CQOC reviewed and approved EIU behavioral clinical policies developed by CTAC • If CQOC determine that any internally developed medical/behavioral clinical policies are not appropriately supported by clinical evidence, then CQOC refer the medical necessity criteria back to CTAC. Review of Use of Medical Necessity Criteria MH/SUD utilize medical and behavioral clinical policies and medical necessity criteria when making medical necessity clinical coverage benefit determinations related to MH/SUD services and technologies. All MH/SUD clinical staff and peer reviewers who make clinical coverage benefit determinations utilizing medical and behavioral clinical policies and medical necessity criteria are required to participate in an IRR assessment to ensure	• approve third-party, externally developed clinical criteria for use in UM clinical coverage determinations and found they were comparable to, and no more stringently applied than, the strategies, processes, factors, evidentiary standards, and source information used by M/S "in operation." Review of Factor and Evidentiary Standards When reviewing and developing medical/behavioral clinical policies and medical necessity criteria, M/S committees both consider clinical efficacy, safety, and appropriateness of the proposed services and technologies. The MS Hierarchies of Clinical Evidence are comparable. The factors and evidentiary standards were applied to M/S and MH/SUD services and technologies comparably and not more stringently to MH/SUD services than to M/S services and technologies "in operation." Review of Operational Policies and Procedures The Plan reviewed M/S operational policies and procedures to confirm comparability and found MH/SUD policies, procedures, and processes to be comparable and no more stringent than M/S policies, procedures, and processes. The M/S Clinical Review Criteria Operational Policy outline the processes to ensure medical necessity criteria are developed consistently. Second level, or peer review, determinations include clinical judgment; the M/S Peer Clinical Review Operational Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member's specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical clinical policies. Further, review of the committee charters confirms that both committees are comprised of licensed clinicians with applicable specialties and are chaired by executive-level medical directors. Review of process to develop and approve medical necessity criteria The strategy for developing and approving medical necessity criteria is comparable for both M/S and MH/SUD and applied no more stringently to MH/SUD services and technologies. The Plan conducted a review of the M/S processes to confirm comparability. The review focused on the following aspects of the process for both M/S and MH/SUD: • The committees follow standard processes outlined in their respective charters and apply their respective Hierarchies of Clinical Evidence when developing, assessing, and approving medical/behavioral clinical policies and medical necessity criteria. o MTAC reviewed and approved the use of third-party externally developed medical necessity criteria and developed new medical clinical policies when external criteria were not available • UMPC reviewed and validated the MTAC assessment and approval of medical necessity criteria. • If UMPC determine that any internally developed medical/behavioral clinical policies are not appropriately supported by clinical evidence, then UMPC refer the medical necessity criteria back to MTAC. Review of Use of Medical Necessity Criteria M/S utilize medical and behavioral clinical policies and medical necessity criteria when making medical necessity clinical coverage benefit determinations related to M/S services and technologies. All M/S clinical staff and peer reviewers who make clinical coverage benefit determinations utilizing medical and behavioral clinical policies and medical necessity criteria are required to participate in an IRR assessment to ensure clinical policies and medical necessity criteria are applied in a consistent and appropriate manner "in operation." Clinical staff are required

	clinical policies and medical necessity criteria are applied in a consistent and appropriate manner “in operation.” Clinical staff are required to achieve a passing score of at least 90%. The IRR assessment process identifies areas of improvement for clinical staff who do not achieve a passing score and additional training is provided on the use and application of the relevant policies. If necessary, remediation planning, and training will be directed by a supervisor/manager. Second level, or peer review, medical necessity benefit coverage determinations include clinical judgment. The MH/SUD Management of Behavioral Health Benefits Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member’s specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical/behavioral clinical policies.	to achieve a passing score of at least 90%. The IRR assessment process identifies areas of improvement for clinical staff who do not achieve a passing score and additional training is provided on the use and application of the relevant policies. If necessary, remediation planning, and training will be directed by a supervisor/manager. Second level, or peer review, medical necessity benefit coverage determinations include clinical judgment. The M/S Peer Clinical Review Operational Policy outline the processes. Clinicians use their clinical judgment when they apply evidence-based medical necessity criteria to each member’s specific clinical condition. Clinicians use their independent clinical judgment when they evaluate whether the member's clinical condition meets the medical necessity criteria per the applicable externally developed medical necessity criteria or internal medical/behavioral clinical policies.
In-Patient & In-Network NQTL Practices	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.
In-Patient & Out-of-Network NQTL Practices	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.

Out-Patient & In-Network NQTL Practices	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.
Out-Patient & Out-of-Network NQTL Practices	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.	The Plan separates NQTLs into the following benefit classifications: • Inpatient, in-network • Inpatient, out-of-network • Outpatient, in-network • Outpatient, out-of-network • Emergency • Pharmacy Where processes are different or applicable services are different, NQTLs analyses are conducted separately. For example, the Plan conducts a separate analysis and has a separate NQTL for prior authorization inpatient, in-network and prior authorization outpatient, in-network. Where processes are similar, NQTLs are combined. For example, the Network Adequacy NQTL applies to multiple benefit classifications. The Plan confirms that the comparative analyses conducted included a review of all processes related to the limitations, including dissimilar or non-identical benefit limiting practices.
Emergency Services/Benefits NQTL Practices	Prior Authorization, Concurrent Review and Retrospective Review are not performed on MH/SUD Emergency services. Emergency services for MH/SUD, as defined by the prudent layperson standard (and as defined by the state), are covered without medical necessity.	Prior Authorization and Concurrent Review are not performed on M/S Emergency services. Emergency services for M/S, as defined by the prudent layperson standard (and as defined by the state), are covered without medical necessity.
Rx Formulary Design, Management and Pharmacy Services NQTL Practices	Prescription Drug List (PDL) Design Step 1 There are no differences in how the NQTL procedure is generally applied Step 2 There are no differences in the factors Step 3 There are no differences in the evidentiary standards and sources	Prescription Drug List (PDL) Design Step 1 There are no differences in how the NQTL procedure is generally applied. Step 2 There are no differences in the factors. Step 3 There are no differences in the evidentiary standards and sources.

	Step 4 The Pharmacy & Therapeutics (P&T) Committee assesses a MH/SUD 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. For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop clinical policies through a single P&T Committee. The Plan reviewed the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis 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 2023). The Plan 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 2023: • January 2023 o 56.5% of MH/SUD drugs are on Tiers 1 and 2 • May 2023 o 56.5% of MH/SUD drugs are on Tiers 1 and 2 • September 2023 o 56.3% of MH/SUD drugs are on Tiers 1 and 2 These evaluations were based on the Advantage PDL, which is the most commonly used PDL. Prescription Drug Prior Authorization / Step Therapy / Quantity Limits For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop MH/SUD drug policies through a single Pharmacy & Therapeutics (P&T) Committee. The findings of the prescription drug prior authorization or step therapy outcomes analysis for each Plan (see data below) indicated the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for MH/SUD prescription drugs were comparable to the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for M/S prescription drugs. Data is for (January, May, and September 2023). 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 2023: • January 2023 – 33.7% (165) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits • May 2023 – 33.7% (165) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits • September 2023 – 34.0% (166) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits	Step 4 The Pharmacy & Therapeutics (P&T) Committee assesses a M/S 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. For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop clinical policies through a single P&T Committee. The Plan reviewed the number of M/S and MH/SUD prescription drugs by tier on a tri-annual basis. 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 2023). The Plan also notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance. • January 2023 o 56.5% of MH/SUD drugs are on Tiers 1 and 2 o 52.3% of M/S drugs are on Tiers 1 and 2 • May 2023 o 56.5% of MH/SUD drugs are on Tiers 1 and 2 o 52.0% of M/S drugs are on Tiers 1 and 2 • September 2023 o 56.3% of MH/SUD drugs are on Tiers 1 and 2 o 52.5% of M/S drugs are on Tiers 1 and 2 Prescription Drug Prior Authorization / Step Therapy / Quantity Limits For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop M/S drug policies through a single Pharmacy & Therapeutics (P&T) Committee. The findings of the prescription drug prior authorization or step therapy outcomes analysis for each Plan (see data below) indicated the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for MH/SUD prescription drugs were comparable to the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for M/S prescription drugs. Data is for (January, May, and September 2023). 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 2023 • January 2023 – 38.5% (1,575) of M/S drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits • May 2023 – 39.3% (1,618) of M/S drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits • September 2023 – 40.1% (1,657) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits"

	All analysis and material documentation is available upon request.	
Prior-Authorization NQTL Practices	**In-Network Inpatient** N/A. This plan does not perform Prior Authorizations **Out-of-Network Inpatient** N/A. This plan does not perform Prior Authorizations **In-Network Outpatient** N/A. This plan does not perform Prior Authorizations **Out-of-Network Outpatient** N/A. This plan does not perform Prior Authorizations	**In-Network Inpatient** N/A. This plan does not perform Prior Authorizations **Out-of-Network Inpatient** N/A. This plan does not perform Prior Authorizations **In-Network Outpatient** N/A. This plan does not perform Prior Authorizations **Out-of-Network Outpatient** N/A. This plan does not perform Prior Authorizations
Concurrent Review Benefit NQTL Practices	**In-Network Inpatient** N/A. This plan does not perform Concurrent Reviews on IP services. This plan only performs Concurrent Reviews on Outpatient Physiotherapy services, after 12-24 visits per injury or sickness, per plan language. **Out-of-Network Inpatient** N/A. This plan does not perform Concurrent Reviews on IP services. This plan only performs Concurrent Reviews on Outpatient Physiotherapy services, after 12-24 visits per injury or sickness, per plan language. **In-Network Outpatient** Step 1 The Plan structures outpatient Concurrent Review 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 the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted. The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. Concurrent Review MH/SUD outpatient services consists of the following: Student Resources only performs Concurrent Review on Outpatient Physiotherapy services, after 12-24 visits, per injury or sickness, per Plan language. **Out-of-Network Outpatient** Step 1 The Plan structures outpatient Concurrent Review 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 the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at the state and federal level, which includes consumer	**In-Network Inpatient** N/A. This plan does not perform Concurrent Reviews on IP services. This plan only performs Concurrent Reviews on Outpatient Physiotherapy services, after 12-24 visits per injury or sickness, per plan language. **Out-of-Network Inpatient** N/A. This plan does not perform Concurrent Reviews on IP services. This plan only performs Concurrent Reviews on Outpatient Physiotherapy services, after 12-24 visits per injury or sickness, per plan language. **In-Network Outpatient** Step 1 The Plan structures outpatient Concurrent Review 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 the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted. Concurrent Review of M/S outpatient services consists of the following: Student Resources only performs Concurrent Review on Outpatient Physiotherapy services, after 12-24 visits per injury or sickness, per Plan language. **Out-of-Network Outpatient** Step 1 The Plan structures outpatient Concurrent Review 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 the Plan's operations and policies identify appropriate timeframes for decisions, requires decision-making by appropriate personnel, and governs communication of adverse benefit determinations. In addition, Concurrent Review is governed at both the state and federal level, which includes consumer protections such as external review for adverse benefit determinations after internal appeals options are exhausted. Concurrent Review of M/S outpatient services consists of the following:

	protections such as external review for adverse benefit determinations after internal appeals options are exhausted. The Plan delegates management of MH/SUD outpatient services, including Concurrent Review to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. Concurrent Review MH/SUD outpatient services consists of the following: Student Resources only performs Concurrent Review on Outpatient Physiotherapy services, after 12-24 visits, per injury or sickness, per Plan language.	Student Resources only performs Concurrent Review on Outpatient Physiotherapy services, after 12-24 visits per injury or sickness, per Plan language.
Retrospective Review Benefit NQTL Practices	**In-Network Inpatient** Step 1 The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. MH/SUD claims/requests for inpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for requests or claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) reviews the claim to determine if the inpatient admission billed meets clinical criteria for coverage based on application of objective, evidence-based, clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve requests for payment or refer requests to peer clinical reviewers (Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that an admission was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical	**In-Network Inpatient** Step 1 Retrospective Review for certain inpatient services begins after the Plan receives claims or notification of inpatient admission post discharge from an INN facility. The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services EIU, or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the inpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (e.g., Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials.

	criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria, 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. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Retrospective Review determinations are appropriate. The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty, and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable. List of MH/SUD Services Subject to NQTL • MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment Step 2 There are no differences in the factors used Step 3 • The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor:	Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual or MCG guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate. The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable. List of M/S and MH/SUD Services Subject to NQTL • Services that have not previously been reviewed in Prior Authorization or Concurrent Review • M/S Claims that are denied, if requested by an INN facility • Services where the service or procedure codes do not match a diagnosis code • EIU services

	o Clinical criteria from nationally recognized, third-party sources (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services) o Clinical Technology Assessment Committee (CTAC) review o Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Psychiatric Association, etc.) Step 4 • Timeframe to submit. National Network Manual (for MH/SUD) were reviewed for requirements related to timeliness of notification to the Plan and it was determined that MH/SUD was no more stringent. o For MH/SUD, facilities have 180 days after the service is rendered to request a Retrospective Review • Review of Staff Qualifications. For M/S and MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements. o MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. • Clinical Criteria. For MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines. The Plan subjected claims/requests for M/S and MH/SUD inpatient admissions to Retrospective Review that were not reviewed in the Prior Authorization or Concurrent Review process. Outcomes data reviewed for comparability INN inpatient medical necessity approval and denial rates and appeals outcomes data from 1/1/2024 -12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is no data for MH/SUD INN inpatient cases from 01/01/2024 -12/31/2024 to support an analysis of clinical outcomes data. **Out-of-Network Inpatient** Step 1 The Plan delegates management of MH/SUD inpatient services, including Retrospective Review to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. MH/SUD claims/requests for inpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the	• Services that are subject to benefit limits/exclusions • Codes identified by the Plan as subject to Retrospective Review • Please see the file M/S Retrospective Review Codes for the list of M/S codes that may be subject to Retrospective Review Step 2 There are no differences in the factors used. Step 3 • The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor: o Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG) o Medical Technology and Assessment Committee (MTAC) review o Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.) Step 4 • Timeframe to submit. The Administrative Guide (for M/S) was reviewed for requirements related to timeliness of notification to the Plan and it was determined that MH/SUD was no more stringent. o For M/S, facilities must request the Retrospective Review within the requirements outlined in their provider contract • Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state and federal requirements. o M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses, physicians) and all adverse benefit determinations are made by a physician or other appropriate health care professionals. • Clinical Criteria. For M/S, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual and MCG. The Plan subjected claims/requests for M/S and MH/SUD inpatient admissions to Retrospective Review that were not reviewed in the Prior Authorization or Concurrent Review process. Additionally, M/S claims/requests for inpatient services submitted by INN providers were subject to Retrospective Review if the services or procedure codes did not match a diagnosis code, if services were EIU, or if the services had benefit limits/exclusions. Claims/requests for inpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU. Outcomes data reviewed for comparability INN inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2024 – 12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis.

	billed services or procedure codes do not match the authorized codes, or if services are EIU. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for requests or claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) review the claim to determine if the inpatient admission billed meets clinical criteria for coverage based on application of objective, evidence-based, clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that an admission was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim. The OON provider may bill non-reimbursable charges to the member. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria, 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. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that inpatient Retrospective Review determinations are appropriate. The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness	There are no M/S INN Inpatient cases from 01/01/2024 -12/31/2024 to support an analysis of clinical outcomes data. All analysis and material documentation is available upon request. **Out-of-Network Inpatient** Step 1 Retrospective Review for certain inpatient services begins after the Plan receives claims or notification of an inpatient admission post discharge from an OON facility. The Plan conducts medical necessity Retrospective Review of claims/requests for certain inpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services EIU, or if the services are subject to benefit limits/exclusions. The Plan conducts medical necessity Retrospective Review for inpatient services where Prior Authorization was required but not obtained upon claim submission. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, cases are referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the inpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state, federal, and accreditation requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria: Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual or MCG Guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate.

	requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including inpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable. List of MH/SUD Services Subject to NQTL • MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment Step 2 There are no differences in the factors used Step 3 • The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor: o Clinical criteria from nationally recognized, third-party sources (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services) o Clinical Technology Assessment Committee (CTAC) review o Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Psychiatric Association, etc.) Step 4 • Timeframe to submit. The timeframe for the member to submit the Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent. o For MH/SUD, members have 180 days after the service is rendered to request a Retrospective Review • Notification of Decisions to Providers and Members. The Plan notifies MH/SUD OON facilities and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state and federal requirements.	The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements, and state law where applicable. M/S Services Subject to NQTL • Services that have not previously been reviewed in Prior Authorization or Concurrent Review • Services where the service or procedure codes do not match a diagnosis code • EIU services • Services that are subject to benefit limits/exclusions • Codes identified by the Plan as subject to Retrospective Review • Please see the file M/S Retrospective Review Codes for the list of M/S codes that may be subject to Retrospective Review Step 2 There are no differences in the factors used. Step 3

	• Review of Staff Qualifications. For MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements. o MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors. • Clinical Criteria. For MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines. Outcomes data reviewed for comparability OON inpatient medical necessity approval and denial rates and appeals outcomes data from 1/1/2024 -12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is no data for MH/SUD INN inpatient cases from 01/01/2024 -12/31/2024 to support an analysis of clinical outcomes data. **In-Network Outpatient** Step 1 The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. MH/SUD claims/requests for outpatient services submitted by INN providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (e.g., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) reviews the request or claim to determine if the outpatient service meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors or psychologists). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the	• The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor: o Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG) o Medical Technology and Assessment Committee (MTAC) review o Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.) Step 4 • Timeframe to submit. The timeframe for the member to submit the Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent. o For M/S, members must notify the Plan within timely filing requirements • Notification of Decisions to Providers and Members. The Plan notifies M/S OON facilities and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state and federal requirements. • Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state and federal requirements. o M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses, physicians) and all adverse benefit determinations are made by a physician or other appropriate health care professionals. • Clinical Criteria. For M/S, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual and MCG. Outcomes data used for comparability INN inpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2024 – 12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There are no M/S INN Inpatient cases from 01/01/2024 -12/31/2024 to support an analysis of clinical outcomes data. All analysis and material documentation is available upon request. **In-Network Outpatient** Step 1 Retrospective Review for certain outpatient services begins after the Plan receives claims from INN providers. The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are EIU, or if the services are subject to benefit limits/exclusion. The Plan also conducts medical necessity Retrospective Review for outpatient services where Prior Authorization was required, but not obtained upon claim submission. INN providers may also request Retrospective Review of outpatient claims that are denied.

	peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination is issued. The Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies, or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria, 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. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Retrospective Review determinations are appropriate. The Plan conducts monthly quality audits of individual non-clinical staff, clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons.	Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (physician or nurse) reviews the claim to determine if the outpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual or MCG guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate. The Plan conducts end-to-end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior

	MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable. List of MH/SUD Services Subject to NQTL - OHI, OHP, and UHIC: • Partial Hospitalization (PHP)/Day Treatment/ High Intensity Outpatient • Intensive Outpatient (IOP) • Psychological Testing • Applied Behavior Analysis (ABA) • Transcranial Magnetic Stimulation (TMS) Step 2 There are no differences in the factors used Step 3 • The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor: o Clinical criteria from nationally recognized, third-party sources (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services) o Clinical Technology Assessment Committee (CTAC) and review o Objective, evidence-based medical/behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Psychiatric Association, etc.) Step 4 • Timeframe to submit. National Network Manual (for MH/SUD) were reviewed for requirements relating to timeliness of notification to the Plan and it was determined MH/SUD was no more stringent. o For MH/SUD, providers have 180 days after the service is rendered to request a Retrospective Review • Review of Staff Qualifications. For MH/SUD, clinical staff qualifications align with the type of clinical review and state and federal requirements. o MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. Outcomes data reviewed for comparability INN outpatient medical necessity approval and denial rates and appeals outcomes data from 1/1/2024 -12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD INN outpatient cases from 1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for Plans 1, 2 and 3. MH/SUD INN OP Cases Plan 1 Administrative Denial Rate - 0% (0 out of 4 cases) Clinical Denial Rate - 0% (0 out of 4 cases)	Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements and state law where applicable. List of M/S Services Subject to NQTL • Services that have not previously been reviewed in Prior Authorization or Concurrent Review • Claims that are denied, if requested by INN provider • Services where the service or procedure codes do not match a diagnosis code • EIU services • Services that are subject to benefit limits/exclusions • Codes identified by the Plan as subject to Retrospective Review o Please see the file M/S Retrospective Review Codes for the list of M/S codes that may be subject to Retrospective Review Step 2 There are no differences in the factors used. Step 3 • The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor: o Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG) o Medical Technology and Assessment Committee (MTAC) review o Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.) Step 4

	Plan 2 Administrative Denial Rate - 0% (0 out of 2 cases) Clinical Denial Rate - 0% (0 out of 2 cases) Plan 3 Administrative Denial Rate - 0% (0 out of 16 cases) Clinical Denial Rate - 12.50% (2 out of 16 cases) All analysis and material documentation is available upon request. **Out-of-Network Outpatient** Step 1 The Plan delegates management of MH/SUD outpatient services, including Retrospective Review to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. MH/SUD claims/requests for outpatient services submitted by OON providers may be subject to Retrospective Review if the service or procedure code required Prior Authorization or Concurrent Review, but that review was not conducted and there is a mitigating circumstance. Additionally, claims may be subject to Retrospective Review if the billed services or procedure codes do not match the authorized codes or if services are EIU. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) reviews the request or claim to determine if the outpatient service meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, or nationally recognized guidelines. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors or psychologists). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If the peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination is issued. The Plan communicates the adverse benefit determination, including appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a request/claim. The OON provider may bill non-reimbursable charges to the member. Adverse Benefit Determination. For MH/SUD, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a	• Timeframe to submit. The Administrative Guide (for M/S) was reviewed for requirements relating to timeliness of notification to the Plan and it was determined MH/SUD was no more stringent. o For M/S, providers must request the Retrospective Review within the requirements outlined in their provider contract • Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state and federal requirements. o M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses) and all adverse benefit determinations are made by a physician or other appropriate health care professionals. • Clinical Criteria. For M/S, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual and MCG. Outcomes data reviewed for comparability INN outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2024 – 12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD INN outpatient cases from 1/1/2024 -12/31/2024 to support an analysis of clinical outcomes data for Plan 1 and 3. There is an insufficient number of M/S and MH/SUD INN outpatient cases from 1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for Plan 2. M/S INN OP Cases Plan 1 Administrative Denial Rate - 0% (0 out of 680 cases) Clinical Denial Rate – 15.61% (103 out of 680 cases) Plan 2 Administrative Denial Rate - 0% (0 out of 55 cases) Clinical Denial Rate – 14.55% (8 out of 55 cases) Plan 3 Administrative Denial Rate – 0.22% (6 out of 1,836 cases) Clinical Denial Rate – 22.82% (419 out of 1,836 cases) All analysis and material documentation is available upon request. **Out-of-Network Outpatient** Step 1 Retrospective Review for certain outpatient services begins after the Plan receives claims from OON providers. The Plan conducts medical necessity Retrospective Review of claims/requests for certain outpatient services that have not previously been reviewed as part of the Prior Authorization or Concurrent Review processes. The Plan may conduct Retrospective Review if the service or procedure codes do not match a diagnosis code, if services are EIU, or if the services are subject to benefit limits/exclusion. The Plan also conducts medical necessity Retrospective Review for

	benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based behavioral clinical policies, or use clinical criteria from third party sources such as American Society of Addiction Medicine (ASAM) Criteria, 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. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that outpatient Retrospective Review determinations are appropriate. The Plan conducts monthly quality audits of individual non-clinical staff clinical reviewers, and peer clinical reviewers, including staff performing appeal functions. These audits are designed and approved by clinical leadership each year. The results of these real-time audits are shared with supervisors for staff oversight, and all findings are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization. The Plan's national Clinical Quality & Operations Committee (CQOC) annually reviews overall UM program outcomes, including outpatient Retrospective Review outcomes, to confirm overall utilization is appropriate. The national CQOC is comprised of representatives from sub-committees, and representatives from the clinical quality improvement, UM, care engagement, medical operations, medical policy and standards, clinical operations, appeals, product, legal, compliance, network strategy, provider experience, accreditation, and benefits teams. The Chair of the CQOC must be an executive leader, board certified in psychiatry or psychiatric subspecialty and a licensed physician. Per the MH/SUD policy entitled, Core Principles and Practices, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse clinical coverage benefit determinations (clinical denials) for financial reasons. MH/SUD generally structures UM processes to comply with federal ERISA requirements, and state law where applicable. List of MH/SUD Services Subject to NQTL - • Partial Hospitalization (PHP)/Day Treatment/ High Intensity Outpatient • Intensive Outpatient (IOP) • Psychological Testing • Applied Behavior Analysis (ABA) • Transcranial Magnetic Stimulation (TMS) Step 2	outpatient services where Prior Authorization was required, but not obtained upon claim submission. Non-clinical staff confirm member eligibility and benefit plan coverage upon receipt of the notification. If needed, non-clinical staff request medical records for claims containing services that are subject to Retrospective Review. When medical records are received, the case is referred to clinical reviewers to assess medical necessity. First Level Clinical Review/Initial Review. The clinical reviewer (physicians or nurses) reviews the claim to determine if the outpatient service billed meets clinical criteria for coverage based on application of objective, evidence-based clinical criteria, nationally recognized guidelines, and the member's benefit plan documents. Clinical reviewers either approve claims for payment or refer claims to peer clinical reviewers (Medical Directors). Second Level Clinical Review/Peer Review. The clinical reviewer refers cases to a same or similarly licensed (peer) clinical reviewer if the case cannot be approved. Only qualified peer clinical reviewers (e.g., physicians) can issue adverse benefit determinations. If a peer clinical reviewer determines that a service was not medically necessary, then an adverse benefit determination will be issued for the claim. The Plan communicates the adverse benefit determination, including applicable appeal rights, and offers a peer-to-peer conversation consistent with state and federal requirements. Appeal rights are set forth in the member's benefit plan document (Certificate of Coverage). The Plan communicates results of Retrospective Review within 30 days of receipt of a claim. The OON provider may bill non-reimbursable charges to the member. Adverse Benefit Determination. For M/S, an adverse benefit determination is an administrative or clinical review decision resulting in a denial, reduction or termination of a benefit. Adverse benefit determinations are recorded as clinical denials when they are based on clinical criteria and member clinical information and are recorded as administrative denials when benefits are exhausted. Based on individual state requirements, cases may be cancelled if the member is not eligible for benefits. Cancelled cases are not considered administrative or clinical denials. Clinical Criteria. Clinical reviewers and peer clinical reviewers base medical necessity determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual or MCG guidelines. Monitoring/Quality Oversight. The Plan conducts a variety of activities that ensure that Retrospective Review determinations are appropriate. The Plan conducts end-to- end case audits that are designed and approved by clinical leadership each year. The end-to-end audits include all stages of a case review, from intake through appeal. These audits are conducted monthly and approximately 1500 cases are reviewed per month. Results are reported to an oversight team. All deficiencies are remediated. Remediation may include corrective actions and/or additional education, as indicated. The Plan routinely monitors Retrospective Review performance through its clinical performance oversight functions. Outcomes are monitored against timeliness requirements, performance guarantees, and for potential trends, including overall utilization.

	There are no differences in the factors used Step 3 • The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor: o Clinical criteria from nationally recognized, third-party sources (e.g., ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services) o Clinical Technology Assessment Committee (CTAC) review o Objective, evidence-based behavioral clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Psychiatric Association, etc.) Step 4 • Timeframe to submit. The timeframe for the member to submit a Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent. o For MH/SUD, members have 180 days after the service is rendered to request a Retrospective Review • Review of Staff Qualifications. For MH/SUD, clinical staff qualifications align with the type of clinical review and state, and federal requirements. o MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians etc.) and all adverse benefit determinations are made by Medical Directors or psychologists. • Clinical Criteria. For MH/SUD, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based behavioral clinical policies or use clinical criteria from third party sources such as ASAM Criteria, LOCUS, CALOCUS-CASII and ECSII guidelines. Outcomes data for comparability OON outpatient medical necessity approval and denial rates and appeals outcomes data from1/1/2024 -12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There is an insufficient number of MH/SUD OON outpatient cases from 1/1/2024 - 12/31/2024 to support an analysis of clinical outcomes data for plan 1, plan 2, and plan 3. MH/SUD OON OP Cases Plan 1 Administrative Denial Rate - 0% (0 out of 5 cases) Clinical Denial Rate - 20% (1 out of 5 cases) Plan 2 Administrative Denial Rate - 0% (0 out of 1 case) Clinical Denial Rate - 0% (0 out of 1 case) Plan 3 Administrative Denial Rate - 0% (0 out of 3 cases	As of April 1, 2023, the Utilization Management Program Committee (UMPC) began overseeing the M/S UM program. The UMPC is responsible for the development and maintenance of the M/S Prior Authorization processes. The UMPC ensures that the UM program considers the factors and evidentiary standards for applying UM. The UMPC is comprised of: • Chief Medical Officer, Medical Management (Co-Chair) • Senior Vice President, Clinical Advancement (Co-Chair) • Chief Medical Officer • Senior Vice President, Clinical Appeals & Grievances • Chief Medical Officer, Clinical Policy • Chief Medical Officer, Employer & Individual • Chief Medical Officer, Medicare & Retirement • Chief Medical Officer, Community & State • Chief Medical Officer, Individual & Family Plans • Vice President, Clinical Transformation & Affordability • Senior Director, Mental Health Parity • Vice President, Utilization Management Strategy & Implementation One of the chairs must be an executive leader and a licensed physician. UMPC meets at least six times per year but may meet more frequently if needed. Per the M/S policy entitled, Performance Assessment and Incentives, at no time are clinical reviewers or peer clinical reviewers incentivized to make adverse benefit determinations (clinical denials) for financial reasons. M/S generally structures UM processes to comply with federal Employee Retirement Income Security Act of 1974 (ERISA) requirements and state law where applicable. List of M/S and MH/SUD Services Subject to NQTL • Services that have not previously been reviewed in Prior Authorization or Concurrent Review • Services where the service or procedure codes do not match a diagnosis code • EIU services • Services that are subject to benefit limits • Codes identified by the Plan as subject to Retrospective Review o Please see the file M/S Retrospective Review Codes for the list of M/S codes that may be subject to Retrospective Review Step 2 There are no differences in the factors used. Step 3 • The Plan's evidentiary standards and sources that define and/or trigger the Consistency with Clinical Criteria factor: o Clinical criteria from nationally recognized, third-party sources (e.g., InterQual or MCG) o Medical Technology and Assessment Committee (MTAC) review o Objective, evidence-based medical clinical policies and nationally recognized guidelines approved by professional healthcare associations (e.g., clinical guidance from the American Medical Association, etc.) Step 4

	Clinical Denial Rate - 0% (0 out of 3 cases) All analysis and material documentation is available upon request.	• Timeframe to submit. The timeframe for the member to submit the Retrospective Review request was reviewed and it was determined that MH/SUD was no more stringent. o For M/S, members must notify the Plan within timely filing requirements • Notification of Decisions to Providers and Members. The Plan notifies M/S OON facilities and members of approvals and adverse benefit determinations, including applicable appeal rights consistent with state and federal requirements. • Review of Staff Qualifications. For M/S, clinical staff qualifications align with the type of clinical review and state and federal requirements. o M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are conducted by clinical staff (nurses, physicians) and all adverse benefit determinations are made by a physician or other appropriate health care professionals. • Clinical Criteria. For M/S, clinical reviewers and peer clinical reviewers base determinations on objective, evidence-based medical clinical policies or use clinical criteria from third party sources such as InterQual and MCG. Outcomes data reviewed for comparability OON outpatient medical necessity approval and denial rates and appeals outcomes data from 01/01/2024 – 12/31/2024 were evaluated where a minimum threshold of 100 cases were available to ensure a valid data set for analysis. There are no of OON outpatient for M/S cases or MH/SUD OON outpatient cases from 01/01/2024 -12/31/2024 to support an analysis of clinical outcomes data. All analysis and material documentation is available upon request.
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	There are no differences in clinical procedure coding, billing coding and process NQTL practices that limit benefits within the similarly mapped classification when compared between medical/surgical and mental health/substance use disorder.	There are no differences in clinical procedure coding, billing coding and process NQTL practices that limit benefits within the similarly mapped classification when compared between medical/surgical and mental health/substance use disorder.
Case & Medical Management NQTL Practices	Medical Case Management is a collaborative process between a member, that member's treating providers, and the Plan to improve the member's functional health and well-being and support the member's recovery. Such programs seek to achieve this goal by proactively engaging members before their health declines and helping them avoid escalation to higher levels of care (for example inpatient hospitalization). Case management is a voluntary member-facing program that does not include coverage determinations. Medical Case Management does not modify or influence a benefit determination. Case Managers do not make or recommend medical necessity determinations, do not direct treatment, or place treatment limitations based on program participation or lack thereof.	Medical Case Management is a collaborative process between a member, that member's treating providers, and the Plan to improve the member's functional health and well-being and support the member's recovery. Such programs seek to achieve this goal by proactively engaging members before their health declines and helping them avoid escalation to higher levels of care (for example inpatient hospitalization). Case management is a voluntary member-facing program that does not include coverage determinations. Medical Case Management does not modify or influence a benefit determination. Case Managers do not make or recommend medical necessity determinations, do not direct treatment, or place treatment limitations based on program participation or lack thereof.
Network Adequacy & Provider Reimbursement Rates	Step 1 For MH/SUD, the Plan conducts 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 MH/SUD provider specialties. MH/SUD utilize the network adequacy report and ensure that the	Step 1 For M/S, the Plan conducts 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.

	Network Variation Tracker (NVT) and Analytics tools are used when inconsistencies are identified. 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 Oversite 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. Step 2 There are no differences in the factors used Step 3 There are no differences in the standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis. **Provider Reimbursement - Professional** Step 1 For MH/SUD providers, the Plan uses a comparable process to negotiate and establish reimbursement rate(s) for INN professional services. The Plan delegates negotiation of reimbursement rates for MH/SUD providers to its delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. Key steps in the INN professional services reimbursement negotiation process for MH/SUD services include: • The provider submits a completed application to the Plan to be included in the Plan's provider network • Based on the above, the Plan offers a contract and reimbursement rate package to the provider for the services/programs the provider intends to offer • If the provider rejects the contract proposal, the Plan may negotiate with the provider using the factors described Detailed process for the INN professional services reimbursement negotiation: For MH/SUD professionals, the Plan follows a comparable process. The Plan starts with the CMS national physician fee schedule rate for the service type and practitioner type at issue and then determines the percentage of CMS reimbursement based upon CMS locality fee schedules and the factors, evidentiary standards, and sources described in Steps 2 and 3 below. The Plan maintains five (5) internally developed standard fee schedules based on the CMS national physician fee schedule rates and the CMS geography-specific rates for the provider's area. Individual or group MH/SUD care providers are assigned to one of these standardized fee schedules based on their geographic location. For MH/SUD professional providers, the Plan uses CMS annual national RVUs and other data to determine whether routine, non-negotiation-based adjustments to the fee	For M/S, the results of the network adequacy report are sent to the 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. Step 2 There are no differences in the factors used. Step 3 There are no differences in the standards and sources used. Step 4 There are no differences in the ""As Written"" and ""In Operation"" analysis. All analysis and material documentation is available upon request. **Provider Reimbursement - Professional** Step 1 For M/S providers, the Plan uses a comparable process to negotiate and establish reimbursement rate(s) for INN professional services. Key steps in the INN professional services reimbursement negotiation process for both M/S and MH/SUD services include: • The provider submits a completed application to the Plan to be included in the Plan's provider network • Based on the above, the Plan offers a contract and reimbursement rate package to the provider for the services/programs the provider intends to offer • If the provider rejects the contract proposal, the Plan may negotiate with the provider using the factors described Detailed process for the INN professional services reimbursement negotiation: For M/S professionals, the Plan contracts for services using standardized reimbursement templates. These templates are organized by Medicare carrier locality and reflect 100% of Geographic Practice Cost Indices (GPCI)-adjusted Centers for Medicare & Medicaid Services (CMS) reimbursement for a given rate year. The Plan uses the following fee sources to create these templates: • CMS Resource Based Relative Value Scale (RBRVS) is determined by calculating the CMS relative value units (RVU): o The CMS RVU for a given service or procedure is derived using the following mathematical formula: (work RVU x work GPCI) + (PE RVU x PE GPCI) + (MP RVU x MP GPCI) x CF. This is also referred to as the CMS benchmark rate o Definitions: - Work = Provider work reflects the provider's work when performing a procedure or service including provider's technical skills, physical effort, mental effort and judgment, stress related to patient risk, and the amount of time required to perform the service or procedure - PE = Provider Expense reflects the costs for medical supplies, office supplies, clinical and administrative staff, and pro rata costs of building space, utilities, medical equipment, and office equipment - MP = Malpractice Insurance expense reflects the cost of professional liability insurance based on an estimate of the relative risk associated with procedure or service

	schedules may be necessary. If an RVU is not available for a particular code, the Plan uses other sources such as the FairHealth Medicare Gap Fill Database and then market research to determine an appropriate rate. Providers already in the network may also negotiate for non-routine adjustments upon contract renewal or changing market circumstances. For MH/SUD professional providers, the fee schedule rates are negotiable, and the Plan assesses the market dynamic factors listed in Step 2 to reach agreement with providers. Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis All analysis and material documentation is available upon request. **Provider Reimbursement - Facility** Step 1 Negotiation For MH/SUD facilities, the Plan uses a substantially similar process to negotiate and establish reimbursement rates for INN facility services. The Plan delegates negotiation of reimbursement rates for MH/SUD facility providers to it's delegated MH/SUD Managed Behavioral Health Organization (MBHO) vendor. Key steps in the INN facility reimbursement negotiation process for MH/SUD services include: • The facility submits a completed application to the Plan to be included in the Plan's provider network • The Plan reviews the facility reimbursement proposal • Based on the above, the Plan 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 the Plan provider network submit a reimbursement proposal to the Plan. The Plan 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. The Plan does not apply defined formulae to establish base rates or standard fee schedules. 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.	CF = Conversion Factor GPCI = Geographic Practice Cost Indices • Applicable CMS RVU • FAIR Health Medicare GapFill PLUS database • CMS Clinical Lab Fee Schedule • CMS DMEPOS (Durable Medical Equipment, Prosthetics/Orthotics, and Supplies) Fee Schedule • CMS ASP (Average Sales Pricing) and RJ Health ASP (for drug pricing) • CMS Ambulance Fee Schedule • RBRVS (for codes not priced by CMS) M/S providers only • CMS Carrier Priced Fees (for codes referred to the local carrier for pricing) • Within these templates, Current Procedural Technology (CPT), Healthcare Common Procedure Coding System (HCPCS) codes are organized into 54 type of service categories: o Evaluation & Management – 4 categories o Surgery – 15 categories o Radiology – 10 categories o Laboratory/Pathology – 3 categories o Medicine – 10 categories o Obstetrics – 1 category o Immunizations/Injectables – 5 categories o DME & Supplies – 5 categories o Ambulance – 1 category This standardized structure enables the Plan to tailor fee schedules around specific CPT/HCPCS codes, generally the highest volume codes, billed by different types of providers. Thus, the fee schedules are not specialty-specific; but instead based on the codes most likely to be billed by a particular provider. Before creating a new fee schedule for a negotiation, the Plan determines if there is an existing fee schedule that will meet the needs of the negotiation; for example, if the negotiation is with a primary care group in Bridgeport, the Plan would look to find other primary care group fee schedules for that geographic locality that included the relevant codes. If no existing fee schedule fits the factual scenario, then the creation of a new fee schedule will be approved. The Plan does not maintain designated "go-out" or "base rate" fee schedules for M/S services. Rather, the Plan begins with the standardized structure described here and then negotiates a percentage of CMS reimbursement with providers for the service categories listed above, applying the factors described in Step 2 and evidentiary sources described in Step 3 below. Any CPT/HCPCS codes not reflected in the fee schedule templates are paid at a negotiated percentage of charges. Step 2 There are no differences in the factors used. Step 3 There are no differences in the evidentiary standards and sources used. Step 4 There are no differences in the ""As Written"" and ""In Operation"" analysis.

	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. The Plan does not apply defined formulae to establish base rates or standard fee schedules. 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 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. Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "as written" and "in operation" analysis All analysis and material documentation is available upon request. **OON Reimbursement - Inpatient/Outpatient** Step 1 There are no differences in how the NQTL procedure is generally applied Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used	All analysis and material documentation is available upon request. **Provider Reimbursement - Facility** Step 1 Negotiation For both M/S facilities, the Plan uses a substantially similar process to negotiate and establish reimbursement rates for INN facility services. Key steps in the INN facility reimbursement negotiation process for M/S services include: • The facility submits a completed application to the Plan to be included in the Plan's provider network • The Plan reviews the facility reimbursement proposal • Based on the above, the Plan 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 the Plan provider network submit a reimbursement proposal to the Plan. The Plan 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 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. M/S 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 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

	Step 4 There are no differences in the "As Written" and "In Operation" analysis All analysis and material documentation is available upon request. **OON Reimbursement - Emergency** Step 1 There are no differences in how the NQTL procedure is generally applied Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis All analysis and material documentation is available upon request.	• 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. 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: • 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. Step 2 There are no differences in the factors used. Step 3 There are no differences in the evidentiary standards and sources used. Step 4 There are no differences in the ""as written"" and ""in operation"" analysis. All analysis and material documentation is available upon request." **OON Reimbursement - Inpatient/Outpatient** Step 1 There are no differences in how the NQTL procedure is generally applied Step 2 There are no differences in the factors used. Step 3 There are no differences in the evidentiary standards and sources used. Step 4 There are no differences in the ""As Written"" and ""In Operation"" analysis All analysis and material documentation is available upon request." **OON Reimbursement - Emergency** Step 1 There are no differences in how the NQTL procedure is generally applied

		Step 2 There are no differences in the factors used Step 3 There are no differences in the evidentiary standards and sources used Step 4 There are no differences in the "As Written" and "In Operation" analysis All analysis and material documentation is available upon request.
(STEP-5): *A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.*	The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information for the NQTLs. The findings of the comparative analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used by MH/SUD were comparable to, and applied no more stringently than the strategies, processes, factors, evidentiary standards, and source information used by M/S both “as written” and "in operation." The Plan concluded the methodologies used by MH/SUD were comparable to, and applied no more stringently than, the methodologies used by M/S.	