Summary of Various Quantitative and Non-Quantitative Treatment Limitations Mental Health Parity and Addiction Equity Act Alliant Health Plans 2022		
Definitions	**General Medical/Surgical**	**Behavioral Health**
	Alliant defines medical/surgical benefits as benefits for the treatment of medical/surgical conditions included in the International Classification of Diseases (ICD) with the exception of the mental disorders classification.	Alliant defines behavioral health benefits as benefits for the treatment of MH/SUD conditions included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). This includes services rendered by licensed specialists for the treatment of behavioral health conditions.
Classification of Benefits	**General Medical/Surgical**	**Behavioral Health**
Inpatient	Non-emergent medical/surgical services requiring admission to a hospital or other facility and providing lodging and food as well as treatment. The facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by Alliant. This includes: • Services rendered by acute care hospitals licensed by the appropriate state agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty.; and • Services rendered by licensed subacute care hospitals and facilities including skilled nursing facilities, long term acute care facilities, and rehabilitation hospitals. To include: • Acute inpatient hospital services • Skilled nursing facilities • Long term acute care facilities • Physical rehabilitation hospitals	Non-emergent MH/SUD services requiring admission to a hospital or other facility and providing lodging and food as well as treatment. The facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by Alliant. This includes: • Services rendered by licensed acute care facilities licensed by the appropriate state agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the diagnosis and treatment of mental illness by or under the supervision of physicians and 24-hour nursing services under the supervision of registered nurses; and • Services rendered by licensed subacute care facilities including residential treatment centers. To include: • Mental health/Substance use disorder inpatient facility services • Mental health/Substance use disorder residential treatment services • Mental health/Substance use disorder inpatient professional services • Substance use disorder inpatient detoxification

	• Inpatient professional services	
Outpatient	Non-emergent medical/surgical services not requiring admission to a hospital or other facility. The practitioner or facility must be licensed, registered or approved by the appropriate medical board or commission or meet specific requirements established by Alliant. Outpatient services include, but are not limited to: • Outpatient: PCP or Specialist office visit, Urgent Care, Telehealth • Outpatient: Hospital, ASC, non-emergent Ambulance • Outpatient: Home Health, PT, OT, ST • Outpatient: Imaging, Lab services Alliant further subclassifies outpatient services into office visits and all other outpatient services. Office visits include urgent care, telehealth, and some therapy services dependent on place of service. Alliant classifies both rehabilitation and habilitation as medical/surgical services.	Non-emergent MH/SUD services not requiring admission to a hospital or other facility. The practitioner or facility must be licensed, registered or approved by the appropriate medical board or commission or meet specific requirements established by Alliant. Outpatient services include, but are not limited to: • Outpatient: Practitioner office visit, Telehealth • Outpatient: IOP, PHP • Outpatient: Lab services Alliant further subclassifies outpatient services into office visits and all other outpatient services. Office visits include telehealth, and some therapy services dependent on place of service.
Quantitative Treatment Limitations	**General Medical/Surgical**	**Behavioral Health**
General Visit or Length of Stay Limits	No difference in limits based on provider network participation. Stay limits for Inpatient services are based on medical necessity criteria and clinical documentation of the provider, as well as the availability of services at a lower level of care. Currently the limit for SNF is 60 days per year. Outpatient service limits for rehabilitation, habilitation, and home health are based on evidence-based criteria for length of care needed for specific services. Current limits for rehabilitation for PT, OT combined is 40 visits per year, ST is 40 visits per year, habilitation is 40 visits per year. Home health is limited to 120 visits per year. Custodial care is not a covered service.	No difference in limits based on provider network participation. Stay limits for Inpatient services are based on medical necessity criteria and clinical documentation of the provider as well as the availability of services at a lower level of care. Currently there is no limit for residential treatment number of days. Outpatient service limits for are based on evidence-based criteria for length of care needed for specific services. Currently there are no limits for IOP or PHP number of days allowable. Custodial care is not a covered service. • Inpatient: Hospital, Residential Treatment • Outpatient: Practitioner office visit, Telehealth

	• Inpatient: Hospital, SNF, LTAC • Outpatient: PCP or Specialist office visit, Urgent Care, Telehealth • Outpatient: Hospital, ASC, non-emergent Ambulance • Outpatient: Home Health, PT, OT, ST • Outpatient: Imaging, Lab services • Emergency Room • Emergency Transport: Ground Ambulance, Air Ambulance • Prescription Drugs Based on this information Alliant considers the application of criteria to be in substantial compliance with Mental Health Parity.	• Outpatient: IOP, PHP • Outpatient: Imaging, Lab services • Emergency Room • Emergency Transport • Prescription Drugs Based on this information Alliant considers the application of criteria to be in substantial compliance with Mental Health Parity.
Non-Quantitative Treatment Limitations	**General Medical/Surgical**	**Behavioral Health**
Standards for Medical Necessity and Utilization Review	**Medical Necessity** Nationally recognized evidence-based criteria and corporate medical policies that consider regional and local variations in medical practice and member needs are used to determine the medical necessity and clinical appropriateness of utilization decisions. MCG criteria are embedded into the care management system and are available to all medical and behavioral health clinicians. All medical policies can be requested by providers and accessed electronically by staff. The fact that a Physician has prescribed, ordered, recommended, or approved a service or supply does not, in itself, make it Medically Necessary. We consider a health care service Medically Necessary if it is: • Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition, • Compatible with the standards of acceptable medical practice in the United States, • Not provided solely for the patient's convenience or the convenience of the doctor, health care Provider or Hospital, • Not primarily Custodial Care, and • Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms. For example, a Hospital stay is necessary when treatment cannot be safely provided on an outpatient basis. AHP may choose to develop its own policies, use modified MCG criteria or when a situation occurs where there is no MCG guideline, other approved clinical guidelines may be utilized. Medical and behavioral health policies are created to formalize and document criteria that does not currently exist or to clarify or modify existing criteria. These policies cover technologies and procedures based on sound medical practice that are not addressed by standard MCG criteria or require modification of MCG criteria when deemed necessary. References used to develop policies include, but are not limited to, the following: • Guidelines and practice parameters from nationally recognized condition-specific societies (e.g., NCCN, American Diabetes Association)	

- Guidelines and practice parameters from medical societies (e.g., American Academy of Allergy Asthma and Immunology)
- Cochrane, ICER and other recognized sources emphasizing high quality peer reviewed sources
- Actively practicing physician experts

Criteria are not intended to be a substitute for practitioner judgment. The Medical Director or designee for AHP, UM consultant group, or DE reviews all potential medical necessity denials following currently accepted healthcare practices, considering the unique circumstances of each case. Only a physician or qualified Nurse Practitioner may issue a medical denial. When applying criteria to a member's case, the reviewer will consider at least the following:

- Age
- Comorbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment, when applicable

The reviewer also considers the characteristics of the local delivery system available to specific members, including:

- Availability of inpatient outpatient and transitional facilities
- Availability of outpatient services instead of inpatient services such as ambulatory surgery centers vs. inpatient surgery
- Availability of highly specialized services, such as transplant facilities or cancer centers
- Availability of skilled nursing facilities or home care in the organization's service area to support the patient after hospital discharge
- Local hospitals' ability to provide all recommended services within the estimated length of stay

Prior Authorization, Concurrent Review, Retrospective Review

A prospective review and concurrent review provide opportunities to identify potentially high-dollar and other cases appropriate for additional services, such as Case and Disease Management. Prospective review further allows for redirection to network facilities and providers. There is parity in decision making between medical and behavioral health. Services requiring Prior Authorization are reviewed and available to members and providers via the Alliant website, alliantplans.com, or by calling customer service. An annual notification is distributed to both members and providers directing them to the website or customer service where a list of services requiring Prior Authorization is found.

Information is accepted from any reasonably reliable source that will assist in the certification process. The reviewers request only the information relevant to the case being reviewed and necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services. Numeric diagnosis and/or procedure codes may be requested but are not required for review. The reviewer does not routinely request copies of all medical records on all enrollees reviewed, requiring only the sections of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, or frequency or duration of service. Clinical information is gathered consistently for non-behavioral and behavioral health care requests.

The collected information is evaluated using the established criteria (MCG Guidelines, AHP-specific policies). The reviewer ensures the requested service is a covered benefit under the applicable plan and takes into consideration all special circumstances with each request when applying the criteria, i.e., comorbidities, disabilities, special needs. For extensions of initial determinations, the frequency of reviews is based on the severity or complexity of the enrollee's condition or on necessary treatment and discharge planning activities.

	If medical criteria are not met, or when criteria are unavailable for the request, the case is referred to the designated Medical Director for review. The designated Medical Director reviews all available criteria and medical information. The designated Medical Director may consult with the requesting provider and outside board- certified consultants, as needed, to render a determination. For retrospective review, determinations are based only on the medical information available to the attending physician or ordering provider at the time the medical care was provided. The following reasons may result in the allowance of a medical necessity review. Otherwise, retro reviews shall be reviewed administratively. This information must be supplied in the appeal or given to the intake personnel when a PA is requested. • A Provider was not given member's insurance information due to member incapacitated in some way at the time of service rendered or member gave prior coverage information • A Provider or member was given inaccurate information by an authorized representative of the company related to PA requirement(s) • Provider performed unplanned service in addition to some other planned service due to the discovery of the need to perform the service at the time of service • Based on contract • A request is made by a member that has received services from a provider that is participating with the PHCS network.	
General PA Requirements by Category	No difference in PA requirements based on provider network participation. Participating providers are responsible for requesting a PA when required for specific services, while the member is responsible for requesting a PA when required for Out-of-Network services. General classification of services: • Inpatient: Hospital, SNF, LTAC, Hospice, Maternity • Outpatient: PCP or Specialist office visit, Urgent Care, Telehealth • Outpatient: Hospital, ASC, non-emergent Ambulance • Outpatient: Home Health, PT, OT, ST • Emergency Room • Emergency Transport: Ground Ambulance, Air Ambulance • Prescription Drugs When determining which medical/surgical benefits are subject to PA, the following factors are considered: • Cost of the service • Service is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, service, provider type and/or geographic region	No difference in PA requirements based on provider network participation. Participating providers are responsible for requesting a PA when required for specific services, while the member is responsible for requesting a PA when required for Out-of-Network services. General classification of services: • Inpatient: Hospital, Residential Treatment • Outpatient: Practitioner office visit, Telehealth • Outpatient: IOP, PHP • Emergency Room • Emergency Transport • Prescription Drugs When determining which behavioral health benefits are subject to PA, the following factors are considered: • Cost of the service • Service is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, service, provider type and/or geographic region • Claim volume for service including total paid and denied claims • Services subject to a higher potential for fraud,

	• Claim volume for service including total paid and denied claims • Services subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for service if subject to PA • Plan savings if service is subjected to PA Alliant considers the administrative cost of requiring a PA for certain services when deciding when applying the above factors and if the benefit outweighs the cost a PA is applied. Selected services that require a PA: • All inpatient admissions require Prior Authorization, including but not limited to: • Neonatal Intensive Care Unit admissions Levels II, III, or IV (Revenue codes0172, 0173, or 0174) • Inpatient rehabilitation • Skilled Nursing Facility (SNF) • All Observation stays require Prior Authorization, except observation admissions from the Emergency Room do not require Prior Authorization. • CT • PET • MRI • MRA • Magnetic Resonance Cholangiopancreatography • Magnetic Resonance Spectroscopy • Myocardial Perfusion Imaging • Magnetic Resonance Guidance • All Home Health and Hospice Services • Lab services: o Genetic o Chromosomal o DNA o Molecular Pathology	waste and/or abuse • Cost of UM and appeals for service if subject to PA • Plan savings if service is subjected to PA Alliant considers the administrative cost of requiring a PA for certain services when deciding when applying the above factors and if the benefit outweighs the cost a PA is applied. Selected services that require a PA: • Detoxification • Inpatient • Intensive Outpatient Treatment Program • Partial Hospitalization Program (PHP) • Residential Treatment Center services • Drug Screens **EXCEPTIONS:** Drug screens billed with a POS 11 (Office) or POS 81 (Independent Laboratory) do **not** require Prior Authorization.

<table>
<tr>
<td>Medical Necessity Review/PA Application Evidentiary Analysis</td>
<td>Prior Authorization Denial Rates for Medical/Surgical Conditions

For 2021 Alliant received 17789 requests for prior authorization of services related to medical conditions that were Approved, Partially Approved, or Denied. These categories included:
Acute Physical Health
DME
Home Health
Long-Term Acute Care
Observation
Procedures (Surgical/Imaging/Other)
Rehabilitation
Skilled Nursing Facility
Of these, 16969 or 95% of the services were approved and 4% were denied. Procedures accounted for the majority (83%) of requests with a 5% denial rate. Acute Physical Health (13% of requests) had a 1% denial rate.

Based on this information Alliant considers the application of criteria to be in substantial compliance with Mental Health Parity.</td>
<td>Prior Authorization Denial Rates for Behavioral Health Conditions

For 2021 Alliant received 355 requests for prior authorization of services related to behavioral health conditions that were Approved, Partially Approved, or Denied. These categories included:
Acute Behavioral Health
Intensive Outpatient
Partial Hospitalization
Residential Treatment
Of these, 342 or 96% of the services were approved 2% were partially approved and 1% were denied. Acute Behavioral Health accounted for the majority (51%) of requests with a 1% denial rate. Partial Hospitalization (15% of requests) had a 5% denial rate.

Based on this information Alliant considers the application of criteria to be in substantial compliance with Mental Health Parity.</td>
</tr>
<tr>
<td>Exclusions for Failure to Complete a Course of Treatment</td>
<td colspan="2">Alliant does not provide for any exclusions or limitations of benefits due to a member not completing a course of treatment.</td>
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Claims Procedures & Claim Edits	Minimum claims procedures follow the federal guidelines under 29 CFR 2560.503-1. Claim submission, determinations, adverse determinations, and appeals follow the prescribed guidelines. Claim edits are handled through a software system, Optum CES, that is a duly recognized source of industry current coding practices. Claims procedures and edits are agnostic to medical and behavioral health services and are solely based on industry standard coding practices. Claim adjudication and methodology includes identifying claims that do not meet accepted industry/evidentiary standards, internally developed reimbursement policies, and negotiated contract requirements. Sources of industry standards may include: • The most current edition of Current Procedural Terminology (CPT) • The most current edition of the Healthcare Common Procedure Coding System (HCPCS) • The most current edition of the UB-04 Manual and/or other published guidance from the National Uniform Billing Committee (NUBC) • CMS claim processing manuals, including Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) • The most current version of International Classification of Diseases (ICD), currently ICD-10 • Plan general exclusions and limitations • Coding guidelines from other sources, for example EncoderPro Additional sources of evidentiary standards may include: • Internally developed guidelines reviewed by Medical Professionals, including the Medical Director • Internal committees (Clinical Quality Improvement, Pharmacy & Therapeutics, Credentialing) • Office of the Inspector General (OIG) reports • Current case law related to ERISA, ACA **Level I and Level II Internal Appeals** A member or his/her representative, or a provider acting on behalf of a member, may file an appeal verbally or in writing by one of the following processes. • An appeal may be filed verbally by contacting Customer Service at (866) 403-2785 • An appeal may be faxed to Customer Service at (866) 634-8917 • An appeal may be filed in writing to the following address: Alliant Health Plans PO Box 1247 Dalton, GA 30722 Alliant has two levels of internal appeal. The Level I must be initiated within 180 days of the initial Adverse Benefit Determination. Level II must be initiated within 60 days of the date of denial of the first level of appeal as applicable. Level I and Level II appeals undergo a full investigation and is conducted by personnel who were not involved in the making of the initial Adverse Benefit Determination. The completion period of the investigation is based on the appeal type. • Pre-Service Appeals are completed within 15 calendar days of receipt of the appeal or the date all information regarding the appeal has been received. • Post-Service Appeals are completed within 30 calendar days of receipt of appeal or the date all information regarding the appeal has been received.

If additional information is needed to complete the investigation of a Post-Service Appeal, Alliant will telephone the provider and/or member with the telephone number supplied in the appeal. This contact will happen as soon as possible but within 3 business days of receipt of appeal. Outreach will be attempted 3 times, if contact is not made within the 3 business days Alliant will notify the provider and member to request the missing information. If only a portion of the information is received, Alliant will request the missing information, in writing, within 3 business days of receipt of the partial information.

If additional information is needed to complete the investigation of a Post-Service Appeal, Alliant will notify the provider and/or member in writing, as soon as possible but within 15 business days of receipt of the appeal, of such request for information. If only a portion of the information is received, Alliant will request the missing information, in writing, within 15 business days of receipt of the partial information.

A final written response will be sent to the member and/or provider upon completion of the investigation. If the appeal decision is to uphold the Adverse Benefit Determination, Alliant sends written confirmation of the appeal decision, including an explanation of the member's right to appeal further. If the adverse benefit determination is overturned and benefits are approved, the notice will be included the EOB or EOP and will include an explanation that an appeal was received and reviewed resulting in additional benefits.

The foregoing procedures and process are mandatory and must be exhausted prior to establishing litigation or arbitration or any administrative proceeding regarding matters within the scope of this Complaint and Appeals section.

The decision of the Level II appeal is considered the Final Adverse Benefit Decision and there are no other internal appeal options. If an appeal is received after the Final Adverse Benefit Decision, this will be returned to the member with a copy of the Level II decision letter and the Appeal Rights and Information document. Any subsequent appeals will be added to the member's records, but a response will not be sent.

External Appeal

After the member has exhausted the Internal Level I and Level II appeal processes, the member or their authorized representative has the right to request an external review at no cost. Member must file a request for an external review within 123 calendar days from the date of the Level II appeal decision notice.

For Administrative/Benefit denials Member may request an external review by contacting the Georgia Office of Commissioner of Insurance and Safety Fire (OCI), Customer Service Division by:

1. Calling OCI toll-free at (800) 656-2298; or
2. Faxing to (404) 657-8548
3. Submitting the request online through the Consumer Portal; or
4. Downloading and printing the Consumer complaint form at www.oci.ga.gov, under Insurance Resources. Member may send the form by mail to the following:

   Office of Commissioner of Insurance
   Customer Service Division
   2 Martin Luther King, Jr. Dr. SE
   Suite 716 West Tower 30334

	If member is enrolled in a private employer plan, they may also have the right to bring a civil action under Section 502 (a) of ERISA following the full internal review of the complaint and decision by Alliant Health Plans. For Medical Necessity denials Member may request an external review by contacting Maximus Federal Services by: 1. Calling Maximus toll-free at (888) 866-6205; or 2. Submitting the request online at: www.externalappeal.com under the "Request a Review Online" heading; or 3. Downloading and printing the External Review Request form at www.externalappeal.com, under the "Forms" heading. You may send a written request by fax or mail to the following: MAXIMUS Federal Services 3750 Monroe Avenue, Suite 705 Pittsford, NY 14534 Fax: (888) 866-6190	
Claims Procedures Evidentiary Analysis	**Claim Edit and Appeal Data for Medical/Surgical Conditions** Claim edits are handled through a software system, Optum CES, that is a duly recognized source of industry current coding practices. Alliant adheres to the software allowances. Claim appeals totaled 5242 for 2021 of which 5225 were medical services related. Only 413 appeals were eventually overturned (8%), and the remainder were upheld due to non-covered benefits, PA requirements, or other coding and/or billing requirements including timely filing. The number of medical services appeals per 1000 Members in 2021 was 90. Based on this information Alliant considers the application of criteria to be in substantial compliance with Mental Health Parity.	**Claim Edit and Appeal Data for Behavioral Health Conditions** Claim edits are handled through a software system, Optum CES, that is a duly recognized source of industry current coding practices. Alliant has only one contract that allows and prescribes a contradicting combination of a HCPCS and REV code. This is allowed and overridden in the claim processing system. Claim appeals totaled 5242 for 2021 of which 17 were behavioral health services related. Only 2 appeals were eventually overturned (11%), and the remainder were upheld due to non-covered benefits, PA requirements, or other coding and/or billing requirements including timely filing. The number of behavioral health services appeals per 1000 Members in 2021 was 0.29 or <1. Based on this information Alliant considers the application of criteria to be in substantial compliance with Mental Health Parity.
Reimbursement Rate Calculation for In-Network & Out-of-Network Services	For Covered Services performed by an In-Network provider the allowed amount is the rate the provider has agreed with Alliant to accept as reimbursement for covered services.	Providers who have not signed a contract with Alliant Out-of-Network Providers. The Maximum Allowable Cost (MAC) rate is determined by Alliant by one of the following methods: • An amount based on Our out-of-network fee schedule/rate, which we have established at our

		discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with Alliant, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or • An amount based on information provided by a third-party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or • An amount negotiated by us or a third- party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or • An amount equal to the total charges billed by the Provider, but only if such charges are less than the MAC calculated by using one of the methods described above. The MAC for out-of-network emergency medical services is calculated as described in Title 33 of the Official Code of Georgia Annotated (OCGA) 33-20E-4. We will calculate the MAC as the greater of: • The verifiable contracted amount paid by all eligible insurers for the provision of the same or similar services as determined by the Georgia Department of Insurance. • The most recent verifiable amount agreed to by Alliant and the non-participating emergency medical provider for the provision of the same services during such time as such Provider was In-Network with Alliant. • Such higher amount as Alliant may deem appropriate given the complexity and circumstances of the services provided. The amount paid does not include any amount of coinsurance, copayment, or deductible.

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<tr>
<td>Reimbursement Rate Calculation Evidentiary Analysis</td>
<td>
INN Services Reimbursement Data

2021 claims data was broken down into three categories, emergency, inpatient, and outpatient. The assumption is made that emergency room services are not differentiated in facility cost between medical/surgical and behavioral health. Medicare fees schedules were used as the benchmark to compare medical/surgical reimbursement to behavioral health reimbursement. Ranges and averages are calculated as below:

Medical/Surgical ER: 169% of Medicare
IP: range 118% - 137%, avg. 117%
OP: range 257% - 343%, avg. 214%

Behavioral Health ER: 169% of Medicare
IP: range 15% - 258%, avg. 103%
OP: range 103% - 333%, avg. 249%

Due to an extreme outlier of 15% the behavioral health IP rates appear low, however by removing the 15% outlier the avg rate changes to 119% which is comparable to the medical/surgical IP rate.

Based on this information Alliant considers the reimbursement rates to be in substantial compliance with Mental Health Parity.
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<td>
OON Services Reimbursement Data

2021 claims data was broken down into three categories, emergency, inpatient, and outpatient. The assumption is made that emergency room services are not differentiated in facility cost between medical/surgical and behavioral health. Medicare fees schedule s were used as the benchmark to compare medical/surgical reimbursement to behavioral health reimbursement. Ranges and averages are calculated as below:

Medical/Surgical ER: 140% of Medicare
IP: range 41% - 50%, avg. 47%
OP: range 84% - 193%, avg. 99%

Behavioral Health ER: 140% of Medicare
IP: 49%
OP: 120%

Based on this information Alliant considers the reimbursement rates to be in substantial compliance with Mental Health Parity.
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<tr>
<td>Experimental and/or Investigational Services</td>
<td colspan="2">
Alliant Health Plans (AHP) may exclude coverage of investigational and/or experimental procedures where reliable or detailed clinical evidence of superior clinical outcomes is not present. Experimental and/or Investigational shall mean any drug, biological product, medical treatment/procedure and/or medical device/equipment (herein collectively known as health care services or services) that are not commonly and widely used or accepted by the vast majority of practitioners in the United States, and/or services that lack credible evidence to support positive short-term and/or long-term outcomes from the services rendered; further, the health care services are not reimbursable under the CMS guidelines established for Medicare coverage and/or are health care services which meet any of the following criteria:

In any phase of clinical trials;
Not of proven benefit for the specific diagnosis or treatment of the coveredpatient’s particular condition;
Do not constitute acceptable medical practice under the standards of the covered patient’s caseand by the standards of a reasonable segment of the medical community or governmental oversight agencies at the time services were rendered, including, but not limited to, the American Medical Association (AMA), the United States Food and Drug Administration (“FDA”), the National Comprehensive Cancer Network (NCCN), and/or the Federal National Library of Medicine-National Institute of Health;

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	• Rendered on a research basis as determined by governmental oversight agencies, including,but not limited to, the FDA and the AMA's Council on Medical Specialty Societies. • Generally recognized that additional study on its safety and efficacy for the specific diagnosis ortreatment of the covered patient's particular condition is recommended, taking into consideration the medical community or governmental oversight agencies at the time services were rendered, including, but not limited to, the AMA, FDA, NCCN and/or the Federal National Library of Medicine-National Institute of Health. A drug, biological product, medical treatment, medical procedure, medical device/equipment or anyother health care service is considered Experimental and/or Investigational if any of the following apply: • It cannot be lawfully marketed without the approval of the FDA and the approval for marketing hadnot been given at the time the aforementioned health care services were rendered or furnished to the covered patient; • Reliable evidence shows that any of the aforementioned health care services are: o the subject of ongoing Phase I, II or III clinical trials; or o under study to determine its safety, efficacy, maximum tolerated dose, toxicity and/or itsefficacy as compared with the standard means of treatment or diagnosis; or o considered among experts to need further studies or clinical trials to determine its safety,efficacy, maximum tolerated dose, toxicity and/or its efficacy as compared with the standard means of treatment or diagnosis. • In the case of a drug, biological product or device/equipment, it is not being used to treat the particular diagnosis or condition that it has been approved for by the FDA; in other words, it isconsidered off-label use. • It does not meet the Technology Assessment Criteria as defined by AHP. Reliable evidence includes: • Published reports and articles in authoritative and scientific literature from the medical communityand/or governmental oversight agencies, including, but not limited to, the American Medical Association (AMA), the United States Food and Drug Administration (FDA), the National Comprehensive Cancer Network (NCCN), and/or the Federal National Library of Medicine-National Institute of Health; • The written protocol(s) used by the treating provider/facility or the protocol(s) of another comparable provider/facility that is significantly studying the drug, biological product, medicaltreatment, medical procedure, medical device/equipment or other health care service in question; • The written informed consent used by the treating provider/facility or by another comparableprovider/facility that is significantly studying the drug, biological product, medical treatment, medical procedure, medical device/equipment or other health care service in question.
Network Admission Criteria	In selecting and credentialing providers for the associate networks, Alliant does not discriminate in terms of participation or reimbursement against any health care professional who is acting within the scope of their license or certification. In addition, Alliant does not discriminate against professionals who serve high-risk populations or who specialize in the treatment of costly conditions. If a provider does not meet Health One's criteria, a written notice outlining why the provider is not eligible for participation is sent to the affected provider. The criteria for admission to the network is no more stringent for behavioral health practitioners than for medical/surgical. **MD/DO/DPM Criteria** Education • Practitioner must be a graduate of an accredited school of medicine or osteopathy,completed a Residency at an accredited

facility and provide complete information with respect to professional training/activities which shall include, without limitation, the following:

- Undergraduate Education
- Medical and/or Professional Education
- Internships and Residencies
- Fellowships
- Licensed Professional References
- Work History

- Practitioner must achieve Board Certification within the lesser of seven (7) years from completion of education (Residency/Fellowship) or the eligibility timeframe defined by each specialty's Board, as required by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Board of Foot and Ankle Surgery (ABFAS) or American Board of Oral and Maxillofacial Surgery(ABOMS)

License

- Practitioner must maintain a current, valid medical license that is not probationary, suspended, lapsed, expired or voluntarily surrendered in the State of Georgia and/or any other state where licensed unless the Practitioner relinquished the license in another state in good standing without any adverse action or being subject to review orinvestigation. If Practitioner is subject to facility licensure requirements, as set forth bythe applicable state laws, Practitioner must maintain a current, valid facility license or permit as required by state law.

DEA

- Practitioner must hold a current, valid and unrestricted Drug Enforcement Agency (DEA)registration, as appropriate in the State of Georgia and/or any other state in which they actively practice or provide evidence satisfactory to Health One that the Practitioner does not require such registration in order to deliver appropriate care.

Insurance

- Practitioner shall purchase and maintain, at the sole cost and expense of Practitioner, policies of professional liability in amounts required by Health One. The current minimum amounts set forth by Health One are ONE MILLION DOLLARS ($1,000,000) per occurrence/THREE MILLION DOLLARS ($3,000,000) aggregate.

Malpractice

- Details of any professional liability actions that have resulted in adverse judgmentsor any financial settlements.
- Details of any pending professional liability actions.

Admitting Privileges

- Practitioner has current and unrestricted admitting privileges, at a participating hospitalaccredited by a Health One approved Accrediting body; or written evidence that the applicant does not require hospital admitting privileges in order to deliver satisfactory professional services.

Call Coverage

- Practitioner must have made arrangements to allow patients and other practitioners to contact Practitioner (or covering provider) 24 hours a day, 7 days aweek. Automatic referrals to the emergency department shall not satisfy the call coverage obligations of a Participating Practitioner.

Allied Criteria

Audiologist (AUD)
Chiropractors (DC)
Licensed Athletic Trainers (LAT)
Licensed Clinical Social Workers (LCSW)
Licensed Marriage and Family Therapist (LMFT)

Licensed Professional Counselor (LPC)
Master of Social Work (MSW)
Physical Therapists (PT, MPT and DPT)
Psychologists (PhD and PsyD)
Occupational Therapists (OT, MOT and ODT)
Optometrists (OD)
Speech Pathologists (SP and SLP)
Registered Dietitian (RD)

Education

- Practitioner shall present official documentation indicating he/she has completed an acceptable training program, or postgraduate training from an accredited professional school,as required by the applicable state licensing or registration agency of the Practitioner's profession.
    - Undergraduate Education
    - Medical and/or Professional Education
    - Licensed Professional References
    - Work History

License

- Practitioner is a person with a current, valid professional/medical license that is not probationary, suspended, lapsed, expired or voluntarily surrendered in the State of Georgia and/or any other statewhere licensed, unless the Practitioner relinquished the license in another state in good standing without any adverse action or being subject to review or investigation.

DEA

- Eligible practitioners may hold a current, valid and unrestricted Drug Enforcement Agency (DEA) registration, as appropriate in the State of Georgia and/or any other state in which they actively practice or provide evidence satisfactory to Health One that the Practitioner does not require suchregistration in order to deliver appropriate care.

Insurance

- Practitioner shall purchase and maintain, at the sole cost and expense of Practitioner, policies of professional liability in amounts required by Health One. The current minimum amounts set forth by Health One are ONE MILLION DOLLARS ($1,000,000) per occurrence/THREE MILLION DOLLARS ($3,000,000) aggregate.

Malpractice

- Details of any professional liability actions that have resulted in adverse judgmentsor any financial settlements.
- Details of any pending professional liability actions.

Organizational Providers

Accreditation

- Provider must attain Accreditation in accordance with one of the Health One approved Accrediting Bodies as appropriate for their provider type.

License

- Provider must hold a current, valid and unrestricted facility license or facility permit as appropriate for the State of Georgia and/or any other state where licensed unless the facility relinquished the license in another state in good standing without any adverse action or being subject to review or investigation. Providers must hold a current, valid and unrestricted facility license in the State of Georgia in order to dispense or provide any clinical services to Georgia residents, unless the State of Georgia does

	not maintain a license or certification requirement for the provider type. DEA • Provider must hold a current, valid and unrestricted Drug Enforcement Agency (DEA) registration, as appropriate in the State of Georgia and/or any other state in which they actively render services, or provide evidence satisfactory to Health One that the Provider does not require such registration in order to deliver appropriate care. Insurance • Provider shall purchase and maintain, at the sole cost and expense of Provider, policies of professional liability in amounts required by Health One. The current minimum amounts set forth by Health One are ONE MILLION DOLLARS ($1,000,000) per occurrence/THREE MILLION DOLLARS ($3,000,000) aggregate. Malpractice • Details of any professional liability and/or general liability actions that have resulted in adverse judgmentsor any financial settlements. • Details of any pending professional liability actions.
Formulary Design and Protocols	**Formulary Design** Factors considered by the PBM committees: • Tiering: When assigning drugs to tiers on the formulary, the same factors are used to assign the drugs without any regard for whether a drug is generally prescribed for medical/surgical benefits or for mental health or substance use disorder benefits. All FDA approved medications for mental health and substance use disorders and for medical surgical conditions are reviewed with the same factors and decision-making process before final formulary status and criteria are determined. Clinical factors are considered first and then financials through separate committees. Clinical considerations include, evidenced based safety and efficacy data from the FDA approved package insert, peer-reviewed medical literature, nationally accepted treatment guidelines, and patient considerations. Financial considerations include net cost, utilization trends, and cost effectiveness of clinically similar medications. The factors regarding each drug is reassessed regularly to ensure that the formulary management is consistent with the latest information. • PA: When establishing prior authorizations for pharmacy services, the same factors are used to assign the drugs without any regard for whether a drug is generally prescribed for medical/surgical benefits or for mental health or substance use disorder benefits. All FDA approved medications for mental health and substance use disorders and for medical surgical conditions are reviewed with the same factors and decision-making process before final formulary status and criteria are determined. Clinical factors are considered first and then financials through separate committees. Clinical considerations include, evidenced based safety and efficacy data from the FDA approved package insert, peer-reviewed medical literature, nationally accepted treatment guidelines, and patient considerations. Financial considerations include net cost, utilization trends, and cost effectiveness of clinically similar medications. The factors regarding each drug is reassessed regularly to ensure that the formulary management is consistent with the latest information. • Step therapy: When imposing any fail-first or step therapy requirements for pharmacy services, the same factors are used to assign the drugs without any regard for whether a drug is generally prescribed for medical/surgical benefits or for mental health or substance use disorder benefits. All FDA approved medications for mental health and substance use disorders and for medical surgical conditions are reviewed with the same factors and decision-making process before final formulary status and criteria are determined. Clinical factors are considered first and then financials through separate committees. Clinical

considerations include, evidenced based safety and efficacy data from the FDA approved package insert, peer-reviewed medical literature, nationally accepted treatment guidelines, and patient considerations. Financial considerations include net cost, utilization trends, and cost effectiveness of clinically similar medications. The factors regarding each drug is reassessed regularly to ensure that the formulary management is consistent with the latest information.

Magellan Rx Management, LLC Precision Formulary Mental Health Parity and Addiction Equity Act Compliance

The Mental Health Parity and Addiction Equity Act ('MHPAEA') requires that health plans sort their benefits into six classifications for review. One of these classifications is prescription drugs. MHPAEA requires that the benefits be reviewed for Quantitative Treatment Limitations (e.g., quantity limits, day/visit limits), financial requirements (e.g. copayments, coinsurance) and nonquantitative treatment limitations ('NQTLs') (e.g. limitations that are not numeric in nature).

There is a special rule for multi-tiered prescription drug benefits in evaluating financial requirements. This provides that if a plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with the rules for NQTLs and without regard to whether a drug is generally prescribed with respect to medical/ surgical benefits or with respect to mental health or substance use disorder benefits, the plan will be deemed to have satisfied the parity requirements for prescription drugs. They note that reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

Any quantitative treatment limitations are based off of package inserts and FDA approval. These limits can be overridden for medical necessity.

This document focuses on the NQTL analysis for the Magellan Rx Management, LLC formulary.

The MHPAEA rule contained an illustrated list of NQTLs which included the following that are applicable to the prescription drug benefit:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols).

The standard for review of NQTLs is that a health plan cannot impose any non-quantitative treatment limitation for mental health/ substance use disorders unless any processes, strategies, evidentiary standards or other factors used in applying the NQTL are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used in applying the limitation to medical /surgical disorders in the same classification.

The Magellan Pharmacy and Therapeutic (P&T) committees made up of licensed physicians and pharmacists establishes the NQTLs used by the Magellan PBM. When Magellan assigns drugs to tiers, sets step therapy requirements, and when Magellan establishes utilization management requirements for the formulary, the same factors are used to assign the drugs without any regard for whether a drug is generally prescribed for medical/surgical conditions or for mental health or substance use disorder conditions.

All FDA approved medications for mental health and substance use disorders and for medical surgical conditions are reviewed with the

	same factors and decision-making process before final formulary status and criteria are determined. Clinical factors are considered first and then financial factors through separate committees. Any new drugs that are approved go through a clinical committee, a financial committee and the P&T committee makes the final approval. Evidentiary standards reviewed include evidenced-based safety and efficacy data from the FDA approved package insert, peer-reviewed medical literature, nationally accepted treatment guidelines, and patient considerations. Evidentiary standards for the cost factors include net cost, utilization trends, and cost effectiveness of clinically similar medications. The evidentiary standards for each drug are reassessed regularly to ensure that the formulary management is consistent with the latest information. Pill limits can be restricted based on clinical criteria. For example, our behavioral health medications are based on FDA recommended limitations. While some of our opioid medications (which don't have FDA max doses) have quantitative limits. These limits can be overridden for medical necessity if an individual's clinical situation warrants this. This same process applies to medications used to treat both medical/surgical and mental health and substance use disorder conditions. There are no differences in the percentage of FDA approved drugs on the PDL for behavioral and medical conditions. Our position is to offer a vast amount of medication options for providers to choose from that are based on evidence-based medicine. Safety and evidence-based medicine are among the primary factors we consider when determining off label coverage. Off label coverage will generally require prior authorization to determine the need and allow our team to research any studies to validate effectiveness. The procedure is the same for medical/surgical and mental health and substance use disorder medications. Brand names with no generics available are approved in the same manner for both medical/surgical and mental health and substance use disorder medications. These approvals are made on a preferred or non-preferred basis. The majority of preferred drugs are on the PDL and will generally adjudicated with no additional review. There are no extra steps for a member to go through for situations where there is a brand name medication with no generic or where brand names are preferred by the state. If a medication is non-preferred, it can still be obtained, however it will require a prior authorization or medical exception review. The process is the same for both medical/surgical and mental health and substance use disorder medications. The plan considers and encourages generic substitutions. Generic substitutions are handled the same for both medical/surgical and mental health and substance use disorder medications. Our only restriction on pharmacy providers is the requirement that they must be in network. Our PBM has a credentialing process that evaluates pharmacies and makes a determination on them having the necessary requirements to join our network.

Formulary Design Evidentiary Analysis	**Denial Rates of Drugs used for Medical/Surgical Conditions** Based on data from the PBM the total number of Approvals for drugs requiring a PA during year 2021 was 6105. Total number denied was 2996. The drug classes associated with medical conditions had a denial rate of 30.46%. The denials were based on established criteria as described above. Total number of drug exception requests for medications used to treat medical conditions during 2021 was 1348. The total number of denials was 1027 or 76%. The denials were based on established criteria and availability of other therapeutic drugs. Based on this information Alliant considers the application of criteria to be in substantial compliance with Mental Health Parity	**Denial Rates of Drugs used for Behavioral Health Conditions** Based on data from the PBM the total number of Approvals for drugs requiring a PA during year 2021 was 6105. Total number denied was 2996. The drug classes associated with behavioral health conditions had a denial rate was 26.52%. The denials were based on established criteria as described above. Total number of drug exception requests for medications used to treat behavioral health conditions during 2021 was 24. The total number of denials was 7 or 29%. The denials were based on established criteria and availability of other therapeutic drugs. Based on this information Alliant considers the application of criteria to be in substantial compliance with Mental Health Parity
Network Access	**Providers of Primary Care:** • Provider Network will make best efforts to provide a PCP Network that is sufficient for Alliant members. The Alliant Health Plans PCP Network consists of Family Practice, General Practice, Internal Medicine and Pediatric providers. Alliant makes a best effort to have a 1:2,000 ratio of primary care providers to members. Members in a Rural Area may fall outside this standard due to provider availability. *Rural Area* means an area that is not an Urban Area as defined by a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget. • Alliant will make best efforts to provide a PCP Network that is sufficient for Alliant members a choice of at least 2 PCP locations within 30 miles from an Alliant member's residence. Members in a Rural Area may fall outside this standard due to provider availability. *Rural Area* means an area that is not an Urban Area as defined A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area. (NECMA), as defined by the Executive Office of Management and Budget. • Alliant will review a geographic access report annually. The report will show if Alliant is meeting PCP Network adequacy requirements as outlined above. Members in a Rural Area may fall outside this standard due to provider availability.	**Providers of Behavioral Healthcare:** • Alliant Health Plans defines high volume behavioral healthcare providers as: Psychiatrist, Psychologists and Licensed Practicing Counselors because these provider types are the most likely to provide care across the continuum of behavioral healthcare delivery. • Provider Network will make best efforts to provide a Behavioral Provider Network that is sufficient for Alliant members. The Alliant Health Plans Behavioral Provider Network consists of (Psychiatrist, Psychologist and Licensed Practicing Counselors) providers. Alliant makes a best effort to have least 2 behavioral health providers to the extent that qualified willing providers are available with a goal of 1:5,000 ratio of high-volume behavioral healthcare providers to members. Members in a Rural Area may fall outside this standard due to provider availability. *Rural Area* means an area that is not an Urban Area as defined A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget. • Provider Network will make best efforts to provide a Behavioral Provider Network located within the service area that is sufficient for members and provides a choice of at least 1 behavioral health location within 60 miles from a member's residence. Members in a Rural Area may fall outside this standard due to provider availability. *Rural*

	Rural Area means an area that is not an Urban Area as defined A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area. • Based on the analysis, Alliant prioritizes opportunities for improvement identified from analysis of the availability of primary care providers. If Alliant identifies opportunities based on geographic or member-to-provider ratio deficiencies, at least one intervention is implemented, and Alliant measures the effectiveness of the intervention at least annually. **Providers of Specialty Care:** • Alliant Health Plans defines high volume provider specialists as follows: Obstetrics and Gynecology, Orthopedics, and Dermatology. High volume specialties are determined by claims encounter data. High impact providers are defined as provider types that treat conditions that have high mortality and morbidity rates. Alliant Health Plans considers oncologists to be high-impact providers. • Provider Network will make best efforts to provide a Specialist Network that is sufficient for Alliant members. Alliant makes a best effort to have a 1:5,000 ratio of high-volume or high-impact specialty providers (Obstetrics and Gynecology, Orthopedics, Dermatology and Oncology), to members. Members in a Rural Area may fall outside this standard due to provider availability. *Rural Area* means an area that is not an Urban Area as defined A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget. • Provider Network will make best efforts to provide a Specialist Network located within the Alliant Health Plans service area that is sufficient for Alliant members a choice of at least 1 high-volume specialist and 1 high-impact specialist location within 60 miles from an Alliant member's residence. Members in a Rural Area may fall outside this standard due to provider availability. *Rural Area* means an area that is not an Urban Area as defined A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area. (NECMA), as defined by the Executive Office of	*Area* means an area that is not an Urban Area as defined A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area. (NECMA), as defined by the Executive Office of Management and Budget. • Alliant will review a geographic access report annually. The report will show whether Alliant is meeting the Behavioral Health Provider Network adequacy requirements as outlined above. As noted above, members in a Rural Area may fall outside this standard due to provider availability. *Rural Area* means an area that is not an Urban Area as defined A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area. • Based on the analysis, Alliant prioritizes opportunities for improvement identified from analysis of the availability of behavioral healthcare providers. If Alliant identifies opportunities based on geographic or member-to-provider ratio deficiencies, at least one intervention is implemented, and Alliant measures the effectiveness of the intervention at least annually.

	Management and Budget. • Alliant will review a geographic access report annually. The report will show whether Alliant Health Plans is meeting the Specialist Network adequacy requirements as outlined above. As noted, Members in a Rural Area may fall outside this standard due to provider availability. *Rural Area* means an area that is not an Urban Area as defined A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area. • Based on the analysis, Alliant prioritizes opportunities for improvement identified from analysis of the availability of high-volume and high-impact SCPs. If Alliant identifies opportunities based on geographic or member-to-provider ratio deficiencies, at least one intervention is implemented, and Alliant measures the effectiveness of the intervention at least annually.	
Network Access Evidentiary Analysis	Alliant analyzed 2021 claims data and determined there were 97,513 OON claims for medical/surgical services and 2,103 OON claims for behavioral health services. For an equal comparison we calculated the number per 1000 members. For medical it was 1695 OON claims per 1000, and for behavioral 37 per 1000. The denial rate for OON claims were 16% and 13% respectively. Members may request out-of-network care due to geographic location and availability of specific specialty care. Alliant monitors appeals related to out-of-network requests for service and LTAs (Limited Treatment Agreement) granted for those requests as both a measure of network adequacy and member satisfaction. LTAs are negotiated rates for a limited length of treatment that may help reduce a member's cost-share when no other In-Network services are available or close to the member's home. For 2021 there was a total of 56 LTAs approved. Of the 56 LTAs, only one was for behavioral health. Based on this information Alliant considers the network access to be in substantial compliance with Mental Health Parity.	