Anthem

NQTL SELF COMPLIANCE TOOL

Overview: Anthem's fully insured policies and the plans that it administers on behalf of self-funded employers utilize a provider network established by Anthem. Although Anthem has multiple networks, the same processes described below are used in the formation and modification of each network arrangement.

1. Identify the NQTL: Network Adequacy – CA, CO, CT, GA, IN, KY, ME, MO, NV, NY, OH, VA, WI

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 Anthem'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. Identify the factors considered in the design of the NQTL:

Factors:

- Is there an NCQA accreditation standard that applies for practitioner availability?

    a. 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.
- Is there an NCQA accreditation standard that applies for practitioner accessibility?
    a. If yes, the accreditation standard becomes the baseline measurement to determine compliance with network appointment accessibility requirements for M/S and MH.SUD providers.
    b. 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.
- What are the results of the various member surveys?
- Does Anthem have any internal member complaints on provider access or availability?

NCQA accreditation standards are the primary weighted factor in determining appropriate access and availability measurement guidelines unless a state or federal law provides a more stringent standard.

3. Identify the sources (including any processes, strategies, evidentiary standards) used to define the factors identified above to design the NQTL:

Sources:

- NCQA Accreditation Standards for Network Management (NET1-Availability of Practitioners and NET2-Accessibility of Services).
- State statute or regulation directive for availability or accessibility standards. State statutes are referenced below.
- Quest Analytics Suite™ 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

State statues outside of base policy metrics.	
California	Title 10, California Code of Regulations, Title 28, California Code of Regulations
Colorado	Title 10, Article 16, Part 7 Network availability Colorado Regulation 4-2-53. Network Adequacy Standards
Maine	Revised Statue Title 24-A (non-descriptive) and Bureau of Insurance Rule Chapter 850
Missouri	Title 20 / Chapter 7 / 20 CSR 400-7.095 MO Reg: 354.603, 354.602
Nevada	Nevada Administrative Code **Nevada Regulation** NAC 695C.160.
Virginia	Title 38 Virginia regulation 12 VAC 5-408-260, 12 VAC 5-408-270, 12 VAC 5-408-280

Anthem 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.

Anthem Practitioner Availability Process

Anthem 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. Anthem annually measures compliance with the geographic guideline standards through Quest Analytics Suite™ 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, Anthem 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.

Anthem also considers other factors in the monitoring of its provider availability. First, reviews of open practice rates confirm new patient selection and availability. Anthem has a standard goal, 90%, for open practices for each primary care practice type and behavioral health practitioners per network. Anthem 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 Anthem specific goals.

Anthem Practitioner Accessibility Process

Anthem 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.

Anthem 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 5 miles	2 practitioners within 12 miles	2 practitioners within 30 miles
Specialists	All members – 1 within 30 miles		
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**
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
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.
** NCQA allows the organization to determine urgent appointment wait time standard for PCP, however, requires BH urgent at 48 hours.

4. Is the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical surgical benefits, both as written and in operation?

Yes. As noted above, Anthem uses standard, objective criteria established by the NCQA and various state laws, as applicable, to determine the measurements for compliance with network adequacy availability and access requirements. Anthem 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.

The comparative analysis for each state demonstrates the Anthem Provider Availability and Provider Accessibility policies achieve parity in operation. Upon review, the network of MH/SUD practitioners generally meet or exceed the compliance standards for network adequacy as measured by Quest Analytics Suite™ for MH/SUD practitioners. Additionally, when compared with M/S provider compliance, the MH/SUD providers in almost every instance meet or exceed the goal percentage satisfaction of M/S providers. For example, the Virginia HMO network satisfies the psychiatrist geographic measurements for urban and suburban setting 100% of the time. The comparable family medicine practitioners satisfy the same 100% and 99% for urban and suburban settings. Psychiatrists satisfy the Quest Analytics Suite™ requirements for Rural areas (98%), and trail family medicine providers by only 1%. In California, the network availability satisfies the Quest Analytics Suite™ standards at 100% for virtually all providers. Also in California, the behavioral health providers meet and exceed accreditation goals for appointment access and generally perform better than their medical/surgical counterparts. Therefore, the data comparison demonstrates parity in operation for network adequacy requirements.

5. Does the group health plan or group or individual market health insurance issuer adhere to the mental health parity requirements regarding this NQTL on MH/SUD benefits?

Yes. 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. Anthem 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 very similar with MH/SUD often outperforming M/S providers.

NETWORK ADEQUACY GEO STANDARDS *

GEOGRAPHIC AVAILABILITY RESULTS		Behavioral Health	Urban 2 w/in10 miles	Suburban 2 w/in 25 miles	Rural 2 w/in 60 miles	Medical - PCP	Urban 2 w/in 5 miles
STATE	NETWORK	PRACTITIONER	2021			PRACTITIONER	
GA	H M O	Psychiatrist	100%	100%	100%	Family Medicine	99%
		Psychiatrist & Prescribing Prac	100%	100%	100%	Internal Medicine	99%
		Psychologist	100%	100%	100%	Pediatrics	99%
		Masters Level Therapist	100%	100%	100%	PCP's & Prescribing Pracs	
GA	P P O	Psychiatrist	100%	100%	100%	Family Medicine	99%
		Psychiatrist & Prescribing Prac	100%	100%	100%	Internal Medicine	99%
		Psychologist	100%	100%	100%	Pediatrics	99%
		Masters Level Therapist	100%	100%	100%	PCP's & Prescribing Pracs	
EXCHANGE GA	H M O	Psychiatrist	100%	100%	100%	Family Medicine	99%
		Psychiatrist & Prescribing Prac	100%	100%	100%	Internal Medicine	99%
		Psychologist	100%	100%	100%	Pediatrics	99%
		Masters Level Therapist	100%	100%	100%	PCP's & Prescribing Pracs	

Accreditation Goal: 90%

* **Data Clarification / Disclaimer - *Do not remove***

Data is not assessed at a level of group, product or treatment criteria.

Office level availability assessment is all membership with availability to all practitioners by type within the established mileage of their residence.

Suburban 2 w/in 12 miles	Rural 2 w/in 30 miles	Medical - Specialist	Urban 1 w/in 15 miles	Suburban 1 w/in 30 miles	Rural 1 w/in 40 miles	Medical - Specialist	1 w/in 30 miles
2021		PRACTITIONER		2021		PRACTITIONER	2021
99%	99%	OB/Gyn	100%	100%	100%	Oncology	100%
99%	99%		-	-	-	Ortho Surg	100%
99%	99%		-	-	-		-
			-	-	-		-
99%	99%	OB/Gyn	100%	100%	100%	Oncology	100%
99%	99%		-	-	-	Ortho Surg	100%
99%	99%		-	-	-		-
			-	-	-		-
99%	99%	OB/Gyn	100%	100%	100%	Oncology	100%
99%	99%		-	-	-	Ortho Surg	100%
99%	99%		-	-	-		-
			-	-	-		-

-

EXHIBIT 2
CONCURRENT REVIEW
GEORGIA – SELF FUNDED GROUP (ASO)–LOCAL COMMERCIAL

Inpatient, In-Network

Line of Business	Approved	Denied	Percentage Approved
Group M/S	54334	3555	94%
Group MH/SUD	7072	317	95%

Inpatient, Out-of-Network

Line of Business	Approved	Denied	Percentage Approved
Group M/S	8057	823	91%
Group MH/SUD	1207	93	92%

Outpatient, In-Network

Line of Business	Approved	Denied	Percentage Approved
Group M/S	263	12	96%
Group MH/SUD	413	9	98%

Outpatient, Out-of-Network

Line of Business	Approved	Denied	Percentage Approved
Group M/S	25	15	63%
Group MH/SUD	55	10	85%

Note: Data is for self-funded plans whose plans are headquartered in Georgia without regard to where the members of the plan reside (e.g., group is headquartered in Georgia, but members may live in-or-outside of Georgia). Data includes requests for precertification as well (i.e., services that are not on the prior authorization list). It also includes requests to see an out-of-network provider.

Report run in the month of March 2022 by Business Info Developer Cons Sr. for requests received between January 1, 2021, and December 31, 2021.

NQTL SELF COMPLIANCE TOOL
CONTINUED STAY/CONCURRENT REVIEWS
GEORGIA – SELF FUNDED GROUP LOCAL COMMERCIAL

Overview

Anthem'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. This analysis explains when Anthem performs a continued stay/concurrent review and how Anthem'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.

1. Definitions:

Continued Stay/Concurrent Review – A utilization review of a service, treatment or admission for a benefit coverage determination that must be done during an ongoing stay in a Facility or course of treatment.

2. Identify the factors considered in the design of the NQTL:

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. Does Anthem have a medical policy or clinical utilization management (UM) guideline or third-party guideline?
d. Appropriateness of care
    i. Is the service medically necessary?
    ii. Is the service being provided at the most clinically appropriate level of care for the member's condition (e.g., can the surgery be done at an ASC instead of on an outpatient hospital basis)?

3. Identify the sources (including any processes, strategies, evidentiary standards) used to define the factors identified above to design the NQTL:

Sources:
Anthem's medical policy, clinical UM guidelines, or third-party guidelines
State or federal law
Plan provisions (The plan language that applies to Anthem's fully insured policies is attached as Exhibit 1.)

Anthem 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. Anthem does not initiate any concurrent reviews.

4. Is the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical surgical benefits, both as written and in operation?

Anthem applies the same processes, strategies, evidentiary standards and other factors for continued stay/concurrent reviews for both MH/SUD and medical surgical benefits. Anthem does not apply these processes, strategies, evidentiary standards and other factors more stringently to MH/SUD benefits. As noted above, the treating provider, not Anthem, initiates the continued stay/concurrent review. The data showing the number of concurrent reviews conducted in 2021 is attached as Exhibit 2. The percentage of continued stay/concurrent reviews approved by AUMSI is equal to or greater than for MH/SUD services than medical/surgical services in the same classification.

5. Does the group health plan or group or individual market health insurance issuer adhere to the mental health parity requirements regarding this NQTL on MH/SUD benefits?

Yes, Anthem applies the same processes, strategies, evidentiary standards and other factors for continued stay/concurrent reviews for both MH/SUD and medical surgical benefits. Anthem 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, Anthem complies with parity requirements for concurrent review in writing and in operation.

EXHIBIT 1
STANDARD FULLY INSURED EOC PROVISION

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigative as those terms are defined in this Contract. Utilization Review aids in the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

Reviewing Where Services Are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to You in a lower level place of care or lower cost setting, will not be Medically Necessary if they are given in a higher level place of care, or higher cost setting. This means that a request for a service may be denied because it is not Medically Necessary for that service to be provided in the place of care or setting that is being requested. When this happens the service can be requested again in another setting or place of care and will be reviewed again for Medical Necessity. At times a different type of Provider or Facility may need to be used in order for the service to be considered Medically Necessary.

Examples include, but are not limited to:

- A service may be denied on an Inpatient basis at a Hospital but may be approved if provided on an Outpatient basis in a Hospital setting.
- A service may be denied on an Outpatient basis in a Hospital setting but may be approved at a free-standing imaging center, infusion center, ambulatory surgical Facility, or in a doctor's office.
- A service may be denied at a Skilled Nursing Facility but may be approved in a home setting.

Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. We may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment is more cost effective, available and appropriate. "Clinically equivalent" means treatments that for most Members, will give You similar results for a disease or condition.

If You have any questions about the Utilization Review process, the medical policies or clinical guidelines, You may call the Member Services phone number on the back of Your Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if We decide Your services are Medically Necessary. For benefits to be covered, on the date You get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under Your Plan;
4. The service cannot be subject to an exclusion under Your Plan;and
5. You must not have exceeded any applicable limits under Your Plan.

Types of Reviews

- **Prior Authorization Review** – 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.

- **Precertification –** A required Prior Authorization Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for You to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative as those terms are defined in this Contract.

  For admissions following Emergency Care, You, Your authorized representative or doctor must tell Us within 48 hours of the admission or as soon as possible. For labor / childbirth admissions, Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.

- **Continued Stay/Concurrent Review** – A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a Facility or course of treatment.

Both Prior Authorization and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any doctor with knowledge of Your medical condition, without such care or treatment, Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment.

Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service or supply has been provided. 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.

Who is Responsible for Precertification

Typically, Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending doctor (“requesting Provider”) will get in touch with Us to ask for a Precertification. However, You may request a Precertification, or You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsible Party	Comments
Network	Provider	The Provider must get Precertification when required.

Non-Network	Member	Member has no benefit coverage for a Non- Network Provider unless: • The Member gets approval to use a Non-Network Provider before the service is given; or • The Member requires an Emergency Care admission (See note below). Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not to be Medically Necessary.
BlueCard® Provider	Member **(Except for Inpatient admissions)**	• Member must get Precertification when required (call Member Services). • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not to be Medically Necessary.
Note: Precertification is not required to receive Emergency Care. For Emergency Care admissions, You, Your authorized representative or doctor must tell Us within 48 hours of the admission or as soon as possible.		

How Decisions are Made

We will use Our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make Our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section "Prescription Drugs Administered by a Medical Provider". Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning Your request. To ask for this information, call the Precertification phone number on the back of Your Identification Card.

If You are not satisfied with Our decision under this section of Your benefits, please refer to the "If You Have a Complaint or an Appeal" section to see what rights may be available to You.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on State and federal laws. Where State laws are stricter than federal laws, We will follow State laws. If You live in and/or get services in a State other than the State where Your Contract was issued, other State-specific requirements may apply. You may call the phone number on the back of Your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision	Timeframe Requirement for Notification

Precertification Requests		
Prior Authorization Review Urgent	36 hours from the receipt of request, including one business day If the Member receives an Emergency service that requires immediate post evaluation or post stabilization services, We will provide an authorization decision within 60 minutes of receiving the request; if the authorization decision is not made within 60 minutes, such services shall be deemed approved.	For approval determination, We will notify the Provider by telephone or electronically within 24 hours of the decision and notify the Member or Member representative and Provider by written or electronic means within two business days of the decision. For Adverse Determination, We will notify the Provider by telephone or electronically within 24 hours of the decision and notify the Member or Member representative and Provider by written or electronic means within one business day of the decision.
Prior Authorization Review Non-Urgent	36 hours from the receipt of the request, including one business day	
Urgent Continued Stay/Concurrent Review when no previous days authorized	One business day from the receipt of all necessary information	For approval determination, We will notify the Provider by telephone or electronically within one business day of the decision and notify the Member or Member representative and Provider by written or electronic means within one business day of the telephonic or electronic notification. For Adverse Determination, We will notify the Provider by telephone or electronically within 24 hours of the decision and notify the Member or Member representative and Provider by written or electronic means within one business day of the telephonic or electronic notification. The service will

Urgent Continued Stay/Concurrent Review when request is received more than 24 hours before the end of the previous authorization	One business day from the receipt of all necessary information	continue without Member liability until the Member has been notified of the determination.
Urgent Continued Stay/Concurrent Review when request is received less than 24 hours before the end of the previous authorization	One business day from the receipt of all necessary information	
Concurrent / Continued Stay Review Non-Urgent	One business day from the receipt of all necessary information	
Post-service Review	30 business days from the receipt of the request	We will notify the Member by written means of the determination within 10 business days of the determination.

If more information is needed to make our decision, we will tell the requesting Provider of the specific information needed to finish the review. If we do not get the specific information we need by the required timeframe, We will make a decision based upon the information We have.

We will notify You and Your Provider of Our decision as required by State and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

NQTL SELF COMPLIANCE TOOL
Commercial and Medicaid Products

1. Identify the NQTL: ***Credentialing***

If a plan that Anthem insures or administers, including Medicaid, requires the use of a provider network, this document explains how a provider within the scope of Anthem's credentialing program qualifies, based upon Anthem credentialing criteria, to participate in one or more networks in the states in which we do business. Out-of-network and certain in-network providers are not in scope for Anthem's credentialing program. Examples of plans that require the use of a network are Preferred Provider Option (PPO) plans, Point of Service (POS) plan, Health Maintenance Organization (HMO) plans or Exclusive Provider Organization (EPO) plans. HMO and EPO plans require the use of an in-network provider, except in the case of an emergency or if a referral to a non-network provider is approved in advance of the care. PPO and POS plans cover services from both in-network and out-of-network providers, but members will pay more in cost-sharing (i.e., deductible, coinsurance and copayments) if they use an out-of-network provider.

The Credentialing NQTL is applied to any M/S and MH/SUD services rendered by a network provider in-scope for credentialing within the inpatient in-network, outpatient in-network, and emergency benefit classifications.

2. Identify the factors considered in the design of the NQTL:

- Did the provider submit a complete and accurate application to join the applicable provider network?
- Is the provider licensed in the State with an unencumbered license? Has the license ever been encumbered?
- Does the provider have education and training from an accredited educational organization and, depending on the specialty, have the appropriate board certification?
- If the provider is a facility, is it accredited by an appropriate accreditation entity?
- Is the provider currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP?
- If the provider can prescribe controlled substances, does the provider have a current, valid, unencumbered DEA/CDS registration in the state?
- For Medicaid plans, some states require the provider be approved by the State before participating in a network. That approval request is made after Anthem has credentialed the provider.

Anthem does not give more weight to any of the above referenced factors. Any one of these factors may be a sufficient basis for Anthem to deny admission to a network.

3. Identify the sources (including any processes, strategies, evidentiary standards) used to define the factors identified above to design the NQTL:

- State provider licensure laws

- State and federal resources, such as websites, that indicate provider licensure status
- NCQA Health Plan Accreditation (HPA) Standards for Credentialing
- CMS Medicare Managed Care Manual Chapter 6 - Relationships With Providers: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c06.pdf

The attached Credentialing Program Summary describes in more detail Anthem's credentialing requirements that help ensure we have qualified providers in our networks.

Anthem's National Credentials Committee ("NCC") oversees the credentialing process. The NCC establishes the policies and procedures for:

a. Credentialing, re-credentialing, ongoing monitoring and oversight of network Practitioners[1] and Health Delivery Organizations ("HDO")[2];
b. The delegation of credentialing related activities;
c. Appeals of adverse credentialing decisions; and
d. Review of Company clinical staff qualifications and approval for those staff to perform clinical functions on behalf of the Company.

The NCC policies are required to:

a. Comply with relevant federal law;
b. Meet standards set by relevant regulatory and accrediting bodies;
c. Be modified for state specific use to comply with state law where applicable; and
d. Be reviewed at least annually and revised as necessary.

The NCC is composed of ten to twelve Anthem medical directors (excluding the chair) selected to represent various clinical and business areas of Anthem. It is chaired by an Anthem medical director as designated by the Vice President (VP) responsible for Enterprise Credentialing Policy. The VP responsible for Enterprise Credentialing Policy reports to the Chief Medical Officer. Other representatives of the NCC include:

• At least two medical directors representing Commercial and Medicaid lines of business, respectively, and one medical director representing Medicare line of business;
• At least one medical director representing behavioral health; and
• At least two medical directors who act as chairs/vice-chairs of geographic Credentials Committees.

Policies approved by NCC will govern credentialing of network practitioners and HDOs including, but not limited to scope, criteria, confidentiality, delegation, and appeals. Credentialing Policies established by the NCC will be presented to the GCC for input, review and adoption at least annually.

Anthem has established geographic Credentials Committees ("GCC") on either a specific state or regional basis.[3] Each GCC is made up of a chair, who is the medical director for the state or a state within the designated region, a vice chair and at least five (but no more than ten) external participating physicians

[1] A Practitioner is an individual person who is licensed or certified (as applicable) in accordance with all applicable state and federal laws to deliver health care services
[2] An HDO is a facility, institution or entity that is licensed or certified (as applicable), in accordance with all applicable state and/or federal laws, and that provides or delivers health care services
[3] Anthem has 21 GCCs.

representing multiple medical specialties. In general, the following specialties or practice-types are represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine), surgery, and behavioral health. At least two of the physician committee members must be credentialed for each line of business (e.g. Commercial, Medicare, and Medicaid) offered within the geographic purview of the GCC.

The GCC meets, at a minimum, every 45 days. Determinations to deny an applicant's participation or terminate a Practitioner or HDO from participation in one or more of the Company's programs or provider network(s) require a majority vote of the voting members of the GCC in attendance, the majority of whom are participating providers.

MH/SUD and M/S practitioners or HDOs are subject to Anthem's credentialing if they satisfy three requirements (identical to NCQA scope requirements):

- Practitioners are licensed, certified or registered by the state to practice independently (without direction or supervision);
- Practitioners have an independent relationship with the organization; and
- Practitioners provide care to Anthem members.

The scope determination is applied uniformly to all MH/SUD and M/S providers. Providers within the scope of credentialing must complete the entire process to be permitted to join the Anthem network.

If a Practitioner or HDO meets all of the participation criteria for initial or continued participation, then the Credentialing staff will present that provider for approval by the chair or vice chair of the GCC. The participation criteria include the necessary elements to demonstrate professional competency and is tailored to the specific M/S and MH/SUD provider types within scope for credentialing. Narrowly tailored exceptions to certain participation criteria (e.g., board certification requirement) are available for M/S and MH/SUD providers. Practitioners or HDOs who do not meet all of the participation criteria or have other issues that require individual consideration, will be presented to the GCC for an individual review and credentialing determination.

Determinations to deny an applicant's participation or terminate a Practitioner or HDO from participation in one or more of the Company's programs or provider network(s) require a majority vote of the voting members of the GCC in attendance, the majority of who are participating providers.

Additionally, the GCC will review the credentialing program and conformance to the Company's standards of any entity for which delegation of credentialing is being considered and will determine the acceptance or denial of the entity for such delegation.

Practitioners requesting initial participation will be notified of the decision by appropriate Company personnel within ninety (90) days of receipt of a completed application or within 60 days of the GCC decision, whichever is earlier. This notification may occur electronically or via standard mail.

Practitioners can submit an application by visiting www.anthem.com, selecting "Providers" then selecting "Credentialing."

A complete application includes:

- Signature and application date
- CAQH status of “Initial Application Complete” or “Reattestation”
- Current license to practice in each state where services are provided
- Education/Training to support requested specialty(ies) (or documentation that provider will complete training within 60 days of application)
- Current Hospital Privilege information
- Current DEA or CDS certificate in each state where services are provided
- Explanations to questions on the application
- Five years’ work history, in month/year format
- Current Professional Liability Insurance
- Applicant must also allow a site review within 30 days of our request, if applicable

If a Practitioner or HDO’s application is declined or the Practitioner or HDO is terminated during a credentialing review, a letter will be sent and, depending on the circumstances, the Practitioner or HDO may have the right to either (1) submit additional information for reconsideration; or (2) file a formal appeal.

In any case in which the Company delegates any credentialing functions, the delegation will be governed by a mutually agreed upon delegation agreement. The delegation agreement must be in place before delegated activities are performed. The Company oversight entails a process for routine, ongoing reports, and a clearly defined audit program.

4. Is the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical surgical benefits, both as written and in operation?

Anthem’s processes, strategies, evidentiary standards and other factors for provider credentialing are comparable for both mental health/substance use disorder providers and medical/surgical providers. Anthem applies its credentialing policies uniformly to all providers. The participation criteria is also generated based on NCQA standards, state licensure standards, and Anthem internal considerations, and apply to all M/S and MH/SUD within scope of Anthem’s credentialing program. The criteria is defined based on the specific provider level. For example, all M/S and MH/SUD providers at the MD or DO level, must satisfy the criteria applicable to MDs and DOs. Providers outside of MDs and DOs have participation criteria tailored to their specific type as much of the MD/DO criteria would not be applicable. Nurse Practitioners, Certified Midwives, Licensed Clinical Social Workers, Psychologists, among others, have to satisfy the education and training requirements specific to their profession as all MH/SUD and M/S providers must satisfy education and training requirements to demonstrate professional competency to treat Anthem members.

At least annually, usually in January or February, Anthem conducts an analysis to evaluate and ensure that Anthem is administering its credentialing program according to its policies. This report tracks the reason for denials and terminations and a review is done to ensure the reason for the denial or termination is consistent with policy.

The comparative analysis demonstrating the comparable application of credentialing policy and process is shown below for calendar year 2021, based on the annual report run on February 23, 2022 by a

Credentialing Director. There are very few denied/terminated cases for professional competency reasons out of the total cases reviewed.

Initial Credentialing

Total applications: 51,171
Total denials: 83
Reasons for denial:

Not Board Certified:	Medical/Surgical: 23	Behavioral Health: 4
License/Board Action:	Medical/Surgical: 24	Behavioral Health: 8
License Suspension:	Medical/Surgical: 2	Behavioral Health: 0
Malpractice:	Medical/Surgical: 2	Behavioral Health: 0
Education/Training:	Medical/Surgical: 2	Behavioral Health: 1
Hospital Privileges:	Medical/Surgical: 5	Behavioral Health: 0
No Admitting:	Medical/Surgical: 3	Behavioral Health: 0
Hospital Action:	Medical/Surgical: 4	Behavioral Health: 0
Work History Gap:	Medical/Surgical: 3	Behavioral Health: 1
Quality of Care:	Medical/Surgical: 1	Behavioral Health: 0

Recredentialing Termination:

Total recredentialing cases: 68,887
Total denials: 46

Not Board Certified:	Medical/Surgical: 8	Behavioral Health: 1
License/Board Action:	Medical/Surgical: 16	Behavioral Health: 3
Malpractice:	Medical/Surgical: 1	Behavioral Health: 0
Hospital Privileges:	Medical/Surgical: 4	Behavioral Health: 0
No Admitting:	Medical/Surgical: 9	Behavioral Health: 0
DEA:	Medical/Surgical: 1	Behavioral Health: 0
Hospital Action:	Medical/Surgical: 2	Behavioral Health: 0
Nondisclosure:	Medical/Surgical: 1	Behavioral Health: 0

Off-cycle Reviews:

Total off-cycle reviews: 681
Total terminations: 138

Not Board Certified:	Medical/Surgical: 2	Behavioral Health: 0
License/Board Action:	Medical/Surgical: 85	Behavioral Health: 11
License Suspension:	Medical/Surgical: 27	Behavioral Health: 6
Education/Training:	Medical/Surgical: 1	Behavioral Health: 0
Criminal Conviction:	Medical/Surgical: 1	Behavioral Health: 0
Federal Sanctions:	Medical/Surgical: 5	Behavioral Health: 0

Total initial applications breakdown based on updated report run on August 31, 2022 (50,337):

- M/S Providers: 34,517 (0.20% of total initial applicants denied)
- MH/SUD Providers: 15,820 (0.09% of total initial applicants denied)

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. Anthem's processes, strategies, and factors are the same for MH/SUD and M/S providers. The processes are largely dictated by federal law, state law, and accreditation organization requirements (i.e., NCQA), and are focused on ensuring professionally competent practitioners are treating Anthem members. The specific professional competency criteria requirements are developed as applicable to the particular provider specialty within the scope of Anthem's credentialing program as dictated by the NCQA. Exceptions to certain criteria are available to both M/S and MH/SUD providers. Lastly, the comparative analysis demonstrates relatively few providers are denied overall, and it isn't applied in a more restrictive manner to MH/SUD providers.

Credentialing

ANTHEM'S DISCRETION

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Anthem's discretion in any way to amend, change or suspend any aspect of Anthem's credentialing program ("Credentialing Program") nor is it intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to Members. Anthem further retains the right to approve, suspend, or terminate individual physicians and health care professionals, and sites in those instances where it has delegated credentialing decision making.

Credentialing Scope

Credentialing requirements apply to the following:

1. Practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision);
2. Practitioners who have an independent relationship with Anthem
   - An independent relationship exists when Anthem directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as primary care practitioners; and
3. Practitioners who provide care to Members under Anthem's medical benefits.

The criteria listed above apply to practitioners in the following settings:

1. Individual or group practices;
2. Facilities;
3. Rental networks:
   - That are part of Anthem's primary Network and include Anthem Members who reside in the rental network area.
   - That are specifically for out-of-area care and Members may see only those practitioners or are given an incentive to see rental network practitioners; and
4. Telemedicine.

Anthem credentials the following licensed/state certified independent health care practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors
- Optometrists providing Health Services covered under the Health Benefit Plan
- Doctors of dentistry providing Health Services covered under the Health Benefit Plan including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training
- Other behavioral health care specialists who provide treatment services under the Health Benefit Plan

- Telemedicine practitioners who provide treatment services under the Health Benefit Plan
- Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- Genetic counselors
- Audiologists
- Acupuncturists (non-MD/DO)
- Nurse practitioners
- Certified nurse midwives
- Physician assistants (as required locally)
  Registered Dietitians

The following behavioral health practitioners are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Abuse Practitioners

Anthem credentials the following Health Delivery Organizations (HDOs):

- Hospitals
- Home Health agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance abuse treatment in inpatient, residential or ambulatory settings, including:
  - Adult Family Care/Foster Care Homes
  - Ambulatory Detox
  - Community Mental Health Centers (CMHC)
  - Crisis Stabilization Units
  - Intensive Family Intervention Services
  - Intensive Outpatient – Mental Health and/or Substance Abuse
  - Methadone Maintenance Clinics
  - Outpatient Mental Health Clinics
  - Outpatient Substance Abuse Clinics
  - Partial Hospitalization – Mental Health and/or Substance Abuse
  - Residential Treatment Centers (RTC) – Psychiatric and/or Substance Abuse
- Birthing Centers
- Home Infusion Therapy when <u>not</u> associated with another currently credentialed HDO

The following HDOs are not subject to professional conduct and competence review under the Credentialing Program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)

End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission
- Portable x-ray Suppliers (CMS Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)

CREDENTIALS COMMITTEE

The decision to accept, retain, deny or terminate a practitioner's or HDO's participation in on one or more of Anthem's networks or plan programs is conducted by a peer review body, known as Anthem's Credentials Committee (the "CC").

The CC will meet at least once every 45 calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the Vice President of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. In states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated. In states or regions where an Anthem affiliated provider organization is represented, a second vice-chair representing that organization may be designated. The chair must be a state or regional lead medical director, or an Anthem medical director designee and the vice-chair must be a lead medical officer or an Anthem medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than 10 external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (e.g., nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (e.g., Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more Networks or Plan programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are network practitioners.

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of the

Credentialing Program. Specifically, information supplied by the practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulatory agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs are notified of their right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, Anthem's credentialing staff ("Credentialing Department") will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will notify the practitioner or HDO of their right to correct erroneous information or provide additional details regarding the issue and will include the process for submission of this additional information. Depending on the nature of the issue, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue, including copies of the correspondence or a detailed record of phone calls, will be documented in the practitioner's or HDO's credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Upon request, the practitioner or HDO will be provided with the status of their credentialing or re-credentialing application.

Anthem may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

NONDISCRIMINATION POLICY

Anthem will not discriminate against any applicant for participation in its Plan programs or provider Networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Anthem will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the Members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence. The CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Anthem will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. In the event discriminatory practices are identified through an audit or through other means, Anthem will take appropriate action to track and eliminate those practices.

INITIAL CREDENTIALING

Each practitioner or HDO must complete a standard application form deemed acceptable by Anthem when applying for initial participation in one or more of Anthem's networks or plan

programs. For practitioners, the Council for Affordable Quality Healthcare (CAQH) ProView system is utilized. To learn more about CAQH, visit their web site at www.CAQH.org.

Anthem will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180 calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Anthem will review, among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, NIAHO or AOA accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state controlled substance registrations • The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable

Medicare, Medicaid or FEHBP sanctions

RE-CREDENTIALING

The re-credentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Anthem credentialing standards ("Credentialing Standards").

All applicable practitioners and HDOs in the Network within the scope of the Credentialing Program are required to be re-credentialed every three years unless otherwise required by applicable state contract or state regulations.

HEALTH DELIVERY ORGANIZATIONS

New HDO applicants will submit a standardized application to Anthem for review. If the candidate meets Anthem screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail below, in the "Anthem Credentialing Program Standards" section, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

ONGOING SANCTION MONITORING

To support certain Credentialing Standards between the re-credentialing cycles, Anthem has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with Credentialing Standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the Credentialing Department will review periodic listings/reports within 30calendar days of the time they are made available from the various sources including, but not limited to, the following:

- Office of the Inspector General ("OIG")
- Federal Medicare/Medicaid Reports
- Office of Personnel Management ("OPM")
- State licensing Boards/Agencies
- Member/Customer services departments
- Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
- Other internal Anthem departments
- Any other information received from sources deemed reliable by Anthem.

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

APPEALS PROCESS

Anthem has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Anthem's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Anthem may wish to terminate practitioners or HDOs. Anthem also seeks to treat network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Anthem's Networks for professional conduct and competence reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB).

Additionally, Anthem will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is Anthem's intent to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Anthem's Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional conduct and competence considerations.

Immediate terminations may be imposed due to the practitioner's or HDO's license suspension, probation or revocation, if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, has a criminal conviction, or Anthem's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. Participating practitioners and HDOs whose network participation has been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for informal review/reconsideration or formal appeal. Participating practitioners and HDOs whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for informal review/reconsideration or formal appeal.

REPORTING REQUIREMENTS

When Anthem takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its Networks or Plan programs, Anthem may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

ANTHEM CREDENTIALING PROGRAM STANDARDS

Eligibility Criteria

A. Health care practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

1. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP;
2. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he or she provides services to Members;
3. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state; and
4. Meet the education, training and certification criteria as required by Anthem.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

1. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying.
2. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
3. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
4. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

    a. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
        i. Previous board certification (as defined by one) of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired and a minimum of 10 consecutive years of clinical practice;
        ii. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty; or
        iii. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty and a faculty appointment of assistant professor or higher at an academic medical center and teaching facility in Anthem's network and the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

b. Practitioners meeting one of these three alternative criteria (i., ii., iii.) will be viewed as meeting all Anthem education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Anthem review and approval. Reports submitted by delegates to Anthem must contain sufficient documentation to support the above alternatives, as determined by Anthem.

5. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO), Center for Improvement in Healthcare Quality (CIHQ), a Healthcare Facilities Accreditation Program (HFAP) accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

6. For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

<u>Criteria for Selecting Practitioners</u>

New Applicants (Credentialing):

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions.
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote.
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies.
4. No evidence of potential material omission(s) on application.
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members.
6. No current license action.
7. No history of licensing board action in any state.
8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report).
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he or she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one state must have a valid DEA/CDS registration for each applicable state.
10. Initial applicants who have no DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can

provide evidence that he or she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:

a. It can be verified that this application is pending.
b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber;
c. The applicant agrees to notify Anthem upon receipt of the required DEA/CDS registration.
d. Anthem will verify the appropriate DEA/CDS registration via standard sources.
    i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90 calendar day timeframe will result in termination from the Network.

Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Anthem's Members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:

a. It can be verified that the applicant's application is pending; and
b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
c. The applicant agrees to notify Anthem upon receipt of the required DEA registration; and
d. Anthem will verify the appropriate DEA/CDS registration via standard sources; and
e. The applicant agrees that failure to provide the appropriate DEA registration within a 90 day timeframe will result in termination from the network.

Practitioners who voluntarily choose to not have a DEA/CDS registration if that practitioner certifies the following:

a. controlled substances are not prescribed within his/her scope of practice; or in their professional judgement, the patients receiving their care do not require controlled substances and
b. he or she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances should it be clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. The Company is not required to arrange an alternative prescriber; and
c. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.

11. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions; or for Practitioners in specialties defined as requiring hospital privileges who practice solely in the outpatient setting, there exists a defined referral arrangement with a participating Practitioner of similar specialty at a participating hospital who provides inpatient care to members requiring hospitalization.
12. No history of or current use of illegal drugs or history of or current alcohol use disorder.

13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
14. No gap in work history greater than six months in the past five years; however, gaps up to 12 months related to parental leave or immigration will be acceptable and viewed as Level I. All gaps in work history exceeding six months will require additional information and review by the Credentialing Department. A verbal explanation will be accepted for gaps of six to 12 months. Gaps in excess of 12 months will require written explanations. All work history gaps exceeding six (months may be presented to the geographic CC if the gap raises concerns of future substandard Professional Conduct and Competence.
15. No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.
16. A minimum of the past 10 years of malpractice claims history is reviewed.
17. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Anthem's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
18. No involuntary terminations from an HMO or PPO.
19. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
    a. Investment or business interest in ancillary services, equipment or supplies;
    b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. Voluntary surrender of state license related to relocation or nonuse of said license;
    d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    e. Non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five year post residency training window.
    g. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

    Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Additional Participation Criteria and Exceptions for Behavioral Health practitioners (Non Physician) Credentialing.

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
    a. Master or doctoral degree in social work.
    b. If master's level degree does not meet criteria and practitioner obtained PhD degree as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a doctor of social work will be viewed as acceptable.

2. Licensed professional counselor ("LPC"), marriage and family therapist ("MFT"), licensed

mental health counselor (LMHC) or other master level license type:

a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above;
b. Master or doctoral degrees in divinity, masters in biblical counseling, or other primarily theological field of study do not meet criteria as a related field of study.
c. Practitioners with PhD training as a clinical psychologist can be reviewed.
d. Practitioners with a doctoral degree in one of the fields of study will be viewed as acceptable.
d. Licensure to practice independently or in states without licensure or certification:
    i. Marriage & Family Therapists with a master's degree or higher: Certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).

3. Pastoral Counselors:
    a. Master's or doctoral degree in a mental health discipline.
    b. Licensed as another recognized behavioral health provider type (e.g. MD/DO, PsyD, SW,RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur, OR must be licensed or certified as a pastoral counselor in the state where the practice is to occur.
    c. A fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) OR meet all requirements to become a fellow or diplomat member of the ACPE [documentation of eligibility of ACPE required].

4. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
    a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.
    b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
    c. Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing, or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner; and
    d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.

4. Clinical Psychologists:
    a. Valid state clinical psychologist license;
    b. Doctoral degree in clinical or counseling, psychology or other applicable field of study.
    c. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the

Network and will not be subject to the above education criteria.

5. Clinical Neuropsychologist:
    a. Must meet all the criteria for a clinical psychologist listed in Section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN);
    b. A practitioner credentialed by the National Register of Health Service Providers (National Register) in psychology with an area of expertise in neuropsychology may be considered; and
    c. Clinical neuropsychologists who are not board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
        i. Transcript of applicable pre-doctoral training;
        ii. Documentation of applicable formal one year post-doctoral training (participation in CEU training alone would not be considered adequate);
        iii. Letters from supervisors in clinical neuropsychology (including number of hours per week); or
        iv. Minimum of five years' experience practicing neuropsychology at least ten hours per week.

6. Licensed Psychoanalysts:
    a. Applies only to practitioners in states that license psychoanalysts.
    b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Anthem Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).
    c. Practitioner must possess a valid psychoanalysis state license.
        (a) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
        (b) Meet examination requirements for licensure as determined by the licensing state.

Additional Participation Criteria and Exceptions for Nurse Practitioners, Certified Nurse Midwives, Physicians Assistants (Non-Physician) Credentialing.

1. Process, requirements and Verification – Nurse Practitioners:
    a. The nurse practitioner (NP) applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a registered nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force

adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.
e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
    i. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association;
    ii. American Academy of Nurse Practitioners – Certification Program;
    iii. National Certification Corporation;
    iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner) ;
    v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY; or
    vi. American Association of Critical Care Nurses Acute Care Nurse Practitioner Certification (ACNPC); ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Anthem is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

f. If the NP has hospital privileges, he or she must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the nurse practitioner will be obtained. Any adverse action against any hospital privileges will trigger a Level II review.
g. The NP applicant will undergo the standard credentialing processes outlined in Anthem's Credentialing Policies. NPs are subject to all the requirements outlined in the Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
h. Upon completion of the credentialing process, the NP may be listed in Anthem's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
i. NPs will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

2. Process, Requirements and Verifications – Certified Nurse Midwives:
    a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.
    b. The required educational/training will be at a minimum that required for licensure as a registered nurse with subsequent additional training for licensure as a Certified

Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.

c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are current adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
e. All CNM applicants will be certified by either:
    i. The National Certification Corporation for Ob/Gyn and neonatal nursing; or
    ii. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

This certification must be active and primary source verified. If the state licensing board primary source verifies one) of these certifications as a requirement for licensure, additional verification by Anthem is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic CC.

h. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. In the event the CNM provides only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
i. The CNM applicant will undergo the standard credentialing process outlined in Anthem's Credentialing Policies. CNMs are subject to all the requirements of the Credentialing Policies including (but not limited to): the requirement for CC review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the Network.
j. Upon completion of the credentialing process, the CNM may be listed in Anthem's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
k. CNMs will be clearly identified:
    i. On the credentialing file;
    ii. At presentation to the CC; and
    iii. Upon notification to network services and to the provider database.

3. Process, Requirements and Verifications – Physician's Assistants (PA):
    a. The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.
    b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
    c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
    d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
    e. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Anthem is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy #8, as adopted or amended by each Anthem Health Plan and submitted for individual review by the CC.
    f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
    g. The PA applicant will undergo the standard credentialing process outlined in Anthem's Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
    h. Upon completion of the credentialing process, the PA may be listed in Anthem provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
    i. PA's will be clearly identified:
        i. On the credentialing file;
        ii. At presentation to the CC; and
        iii. Upon notification to network services and to the provider database.

Currently Participating Applicants (Re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date 180 calendar days of the date of submission to the CC for a vote;
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a practitioner participates in Anthem's Plan programs or provider Networks, federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Anthem's other credentialed provider Networks.
4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
5. No new history of licensing board reprimand since prior credentialing review;
6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
7. Current DEA/CDS registration and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;
8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; or for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;
9. No new (since previous credentialing review) history of or current use of illegal drugs or alcohol use disorder;
10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
12. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    b. Voluntary surrender of state license related to relocation or nonuse of said license;
    c. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    d. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    e. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five year post residency training window;
    f. Actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;

g. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

15. No quality improvement data or other performance data including complaints above the set threshold.
16. Re-credentialed at least every three years to assess the practitioner's continued compliance with Anthem standards.

*It is expected that these findings will be discovered for currently credentialed network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for re-credentialing.

B. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Anthem may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member access need only when the CC review indicates compliance with Anthem standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are re-credentialed at least every three years to assess the HDO's continued compliance with Anthem standards.

1. General Criteria for HDOs:
   a. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
   b. Valid and current Medicare certification.
   c. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in Anthem's Plan programs or provider Networks, exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Networks as well as Anthem's other credentialed provider Networks.
   d. Liability insurance acceptable to Anthem.
   e. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Anthem's quality and certification criteria standards have been met.

2. Additional Participation Criteria for HDO by Provider Type:

HDO TYPE AND ANTHEM APPROVED ACCREDITING AGENT(S)

Medical Facilities

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, CTEAM, DNV/NIAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, CTEAM , DNV/NIAHO, TJC
Home Infusion Therapy (HIT)	ACHC, CHAP, CTEAM, HQAA, TJC
Skilled Nursing Facilities/Nursing Homes	CARF, TJC

Behavioral Health

Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, HFAP, TJC

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	CTEAM, DNV/NIAHO, HFAP, TJC
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Abuse	ACHC, CARF, COA, DNV/NIAHO, TJC
Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinics	CARF, CHAP, COA, HFAP, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Abuse	CARF, DNV/NIAHO, HFAP, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Abuse	CARF, COA, DNV/NIAHO, HFAP, TJC

Rehabilitation

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	CTEAM, DNV/NIAHO, HFAP, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Abuse Clinics	CARF, TJC, COA,

Anthem

NQTL SELF COMPLIANCE TOOL

1. Identify the NQTL: ***Formulary Development***

2. Identify the factors considered in the design of the NQTL:

- Food and Drug Administration (FDA) approved prescribing information, especially indications;
- 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
- Effectiveness data, when available
- Safety
- Clinical attributes
    - Clinical Attributes are any characteristic of a drug product that differentiates it from alternative products (e.g., pharmacokinetic parameters, once-daily dosing, oral dosing, tablet size, availability of pediatric dosages and dosage forms, FDA-approved indications).

3. Identify the sources (including any processes, strategies, evidentiary standards) used to define the factors identified above to design the NQTL:

Anthem's pharmacy services are provided by its PBM, IngenioRx. Developing the formulary is a two part process. The clinical work, which is the initial step, is done by the IngenioRx 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 shall be 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 IngenioRx and the health plans under contract with IngenioRx ("Delegating Entities"). All of the P&T voting members are practicing physicians, including one psychiatrist, or pharmacists who are in good standing with IngenioRx or Anthem. In addition, voting members of the P&T are not employees of IngenioRx or Anthem. 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.

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:

Efficacy

Safety

Health outcomes/effectiveness based on delegating entities' population and/or comparable data (if available) or

Clinical attribute(s) relative to comparator products.

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:

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 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 <u>NOT</u> 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.

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.

<u>Tiering</u>

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.

VAC DECISION-MAKING GUIDELINES

Formulary/Non-Formulary Determinations:
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.[1] 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.

[1] *Please note that Tier 1 is considered the lowest Tier (meaning it has the lowest copay or coinsurance associated with it), and, in a 3-Tier formulary, Tier 3 is considered the highest Tier (meaning it has the highest copay or coinsurance associated with it).*

Anthem

Clinical Edits on products will follow similar rules. 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.

Notwithstanding the prior two paragraphs, 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

O R

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.
- Grievance and appeal experience

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:
Approval is by a simple majority vote of the VAC voting members. 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.

4. Is the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical surgical benefits, both as written and in operation?

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

Comparative Analysis
To determine whether the formulary treats behavioral health conditions no less stringently than medical/surgical conditions, Anthem 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)	48.2%	1.3%	29.4%	2.3%	18.8%
Non- Behavioral Health	15.8%	11.0%	46.8%	4.2%	22.%

Anthem also reviewed the number of behavioral health drugs that are subject to step therapy or prior authorization as compared to medical surgical drugs.

	Total NDC Codes	NDC codes reviewed	Prior Auth	Step Therapy	Percent reviewed
Behavioral Health (Mental Health/Substance Use Disorder)	5459	608	375	233	11%
Non- Behavioral Health	48,648	9,445	4,404	5,041	19%

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. IngenioRx utilizes the same process and procedures to determine what mental health/substance abuse treatment drugs are on the formulary as used for drugs to treat medical/surgical conditions. A greater percentage of drugs are in Tier 1 for MH/SUD than for medical/surgical. Additionally, IngenioRx requires a review, whether prior authorization or step therapy, on smaller percentage of MH/SUD drugs than medical/surgical.

Therefore, IngenioRx's process for creating its formulary and administering its formulary is in compliance with MHPAEA.

NQTL SELF COMPLIANCE TOOL (only applicable for Commercial LOB*)**

1. Identify the NQTL: ***Nonparticipating Provider Reimbursement – Georgia***

2. Identify the factors considered in the design of the NQTL:
   - Is there a state mandate that dictates how a service should be reimbursed if the provider is nonparticipating
   - What are participating providers paid for the same service
   - Is the provider a professional provider, facility or an emergency provider
   - Overall cost-of-care to keep premium reasonable

3. Identify the sources (including any processes, strategies, evidentiary standards) used to define the factors identified above to design the NQTL:
   In general, the rates we use to price or pay for services rendered by providers that do not participate in our networks are based on rates that are accepted by providers that do participate in Anthem networks. Anthem's methodology for pricing, except where a state mandate dictates another rating methodology (states that do so typically do so with respect to Emergency (ER and/or ambulance services) or where a nonparticipating provider is providing services in a network facility), is as follows:

   I. Professional Claims

   We apply a fee schedule that applies 85%-100% of the rates contains rates that have been accepted by providers who participate in our networks in that market and have not individually negotiated rates with some exceptions.
   - MH/SUD applies 100% of the rates that have been accepted by providers who participate in our networks.
     - Exception would be the E&M codes because the same fee schedule is utilized for psychiatrists and medical/surgical providers. Therefore, non-network providers that provide MS/SUD services will receive anywhere from 85% -100% of the rate used for participating providers.
   - In New York, payment is based on a percentage of National Medicare or, for large groups (50 or more employees), a methodology chosen by the large group employer as permitted by a State mandate.

   II. Non Hospital Facility Claims

   A. ASC, Dialysis, HHC, Hospice, Mental Health/Substance Abuse Facilities and SNF*

   We apply a rate that is based on 85%-100% of the median rates applicable to our participating providers in that state, subject to limited exceptions.
   - Behavioral Health is based on 100% of the median rates applicable to our participating providers in that state.
   - In New York, pricing is based on the average county rate negotiated with participating providers.

   B. Other Non-Hospital Facility Claims billed on UB04

We apply a percent off of charge methodology that reflects the aggregate participating provider rates for the PPO network, except New York. In New York, pricing is based on the average county rate negotiated with participating providers.

III. Hospital Claims

We apply 15% mark up above the individual hospitals' own reported cost. In New York, pricing is based on the average county rate negotiated with participating providers.

** This non-par facility pricing only applies when services are billed on a UB-04/Facility Claim form.*

IV. States Outside of Anthem's 14 State Footprint. Anthem sells Blue Cross or Blue Cross and Blue Shield plans in California, Nevada, Colorado, Wisconsin, Missouri, Kentucky, Indiana, Ohio, Georgia, Virginia, New York, Connecticut, New Hampshire and Maine. If nonparticipating provider claims are received from states other than those 14, Anthem prices the claim using either the local Blue Cross and/or Blue Shield plan's pricing or our own.

4. Is the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical surgical benefits, both as written and in operation?

As noted above, Anthem's practice is to always pay non-network MH/SUD providers using the rating methodology specified above (E&M codes pay at 85%-100% of network providers, all other CPT codes pay at 100%). For medical/surgical providers, depending on the CPT code, they may be paid anywhere from 85-100% of that rate. For E&M codes that are in common between MH/SUD providers and medical/surgical providers, the comparative analysis below shows we pay the same amount to both types of providers.

Comparative Analysis

GAP5 334A									
GEORGIA - Atlanta	99202	99203	99204	99205	99211	99212	99213	99214	99215
Family Prac	$80.33	$114.21	$175.75	$222.51	$22.04	$44.02	$73.30	$106.66	$143.66
Psych	$80.33	$114.21	$175.75	$222.51	$22.04	$44.02	$73.30	$106.66	$143.66
GAP5 335A									
GEORGIA - outside Atlanta	99202	99203	99204	99205	99211	99212	99213	99214	99215
Family Prac	$85.23	$120.67	$184.42	$233.04	$23.89	$47.06	$77.57	$112.51	$151.12
Psych	$85.23	$120.67	$184.42	$233.04	$23.89	$47.06	$77.57	$112.51	$151.12

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. Anthem always reimburses non-network providers that provide MH/SUD benefits at 100% of the rate used for participating providers. Exception would be for E&M codes where non-network providers that provide MH/SUD services will receive anywhere from 85% -100% of the rate used for participating providers, just like medical/surgical services. Non-network providers

that provide medical/surgical services will receive anywhere from 85% -100% of the rate used for participating providers. Thus, Anthem's methodology is equal to or more generous to MH/SUD providers, depending on the services being billed.

NQTL SELF COMPLIANCE TOOL

PRIOR AUTHORIZATION

Overview

Anthem'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. This analysis explains when Anthem performs a prior authorization review and how Anthem's processes, strategies, evidentiary standards and other factors for prior authorization review comply with theNQTL requirements under MHPAEA. If a self-funded group utilizes Anthem's standard prior authorization list, this NQTL applies to that groupplan as well, although the plan language may differ.

The Prior Authorization NQTL applies to medical/surgical and mental health/substance use disorder in the inpatient (in-network/out of network) and outpatient (in-network/out of network) benefit classifications. The specific services requiring prior authorization are identified in Exhibit 2.

1. Definitions:

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.

2. Identify the factors considered in the design of the NQTL:

   a. Does Anthem have a medical policy for the service?
      i. If it does, then prior authorization is required unless the service is investigational for all conditions.
      ii. If it does not, but the service is one for which MCG maintains a policy and the outpatient service is one that could be high cost due to length of stay/course of treatment or the cost of the service, Anthem may elect to add it to the prior auth list in order to minimize member/provider abrasion due to retrospective denials.

   b. Has the state adopted a clinical UM guideline established by Anthem? If yes, then the service requires prior authorization unless the service is investigational for all conditions.
      i. A decision to adopt a clinical UM guideline is based on one or more of these factors, none of which weigh higher than any other:
         1. Appropriateness of care
            a. Is the service medically necessary?
            b. Is the service being provided at the most clinically appropriate level of care for the member's condition (e.g., can the surgery be done at an ASC instead of on an outpatient hospital basis)?
         2. Member safety
            a. Procedures involving anesthesia, especially surgery

b. Other procedures based on approving Medical Director's medical judgement, such as a newer treatment where it might not have a long history of safety or where the service is always not medically necessary or investigational.

3. Member or provider impact/abrasion in the professional judgement of the Medical Director
    a. Examples include:
        i. Service that may be excluded from coverage in many plans (e.g., bariatric surgery)
        ii. Instances where retrospective review would cause abrasion, particularly for services involving a course of multiple visits
4. High Cost Services. High cost may look at overall anticipated length of stay or the cost of the actual service/inpatient stay. For outpatient services only, a Return on Investment ("ROI") of 3-1 for the services for the clinical UM guideline is necessary, absent other factors listed in this section

c. Inpatient preauthorization only
    i. Competitor policies
    ii. Member convenience – is the member's inpatient stay medically necessary or is it for the member's convenience
    iii. Likelihood of high cost services
        1. High Cost Services. High cost may look at overall anticipated length of stay or the cost of the actual service/inpatient stay
d. Services that AIM Specialty Health, an Anthem affiliate, reviews for Anthem and other third party plans.
e. State laws, regulations or other requirements[1]

If Anthem has a medical policy or has adopted an Anthem clinical UM guideline for a service, then the service will require prior authorization except where the service is considered investigational for all conditions.

3. Identify the sources (including any processes, strategies, evidentiary standards) used to define the factors identified above to design the NQTL:

Sources:
Anthem's medical policy, clinical UM guidelines, or third-party guidelines
State or federal law
Plan provisions (The plan language that applies to Anthem's fully insured policies is attached as Exhibit 1.)
For Return on Investment Analysis or determining high cost in general, Anthem's claim history

[1] For example, federal law prohibits requiring prior authorization of emergency services.

General Overview: Anthem 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). Anthem also has an Administrative Medical Policy, ADMIN.00006, that provides a framework for review of services for medical necessity determinations in certain circumstances where Anthem 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 Anthem 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 Anthem doesn't require prior authorization. Anthem 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.

Inpatient Preauthorization: Anthem requires that all inpatient stays be preauthorized, whether for medical/surgical services or mental health/substance abuse services. Anthem takes into consideration the significant member and provider abrasion that would occur if services were reviewed on a retrospective basis, since the member may be financially responsible for the inpatient stay and neither the member nor the provider would know that until after the services were performed. Other plans andinsurers also perform preauthorization for inpatient stays, so Anthem's requirement is in line with industry practices and expectations of employers who want to ensure that health plan costs are appropriately managed.

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 Anthem's standard prior authorization list could be done in an inpatient or outpatient facility setting.

Outpatient Preauthorization:

Anthem 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 preauthorization list begins with a Cost of Care (CoC) Inquiry received from a source such as:

a. Post Medical Policy & Technology Assessment (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

The following factors and process are applied to determine if prior authorization is appropriate or whether an existing prior authorization should be removed.

1. Data Analysis is performed using data models established by the Finance team using the same methodology across all lines of business (LOB), including the cost of prior authorization. (Data models are based on 12 months of data with a 3 month claim lag.) Reports may be requested from the appropriate Finance team within each LOB being evaluated.

    a. Determine if clinical criteria or medical policy (Anthem, Medicare National Coverage Determination (NCD) Medicare Local Coverage Determination (LCD), AIM, State criteria) is present;
    b. Determine if Current Procedural Terminology (CPT) and/or /Healthcare Common Procedure Coding System (HCPCS) codes are currently on a post service (relational) edit;
    c. Determine if CPT/HCPCS codes are considered Not Otherwise Classified (NOC) or Add On codes.

3. A Business Analyst determines if the savings meets the established Anthem methodology for ROI (CoC ROI or administrative). Ensures full code set is reviewed to evaluate services to be added or removed from requiring prior authorization.
    a. Clinical criteria or medical policy must be present to add authorization:
        i. Criteria created when a new treatment appears on the scene. Judgment made on known or potential risk for harm to the member.
        ii. Criteria created when treatment is used all of the time in the standard of care and there is a potential for overutilization, fraud, waste and abuse.
    b. Items considered before adding services to require prior authorization (no one factor weighs more heavily than another):
        i. Member impact,
        ii. Provider Abrasion,
        iii. High cost,
        iv. Opportunity for a sentinal impact to improve quality and value of care.

4. Business Analyst prepares summary and recommendation to present to the Clinical Criteria Review team (CCRT) to be vetted in preparation for submission for approval.
5. CCRT reviews recommendations and agrees to either send for review and approval or may recommend modifications based on other data points (i.e., relational edits, over utilization, PSCCR or sentinel effect).
6. When CCRT determines this is not a viable project, the process will be terminated and the requestor will be notified of the outcome.
7. Business Analyst submits formal request for approval by the State's Medical Director or designee via the Transformation Office and notifies requestor.
8. Once the initiative is approved, the Anthem UM Rule team will assign an Initiative Owner (I.O.) and begin the formal implementation project.

Anthem will also perform preauthorization for services not on the prior authorization list when such a review is requested by the provider.

Prior Authorization Penalty

Anthem'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, Anthem is more generous to network MH/SUDproviders 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 Anthem 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.

4. Is the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical surgical benefits, both as written and in operation?

Anthem applies the same processes, strategies, evidentiary standards and other factors for determining whether a service should be added or removed from the prior authorization list for both MH/SUD and medical surgical benefits. Exhibit 2 reflects the standard services that require prior authorization as of June 27, 2022 and is displayed on www.anthem.com for providers. For outpatient services, the specific CPT code and associated medical policy/clinical UM guideline is also reflected on Exhibit 2. Exhibit 3 is a listing of the clinical UM guidelines adopted by Anthem and in effect as of July 1, 2021. Exhibit 4 illustrates the ROI for the associated policy based on claims data from Q1 2021 – Q4 2021 (report run on June 28, 2022 by Business Info Consultant Sr). Anthem standard prior authorization list is reviewed at least semi-annually. The data showing the number of prior authorization reviews by line of business (fully insured or ASO, as applicable) conducted in 2021 is attached as Exhibit 5. As demonstrated by these Exhibits, Anthem does not apply these processes, strategies, evidentiary standards and other factors more stringently to MH/SUD benefits.

More specifically with respect to MH/SUD services:

a. 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.
b. For outpatient services:
    a. Partial hospitalization (PHP) and intensive outpatient (IOP) services, which are generally outpatient facility services, are included because although Anthem does not have its own medical policy or clinical UM guideline for the services, it relies on the MCG policies to determine the medical necessity/length of stay. PHP and IOP represent at least 30% of Anthem's higher level behavioral health spend (i.e., inpatient, residential treatment and

PHP/IOP). Due to the length of treatment (across Anthem's 14 states, the average length of stay for PHP in 2021 was 17.6 days, IOP in 2021 was 19.6 days) and resulting higher costs (PHP per diem was $544, IOP per diem was $340), prior authorization was determined to be appropriate, particularly considering the member and provider abrasion that would apply if a retrospective review was done and the services determined to not be medically necessary.

b. Transcranial magnetic stimulation (TMS) is on the list because Anthem has created a medical guideline for the service, which applies when the service is prescribed for both medical/surgical and MH/SUD conditions. Adaptive behavioral treatment (e.g., applied behavioral analysis) and intensive home behavioral therapy are on the prior authorization list because there is a clinical UM guideline that Anthem has adopted. Each of these have a ROI higher than 3:1 as indicated on Exhibit 4.

5. Does the group health plan or group or individual market health insurance issuer adhere to the mental health parity requirements regarding this NQTL on MH/SUD benefits?

Yes, Anthem treats MH/SUD services no less favorably than medical/surgical services when determining whether to include such a service on the prior authorization list. The above information demonstrates that the same factors, sources, evidentiary standards, and processes are used to determine the prior authorization requirement for a M/S and MH/SUD service. As demonstrated by the prior authorization list, Anthem requires prior authorization for a significantly higher number of M/S services than MH/SUD. When reviewing the in operation comparative analysis, MH/SUD service prior authorization requests are approved at a greater level than M/S requests. The only exception is for inpatient out of network, where the overall number of MH/SUD requests is very low, and yet the percentage approved is relatively close. Therefore, the analysis confirms parity both in writing and in operation.

EXHIBIT 1

STANDARD FULLY INSURED EOC PROVISION

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigative as those terms are defined in this Contract. Utilization Review aids in the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

Reviewing Where Services Are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to You in a lower level place of care or lower cost setting, will not be Medically Necessary if they are given in a higher level place of care, or higher cost setting. This means that a request for a service may be denied because it is not Medically Necessary for that service to be provided in the place of care or setting that is being requested. When this happens the service can be requested again in another setting or place of care and will be reviewed again for Medical Necessity. At times a different type of Provider or Facility may need to be used in order for the service to be considered Medically Necessary.

Examples include, but are not limited to:

- A service may be denied on an Inpatient basis at a Hospital but may be approved if provided on an Outpatient basis in a Hospital setting.
- A service may be denied on an Outpatient basis in a Hospital setting but may be approved at a free-standing imaging center, infusion center, ambulatory surgical Facility, or in a doctor's office.
- A service may be denied at a Skilled Nursing Facility but may be approved in a home setting.

UtilizationReview criteria will be based on many sources including medical policy and clinical guidelines. We may decidethat a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment is more costeffective, available and appropriate. "Clinically equivalent" means treatments that for most Members, will give You similar results for a disease or condition.

If You have any questions about the Utilization Review process, the medical policies or clinical guidelines, You may call the Member Services phone number on the back of Your Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if We decide Your services are Medically Necessary. For benefits to be covered, on the date You get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under Your Plan;
4. The service cannot be subject to an exclusion under Your Plan;and
5. You must not have exceeded any applicable limits under Your Plan.

Types of Reviews

- **Prior Authorization Review** – 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.
    - **Precertification –** A required Prior Authorization Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for You to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative as those terms are defined in this Contract.

      For admissions following Emergency Care, You, Your authorized representative or doctor must tell Us within 48 hours of the admission or as soon as possible. For labor / childbirth admissions, Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.
- **Continued Stay/Concurrent Review** – A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a Facility or course of treatment.

Both Prior Authorization and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any doctor with knowledge of Your medical condition, without such care or treatment, Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment.

Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service or supply has been provided. 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 typicallyinitiated by Us.

Who is Responsible for Precertification

Typically, Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending doctor (“requesting Provider”) will get in touch with Us to ask for a Precertification. However, You may request a Precertification, or You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsible Party	Comments
Network	Provider	The Provider must get Precertification when required.

Non-Network	Member	Member has no benefit coverage for a Non- Network Provider unless: • The Member gets approval to use a Non-Network Provider before the service is given; or • The Member requires an Emergency Care admission (See note below). Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not to be Medically Necessary.
BlueCard® Provider	Member **(Except for Inpatient admissions)**	• Member must get Precertification when required (call Member Services). • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not tobe Medically Necessary.
Note: Precertification is not required to receive Emergency Care. For Emergency Care admissions, You, Your authorized representative or doctor must tell Us within 48 hours of the admission or as soon as possible.		

How Decisions are Made

We will use Our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make Our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section "Prescription Drugs Administered by a Medical Provider". Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning Your request. To ask for this information, call the Precertification phone number on the back of Your Identification Card.

If You are not satisfied with Our decision under this section of Your benefits, please refer to the "If You Have a Complaint or an Appeal" section to see what rights may be available to You.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on State and federal laws. Where State laws are stricter than federal laws, We will follow State laws. If You live in and/or get services in a State other than the State where Your Contract was issued, other State-specific requirements may apply. You may call the phone number on the back of Your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision	Timeframe Requirement for Notification
Precertification Requests		
Prior Authorization Review Urgent	36 hours from the receipt of request, including one business day If the Member receives an Emergency service that requires immediate post evaluation or post stabilization services, We will provide an authorization decision within 60 minutes of receiving the request; if the authorization decision is not made within 60 minutes, such services shall be deemed approved.	For approval determination, We will notify the Provider by telephone or electronically within 24 hours of the decision and notify the Member or Member representative and Provider by written orelectronic means within two business days of the decision. For Adverse Determination, We will notify the Provider by telephone or electronically within 24 hours of the decision and notify the Member or Member representative and Provider by written or electronic means within one business day of the decision.
Prior Authorization Review Non-Urgent	36 hours from the receipt of the request, including one business day	
Urgent Continued Stay/Concurrent Review when no previous days authorized	One business day from the receipt of all necessary information	For approval determination, We will notify the Provider by telephone or electronically within one business day of the decision and notify the Member or Member representative and Provider by written or electronic means within one business day of the telephonic or electronic notification. For Adverse Determination, We will notify the Provider by telephone or electronically within 24 hours of the decision and notify the Member or Member representative and Provider by written or electronic means within one business day of the telephonic or

Urgent Continued Stay/Concurrent Review when request is received more than 24 hours before the end of the previous authorization	One business day from the receipt of all necessary information	electronic notification. The service will continue without Member liability until the Member has been notified of the determination.
Urgent Continued Stay/Concurrent Review when request is received less than 24 hours before the end of the previous authorization	One business day from the receipt of all necessary information	
Concurrent / Continued Stay Review Non-Urgent	One business day from the receipt of all necessary information	
Post-service Review	30 business days from the receipt of the request	We will notify the Member by written means of the determination within 10 business days of the determination.

If more information is needed to make Our decision, We will tell the requesting Provider of the specific information needed to finish the review. If We do not get the specific information We need by the required timeframe, We will make a decision based upon the information We have.

We will notify You and Your Provider of Our decision as required by State and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

EXHIBIT 5
PRIOR AUTHORIZATION
GEORGIA – SELF FUNDED GROUP (ASO) –LOCAL COMMERCIAL

Inpatient, In-Network

Line of Business	Approved	Denied	Percentage Approved
Group M/S	5887	716	89%
Group MH/SUD	143	4	97%

Inpatient, Out-of-Network

Line of Business	Approved	Denied	Percentage Approved
Group M/S	337	76	81%
Group MH/SUD	27	3	90%

Outpatient, In-Network

Line of Business	Approved	Denied	Percentage Approved
Group M/S	433,371	7,918	98%
Group MH/SUD	3492	40	99%

Outpatient, Out-of-Network

Line of Business	Approved	Denied	Percentage Approved
Group M/S	26,900	1459	95%
Group MH/SUD	688	50	93%

Note: Data is for self-funded plans whose plans are headquartered in Georgia without regard to where the members of the plan reside (e.g., group is headquartered in GA but members may live in-or-outside of Georgia). Data includes requests for precertification as well (i.e., services that are not on the prior authorization list). It also includes requests to see an out-of-network provider.

Report run in the month of March 2022 by Business Info Developer Cons Sr. for requests received between January 1, 2021 and December 31, 2021.

Anthem

NQTL SELF COMPLIANCE TOOL

1. Identify the NQTL: Participating Provider Fee Schedule Rates (Georgia)

   Overview: This nonquantitative treatment limitation analysis focuses on how Anthem decides the amount to pay network providers for the services they provide to our members.

2. Identify the factors considered in the design of the NQTL:

   - Product (e.g., PPO, HMO, indemnity, etc.)
   - Provider location – Atlanta and non-Atlanta
   - Provider setting - office or facility
   - State statute or regulation that dictates how we pay a provider (e.g., telehealth, etc.)
   - Competitiveness of our rates (e.g., are providers of a particular type willing to contract with us at the standard rate; feedback from providers that our rates are too low/high, etc.)
   - The CPT/HCPCS Code being billed
   - Medicare reimbursement
   - Education and licensure level of provider
   - 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 (i.e., PCP, PT/OT/ST, Podiatrist)
   - 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 relativity to surrounding CPT codes.

   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

   Anthem does not assign more weight to any one of the factors in either areas identified above.

3. Identify the sources (including any processes, strategies, evidentiary standards) used to define the factors identified above to design the NQTL:

   Sources:

   Centers for Medicare & Medicaid Services Fee Schedules
   Applicable State Statutes, Regulations or Guidance
   Provider feedback and willingness to contract
   CPT and HCPCS Codes

   Process:

   GA has separate base fee schedules:

- PPO
- Facility urban, PPO non-facility urban, PPO facility rural, PPO non-facility rural
- HMO Facility urban, HMO non-facility urban, HMO facility rural, HMO non-facility rural
- Traditional Facility urban, Traditional non-facility urban, Traditional facility rural, Traditional non-facility rural
- PCP Facility urban, PCP non-facility urban, PCP facility rural, PCP non-facility rural
- PT/OT/ST Facility urban, PT/OT/ST non-facility urban, PT/OT/ST facility rural, PT/OT/ST non-facility rural
- Chiropractic Facility urban, Chiropractic non-facility urban, Chiropractic facility rural, Chiropractic non-facility rural
- Podiatrist Facility urban, Podiatrist non-facility urban, Podiatrist facility rural, Podiatrist non-facility rural
- Statewide BH Fee Schedule

For the PCP, PT/OT/ST, Chiropractic and Podiatrist fee schedules, only certain CPT codes are contained on those schedules. If a provider were to bill a code not on that fee schedule, then the fee schedule for the applicable product type (PPO, HMO, Traditional) would apply. Except where we individually negotiate, (e.g. Hospital group), all other providers are paid solely based on the PPO, HMO or Traditional fee schedules.

Non-MD providers are paid at a percentage of the applicable fee schedule rate, based on their level of education, licensure level and how Medicare or Medicaid pays them, as follows:

Mid-level	Percentage of MD rate
0042 - Nurse Practitioner	85%
0334 - Physician Assistants	85%
0041 - Certified Nurse Midwife	85%
0080 - Psychologist	80%
0004- Social Worker	66%
0356- LMFT	66%
0111- Counselor	66%
0374 - Board Certified Behavior Analyst	66%

Historically a work group meets to review reimbursement rates under the various fee schedules. The work group consists of Director of Network Management, Cost of Care Analyst, Health Economics, and Pricing and Configuration. The team does the initial review of data and makes the recommendation to the RVP of Provider Solutions.

Data used to review rates is the most current twelve months of utilization. Review occurs at the type of service, specialty, and geographic locations.

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.

Future State: Georgia has a new RVP; new strategy/process will be developed for the 2022 update.

4. Is the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical surgical benefits, both as written and in operation?

Yes, we apply the same process uniformly to create the rates based on the CPT/HCPCS Codes being billed. All professional providers with whom we directly contract (i.e., providers who are not part of a hospital system or other large grouping of providers) are offered the same rates, with the exception of midlevel providers.

For the comparative analysis, these were the rates in effect, when the Provider Network Management Director pulled the data on April 26, 2021. The Director of Provider Economics ran second report on May 7, 2021. The list below reflects the reimbursement amounts for the evaluation and management codes comparing family practice MD and a psychiatrist. Overall payment is comparable between family practice MD and a psychiatrist. Some evaluation and management codes are paid higher for psychiatrist and some are paid higher for family practice MD.

Comparative Analysis

Specialty	Code	Description	Office
PSYCHIATRY - MD/DO	99202	Office/outpatient visit new	$76.38
FAMILY PRACTICE	99202	Office/outpatient visit new	$76.13
PSYCHIATRY - MD/DO	99203	Office/outpatient visit new	$113.35
FAMILY PRACTICE	99203	Office/outpatient visit new	$110.02
PSYCHIATRY - MD/DO	99204	Office/outpatient visit new	$159.95
FAMILY PRACTICE	99204	Office/outpatient visit new	$168.49
PSYCHIATRY - MD/DO	99205	Office/outpatient visit new	$202.90
FAMILY PRACTICE	99205	Office/outpatient visit new	$212.41
PSYCHIATRY - MD/DO	99211	Office/outpatient visit est	$25.49
FAMILY PRACTICE	99211	Office/outpatient visit est	$21.55
PSYCHIATRY - MD/DO	99212	Office/outpatient visit est	$44.81
FAMILY PRACTICE	99212	Office/outpatient visit est	$44.29
PSYCHIATRY - MD/DO	99213	Office/outpatient visit est	$62.40
FAMILY PRACTICE	99213	Office/outpatient visit est	$74.14
PSYCHIATRY - MD/DO	99214	Office/outpatient visit est	$97.30
FAMILY PRACTICE	99214	Office/outpatient visit est	$109.59
PSYCHIATRY - MD/DO	99215	Office/outpatient visit est	$140.65
FAMILY PRACTICE	99215	Office/outpatient visit est	$148.17

5. Does the group health plan or group or individual market health insurance issuer adhere to the mental health parity requirements regarding this NQTL on MH/SUD benefits?

Yes. 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. Anthem 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[.]" 2019 FAQs, 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.

Anthem'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 Anthem's members and unnecessarily increase the cost of care. Anthem uses a comparable process for setting reimbursement rates for medical/surgical and MH/SUD services.

EXHIBIT 2
RETROSPECTIVE REVIEW
GEORGIA – SELF FUNDED GROUP (ASO)–LOCAL COMMERCIAL

Inpatient, In-Network

Line of Business	Approved	Denied	Percentage Approved
Group M/S	2036	344	85%
Group MH/SUD	201	6	97%

Inpatient, Out-of-Network

Line of Business	Approved	Denied	Percentage Approved
Group M/S	586	120	83%
Group MH/SUD	19	4	83%

Outpatient, In-Network

Line of Business	Approved	Denied	Percentage Approved
Group M/S	8208	45	99%
Group MH/SUD	56	1	98%

Outpatient, Out-of-Network

Line of Business	Approved	Denied	Percentage Approved
Group M/S	1224	81	94%
Group MH/SUD	11	0	100%

Note: Data is for self-funded plans whose plans are headquartered in Georgia without regard to where the members of the plan reside (e.g., group is headquartered in Georgia but members may live in-or-outside of Georgia). Data includes requests for precertification as well (i.e., services that are not on the prior authorization list). It also includes requests to see an out-of-network provider.

Report run in the month of March 2022 by Business Info Developer Cons Sr. for requests received between January 1, 2021 and December 31, 2021.

NQTL SELF COMPLIANCE TOOL
POST SERVICE REVIEWS
ASO LOCAL

Overview

Anthem'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. This analysis explains when Anthem performs a post-service review and how Anthem's processes, strategies, evidentiary standards and other factors for post-service reviews comply with the NQTL requirements under MHPAEA.

1. Definitions:

- **Post-service Review** – 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 Anthem. 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.

2. Identify the factors considered in the design of the NQTL:

   a. Does Anthem have a medical policy or clinical utilization management (UM) guideline or third-party guideline?
   b. Appropriateness of care
      i. Is the service medically necessary?
      ii. If the member's benefits booklet limits services to the most clinically appropriate level of care, is the service being provided at the most clinically appropriate level of care for the member's condition (e.g., can the surgery be done at an ASC instead of on an outpatient hospital basis)?
   c. Was a prior authorization required?

   Anthem 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. Identify the sources (including any processes, strategies, evidentiary standards) used to define the factors identified above to design the NQTL:

Sources:
Anthem's medical policy, clinical UM guidelines, or third-party guidelines
Network provider contract language
Plan provisions (The plan language that describes retrospective review in Anthem's fully insured policies is attached as Exhibit 1.)

Anthem Utilization Management, Inc. ("AUMSI") is the Anthem affiliate that is licensed, where required, to perform utilization management reviews of medical/surgical and behavioral health services.

AUMSI, on behalf of Anthem, conducts a post-service review only for services for which Anthem has a medical policy or clinical guideline. If a service is listed on Anthem's prior authorization list, but prior authorization is not obtained, Anthem would conduct a post-service review unless the provider's contract specifies that the provider must hold Anthem and the member harmless for the claim due to failing to submit a prior authorization request. If a service IS NOT listed on Anthem's prior auth list but Anthem has clinical criteria of medical policy or clinical guidelines, Anthem will conduct a post service review.

4. Is the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical surgical benefits, both as written and in operation?

Anthem applies the same processes, strategies, evidentiary standards and other factors for post-service medical necessity reviews for both MH/SUD and medical surgical benefits. Anthem does not apply these processes, strategies, evidentiary standards and other factors more stringently to MH/SUD benefits. The data showing the number of post-service reviews conducted in 2020 is attached as Exhibit 2. Because Anthem 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 Anthem'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. Anthem does not maintain a medical policy/clinical UM guideline for those services so no utilization management review would be performed.

EXHIBIT 1
STANDARD FULLY INSURED EOC PROVISION

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigative as those terms are defined in this Contract. Utilization Review aids in the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

Reviewing Where Services Are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to You in a lower level place of care or lower cost setting, will not be Medically Necessary if they are given in a higher level place of care, or higher cost setting. This means that a request for a service may be denied because it is not Medically Necessary for that service to be provided in the place of care or setting that is being requested. When this happens the service can be requested again in another setting or place of care and will be reviewed again for Medical Necessity. At times a different type of Provider or Facility may need to be used in order for the service to be considered Medically Necessary.

Examples include, but are not limited to:

- A service may be denied on an Inpatient basis at a Hospital but may be approved if provided on an Outpatient basis in a Hospital setting.
- A service may be denied on an Outpatient basis in a Hospital setting but may be approved at a free-standing imaging center, infusion center, ambulatory surgical Facility, or in a doctor's office.
- A service may be denied at a Skilled Nursing Facility but may be approved in a home setting.

Certain services must be reviewed to determine Medical Necessity in order for You to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. We may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment is more cost effective, available and appropriate. "Clinically equivalent" means treatments that for most Members, will give You similar results for a disease or condition.

If You have any questions about the Utilization Review process, the medical policies or clinical guidelines, You may call the Member Services phone number on the back of Your Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if We decide Your services are Medically Necessary. For benefits to be covered, on the date You get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under Your Plan;
4. The service cannot be subject to an exclusion under Your Plan;and

5. You must not have exceeded any applicable limits under Your Plan.

Types of Reviews

- **Prior Authorization Review** – 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.
    - **Precertification –** A required Prior Authorization Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for You to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative as those terms are defined in this Contract.

      For admissions following Emergency Care, You, Your authorized representative or doctor must tell Us within 48 hours of the admission or as soon as possible. For labor / childbirth admissions, Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.
- **Continued Stay/Concurrent Review** – A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a Facility or course of treatment.

Both Prior Authorization and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any doctor with knowledge of Your medical condition, without such care or treatment, Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment.

Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service or supply has been provided. 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.

Who is Responsible for Precertification

Typically, Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending doctor (“requesting Provider”) will get in touch with Us to ask for a Precertification. However, You may request a Precertification, or You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsible Party	Comments
Network	Provider	The Provider must get Precertification when required.
Non-Network	Member	Member has no benefit coverage for a Non- Network Provider unless: • The Member gets approval to use a Non-Network Provider before the service is given; or • The Member requires an Emergency Care admission (See note below). Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not to be Medically Necessary.
BlueCard® Provider	Member **(Except for Inpatient admissions)**	• Member must get Precertification when required (call Member Services). • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not to be Medically Necessary.
Note: Precertification is not required to receive Emergency Care. For Emergency Care admissions, You, Your authorized representative or doctor must tell Us within 48 hours of the admission or as soon as possible.		

How Decisions are Made

We will use Our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make Our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section "Prescription Drugs Administered by a Medical Provider". Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning Your request. To ask for this information, call the Precertification phone number on the back of Your Identification Card.

If You are not satisfied with Our decision under this section of Your benefits, please refer to the "If You Have a Complaint or an Appeal" section to see what rights may be available to You.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on State and federal laws. Where State laws are stricter than federal laws, We will follow State laws. If You live in and/or get services in a State other than the State where Your Contract was issued, other State-specific requirements may apply. You may call the phone number on the back of Your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision	Timeframe Requirement for Notification
Precertification Requests		
Prior Authorization Review Urgent	36 hours from the receipt of request, including one business day If the Member receives an Emergency service that requires immediate post evaluation or post stabilization services, We will provide an authorization decision within 60 minutes of receiving the request; if the authorization decision is not made within 60 minutes, such services shall be deemed approved.	For approval determination, We will notify the Provider by telephone or electronically within 24 hours of the decision and notify the Member or Member representative and Provider by written or electronic means within two business days of the decision. For Adverse Determination, We will notify the Provider by telephone or electronically within 24 hours of the decision and notify the Member or Member representative and Provider by written or electronic means within one business day of the decision.
Prior Authorization Review Non-Urgent	36 hours from the receipt of the request, including one business day	

Urgent Continued Stay/Concurrent Review when no previous days authorized	One business day from the receipt of all necessary information	For approval determination, We will notify the Provider by telephone or electronically within one business day of the decision and notify the Member or Member representative and Provider by written or electronic means within one business day of the telephonic or electronic notification. For Adverse Determination, We will notify the Provider by telephone or electronically within 24 hours of the decision and notify the Member or Member representative and Provider by written or electronic means within one business day of the telephonic or electronic notification. The service will continue without Member liability until the Member has been notified of the determination.
Urgent Continued Stay/Concurrent Review when request is received more than 24 hours before the end of the previous authorization	One business day from the receipt of all necessary information	
Urgent Continued Stay/Concurrent Review when request is received less than 24 hours before the end of the previous authorization	One business day from the receipt of all necessary information	
Concurrent / Continued Stay Review Non-Urgent	One business day from the receipt of all necessary information	
Post-service Review	30 business days from the receipt of the request	We will notify the Member by written means of the determination within 10 business days of the determination.

If more information is needed to make Our decision, We will tell the requesting Provider of the specific information needed to finish the review. If We do not get the specific information We need by the required timeframe, We will make a decision based upon the information We have.
We will notify You and Your Provider of Our decision as required by State and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

If We authorize medical services, We will not subsequently retract Our authorization after the services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless: Such authorization is based on a material misrepresentation or omission about the Member's health condition or the cause of the health condition; or more than 45 working days have passed since Our authorization and the services have not been provided; or the Member's coverage terminates before the services are provided.

NQTL SELF COMPLIANCE TOOL
UTILIZATION MANAGEMENT REVIEW PROCESS

Overview

Anthem'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. This analysis explains the utilization review process itself and how Anthem's processes, strategies, evidentiary standards and other factors comply with the NQTL requirements in MHPAEA.

1. Identify the factors considered in the design of the NQTL:

    a. Compliance with state laws governing utilization review. Such laws may vary based on (1) the state licensure requirements of the utilization review entity; (2) whether the member resides in the state; or (3) whether the policy is sold in the state.
    b. Compliance with federal laws governing utilization review (e.g., the Employee Retirement Security Act of 1976 or the Public Health Services Act)
    c. Compliance with NCQA accreditation requirements.

2. Identify the sources (including any processes, strategies, evidentiary standards) used to define the factors identified above to design the NQTL:

Anthem Utilization Management, Inc. ("AUMSI") is the Anthem subsidiary that is licensed, where required to perform utilization management reviews of medical/surgical and behavioral health services.

The plan language that applies to our fully insured policies is attached as Exhibit 1.

Sources:

a. State laws
b. Federal laws
c. NCQA Accreditation requirements governing utilization review
d. Anthem's medical policies, clinical UM guidelines or third-party guidelines (collectively "utilization management criteria")

Utilization Review Process:

AUMSI performs utilization review, whether it is for a medical/surgical condition or a behavioral health condition, as follows:

UTILIZATION REVIEW PROCESS PRE-REVIEW SCREENING: Non-clinical administrative staff gather information and conduct pre-review screening under the supervision of appropriately licensed health care professionals when there are explicit utilization management criteria and no clinical judgment is required.

INITIAL CLINICAL REVIEW PROCESS:

Staff will complete the following steps when performing utilization review:
1. Assess the provided clinical information;
2. As needed, request additional information; and
3. Review the case against approved clinical criteria.

PEER CLINICAL REVIEW PROCESS

Peer clinical reviewers possess an active license or administrative license relevant to their assigned review functions. Appropriate peer clinical reviewers review all medical necessity adverse determinations for requested health care, behavioral health, and pharmaceutical services. Peer clinical review is not required for requests for services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.

UTILIZATION REVIEW TIME FRAMES

All utilization review determination time frames are based on applicable law or, if more strict accreditation requirements, and will include verbal (direct dialog or voice mail), and/or electronic or written notification as applicable. The time period for making a determination begins on the date of receipt.

A. NON-URGENT CARE PROSPECTIVE REVIEW:

If AUMSI receives all the information needed to review the request, AUMSI will make a determination within a reasonable period of time appropriate to the medical situation but not later than fifteen (15) calendar days after receipt of the request.

EXTENSION OF DECISION TIME FRAME: If an extension is necessary because AUMSI did not receive the information necessary to make a determination, the notice of extension will specifically describe the required information. AUMSI will suspend the time period for making a determination from the date on which AUMSI sent the notice of the extension until the date the covered person responds to the request for additional information or the expiration of the applicable timeframe.

The covered person will have forty-five (45) calendar days from receipt of the notice to provide the specified information. AUMSI will make a determination: 1. Within fifteen (15) calendar days of receipt of the requested information; or 2. Within fifteen (15) calendar days of the expiration of the forty-five (45) calendar day time period if AUMSI does not receive the requested information.

EXTENSION FOR OTHER REASONS: If AUMSI determines that an extension is necessary due to matters beyond its control (e.g., waiting for an evaluation by a specialist), AUMSI may extend this period one time for up to fifteen (15) calendar days, provided that AUMSI determines that such an extension is necessary due to matters beyond its control and AUMSI notifies the covered person prior to the expiration of the initial fifteen (15) calendar day period of the circumstances requiring the extension of time and the date by which AUMSI expects to render a determination.

B. NON-URGENT CARE CONCURRENT REVIEW

If AUMSI receives all the information needed to review the request, AUMSI will make a determination within a reasonable period of time appropriate to the situation, but not later than fifteen (15) calendar days after receipt of the request.

EXTENSION OF DECISION TIME FRAME: If an extension is necessary because AUMSI did not receive the information necessary to make a determination, the notice of extension will specifically describe the required information. AUMSI will suspend the time period for making a determination from the date on which AUMSI sent the notice of the extension until the date the covered person responds to the request for additional information or the expiration of the applicable timeframe.

The covered person will have forty-five (45) calendar days from receipt of the notice to provide the specified information. AUMSI will make a determination: 1. Within fifteen (15) calendar days of receipt of the requested information; or 2. Within fifteen (15) calendar days of the expiration of the forty-five (45) calendar day time period if AUMSI do not receive the requested information. If AUMSI issues a favorable determination for an ongoing course of treatment provided over a period of time or number of treatments, any reduction or termination before the end of such period or number of treatments will constitute an adverse determination. If AUMSI reduces or terminates a favorable determination for an ongoing course of treatment, AUMSI will notify the covered person sufficiently in advance of such reduction or termination to allow the covered person to appeal and obtain a determination on review of that adverse determination before AUMSI reduce or terminate care.

EXTENSION FOR OTHER REASONS: AUMSI may extend this period one (1) time for up to fifteen (15) calendar days and AUMSI notify the covered person prior to the expiration of the initial fifteen (15) calendar day period of the circumstances requiring the extension of time and the date which AUMSI expect to render a determination.

C. RETROSPECTIVE REVIEW

If AUMSI receives all the information needed to review the request, AUMSI will make a determination within a reasonable period of time but not later than thirty (30) calendar days after receipt of the request.

EXTENSION OF DECISION TIME FRAME: If an extension is necessary because AUMSI did not receive the information necessary to make a determination, the notice of extension will specifically describe the required information. AUMSI will suspend the time period for making a determination from the date on which AUMSI sent the notice of the extension until the date the covered person responds to the request for additional information or the expiration of the applicable timeframe. The covered person will have forty-five (45) calendar days from receipt of the notice to provide the specified information. AUMSI will make a determination: 1. Within fifteen (15) calendar days of receipt of the requested information; or 2. Within fifteen (15) calendar days of the expiration of the forty-five (45) calendar day time period if AUMSI do not receive the requested information.

EXTENSION FOR OTHER REASONS: If AUMSI determines that such an extension is necessary due to matters beyond our control (e.g., waiting for an evaluation by a specialist), AUMSI may extend this

period one (1) time for up to fifteen (15) calendar days, provided that AUMSI determines that such an extension is necessary due to matters beyond our control and AUMSI will notify the covered person prior to the expiration of the initial thirty (30) calendar day period of the circumstances requiring the extension of time and the date which AUMSI expects to render a determination.

D. URGENT CARE PROSPECTIVE REVIEW

If AUMSI receives all the information needed to review the request, AUMSI will make a determination as soon as possible, taking into account the situation but not later than seventy-two (72) hours after receipt of the request. AUMSI may give verbal notification of an adverse determination, provided that written or electronic notification is provided to the covered person and practitioner within three (3) calendar days after the verbal notification. AUMSI records the time and date of notification and the staff member who spoke with the practitioner or covered person. Verbal notification must involve communication with a live person, a voicemail is not an acceptable form of oral notification.

If AUMSI did not receive the necessary information AUMSI will notify the covered person as soon as possible but not later than twenty-four (24) hours after receipt of the request. The covered person will have forty-eight (48) hours to give us the specified information. AUMSI will make a determination as soon as possible but in no case later than forty-eight (48) hours after the earliest of: 1. AUMSI's receipt of the specified information; or 2. The end of the forty-eight (48) hour period provided to the covered person.

URGENT CARE CONCURRENT REVIEW PREVIOUSLY ISSUED FAVORABLE DETERMINATION REQUESTS. AUMSI will make a determination within twenty-four (24) hours after receipt of the request, provided that the request is made at least twenty-four (24) hours prior to the expiration of the previously approved period of time or number of treatments. For requests received less than twenty-four (24) hours before the expiration of the previous favorable determination of period of time or number of treatments, AUMSI will make a determination within seventy-two (72) hours of the request.

NOT PREVIOUSLY ISSUED DETERMINATION REQUESTS: Concurrent urgent care review determinations will be made within twenty-four (24) hours of receipt of the request; however the request may be extended up to seventy-two (72) hours if at least one (1) documented attempt was made to obtain the needed clinical information within the initial twenty-four (24) hours of receipt of the request. AUMSI may give verbal notification of an adverse determination provided that written or electronic notification is provided to the covered person and practitioner within three (3) calendar days after the verbal notification. AUMSI records the time and date of notification and the staff member who spoke with the practitioner or covered person. Verbal notification must involve communication with a live person, a voicemail is not an acceptable form of oral notification. AUMSI may inform and send electronic or written notification to the hospital utilization review department of its determination, with the understanding that staff will inform the attending or treating practitioner. Electronic or written notification may be addressed to the hospital utilization review department but must be addressed to the attention of the attending or treating practitioner. Electronic or written notification of an adverse determination may be addressed to the hospital utilization review department but must be addressed to the attention of the attending practitioner or treating practitioner, provided that written notification is sent to all required individuals.

NOTIFICATION OF DECISION:

NOTIFICATION OF FAVORABLE DETERMINATIONS: AUMSI will provide notification for all favorable determinations to the covered person.

NOTIFICATION OF ADVERSE DETERMINATIONS: AUMSI will provide electronic or written notification for all adverse determinations to the covered person and attending practitioner or treating practitioner, as applicable. Electronic or written notification will include the notification requirements listed above, and the following:

1. The specific reason or reasons for the adverse determination in terms specific to the covered person's condition or request and in language that is easy to understand, so the covered person and practitioner know why AUMSI issued an adverse determination and have enough information to file an appeal. The notification includes a complete explanation of the grounds for the adverse determination, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand. AUMSI are not required to spell out abbreviations/acronyms if they are clearly explained in lay language. To illustrate, for the acronym DNA, spelling out would be "a DNA (deoxyribonucleic acid)" whereas explaining would be "a DNA test is a test that looks at your genetic information." Adverse determination notices sent only to practitioners may include technical or clinical terms.

2. Reference to the specific plan provision(s), guideline(s), protocol(s) or similar criterion on which the determination is based. When referencing a specific plan provision(s), AUMSI must direct the covered person to the information using the section title or page number of the benefit document.

3. A description of any additional material or information necessary for the covered person to perfect the request and an explanation of why such material is necessary.

4. A description of the appeal procedures (prospective, retrospective, and expedited), including the right to submit written comments, documents, or other information relevant to the appeal, where to direct the appeal, what information to include with the appeal, and the applicable time limits for filing an appeal and the applicable time frames for appeal determinations including the covered person's right to bring a civil action under ERISA following an adverse determination on review. Notification will also include a statement of the covered person's right to request an expedited internal appeal at the same time as requesting an expedited external appeal.

5. A statement that the covered person may be represented by anyone the covered person chooses, including an attorney. The notification to the practitioner is not required to include the covered person's right to representation if the practitioner is not acting as an authorized representative.

6. If AUMSI relied on an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person, upon request.

7. If the adverse determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the covered person's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

8. Information sufficient to identify the request involved (including the date of service, the practitioner, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

9. The denial code and its corresponding meaning, and any description of the standard, if any, that was used in denying the request.

10. A statement that a covered person is not required to bear costs of the IRO, including any filing fees, unless state law mandates that the covered person pays an IRO filing fee.

a. For organizations that are not subject to ERISA requirements notification to the covered person of an adverse determination for a continued stay review or retrospective review is not required if the covered person is not at financial risk.

11. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist individuals with internal claims and appeals and external appeal procedures and a description of available internal and external appeal procedures, including information regarding how to initiate an appeal, including the right to submit written comments, documents or other information relevant to the appeal.

a. For group and individual health insurance plans & self-funded non-federal government plans in states (AL, AK, FL, GA, PA, & WI) whose external appeal processes do not to meet the requirements to be an National Association of Insurance Commissioners (NAIC)-parallel process or an NAIC-similar process and the Health & Human Services-administered process has been selected, the notification must include the following information:

1. Include information that the covered person can request an external appeal in writing by submitting as follows: (a) electronically at externalappeal.cms.gov, under the "Request a Review Online" heading; (b) faxing to 888-866-6190; or (c) Mailing to: MAXIMUS Federal Services, 3750 Monroe Avenue, Suite 705, Pittsford, NY 14534.

2. Include information that the covered person can call toll free at 888- 866-6205 for any questions or concerns during the external appeal process;

3. Provide the covered person with the opportunity to submit additional written comments to the IRO at the mailing address above and that any additional information submitted will be shared with Us to afford Us the opportunity to reconsider the adverse determination;

4. Provide the covered person with the Notice of Privacy Act Statement; and 5. Inform the covered person that: i. If they believe their case should be expedited, they can select

"expedited" if submitting the review request online, or by emailing FERP@maximus.com, or calling Federal External Review Process at 888-866-6205 ext. 3326. ii. In urgent care situations, requests for expedited review can be initiated by calling the toll free number 1-888-866-6205.

b. For a Multi-State Plan (MSP), the notification must include the following information:

1. Include information that the covered person can request an external appeal in writing by submitting as follows: (a) Via email at mspp@opm.gov; (b) Via fax at (202) 606-0033; or (c) Via mail to: MSP Program External Review National Healthcare Operations U.S. Office of Personnel Management, 1900 E Street, NW, Washington, DC 20415.

2. Include information that the covered person can call toll free at (855) 318-0714 for any questions or concerns during the external review process

3. Provide the covered person with the opportunity to submit additional written comments at the mailing address above and that any additional information submitted will be shared with AUMSI in order to provide it an opportunity to reconsider the adverse determination.

3. Is the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical surgical benefits, both as written and in operation?

AUMSI associates who perform utilization review are required to abide by the same policies and procedures when conducting the review. To evaluate compliance, AUMSI conducts mandatory clinical adherence audits in order to ensure individual associates comply with all applicable utilization management standards and policies. If such an audit reveals a compliance rate below 90%, AUMSI implements a corrective action plan with that associate to address the deficiency. In addition, no less than annually, AUMSI conducts inter-rater reliability testing. This testing evaluates the consistency with which peer clinical reviewers and health professionals involved in the utilization review process apply criteria in decision making. Processes employed to evaluate consistency may include but are not limited to:

1. Using hypothetical UM test cases; or
2. Using a sample of UM determination files. If a sample of UM determination files is used, one of the following auditing methods will apply: (a) 5 percent or 50 of its UM determination files, whichever is fewer, or (b) NCQA "8/30 methodology," available at http://www.ncqa.org/portals/0/programs/8-30.pdf; or (c) Another statistically valid method.

For 2020, utilizing hypothetical UM test cases, the inter-rater reliability testing results are as follows:

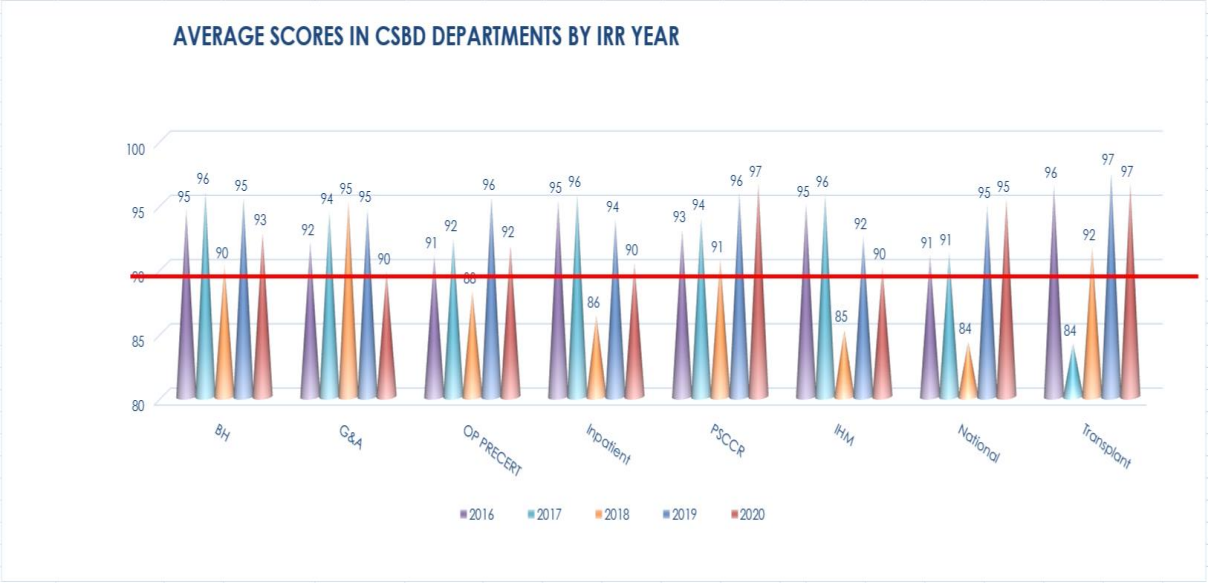
Non-MD clinical staff (includes both medical/surgical reviews and behavioral health reviewers (e.g., nurses or social workers):

Report completed on August 26, 2020 by the IRRA Program Administrator.

The following table shows the level of participation, percent of change, and average score over the life of the enterprise program.

Test Session	# Participants	% of Change in Participation	Average Score	Change in Score
2007-FALL	733			
2008-SPRING	1046	43%	93	
2008-FALL	1156	11%	91	-2
2009-SPRING	1480	28%	89	-2
2009-FALL	1282	-13%	90	1
2010-SPRING	1545	21%	92	2
2011-SPRING	1507	-2%	90	-2
2012-SPRING	1649	9%	91	1
2013-SPRING	1801	9%	90	-1
2014-SPRING	2143	19%	92	2
2015-SPRING	1929	-10%	92	0
2016-SPRING	1728	-10%	94	2
2017-SPRING	1588	-8%	95	1
2018-SPRING	1607	1%	87	-8
2019-SPRING	1534	-5%	94	7
2020-SPRING	1382	-10%	93	-1

For the departments where data exists for the look back period, the chart below illustrates the 5 year scoring trend for Anthem's commercial business (CSBD). The aggregate scoring for all departments have met and exceeded benchmark this year.



Medical/surgical MDs:

The reports were prepared by the Physician Interrater Reliability Committee and approved by the Commercial/Exchange Quality Improvement Committee on February 2, 2021.

Commercial physicians achieved an average score and a passing rate greater than 95% in each of the past 2 years. 2020 was the 5th consecutive year in which these values were above 90%.

Year	# of Respondents	Average Score	% Pass>80%
2020	169	95	96
2019	134	97	100
2018	141	92	94
2017	128	91	94
2016	144	92	96
2015	141	87	84
2014	127	88	85
2013	135	92	87
2012	126	91	89
Fall 2011	145	92	83
Spring 2011	154	89	89

Behavioral Health MD Reviewers:
Report prepared by Staff VP, National Behavioral Health Medical Director, Commercial Business Division and approved by the Behavioral Health Commercial Quality Improvement Committee on December 7, 2020.

Goal: Goal was for each physician to receive a score of 90% correct or more. The minimum passing score was 80% correct.

Results: There were 61 behavioral health physician reviewers who participated in the inter-rater reliability assessment for 2020, which included 25 employed physicians from the Anthem commercial regions, 4 regionally contracted MBO reviewers, and 32 GBD physicians. Overall results showed that 75% or 46 of the 61 physicians received a score at or above the goal of 90%, and of those, 31 physicians achieved a score of 100%. In addition, 61 physicians, 100%, achieved a passing score of 80% or more. The average score for all physicians was 94.1%. These results are above the desired goal (90%) and were comparable to results from 2019 (93.6 %), 2018 (92.5%), 2017 (91.5%) and 2016 (94%).

DETAILS AND RESULTS BY SUBGROUP

Subgroup[1]	# of MD's	Average % score pre-test	Average % score post-test	# with target score of 90% or above	# with passing score between 80% & 90%	# with score below 80%
CSBD Physicians	25	96.2%	97.4%	23 (92%)	2(8%)	0
MBO Physicians	4	91.0%	90.0%	1 (25%)	3(75%)	0
GBD Physicians	32	92.0%	95.0%	22 (69%)	10 (31%)	0
Summary Results 2020	61	93.1%	94.1%	46 (75%)	15 (25%)	0

Previous Results	# of MD's	Average % score pre-test	# with target score of 90% or above	# with passing score between 80% & 90%	# with score below 80%
2019	51	90.7%	37 (73%)	13 (25%)	1 (2%)
2018	56	92.5%	40 (71%)	14 (25%)	2 (3.5%)
2017	53	91.5%	33 (62%)	18 (40%)	2 (4%)
2016	49	94%	38 (78%)	10 (20%)	1 (2%)
2015	64	92%	45 (70%)	13 (21%)	6 (9.4%)
2014	58	96%	53 (91.4%)	4 (6.9%)	1 (1.7%)
Fall 2013	39	93%	33 (84.6%)	3 (7.7%)	2 (5.1%)
Spring 2013	39	93%	31 (79.5%)	5 (12.8%)	3 (7.7%)

For 2020, all inter-rater reliability reviews, behavioral health professionals score equal to or better than their peers that review medical/surgical cases. Additionally, the clinical adherence audits, which apply equally to medical/surgical and behavioral health reviewers, ensure all associates are performing their jobs according to AUMSI policies and procedures.

The results of AUMSI's auditing and testing confirm that AUMSI does not apply these processes, strategies and evidentiary standards more stringently to MH/SUD benefits than medical/surgical benefits.

[1] CSBD represents the physicians who support our commercial business (individual and group). MBO represents the physicians who work for AUMSI on a temporary contract basis. GBD represents the physicians who support our Medicaid and Medicare business.

EXHIBIT 1
STANDARD FULLY INSURED EOC PROVISION

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigative as those terms are defined in this Contract. Utilization Review aids in the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

Reviewing Where Services Are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to You in a lower level place of care or lower cost setting, will not be Medically Necessary if they are given in a higher level place of care, or higher cost setting. This means that a request for a service may be denied because it is not Medically Necessary for that service to be provided in the place of care or setting that is being requested. When this happens the service can be requested again in another setting or place of care and will be reviewed again for Medical Necessity. At times a different type of Provider or Facility may need to be used in order for the service to be considered Medically Necessary.

Examples include, but are not limited to:

- A service may be denied on an Inpatient basis at a Hospital but may be approved if provided on an Outpatient basis in a Hospital setting.
- A service may be denied on an Outpatient basis in a Hospital setting but may be approved at a free-standing imaging center, infusion center, ambulatory surgical Facility, or in a doctor's office.
- A service may be denied at a Skilled Nursing Facility but may be approved in a home setting.

Certain services must be reviewed to determine Medical Necessity in order for You to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. We may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment is more cost effective, available and appropriate. "Clinically equivalent" means treatments that for most Members, will give You similar results for a disease or condition.

If You have any questions about the Utilization Review process, the medical policies or clinical guidelines, You may call the Member Services phone number on the back of Your Identification Card.

Anthem

Coverage for or payment of the service or treatment reviewed is not guaranteed even if We decide Your services are Medically Necessary. For benefits to be covered, on the date You get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under Your Plan;
4. The service cannot be subject to an exclusion under Your Plan; and
5. You must not have exceeded any applicable limits under Your Plan.

Types of Reviews

- **Prior Authorization Review** – 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.
    - **Precertification –** A required Prior Authorization Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for You to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative as those terms are defined in this Contract.

      For admissions following Emergency Care, You, Your authorized representative or doctor must tell Us within 48 hours of the admission or as soon as possible. For labor / childbirth admissions, Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.
- **Continued Stay/Concurrent Review** – A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a Facility or course of treatment.

  Both Prior Authorization and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any doctor with knowledge of Your medical condition, without such care or treatment, Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment.

Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service or supply has been provided. 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.

Who is Responsible for Precertification

Typically, Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending doctor ("requesting Provider") will get in touch with Us to ask for a Precertification. However, You may request a Precertification, or You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsible Party	Comments
Network	Provider	The Provider must get Precertification when required.
Non-Network	Member	Member has no benefit coverage for a Non-Network Provider unless: • The Member gets approval to use a Non-Network Provider before the service is given; or • The Member requires an Emergency Care admission (See note below). Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not to be Medically Necessary.
BlueCard® Provider	Member (Except for Inpatient admissions)	• Member must get Precertification when required (call Member Services). • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not to be Medically Necessary.
Note: Precertification is not required to receive Emergency Care. For Emergency Care admissions, You, Your authorized representative or doctor must tell Us within 48 hours of the admission or as soon as possible.		

How Decisions are Made

We will use Our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make Our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section "Prescription Drugs Administered by a Medical Provider". Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning Your request. To ask for this information, call the Precertification phone number on the back of Your Identification Card.

If You are not satisfied with Our decision under this section of Your benefits, please refer to the "If You Have a Complaint or an Appeal" section to see what rights may be available to You.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on State and federal laws. Where State laws are stricter than federal laws, We will follow State laws. If You live in and/or get services in a State other than the State where Your Contract was issued, other State-specific requirements may apply. You may call the phone number on the back of Your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision	Timeframe Requirement for Notification
Precertification Requests		
Prior Authorization Review Urgent	36 hours from the receipt of request, including one business day If the Member receives an Emergency service that requires immediate post evaluation or post stabilization services, We will provide an authorization decision within 60 minutes of receiving the request; if the authorization decision is not made within 60 minutes, such	For approval determination, We will notify the Provider by telephone or electronically within 24 hours of the decision and notify the Member or Member representative and Provider by written or electronic means within two business days of the decision. For Adverse Determination, We

Type of Review	Timeframe Requirement for Decision	Timeframe Requirement for Notification
	services shall be deemed approved.	will notify the Provider by telephone or electronically within 24 hours of the decision and notify the Member or Member representative and Provider by written or electronic means within one business day of the decision.
Prior Authorization Review Non-Urgent	36 hours from the receipt of the request, including one business day	
Urgent Continued Stay/Concurrent Review when no previous days authorized	One business day from the receipt of all necessary information	For approval determination, We will notify the Provider by telephone or electronically within one business day of the decision and notify the Member or Member representative and Provider by written or electronic means within one business day of the telephonic or electronic notification. For Adverse Determination, We will notify the Provider by telephone or electronically within 24 hours of the decision and notify the Member or Member representative and Provider by written or electronic means within one business day of the telephonic or electronic notification. The service will continue without Member liability until the Member has been notified of the determination.
Urgent Continued Stay/Concurrent Review when request is received more than 24 hours before the end of the previous authorization	One business day from the receipt of all necessary information	
Urgent Continued Stay/Concurrent Review when request is received less than 24 hours before the end of the previous authorization	One business day from the receipt of all necessary information	
Concurrent / Continued Stay Review Non-Urgent	One business day from the receipt of all necessary information	
Post-service Review	30 business days from the receipt of the request	We will notify the Member by written means of the determination within 10 business days of the determination.

If more information is needed to make Our decision, We will tell the requesting Provider of the specific information needed to finish the review. If We do not get the specific information We need by the required timeframe, We will make a decision based upon the information We have.

We will notify You and Your Provider of Our decision as required by State and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

If We authorize medical services, We will not subsequently retract Our authorization after the services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless: Such authorization is based on a material misrepresentation or omission about the Member's health condition or the cause of the health condition; or more than 45 working days have passed since Our authorization and the services have not been provided; or the Member's coverage terminates before the services are provided.