

MHPAEA Summary Form

MHPAEA Summary Form Instructions

The below summary form is prepared to satisfy the requirements of §15-144 (n)(2), Insurance Article, Annotated Code of Maryland. The summary form must be made available to plan members and to the public on the carrier's website.

Confidential and proprietary information must be removed from the summary form. Confidential and proprietary information that is removed from the summary form must satisfy § 15-144(h)(1), Insurance Article, Annotated Code of Maryland.

Carriers must use the terms defined in COMAR 31.10.51 and definitions and instructions in the *Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance Reporting Instructions Non-Quantitative Treatment Limitations (NQTL), Seven Step Analysis*, and the data supplements provided by the Maryland Insurance Administration to complete the summary form.

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Under a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA) and Maryland law § 15-144 of the Insurance Article, 4 Ever Life Insurance Company (4EL) must make sure that there is “parity” between mental health and substance use disorder benefits, and medical and surgical benefits in its products. This generally means that financial requirements and treatment limitations applied to mental health or substance use disorder benefits cannot be more restrictive than the financial requirements and treatment limitations applied to medical and surgical benefits. The types of limits covered by parity protections include:

- Financial requirements—such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- Treatment limitations—such as limits on the number of days or visits covered, or other limits on the scope or duration of treatment (for example, being required to get prior authorization).

4 Ever Life Insurance Company (4EL) has performed an analysis of mental health and substance use disorder parity for the 2026 reporting period as required by Maryland law and has submitted the required report to the Maryland Insurance Administration. Below is a summary of that report.

If you have any questions on this summary, please contact Babette Madison, Vice President of Compliance, at bmadison@bcsf.com.

If you have questions on your specific health plan, please call the number on your member ID card.

Overview:

The following is a summary of all of 4 Ever Life Insurance Company’s (4EL) products in the individual, small, and large group markets, as applicable. These products contain items called Non-Quantitative Treatment Limitations (NQTLs) that put limits on mental health and substance use disorder benefits paid. What these NQTL’s are and how the health plans achieve parity under the law are discussed below.

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1. In-Network Provider (Including Facility) Reimbursement and Negotiations

- A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

All covered services from participating providers will be payable at the plan's in-network (INN) benefit level. A participating provider means a hospital, a physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with the health plan's designee to provide covered services with regard to a particular benefit plan under which a participant (i.e., member) is covered.

Applicable benefits include all INN inpatient, INN outpatient, and emergency care covered services.

- B. Identify the factors used in the development of the limitation(s);

Reference is made to the summary made available by the delegate.

- C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Reference is made to the summary made available by the delegate.

- D. Identify the methods and analysis used in the development of the limitation(s); and

The health plan does not directly establish reimbursement rates or associated contracts with providers. Instead, these responsibilities are delegated for the management and maintenance of a provider network to service plan members' INN needs. The health plan's network is developed and maintained by the health plan's network delegate. The health plan's delegate establishes standard rate offerings and negotiated rates with their participating providers for the health plan network. Participating providers submit claims to a health plan claim designee for reimbursement of these services (with reimbursement based upon the provider's associated contractual arrangement with the network delegate).

Any external organization subcontracted by the health plan to perform functions required of the health plan are expected by the health plan to meet and maintain health plan expectations, including in relation to mental health parity compliance. The delegate's Networks Management, including the Provider Contracting and Provider Reimbursement teams, developed the reimbursement methodologies using the aforementioned factors, standards, and sources, which include CMS guidelines, Medicare benchmarks, market data, and internal

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network analyses. Networks Management reviews and approves the reimbursement methodologies through its Provider Contracting and Reimbursement governance processes. No factors were given more weight than any others.

The delegate's participating providers are reimbursed at their contracted rate and may not bill a health plan member for amounts exceeding the allowed amount for covered services. Members may remain responsible for applicable deductibles, copayments, coinsurance, and non-covered services.

- E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

As Written

The health plan delegate conducts its own internal analysis to ensure their organizations as written parity compliance. The health plan conducted comparative analysis using the delegate's reimbursement policies, methodologies, written responses, and supporting documentation applicable to the Maryland Network.

The health plan's network delegate proclaimed, and 4EL concurs, that the written factors, evidentiary standards, processes, strategies, and approval requirements used for the INN Provider Reimbursement and Negotiations NQTL are comparable to and no more stringent for MH/SUD benefits than for M/S benefits.

In Operation

The health plan's delegate conducts its own internal analysis to ensure their organizations in operations parity compliance. The health plan conducted the in operations comparative analysis for this NQTL utilizing the claims data that impacted the total insureds in 2025. There were limited INN claims utilization for 4EL products during this time period for Maryland. There were no Inpatient INN claims for either MH or SUD and only two (2) claims for M/S services. Similarly, Emergency Services reflect no MH or SUD claims compared to only fifteen (15) claims for M/S. The lack of claims for MH/SUD does not afford an ability to conduct comparison to M/S. The Outpatient INN claims demonstrated the bulk of the claims overall with no SUD claims, ninety-five (95) MH claims, and 1,152 claims for M/S services. Low utilization is likely the direct result of the low volume of membership, 180 total insureds.

The health plan is using a claim delegate's reimbursement values/information for comparative analysis of outpatient services, utilizing the excel data report, DS-1 In-Network Reimbursements Prof -Office report which was constructed by the delegate. Evaluating the report data inputs for the combined in person and telehealth utilization, which is dominantly in-person utilization, revealed extremely low claims utilization which created the inability to conduct a valid reasonable comparison due to the insufficient volume of MH/SUD claims. There was only one (1) Psychiatrist claim, three (3) Licensed MH/SUD Provider claims, and no Psychology or Psychiatric Nurse Practitioner

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claims for comparison to M/S practitioners for a total of four (4) MH/SUD office claims. There was also a low volume of M/S claims but more than MH/SUD services.

The health plan's network delegate proclaimed, and 4EL concurs based upon information currently available, that the factors, evidentiary standards, processes, and strategies used for the INN Provider Reimbursement and Negotiations NQTL are comparable to and no more stringent for MH/SUD benefits than for M/S benefits operationally.

Conclusions

The health plan's network delegate proclaimed, and 4EL concurs, based upon the information available for analysis, that the comparative analysis of the INN Provider Reimbursement and Negotiations NQTL did not identify a distinction that results in more restrictive reimbursement requirements for MH/SUD benefits than for M/S benefits, as written or in operation. The delegate applies the same overall framework for establishing standard reimbursement, evaluating requests for negotiated or nonstandard reimbursement, renegotiating existing agreements, and approving final reimbursement terms for M/S and MH/SUD providers. The factors, evidentiary standards, sources, review processes, negotiation requirements, and approval authorities are applied comparably, with no differences in reimbursement methodology attributable to whether the underlying service is classified as M/S or MH/SUD. The factors, evidentiary standards, processes, and strategies used for this NQTL are comparable to and no more stringent for MH/SUD benefits than for M/S benefits both as written and operationally.

2. Single Case Agreements/Network Gap Exceptions and Negotiations

- A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

This plan makes available to members sufficient numbers and types of providers to give members access to all covered services. The health plan's provider networks include hospitals, physicians, and a variety of other types of providers.

If any of the following instances apply, covered services will be payable at the INN benefit level:

- Member is diagnosed with a condition or disease that requires specialized health care services or medical care; or
- The plan does not have a specialist or non-physician specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or
- The plan cannot provide reasonable access to a specialist or non-physician specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.

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Applicable benefits include all inpatient and outpatient out-of-network (OON) covered services. Emergency care is N/A because covered emergency services are payable at the INN benefit level without advance review, including when furnished by an OON provider. Accordingly, a network gap exception or single case agreement (SCA) is not required to obtain INN level coverage for emergency care.

B. Identify the factors used in the development of the limitation(s);

Factor 1: Availability of an Appropriate Provider

Factor 2: Authorization of Out-of-Network Services for a Specific Member

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Factor 1: Availability of an Appropriate In-Network Provider

The availability of an appropriate INN provider to furnish the member's required covered service within the member's geographic area and within an appropriate timeframe for care. A network gap is established when one or more of the following conditions is met:

- The requested service must be medically necessary and covered under the member's benefit plan.
- There is no INN Provider available in the members' area with the appropriate specialty, experience, credentials or capacity to provide the care.
- INN Providers are available in the member's area, but none performs the required covered service or can provide an accommodation necessary for the member to receive the service.
- An INN Provider capable of furnishing the required covered service is not available within a clinically appropriate timeframe for the members' care.
- There are no INN providers capable of furnishing the service within a 25-mile radius of the member's residence.

Sources include Certificate of Coverage; CSRN Implementation Guide; Single Case Agreement Requests; Pre-Cert & Medical Necessity Process; Network Gap Exception Guidelines; and Applicable state (e.g., MD regulations) and/or federal requirements.

Factor 2: Authorization of Out-of-Network Services for a Specific Member

The specific covered services authorized to be furnished to an individual member by the identified OON provider under a Network Gap Exception/Single Case Agreement. The Network Gap Exception/Single Case Agreement is limited to the specific member, OON provider, service(s), and applicable dates or anticipated dates of service identified and approved for the case. Sources include Certificate of Coverage; CSRN Implementation Guide; Single Case Agreement Requests; Pre-Cert & Medical Necessity Process; Network Gap Exception Guidelines; and Applicable state (e.g., Maryland regulations) and/or federal requirements.

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D. Identify the methods and analysis used in the development of the limitation(s); and

The health plan expects to have a robust network for servicing plan members with allocation of use of OON providers at the member's INN benefits, when necessary. This NQTL process is intended to ensure INN benefits for these instances. It should be noted that 4EL's PPO products contain coverage for OON benefits that the plan members may elect without a SCA/Exception request.

The health plan delegates processes for this NQTL that are necessary to ensure Single Case Agreement (SCA)/Network Gap Exception and Negotiation processes are conducted, when appropriate. The delegates perform the operational functions necessary, including the evaluation and coordination of Network Gap Exception and SCA requests and, where applicable, negotiation and execution of case-specific agreements with OON providers for 4EL products. Any external organization subcontracted by health plan to perform functions required of the health plan are expected by the health plan to meet and maintain health plan expectations, including in relation to mental health parity compliance. Factors, evidentiary standards, and sources are used in the design and application of the NQTL processes with no factor given more weight than others.

A Network Gap Exception may be requested when an INN provider cannot provide the required covered service. The delegate identifies circumstances, the aforementioned conditions, that may support a Network Gap Exception. A Network Gap Exception/SCA request may be initiated by a member or may arise through another documented operational channel, including a provider-initiated precertification request. Upon receipt of a request, Customer Experience first confirms benefit coverage, including whether precertification applies, and verifies the network status of the requested provider. The request is associated with the specific provider a member wants to see, or otherwise identifies the requested OON provider as part of the initiating request. Customer Experience does not select the OON Provider as part of this review. The exception process does not replace otherwise applicable benefit coverage or pre-certification requirements.

Customer Experience conducts a provider search to determine whether an INN Provider in the member's area can furnish the required service. If an available INN provider capable of providing the required service is identified, the exception does not proceed, and the member is provided information regarding the available INN provider. If an appropriate INN provider cannot be identified, the request proceeds through the applicable approval process and, if approved, to Provider Contracting for SCA negotiation. Provider Contracting verifies that the requested provider is OON and conducts case-specific negotiation with the provider. If the proposed terms are not approved, negotiations may continue until approval is obtained or negotiations conclude without an agreement. Case-rate negotiations occur between the delegate and the OON provider and, once terms are agreed upon, an SCA is executed. The SCA process is case-specific. An SCA applies to specific covered services furnished by the identified OON provider to the particular member, and the operational request captures the applicable procedures and known or estimated dates of service. Claims falling within the executed SCA are processed as INN and the member's cost-sharing is based on the applicable deductible, copayment, or coinsurance requirements.

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- E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

As Written

The health plan's delegate conducts its own internal analysis to ensure their organizations as written parity compliance. The health plan conducted this NQTL analysis based upon the applicable operational information provided by the health plan delegate since the delegate performs the Single Case Agreement (SCA)/Network Gap Exception and Negotiation process for the health plan. It should be noted that the 4EL is a PPO product that offers coverage for OON services without the need for an exception.

The delegate's written policies and procedures applicable to M/S and MH/SUD benefits were reviewed comparatively at each material stage of the Network Gap Exception and SCA process. The review considered whether the written standards used to identify a network gap, evaluate the requested OON service and Provider, and advance the request through case-specific negotiation differ based on whether the requested service is an M/S or MH/SUD benefit. They do not establish separate Network Gap Exception criteria, request procedures, provider search requirements, approval processes, or negotiation procedures based on whether the requested service is M/S or MH/SUD. Rather, the procedure is structured around the member's benefit coverage, the availability and capability of INN Providers, the network status of the requested provider, applicable precertification requirements, any applicable regulatory requirements, and the circumstances of the individual SCA request.

The written criteria used to determine whether a network gap exists does not distinguish between M/S and MH/SUD services. A network gap may be considered when the covered service is medically necessary but there is no INN Provider in the member's area, when available INN providers do not perform the required service or cannot provide a necessary accommodation, when an INN provider capable of furnishing the required service is not available within a clinically appropriate timeframe or when the member must travel an unreasonable distance to obtain INN care. Customer Experience conducts a provider search and, where necessary, contacts identified providers to determine whether the required service can be furnished. If an appropriate INN provider is available, the SCA process does not proceed.

The Certificate of Coverage similarly establishes a condition-neutral access standard. Covered services may be payable at the INN benefit level when the health plan does not have a specialist or non-physician specialist with the professional training and expertise required to furnish the service, or when reasonable access to such a provider cannot be provided without unreasonable delay or travel. The Certificate does not establish a different access standard for MH/SUD services than for M/S services.

Based on the written documentation reviewed, the factors and evidentiary standards used to identify the existence of a network gap are therefore designed comparably for M/S and MH/SUD benefits. No written criterion was identified that imposes an additional or more restrictive network-availability requirement on MH/SUD services. Once a potential network gap has been identified, the written process

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evaluates the particular service and OON provider associated with the member's request. The same SCA request documentation is used for professional and facility requests and captures the member, requested provider, service or procedure, applicable codes when available, known or estimated dates of service, and authorization information. The form does not establish separate information requirements or a separate approval pathway based on an M/S versus MH/SUD diagnosis or service. Applicable benefit coverage and pre-certification requirements remain in effect during the SCA process. Where a service is subject to precertification and is denied because medical necessity is not met, the SCA does not proceed; where precertification is approved, the SCA request may continue. The supporting precertification documentation likewise describes authorization processes according to the applicable service and Plan requirements rather than identifying a separate SCA authorization standard based on M/S or MH/SUD status. The written process requires verification that the requested provider is OON before case-specific negotiation occurs. Provider Contracting then negotiates with the identified OON provider and may continue negotiations until acceptable terms are approved, or the negotiation concludes without agreement. The written policies do not identify different negotiation personnel, approval pathways, or case-specific contracting procedures for M/S providers compared with MH/SUD providers.

Based on the written policies and procedures reviewed, the criteria and process used to identify a network gap and advance an eligible request through the SCA negotiation process are not designed differently for M/S and MH/SUD benefits. The same written criteria used to determine whether an appropriate INN provider is available, provider-search process, member-specific request information, provider network-status review, and case-specific negotiation workflow apply without an identified distinction based on M/S or MH/SUD status. The factors, evidentiary standards, processes, and strategies for this NQTL are comparable to and no more stringent for MH/SUD benefits than for M/S benefits as written.

In Operation

The health plan's delegate conducts its own internal analysis to ensure their organizations in operations parity compliance. The health plan conducted this NQTL analysis based upon the applicable operational information provided by the delegate. Based upon the data tables from the delegate, an evaluation of OON utilization was conducted overall, as well as an evaluation of the SCA/Exceptions data was conducted. It should be noted that 4EL's PPO products contain coverage for OON benefits that the plan members may elect without a SCA/Exception request. Out-of-Network Utilization and Network Gap Exception Utilization for Calendar Year 2025 demonstrated extremely low or no MH or SUD data for a valid comparison to M/S, except as follows:

- Table A, OON utilization, was reviewed across four (4) benefit service levels to compare the frequency with which M/S and MH claims were processed as OON during the reporting period, measured as the percentage of total submitted claims processed using the OON benefit, which demonstrated:
 - For Outpatient Facility: A total of 940 M/S claims, and ninety-one (91) MH claims were submitted. No claims in either category were processed OON. Accordingly, OON utilization was 0% for both M/S and MH services at this benefit service level.

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- For Office Visits: Of 236 M/S claims submitted, thirty-six (36) were processed OON, resulting in an OON utilization rate of 15.3%. Of three (3) MH claims submitted, one (1) was processed OON, resulting in an OON utilization rate of 33.3%. Numerically, the MH OON utilization rate was eighteen (18) percentage points higher than the M/S rate, or approximately 2.2 times the M/S rate (119% higher). However, the MH rate reflects only one (1) OON claim among three (3) total MH claims. The limited MH claim volume makes the percentage comparison less reliable and does not support a clear utilization pattern.
- Table C, Network Gap Exception utilization, was reviewed across four (4) benefit service levels to compare the frequency with which M/S and MH claims were submitted as Network Gap Exception claims during the reporting period, which demonstrated:
 - Outpatient Facility: A total of 940 M/S claims, and ninety-one (91) MH claims were submitted. No Network Gap Exception claims were reported for either category. Accordingly, Network Gap Exception utilization was 0% for both M/S and MH services at this benefit service level.
 - Office Visits: A total of 236 M/S claims, and three (3) MH claims were submitted. No Network Gap Exception claims were reported for either category. Accordingly, Network Gap Exception utilization was 0% for both M/S and MH services at this benefit service level.

Accordingly, the in operations evaluation supports a finding that the SCA/Network Gap Exception and Negotiation NQTL factors, evidentiary standards, processes, and strategies for this NQTL are comparable to and no more stringent for MH/SUD benefits than for M/S benefits.

Conclusions

The comparative analysis of the Single Case Agreement (SCA)/Network Gap Exception and Negotiation NQTL did not identify a distinction in the factors, evidentiary standards, or processes applied to M/S benefits as compared with MH/SUD benefits. The delegate's process applies the same criteria for determining whether a network gap exists, evaluating the requested OON service and provider, and advancing an eligible request through the SCA negotiation process without establishing separate or more restrictive requirements based on whether the underlying service is M/S or MH/SUD. Limited utilization and data were identified, as well as the plan design as a PPO that freely allows members to access OON coverage without SCAs/Exceptions. Based on this analysis, 4EL concludes that the NQTL is designed comparably and no more stringently for MH/SUD benefits than for M/S benefits. The factors, evidentiary standards, processes, and strategies used for this NQTL are comparable to and no more stringent for MH/SUD benefits than for M/S benefits both as written and operationally.

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3. Crisis and Emergency Services

- A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

Emergency Medical Condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a mental health or substance misuse disorder condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part or
- Serious disfigurement of such individual.

Emergency Services means, with respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Urgent Care is medical, surgical, hospital or related health care services and testing which are not Emergency Services, but which are determined by the plan, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where the member ordinarily receives and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a physician's recommendation that the insured should not travel due to any medical condition.

Residential crisis services are defined, and benefits are paid for crisis services that are medically necessary. Outpatient mental health conditions are covered such as crisis intervention. Charges for emergency services and urgent care are covered expenses.

Applicable benefits include inpatient, outpatient, and emergency care covered services INN and OON as defined below.

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B. Identify the factors used in the development of the limitation(s);

Factor 1 – Regulatory Requirements

Factor 2 – Clinical Appropriateness

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Factor 1 – Regulatory Requirements

The federal and state laws and regulations that define Crisis and Emergency Services and establish applicable coverage, access, authorization, notification, and other requirements. The service and provider/facility must satisfy the applicable statutory and regulatory definition, licensure, and other legal requirements for the service type. For MH/SUD 24-Hour Crisis Residential Facility services, the facility must meet the applicable Maryland requirements for crisis residential services. For the corresponding M/S sub-acute inpatient services, the provider/facility must satisfy the applicable legal and licensing requirements for the facility type furnishing the service. Sources include COMAR 10.63.04.04 and Certificate of Coverage.

Factor 2 – Clinical Appropriateness

The clinical considerations used to determine whether a Crisis or Emergency Service is appropriate for the member's condition, including medical necessity, level and intensity of care, setting, duration, and provider qualifications. The service must be medically necessary and furnished at the level of care and in a setting appropriate to the member's clinical condition. The plan requires services to be appropriate in type, frequency, extent, site, and duration and furnished in the least intensive setting appropriate for delivery of the service. Sources include the Certificate of Coverage.

D. Identify the methods and analysis used in the development of the limitation(s); and

The health plan delegates processes for the administration and processing of benefits and claims associated with Crisis and Emergency Services. The delegate performs the operational functions for this NQTL, including the application of applicable coverage, authorization, medical necessity, and claims processing requirements. Any external organization subcontracted by health plan to perform functions required of the health plan are expected by the health plan to meet and maintain health plan expectations, including in relation to mental health parity compliance. Factors, evidentiary standards, and sources are used in the design and application of the NQTL processes with no factor given more weight than others.

Focusing on the four (4) MH/SUD services targeted by the state of Maryland for this NQTL analysis and comparing to M/S services, as defined below, an analysis was conducted.

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MH/SUD service	M/S service
Crisis Stabilization Facility/Behavioral Health Crisis Stabilization Center	Outpatient Observation and Stabilization Services
Mobile Crisis Team	Ambulance Services
24-Hour Crisis Residential Facility (sub-acute inpatient)	Sub-acute inpatient services furnished in a Skilled Nursing Facility, Rehabilitation Hospital, or other subacute facility
Emergency Department of a Hospital or Freestanding Emergency Medical Facility	Emergency Services for an Emergency Medical Condition

Coverage and requirements were evaluated for these services, comparing MH/SUD services to M/S services.

- E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

As Written

The health plan's delegate conducts its own internal analysis to ensure their organizations as written parity compliance. For purposes of this comparative analysis, the health plan reviewed the written coverage provisions and applicable regulatory requirements identified herein. The review compared the application of each factor, evidentiary standard and sources, including applicable provider qualification requirements, medical necessity requirements, level and setting of care, and authorization requirements. The Certificate establishes applicable requirements that covered services be medically necessary, furnished in an appropriate setting, and provided by an appropriately licensed or certified provider. The documentation reviewed does not establish separate medical necessity definitions or general provider qualification standards based solely on whether the underlying condition is M/S or MH/SUD.

With respect to Regulatory Requirements and Clinical Appropriateness, the written standards applicable to Crisis and Emergency Services are based on the federal and state requirements governing the particular service and provider, together with the plan's generally applicable medical necessity and level-of-care requirements. Where Maryland law establishes specific definitions, licensure requirements, or service requirements for an MH/SUD crisis service, those requirements reflect the regulatory framework applicable to that service type rather than a separate plan standard imposed because the service is MH/SUD. Corresponding M/S services are likewise subject to the licensing requirements applicable to the M/S provider, facility, and service type. The Certificate applies the same overarching medical necessity framework to covered services, requiring that services be appropriate for the covered person's condition, furnished at the appropriate level and intensity of care and in an appropriate setting, and provided by a qualified provider. The written provisions reviewed do not establish a more restrictive medical necessity, level-of-care, setting, or provider qualification standard for MH/SUD Crisis and Emergency Services than for corresponding M/S services.

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For the MH/SUD Crisis Stabilization Facility/Behavioral Health Crisis Stabilization Center, MH/SUD Mobile Crisis Team, and MH/SUD 24-Hour Crisis Residential Facility service types, the written standards are based on the applicable Maryland regulatory requirements governing the particular crisis service and provider or facility type, together with the Certificate's generally applicable coverage and medical necessity requirements. The corresponding M/S service types are likewise subject to the legal and licensing requirements applicable to the particular M/S service and provider or facility type. The written provisions reviewed do not establish a separate or more restrictive medical necessity, level-of-care, setting, or provider qualification standard for these MH/SUD Crisis Services than for the corresponding M/S services. Where the underlying service types differ in structure or setting, those differences reflect the nature of the service and the applicable regulatory framework rather than a different standard applied because the service is MH/SUD.

For Emergency Department and Freestanding Emergency Medical Facility services, the Certificate applies the prudent layperson standard to Emergency Medical Conditions, including both M/S and MH/SUD conditions. Emergency Services include screening and stabilization services, and advance review is not required for emergent or Urgent Care. Covered emergency services are payable at the INN benefit level regardless of whether the provider is participating or non-participating. These requirements are stated without establishing a different or more restrictive standard for MH/SUD emergency conditions.

Based on the written provisions and regulatory requirements reviewed, the factors, evidentiary standards, and related coverage requirements are applied based on the nature of the service, applicable regulatory requirements, and the member's clinical needs, rather than whether the underlying condition is M/S or MH/SUD. Accordingly, the written policies reviewed support comparable and no more stringent application of the Coverage of Crisis and Emergency Services NQTL to MH/SUD benefits as compared with corresponding M/S benefits. The factors, evidentiary standards, processes, and strategies for this NQTL are comparable to and no more stringent for MH/SUD benefits than for M/S benefits as written.

In Operation

The health plan's delegate conducts its own internal analysis to ensure their organizations in operations parity compliance. No claims were identified by the delegate for the DS-3, Crisis and Emergency Services for the Calendar Year 2025 for any of the four (4) MH/SUD Crisis and Emergency Service types during the reporting period. Accordingly, there was no MH/SUD utilization available for comparative in-operation analysis for those service types. Operationally, the factors, evidentiary standards, processes, and strategies for this NQTL are comparable to and no more stringent for MH/SUD benefits than for M/S benefits.

Conclusions

The comparative analysis of the Coverage of Crisis and Emergency Services NQTL did not identify a distinction in the factors, evidentiary standards, or general coverage requirements applied to M/S benefits as compared with MH/SUD benefits. The standards apply applicable federal and state regulatory requirements according to the particular service and provider/facility type and apply the plan's medical

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necessity, appropriate level and setting of care, and provider qualification requirements without establishing separate or more restrictive standards based on whether the underlying condition is M/S or MH/SUD. For Emergency Services, the Certificate expressly applies the prudent layperson standard to both M/S and MH/SUD conditions and does not require advance review of emergent or urgent care. No claims data was identified for any of the four MH/SUD Crisis and Emergency Service types during the reporting period; therefore, no MH/SUD utilization was available for comparative in-operation analysis for those service types. Based on this analysis, the health plan concludes that the Coverage of Crisis and Emergency Services NQTL is designed comparably and no more stringently for MH/SUD benefits than for corresponding M/S benefits. The factors, evidentiary standards, processes, and strategies used for this NQTL are comparable to and no more stringent for MH/SUD benefits than for M/S benefits both as written and operationally.

4. Experimental/Investigational/Unproven Treatments

- A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

Experimental/Investigational means treatment, a device or prescription medication which is recommended by a physician, but is not considered by the medical community as a whole to be safe and effective for the condition for which the treatment, device or prescription medication is being used, including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice; and any of those items requiring federal or other governmental agency approval not received at the time services are rendered. We will make the final determination as to what is Experimental or Investigational. Experimental/Investigational does not include the routine medical costs associated with clinical trials.

Experimental/Investigational determinations are performed through a utilization review program by a Private Review Agent with which 4 Ever Life and its administrator have contracted.

Exclusions and expenses not covered: For or in connection with Experimental, Investigational or unproven services. Experimental, Investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review physician to be:

- Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
- Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
- The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” section(s) of this plan; or

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- The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the “Clinical Trials” section(s) of the plan.

Specific services are determined by the Plan to be experimental/investigational based on the definition of the plan's benefit contracts. Additionally, there are some services considered to be experimental/investigational based on the indications for use.

Applicable benefits include INN and OON inpatient, outpatient, emergency care, and prescription drug.

B. Identify the factors used in the development of the limitation(s);

For Prescription Drugs

Factor 1: Regulatory Status

For Devices and Other Services

Factor 1: Whether a Service is Experimental/Investigational

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

For Prescription Drugs

Factor 1: Regulatory Status

FDA approved prescription drugs that are off prescribed for an off-label use are rejected as experimental/investigational for both M/S and MH/SUD. New Drug/Indication Review for Pharmacy & Therapeutics (P&T) Committee makes a reasonable effort to review a new FDA approved drug product (or new FDA approved indication). Sources include: FDA.

For Devices and Other Services

Factor 1: Whether a Service is Experimental/Investigational

Services (e.g., devices, drugs, procedures, supplies, technologies, treatments) are services whose safety or efficacy is not known or are services that are used in a way that departs from generally accepted standards of practice in the medical community. A technology assessment is conducted that is a process of identification, review, and evaluation of data about medical products and services (laboratory tests, diagnostic procedures, preventive interventions, and treatments) to assess their safety, effect on health outcomes, and appropriate use. The technology assessment weighs the available evidence against the following criteria established by the delegate:

- The technology must have final approval from the appropriate government regulatory bodies.
- The scientific evidence is sufficiently definitive to permit conclusions about the effect of the technology on health outcomes;

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- The technology is as safe and effective as existing alternative treatments;
- The technology improves the net health outcome, i.e., provides evidence that the benefits outweigh the risks; and
- The improvement in health outcomes is reliably attainable outside investigative settings.

The delegate's Technology Assessment Committee is in place which includes appropriate behavioral healthcare practitioners. Services considered experimental/investigational are not covered because the safety and/or effectiveness of these services cannot be established. Sources include clinical trials; peer-reviewed reports; evidence-based guidelines from professional organizations and governmental entities; opinions of the relevant medical community; information from government regulatory agencies; Published scientific literature; Materials submitted by proponents of the technology; Input from relevant specialists and professionals with expertise in the relevant area; Published medical literature in peer-reviewed journals; Nationally recognized professional organizations' opinions; consensus statements or clinical practice guidelines; Clinical trial data; Manufacturer's guidelines for use; Government agencies; Technology review associations and various medical and professional associations; Public print mass media; Covered Person's health status and condition being treated; Health outcomes; and Reliable Evidence (i.e., peer-reviewed reports of clinical studies; medical or scientific journals; evidence-based guidelines from respected professional organizations and governmental entities; Evaluation of data (i.e., laboratory tests, diagnostic procedures, preventive interventions, and treatments); NCQA standards; Published medical literature in peer-reviewed journals; FDA; Peer-reviewed journals; National medical associations; Consensus panels and other technology evaluation bodies; Recommendations from subject matter experts; and/or national physician specialty societies; Network providers; and National experts.

D. Identify the methods and analysis used in the development of the limitation(s); and

The health plan delegates the utilization management (UM) functions to an organization for administration, including experimental/investigational processes. Any external organization subcontracted by health plan to perform functions required of the health plan are expected by the health plan to meet and maintain health plan expectations, including in relation to mental health parity compliance. Factors, evidentiary standards, and sources are used by the delegate in the design and application of the NQTL processes with only single factors by service type, therefore, weighting is not applicable. Designation as to whether a service/drug is experimental/investigational is the catalyst to ensuring it is safe and effective for use with health plan membership, which is in the best interest of the members. Experimental/investigational designation is used to describe services that address a drug, biological product, device, medical treatment, diagnostic test, or procedure that meets any of the following criteria:

- Is the subject of ongoing clinical trials;
- Is the research, experimental, study, or investigational arm of an ongoing clinical trial(s) or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness, as compared with a standard means of treatment or diagnosis;
- Is not of proven benefit for the particular diagnosis or treatment of the covered person's particular condition;
- Is not generally recognized by the medical community, as clearly demonstrated by reliable evidence, as effective and

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- appropriate for the diagnosis or treatment of the covered person's particular condition;
- Is generally recognized, based on reliable evidence, by the medical community, as a diagnostic or treatment intervention for which additional study regarding its safety and effectiveness for the diagnosis or treatment of the covered person's particular condition is recommended.

Members of the network provider community (who are board-certified, clinically practicing, specialty-matched consultants) review, evaluate, and critique the resulting technology assessment. National experts may also be enlisted to participate in this review process. This analysis of the research data results in a medical necessity determination. Specific services are determined by the delegate to be experimental/investigational based on the definition of the plan benefit contracts. Additionally, there are some services considered to be experimental/investigational based on the indications for use.

- E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

As Written

The health plan's delegate conducts its own internal analysis to ensure their organizations as written parity compliance. As reported by the health plan's delegate for both M/S and MH/SUD services, new technology assessments are performed and are used in creating medical policies. The delegate looks to a number of sources in performing technology assessments, including, but not limited to published medical literature in peer-reviewed journals, nationally recognized professional organizations' opinions, consensus statements, or clinical practice guidelines, clinical trial data, manufacturer's guidelines for use, government agencies, and technology review associations and various medical and professional associations. In conducting assessments, the delegate considers whether (1) the technology has final approval from appropriate government regulatory bodies, (2) the scientific evidence is sufficiently definitive to permit conclusions about the effect of the technology on health outcomes, (3) the technology is as safe and effective as existing alternative treatments, (4) the technology improves net health outcomes, and (5) the improvement in health outcomes is reliably attainable outside investigative settings. The written factors, evidentiary standards, processes, and strategies for this NQTL are comparable to and no more stringent for MH/SUD benefits than for M/S benefits as written.

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In Operation

The health plan's delegate conducts its own internal analysis to ensure their organizations in operations parity compliance. Specifically, for the health plan's Maryland products, minimal membership of 180 enrolled resulted in minimal utilization data by Plan members during CY2025. The delegate populated DS-4-EIU report reflects the following: No EIU adverse determinations were conducted as reported by delegate for CY2025 for either M/S or MH/SUD services. No parity concerns were identified during assessment of operational outcomes data. Therefore, operationally, the factors, evidentiary standards, processes, and strategies for this NQTL are comparable to and no more stringent for MH/SUD benefits than for M/S benefits.

Conclusions

For both M/S and MH/SUD services, new technology assessments are performed and are used in creating medical policies. The delegate looks to a number of sources in performing technology assessments, including, but not limited to published medical literature in peer-reviewed journals, nationally recognized professional organizations' opinions, consensus statements, or clinical practice guidelines, clinical trial data, manufacturer's guidelines for use, government agencies, and technology review associations and various medical and professional associations. In conducting assessments, the delegate looks to whether (1) the technology has final approval from appropriate government regulatory bodies, (2) the scientific evidence is sufficiently definitive to permit conclusions about the effect of the technology on health outcomes, (3) the technology is as safe and effective as existing alternative treatments, (4) the technology improves net health outcomes, and (5) the improvement in health outcomes is reliably attainable outside investigative settings. Policy updates occur annually or more frequently. Consistent processes for MH/SUD and M/S, as reported by the delegate, results in this NQTL being applied comparably and no more stringently as written for MH/SUD than for M/S. The factors, evidentiary standards, processes, and strategies used for this NQTL are comparable to and are no more stringent for MH/SUD benefits than for M/S benefits both as written and operationally.

5. Medical Necessity Guidelines/Criteria

- A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

The health plan will decide, based on the medical necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Medically necessary covered services and supplies are those determined by the Medical Director to be:

- Required to diagnose or treat an illness, Injury, disease or its symptoms;

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- In accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Not primarily for the convenience of the patient, Physician or other health care Provider; and
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Medical necessity determinations are performed through a utilization review program by a private review agent with which 4 Ever Life and its administrator have contracted.

Covered expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include any hospital charges for treatment listed above for which Pre-Admission Certification (PAC) was requested, but which was not certified as medically necessary.

Benefits, subject to the copayments, coinsurance, deductibles and limitations as noted are available for a service or supply described in this section when it meets all of these requirements, including: It must be medically necessary and must be furnished in a medically necessary setting.

Covered expenses include: charges for medically necessary behavioral health care services provided by a provider, regardless if that service is provided at a public school or through a school based health center under §7-440 of the Education Article.

Exclusions, General Limitations - No payment will be made for expenses incurred for the member or any one of their dependents: Expenses for supplies, care, treatment, or surgery that are not medically necessary.

Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting. (also referred to as Medical Necessity) as defined in the Certificate of Coverage (54_1315 AD& D (MD) Rider 6_19_17

Applicable benefits include INN and OON inpatient, outpatient, and emergency care covered services.

B. Identify the factors used in the development of the limitation(s);

Factor 1: Medical policies, supported by sound research and clinical studies, which are used in determining medical necessity

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- C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Factor 1: Medical policies, supported by sound research and clinical studies, which are used in determining medical necessity. The delegate develops medical policies. Sources and evidence relied upon include credible scientific evidence published in peer-reviewed medical literature that is recognized by the relevant medical community, physician specialty society recommendations, and the views of physicians practicing in relevant clinical areas, including behavioral health. Additional Outpatient sources include clinical appropriateness criteria developed by the American College of Radiology (ACR); current medical literature and utilize resources from major medical organizations such as the American Cancer Society (ACS); evidence-based guidelines and recommendations from national and international medical societies, and evidence-based medicine research centers, including, but not limited to, American Society of Radiation Oncology (ASTRO), National Comprehensive Cancer Network (NCCN), and ACR; credible scientific evidence published in peer-reviewed medical literature recognized by the relevant medical community, physician specialty recommendations, and the views of the physicians practicing in relevant clinical areas; Care Guidelines including MCG (formerly Milliman Care Guidelines); and applicable federal, state, and industry accreditation requirements, and CMS guidelines. MH/SUD sources include credible scientific evidence published in peer-reviewed medical literature that is recognized by the relevant medical community; Physician specialty society recommendations; the views of physicians practicing in relevant clinical areas, including behavioral health; InterQual; CMS guidelines; American Society of Addition Medicine (ASAM) (Note: ASAM Criteria is used for MH/SUD service reviews. ASAM is also incorporated into other criteria such as InterQual and Magellan Care Guidelines.); Delegate medical policies; Various scientifically based peer-reviewed sources; Magellan Care Guidelines; Emerging and/or new health care technologies, and/or changes in existing technologies; Creation of or changes to federal or local contractor Medicare policies; Legislatively mandated coverage requirements; Scheduled review of existing policies; Updates to coding (e.g., Current Procedural Terminology [CPT], Healthcare Common Procedure Coding System [HCPCS]); Other nationally recognized and accepted sources, including the FDA, nationally recognized professional organizations' opinions, consensus statements, or clinical practice guidelines, manufacturer's guidelines for use, information about clinical trials used in the FDA regulatory approval process, and expert consultant opinion.

- D. Identify the methods and analysis used in the development of the limitation(s); and

The health plan delegates the utilization management (UM) functions to an organization for administration, including experimental/investigational processes. Any external organization subcontracted by health plan to perform functions required of the health plan are expected by the health plan to meet and maintain health plan expectations, including in relation to mental health parity compliance. The factor, evidentiary standards, and sources are used by the delegate in the design and application of the NQTL processes and with only one factor, weighting is not applicable. The delegate's UM involves the use of external and internal delegate medical necessity criteria. In creating medical policies (i.e., coverage criteria), evidence is relied upon by the delegates which involves a number of

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the sources cited above to evaluate safety and efficacy for consistent development and maintenance of medical policies and procedures in accordance with current standards of care, federal and state mandates, and accreditation standards which involves a committee framework.

All services eligible for coverage under the plan, including MH/SUD services, must be medically necessary for the member's condition. Some services can be rendered without a preservice determination of medical necessity by the delegate. The following general principles are the basis for the delegate's determination that a service is medically necessary:

- The service that an appropriate provider, exercising prudent clinical judgement, provides a member is appropriate and effective for preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms for which it is prescribed or performed, and not for experimental/investigational or cosmetic purposes; AND
- The service is clinically appropriate, in terms of type, frequency, extent, and site and duration, and is considered effective for the member's illness, injury, or disease; AND
- The service is appropriate with regard to generally accepted standards of medical practice within the medical community; AND
- The service is not primarily for the convenience of the member, the member's family, the professional provider, or other health care provider; AND
- The service is not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" takes into consideration:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
- Physician specialty society recommendations;
- The views of professional providers practicing in the relevant clinical area; and
- Any other relevant factors.

The delegate's policy bulletin regarding medical necessity is available on the Medical and Claim Payment Policy Portal.

- E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

As Written

The health plan's delegate conducts its own internal analysis to ensure their organizations as written parity compliance. The health plan conducted this NQTL analysis based upon the applicable operational information provided by the delegate. The delegate applies the same definition of medical necessity for physical health and behavioral health services. The delegate relies on many factors to create medical

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policies, including, but not limited to third party industry standards (InterQual, MCG, and ASAM criteria), medical literature, CMS guidelines, physician specialty recommendations, and views of physicians practicing in relevant clinical areas. Medical policies are reviewed and updated annually, or more frequently, as new evidence becomes available for both M/S and MH/SUD services. The delegate's Behavioral Health Oversight Committee meets with representatives monthly to review regular reports and identify issues to, among other things, ensure parity. The written factors, evidentiary standards, processes, and strategies for this NQTL are comparable to and no more stringent for MH/SUD benefits than for M/S benefits as written.

In Operations

The health plan's delegate conducts its own internal analysis to ensure their organizations in operations parity compliance. The health plan conducted this NQTL analysis based upon the applicable operational information provided by the delegate. Specifically, for the plan, minimal membership of 180 enrolled resulted in minimal utilization data by plan members during CY2025. The delegate reported limited utilization data for CY2025 for M/S or MH/SUD comparison. The delegate populated DS-5-A Medical Necessity Denial Rates report reflects the following:

- INN:
 - No prior authorization utilization reviews conducted nor denied for MH/SUD or M/S inpatient or outpatient services before claim submission, and no prior authorization inpatient or outpatient claim reviews or denials conducted for MH/SUD to compare to the single claim line review for M/S;
 - No concurrent utilization reviews conducted nor denied for inpatient or outpatient for MH/SUD or M/S for comparison before claim submission, and no concurrent claim reviews conducted for inpatient or outpatient MH/SUD services to compare to the nominal M/S reviews that were all covered and not denied; and
 - No MH/SUD or M/S retrospective pre-claim or post-claim reviews conducted retrospectively for inpatient or outpatient services for comparison.
- OON:
 - No prior authorization inpatient or outpatient utilization reviews conducted or denied for MH/SUD or M/S either before or after claim submissions for comparison;
 - No concurrent inpatient or outpatient utilization reviews conducted or denied for MH/SUD or M/S either before or after claim submission for comparison; and
 - No retrospective pre-claim or post-claim reviews conducted or denied retrospectively for inpatient or outpatient MH/SUD or M/S services for comparison.

No parity concerns were identified during assessment of operational outcomes data. Operationally, the factors, evidentiary standards, processes, and strategies for this NQTL are comparable to and no more stringent for MH/SUD benefits than for M/S benefits.

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Conclusions

The delegate applies the same definition of medical necessity. The delegate relies on similar factors to create medical policies, including, but not limited to third party industry standards (InterQual, MCG, and ASAM criteria), medical literature, CMS guidelines, physician specialty recommendations, and views of physicians practicing in relevant clinical areas. Medical policies are reviewed and updated annually for both M/S and MH/SUD services.

The delegate performs inter-rater reliability (IRR) testing annually to ensure that licensed professionals performing reviews as part of the utilization management process are applying medical necessity criteria consistently. Outcomes of the IRR also provide potential educational opportunities for the staff.

Medical Policies are reviewed and updated on an annual basis, or more frequently as new evidence becomes available, and are reviewed and approved by the appropriate committee(s) prior to publication.

The factors, evidentiary standards, processes, and strategies used for this NQTL are comparable to and no more stringent for MH/SUD benefits than for M/S benefits both as written and operationally.