

## PURPOSE

This policy outlines Akido MSO LLC (Akido)'s responsibilities and principles for determining the medical necessity of health care services based on application of medical necessity criteria. All decisions, approvals, modifications, denials, or holds follow current evidence-based clinical guidelines and comply with the Compliance Authority as defined below.

The application of clinical criteria is determined by the member's medical condition and the location where services will be delivered.

## DEFINITIONS

<b>Term/Acronym</b>	<b>Definition</b>
<b>Compliance Authority</b>	As applicable in context, all federal, state, and local laws, and regulations; accreditation standards and requirements; the Policies and Procedures ("P&Ps") are reviewed by the Medical Services Committee and adopted to meet contractual requirements.
<b>Clinical Criteria</b>	Systematically developed and evidence-based clinical practice guidelines which assist practitioner and patient decisions about appropriate health care for specific circumstances.
<b>Medically Necessary</b>	Health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice. (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and 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 that patient's illness, injury, or disease. <b>California Code, Health and Safety Code - HSC § 1374.72</b>
<b>Mental Health Parity</b>	Coverage for mental health and substance disorders will be no more restrictive than the coverage that generally is available for medical/surgical conditions. This applies to the Criteria for medical necessity determinations. This standard will apply to

Term/Acronym	Definition
	“Parity Diagnoses” in the State of California and as determined by the Health Plan.
<b>Urgent Request</b>	When the enrollee's condition is such that the enrollee faces an imminent and serious threat to the enrollee's health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees shall be made within 72 hours or shorter.
<b>Artificial Intelligence</b>	“Artificial intelligence” means an engineered or machine-based system that varies in its level of autonomy and that can, for explicit or implicit objectives, infer from the input it receives how to generate outputs that can influence physical or virtual environments.

**POLICY**

1. Akido uses written clinical criteria based on sound clinical evidence to make utilization decisions, and to provide a standardized written process for using and applying clinical criteria that is objective and based on member’s individual needs and assessment of the local delivery system when determining the medical appropriateness of health care services. This process is documented in Akido’s clinical systems for all UM decisions.
2. Non-clinical staff may process denials based on benefit exclusions (services not covered under the member's plan) without clinical review, provided:
  - a. (1) the service is confirmed as a non-covered benefit in the member's EOC or benefit document,
  - b. (2) the request has been verified against the Medicare Non-Coverage List for MA members, and
  - c. (3) the determination is distinguished from benefit limitations (which require clinical review). Benefit exclusion determinations by non-clinical staff must be reviewed by a licensed clinical supervisor and documented in the clinical system with the applicable benefit provision cited.
3. The Akido UMC and QIC reviews and adopt criteria as follows:
  - a) With involvement from actively practicing health care providers (behavioral and non-behavioral), including non-staff network practitioners to apply, adopt, and review criteria.

- b) All criteria sets will be reviewed and evaluated, updated, and modified as necessary, at least annually and when appropriate, more frequently due to regulations and industry change by the UM/QIC Committees.
  - c) Any new criteria that Akido would like to adopt will be additionally subjected to review and evaluation by the QI Committee prior to its approval and implementation by the organization. All changes are reported to the BOD by the Medical Director for final approval.
  - d) Akido reviews its UM criteria and procedures against current clinical and medical evidence and updates them, when appropriate. If new scientific evidence is not available, a designated group may determine if further review of a criterion is necessary.
4. Medical Necessity Defined:  
Medical, dental, behavioral, rehabilitative, or other health care services which:
- a) Are reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatment for conditions that cause suffering or pain, cause physical deformity or limitation in function, cause illness or infirmity, endanger life, or worsen a disability; and
  - b) Are provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical conditions; and
  - c) Are consistent with the diagnoses of the conditions; and
  - d) Are no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency, and independence and.
  - e) Will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, with consideration to both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.
  - f) Procedures, supplies, equipment, or services that are determined to be:
    - i. Appropriate for the symptoms, diagnosis, or treatment of the medical condition, and
    - ii. Provided for the diagnosis or direct care and treatment of the medical condition, and
    - iii. Within the standards of good medical practice within the organized medical community, and
    - iv. Not primarily for the convenience of the patient's physician or another provider.
4. Additionally, the most appropriate procedure, supply, equipment, or service must satisfy the following requirements:
5. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and produce a greater likelihood of benefit for the patient with the particular medical condition being treated than other possible alternatives.

6. For hospital stays, acute care as an inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and that it is not possible to provide safe and adequate as an outpatient or in a less intensified medical setting.
7. Medical Director/Physician Reviewer are currently licensed in the state of CA required to have UM experience & training in medical clinical practice. The medical director is responsible for ensuring the clinical accuracy of all org determinations and reconsiderations involving medical necessity.

## **PROCEDURE:**

Akido utilizes evidence-based clinical criteria from nationally recognized authorities to guide UM decisions involving pre-service, concurrent review, and post service decisions in conjunction with the member's individual needs and assessment of local delivery system as follows:

1. Utilization Management (UM) Authorization Matrix. The UM matrix is a tool developed to delineate the authority (non-clinical, clinical) for approval of specific services based only on appropriateness of care and utilization of practice patterns.
2. Auto-Authorization by Non-Clinical UM Staff
  - a) Non-licensed UM staff may approve requests that meet the approved UM Matrix Auto-Auth List. Document "Auto-Auth – Matrix Code [X]" in case notes.
  - b) All other requests escalate to licensed clinical staff.
3. Line of Business (LOB) guidelines set forth in CMS, DHCS, Upstream Health Plans (plans), and State and Federal regulations.
4. Clinical criteria sources may include but are not limited to:
  - a) Eligibility
  - b) Benefit document: Evidence of Coverage (EOC)
  - c) Medi-Cal & Medicare Commercial Benefit Policy Manuals,
  - d) LOB Claims Processing Manual; and
  - e) Medicare Managed Care Manual- Medi-Cal Part 2 Provider Manuals
  - f) CMS Drug Compendia
  - g) CMS National Coverage Determinations (NCD) and Local Coverage Determinations (LCD)
  - h) Health Plan Medical Policies
  - i) Nationally recognized evidence-based guidelines (i.e., MCG, InterQual, ADA, ACA) will be utilized.
  - j) InterQual Criteria or MCG guidelines may be used in connection with the independent professional judgment of a qualified professional.

5. Behavioral Health when applicable/delegated.
  - a) American Psychiatric Association (APA)
  - b) American Academy of Child and Adolescent Psychiatry (AACAP)
  - c) American Society of Addiction Medicine (ASAM)
  - d) Substance Abuse and Mental Health Services Administration (SAMHSA)
  - e) Guidelines for the treatment of autism spectrum disorders (e.g., CDC Autism Spectrum Disorder Recommendations and Guidelines)
  - f) In the absence of CMS, Medi-Cal, or Health Plan guidelines Nationally recognized evidence-based guidelines (i.e., MCG) will be utilized.
  - g) MCG guidelines may be used in connection with the independent professional judgment of a qualified professional.
  - h) Behavioral health evidence-based guidelines (criteria adopted from an evidence-based source, i.e., medical journals).
  
6. Criteria are applied based on members' individual needs such as:
  - a) Age
  - b) Comorbidities
  - c) Complications
  - d) Progress of treatment
  - e) Psychosocial situation
  - f) Home environment, when applicable
  - g) Other factors that may impact the ability to implement an individual Member's care plan.
  
7. Hierarchy of Clinical Criteria Application - Licensed reviewers must follow the sequence, documenting the source and rationale as indicated for each line of business. Akido does not develop internal criteria. Akido adopts the Upstream Health Plan criteria guidelines and evidence-based clinical criteria from nationally recognized authorities.

## **Medical**

1. Medi-Cal Member Handbook / Evidence of Coverage
2. Medi-Cal Guidelines including:
  - a) Medi-Cal Provider Manuals
3. California Code of Regulations, Title 22
4. DHCS All Plan Letters (APLs), Policy Letters, and Medi-Cal regulatory guidance
5. DMHC regulatory guidance regarding UM
6. Evidence based clinical criteria (e.g., MCG® or other nationally recognized compendia)
7. Professional Society Organizational guidelines such as:
  - a) World Professional Association for Transgender Health (WPATH)

- b) American Academy of Pediatrics
  - c) American Academy of Orthopedic Surgeons
  - d) American College of Cardiology
  - e) American College of Obstetrics and Gynecology
8. Peer Reviewed Publications when no established criteria are available.

### **Medicare**

1. CMS National Coverage Determinations (NCDs)
2. CMS Local Coverage Determinations (LCDs)
3. CMS Medicare Benefit Policy Manual and other CMS program instructions
4. Full-Service Health Plan Medical Necessity Criteria
5. Evidence based clinical criteria (e.g., MCG®, InterQual®, Apollo)
6. Professional Society Organizational Guidelines such as:
  - a) American Academy of Pediatrics
  - b) American Academy of Orthopedic Surgeons
  - c) American College of Cardiology
  - d) American College of Obstetrics and Gynecology
7. Hayes Technology Assessments when applicable
8. Peer reviewed medical literature when no established criteria are available.

### **Commercial**

1. Evidence of Coverage (EOC)
2. Full-Service Health Plan Medical & Pharmacy Criteria
3. MCG or another nationally recognized evidence-based compendium
4. Professional Society Organizational Guidelines such as:
  - a) American Academy of Pediatrics
  - b) American Academy of Orthopedic Surgeons
  - c) American College of Cardiology
  - d) American College of Obstetrics and Gynecology
5. Peer Reviewed Publications when no established criteria are available.
6. For physician-administered drugs,
  - a) Medi-Cal Magellan Rx Management Library of Medical Necessity Criteria, which are applicable evidence-based clinical guidelines based on medical literature, nationally recognized guidelines published in all fields of medicine, practice observations, and database analyses. These criteria are vetted through Magellan's Medical Necessity Criteria (MNC) committee. <https://www.magellanprovider.com/providing-care/clinical-guidelines/medical-necessity-criteria.aspx>

- b) Plan pharmacy coverage guidelines.
  - c) Part B Medicare requirements defined in CMS National Coverage Determinations (NCDs) and relevant Local Coverage Determinations (LCDs).
  - d) Medication Step Therapy in accordance with Plan(s) step therapy requirements for medications. The Plan list of preferred products should be used first.
7. When UM Criteria are applied, an assessment of the local delivery system's ability to meet a member's specific health care needs is required, and the following should be considered:
- a) Inpatient, Outpatient, and transitional care are available within the service area.
  - b) Availability of outpatient services in lieu of inpatient services such as ambulatory surgery centers vs. inpatient surgery.
  - c) Availability of highly specialized services such as transplant facilities or cancer centers
  - d) Availability of skilled nursing facilities, subacute care facilities, or home health care in the services area to support the member after hospital discharge.
  - e) Local hospitals' ability to provide all recommended services within the estimated length of stay.
    - i. Other factors that may impact implementation of an individual member's care plan.
    - ii. Benefit Coverage
8. Only a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for members for reasons of medical necessity.
9. Documentation of Clinical Escalations
- a) For any modification or denial, include the Criteria selected and listing each source and excerpted guideline language.
  - b) Flag "Potential Adverse Decision" and route the case to the Medical Director or Designee.
10. The UM clinical and non-clinical staff have specific UM roles and functions. Non-licensed staff may approve UM referrals that meet the UM Committee's current approved UM Matrix grid of auto authorizations as outlined in UM policies and procedures; auto authorization list may include upstream Plans auto auth list).
11. Referrals that do not meet the auto authorization must be forwarded to the nurse or physician reviewer.
12. Verification of Benefits does not require a licensed health care professional.
13. Properly process requests for Non-Preferred In-Network Providers:
- a) Preferred Network vs In-Network Providers:

- b) If a request for services from an in-network provider meets eligibility and medical necessity requirements, the request must be approved.
14. UM Medical and Behavioral health criteria, and the procedures for applying them are annually approved and updated when appropriate.
- a) Evaluates, at least annually, the consistency with which all appropriate clinical and non-clinical staff included in utilization review applies appropriate criteria for decision-making. (Please refer to Policy UM-2025 Inter-Rater Reliability.)
  - b) Will disclose to network practitioners, members, member's representatives, or the public, upon request, the clinical guideline or criteria used to make utilization of review determinations.
  - c) Member or provider for the criteria used for UM determination; the request criteria may be made in person, or by telephone. The distribution of the clinical guidelines or criteria may be in writing by mail when practitioners do not have fax, email or internet access, fax, telephone, via Provider Manual, Provider Bulletin, on its website, or e-mail and must be accompanied by the following notice:
    - i. "The material provided to you are guidelines used by this plan to authorize, modify, or deny care for a person with similar illnesses of conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."
15. Maintains a record of the request(s) for disclosure and copies of responses to Providers, Members, and the Public.
- a) All disclosures will be maintained in the disclosure log and presented to the UM committee meeting on an annual basis.
  - b) Disclosure includes policies, procedures, and criteria used to make a determination for requests submitted by contracted and non-contracted healthcare practitioners and providers.
16. Akido will proactively publish all coverage criteria (including third-party proprietary tools such as InterQual, MCG, Apollo) on a publicly accessible website, subject to the following:
- a) Criteria must be viewable without any user registration, login, subscription, or paywall.
  - b) No restriction solely to plan members, contracted providers, or requestors.
  - c) Access must not require completion of surveys, extensive forms, or any other unnecessary data collection.
  - d) Akido will provide a direct hyperlink to the published criteria and include that link in all Provider Manuals, bulletins, and upon any ad hoc disclosure.
17. When utilizing Akido approved Clinical Criteria (e.g., MCG or InterQual) for admission stays, the diagnosis and/or reason(s) for admission will be documented using the four (4) basic efficiency principles:
- a) Care provided with the necessary expertise
  - b) Care in the least intensive setting

- c) No delays in treatment
- d) No unnecessary services

18. If the member meets criteria for admission, document the:

- a) Goal length of stay on initial review.
- b) If criteria for continued inpatient stay changes during the member's hospitalization, document the new reference ORG number, criterion/criteria met.
- c) Specific reason(s):
  - i. Age
  - ii. Clinical status
  - iii. Comorbidities
  - iv. Complications
  - v. Delay in transfer to lower level of care
  - vi. Delay in treatment
  - vii. Home environment
  - viii. Progress of treatment
  - ix. Psychosocial situation

19. If the member does not meet criteria for admission, identify alternatives to admission and document:

- a. Referral to the Medical Director or designer
- b. Reason(s) for not meeting criteria.
- c. Clinical Criteria reference that identifies why criteria not met.
- d. Available alternatives to admission per the Medical Director or designee
- e. Notation that alternatives to admission discussed with provider(s), name of contact, date, and time of call.

20. When requests for coverage are received for Behavioral Health/Substance Abuse the member's clinical status and baseline mental health status assessment should include the following:

- a) Clinical presentation, including medical and mental health status, past clinical history, medications, and treatments, (both medical and psychiatric) and family history.
- b) Voluntary or involuntary admission
- c) Diagnostic and Statistical Manual of Mental Disorders (DSM) Axis codes
- d) Document the clinical information and sub-dimensions.
  - i. Homicidal intent
  - ii. Irritability/aggression
  - iii. Potential for self-injury
  - iv. Suicidal ideation/intent
- e) Functional Impairment and sub-dimensions
  - i. Nutritional impairment
  - ii. School or work impairment
  - iii. Sleep disturbance

- iv. Social isolation
- f) Mental Status Examination and sub-dimensions
  - i. Affect
  - ii. Appearance
  - iii. Behavioral condition or neurovegetative status
  - iv. Delusions
  - v. Hallucinations
  - vi. Orientation
  - vii. Speech
  - viii. Thought content.
- g) Substance Use/Abuse/Dependence
  - i. Patterns of use/abuse
  - ii. Scope of use/abuse
  - iii. Withdrawal potential
- h) Mental Illness
  - i. Environmental stress/type
  - ii. Family stress
  - iii. Housing
  - iv. Stress with School
  - v. Stress with job.
  - vi. Other Stressors
  - vii. Support System
- i) Level of care for substance abuse
  - i. Alcohol Intoxication and/or Withdrawal Potential
  - ii. Biomedical Conditions and Complications
  - iii. Emotional/Behavioral Conditions and Complications
  - iv. Recovery Environment
  - v. Relapse/Continued Use Potential
  - vi. Treatment Resistance/Acceptance

21. Admission review for admissions and concurrent review of continued hospital or facility stays, and continued home health requests shall be conducted as often as necessary as determined by UM Criteria and the discharge planning process.

#### Practitioner Reviewer Verification & Reconciliation

- a) The physician/Medical Director must sign off in the case note: “Verified criteria hierarchy compliance – [Date/Initials]”.
- b) UM Coordinators reconcile the case note rationale with the denial letter: “Denial Rationale Matched – [Date/Initials]”.
- c) Any discrepancies escalate back for correction before notification.
- d) Using nationally recognized criteria (such as MCG, InterQual) Akido determines the level of discharge planning the member requires & shall implement discharge planning for that specific member accordingly.

- e) Akido draws from and follows recommendations of several locally and nationally recognized sources in the development of medical policy and criteria related to preventive care, admissions, outpatient surgeries, and diagnostic and therapeutic services.
- f) Approved Criteria Sets and Clinical Practice Guidelines:
  - i. CMS Local and National Coverage Determination
  - ii. CMS Benefit Interpretation Manual
  - iii. Agency for Healthcare Research and Quality
  - iv. National Institute for Health
  - v. American Heart Association
  - vi. American Diabetes Association
  - vii. American College of Obstetrics and Gynecology
  - viii. MCG
  - ix. InterQual (Inpatient)
  - x. Hayes Criteria
  - xi. AIM- Radiology criteria for Anthem
  - xii. Case Management Society of America
  - xiii. ACIP- Advisory Committee on Immunization Practices
  - xiv. USPSTF- US Preventive Services Task Force
  - xv. American Lung Association
  - xvi. NCCN - National Comprehensive Cancer Network
  - xvii. Joint National Committee- US Hypertension Management Guidelines
  - xviii. National Kidney Foundation
  - xix. Other Health Plan Approved Criteria Sets as applicable to Health Plan

22. Akido may employ nationally recognized clinical guidelines (e.g., MCG®, InterQual®, Apollo®) or internally developed (“homegrown”) criteria when Original Medicare Medical criteria require supplementation.

23. Akido will adhere to the following prior implementation:

- a) All supplemental criteria must be reviewed and approved by the upstream health Plan’s Utilization Management, Quality Management or Pharmacy and Therapeutics Advisory Committee as appropriate.

24. Provider Accessibility- Akido contracted providers are educated about the availability and access of Akido Clinical Criteria when onboarding as a contracted provider and then annual thereafter during the provider orientation process.

- a) The criteria will be available to them through the provider portal, or they may access the Akido website.

25. Public Accessibility

- a) Criteria will be published on the Akido publicly accessible website before first use, and must meet these conditions:
  - i. Website Access: Directly viewable via URL without registration or login.

- ii. General Availability: No limitation to plan members, contracted providers, or requestors.
- iii. No Paywall: No requirement for subscription or payment.
- iv. Minimal Data Collection: Must not impose surveys, extensive forms, or other burdensome information requests.

26. When supplementing Medical Necessity criteria or in the absence of Medical Necessity criteria, must include a statement of rationale to explain how the clinical benefits are highly likely to outweigh any clinical harms. The statement of rationale must:

- a) Compare the clinical benefits of the criteria to the harm that members may experience because of the coverage criteria.
- b) Factors that may be considered include, but are not limited to:
  - i. Prevalence of expected clinical benefits and harms
  - ii. Relative morbidity and mortality
  - iii. Frequency of delayed diagnosis
  - iv. Relative treatment outcomes
  - v. Be narrowly tailored to the population that stands to benefit.
  - vi. Do more than assume general benefits from the adoption of internal criteria. The statement of rationale must also systemically explain the benefits and harms.

27. Utilization of Criteria exemptions:

- a) Prior authorization guidelines do not apply to the following:
  - i. Emergency and post-stabilization services for medical/behavioral health,
  - ii. Urgent care, crisis stabilization, urgent care for home and community service-based recipients, family planning, preventive services, basic prenatal care, communicable disease services including STD and HIV, out of area renal dialysis and tobacco cessation services.
  - iii. Requests for treatment authorization from Emergency Rooms will be considered automatic approvals by any representative acting for Akido.
  - iv. Prior authorization requirements are not applied to Emergency Services for network or out-of-network providers.

28. Notice & Letter Requirements

- a) Branding & Logos
  - i. All member-facing clinical determination letters (approval, modification, denial) shall display the delegate's legal name/DBA, Plan logo (for MMP), and State Plan logo where contractually required.
- b) Letter Templates
  - i. Use Plan's standardized CMS OMB-approved letter templates or Notices of Action (NOAs) for all decision-making correspondence.
- c) Plain Language
  - i. Letters must be in 6th–8th grade reading level, 12 pt Arial or Times New Roman.
- d) Service Description Match

- i. Any reference to “requested service” in the letter must exactly mirror the member/provider’s original request.
    - e) Language Assistance & Accessibility
      - i. Translate letters into any language spoken by  $\geq 5\%$  of plan members in the service area (and any state-specified AIP/MMP languages), and DHCS Threshold Languages.
      - ii. Alternative formats (Braille, large print, audio) within 1–2 business days of request (per 42 CFR 422.2267).
    - f) Mailings to members must be in an envelope that must include “Important Plan Information” on the envelope and must be printed in font size equivalent to or larger than Times New Roman twelve (12) point. The equivalence standard applies to both the height and width of the font.
29. Staff evaluation of application of Criteria is evaluated through the Akido IRR Auditing process. Refer to P&Ps UM2025 Titled for MDs. & UM2026 for clinical and non-clinical staff.
30. Staff must ensure every denial notice contains:
- a) Criteria sources - a list of all clinical criteria used (e.g., Medicare NCD/LCD, MCG®, InterQual®), with each source referenced by name and version.
  - b) Criteria access - statement that members may request a copy of any criteria via mail, fax, or secure email.
31. Reversal information - description of additional information or documentation would allow approval.
- a) Readability/format - plain language at 6th–8th grade level, in 12 pt Arial or Times New Roman (unless superseded by state/contract).
  - b) Member-specific rationale - personalized, plain-language explanation of denial reason.
  - c) Alternate treatments - at least one alternative medically appropriate option.
  - d) Appeal process - complete appeal rights, deadlines, contact info, and representation of rights (standard and expedited).
  - e) External review - IMR, state fair hearing, ombudsman/consumer assistance, and ERISA external review contact details, as applicable.
  - f) State-specific fill-ins - all mandatory elements per jurisdiction (e.g., provider license #).
32. Medical Management Leadership/designee will provide training upon staff onboarding and annually thereafter.
33. Review of Specific criteria or guidelines.

## **SPECIFIC CONTRACTED HEALTH PLAN REQUIREMENTS**

## **FORMS**

None

## **REFERENCES**

1. Medicare Managed Care Manual (MMCM), Ch. 5. "Quality Assessment," Section 30.1.1
2. California Health & Safety Code, Section(s) 1368 - 1368.03
3. Title 42 Code of Federal Regulations (CFR) §422.152 (1) (3).
4. The Centers for Medicare and Medicaid and the State of California: California Readiness Review Criteria.
5. California Department of Public Health: Letter AFL 13-04
6. California Department of Public Health: Letter AFL 12-38
7. Full-Service Health Plan as appropriate

## **ATTACHMENTS**

None