Exhibit A

Annual Mental Health and Substance Use Benefits Compliance Report

Non-Quantitative Treatment Limitations

Carrier Information

A. Insurer Na	[redacted]	B. Date:	3/1/2021		
C. Contact Name	[redacted]	D. Telephone Num	[redacted]	E. Email:	[redacted]

Part 1.

Providing a description of process used to develop and select criteria used to select Medical Necessity Criteria and a description of all the NQTL's applied to Mental Health, Substance Use Disorders and Medical/Surgical Benefits;

	Description of All NQTL's & All Medical Necessity Criteria Used & Developed Under Each Benefit Category					
	Non-Quantitative Treatment Limitations			Medical Necessity Criteria Used & Developed		
	Mental Health	*Substance Use Disorder*	*Medical/ Surgical*	*Mental Health*	*Substance Use Disorder*	*Medical/Surgical*
Pre-Authorization & on-going Auth. Review process:	Precertification; Concurrent review	Precertification; Concurrent review	Precertification; Concurrent review	[redacted] utilizes its own internally developed Coverage Policies (medical necessity criteria) and the MCGTM Guidelines when conducting medical necessity reviews of MH services and technologies. [redacted] uses the same process for developing the clinical criteria for medical necessity for its own internally developed Coverage Policies for Medical/Surgical, Mental Health and Substance Use Disorder benefits. The same criteria are used for pre-authorization & on-going authorization review, concurrent review and retrospective review. The [redacted] Coverage Policy Unit (CPU), in partnership with [redacted] Medical Technology Assessment Committee("MTAC" "MTAC Committee" or the "Committee"), conducts evidence-based assessments of the medical literature and other sources of information pertaining to the safety and effectiveness of medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals. The MTAC Committee's evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in [redacted] "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 Level 1 Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs. Level 2 Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials. Level 3 Observational studies – e.g. cohort, case-control studies (non experimental studies). Also systematic reviews and meta-analyses of observational studies. Level 4 Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies. Level 5 Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.	[redacted] utilizes its own internally developed Coverage Policies (medical necessity criteria) and "The ASAM Criteria®" when conducting medical necessity reviews of Substance Use Disorder (SUD) services and technologies. 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Concurrent Review Process:	Concurrent Review	Concurrent Review	Concurrent Review			
Retrospective Review Process:	Retrospective review	Retrospective review	Retrospective review			

Emergency Services Process:	None	None	None	[redacted] utilizes the Prudent Layperson Standard of the Affordacble Care Act for coverage of Medical/Surgial Emergency Services. This states the following The term "emergency medical condition" means a medical condition manifesting 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, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, •Serious impairment to bodily functions, or •Severe dysfunction of any bodily organ or part •Serious disfigurement	[redacted] utilizes the Prudent Layperson Standard of the Affordacble Care Act for coverage of Medical/Surgial Emergency Services. This states the following The term "emergency medical condition" means a medical condition manifesting 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, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, •Serious impairment to bodily functions, or •Severe dysfunction of any bodily organ or part •Serious disfigurement	[redacted] utilizes the Prudent Layperson Standard of the Affordacble Care Act for coverage of Medical/Surgial Emergency Services. This states the following The term "emergency medical condition" means a medical condition manifesting 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, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, •Serious impairment to bodily functions, or •Severe dysfunction of any bodily organ or part •Serious disfigurement
Pharmacy Services Process:	Prior authorization; step therapy; quantity limits	Prior authorization; step therapy; quantity limits	Prior authorization; step therapy; quantity limits	The same process is used to develop the medical necessity criteria for Mental Health/Substance Use Disorder drugs and medical/surgical drugs. PA Guidelines are developed by a designated Clinical PA Pharmacist according to clinical criteria approved at the quarterly P&T Committee meeting and formulary placement approved by Formulary Administration Services. Drug Selection Process 1. Selection Criteria for Recommendations of Drug Status a. Drugs presented to the P&T Committee for consideration will be reviewed on the following evidence-based criteria i. Safety, including concurrent drug utilization review (cDUR) when applicable, ii. Efficacy the potential outcome of treatment under optimal circumstances, iii. Strength of scientific evidence and standards of practice through review of relevant information from the peer-reviewed medical literature, accepted national treatment guidelines, and expert opinion where necessary, iv. Cost-Effectiveness the actual outcome of treatment under real life conditions including consideration of total health care costs, not just drug costs, through utilization of pharmacoeconomic principles and/or published pharmacoeconomic or outcomes research evaluations where available, v. Relevant benefits of current formulary agents of similar use, vi. Condition of potential duplication of similar drugs currently on formulary, vii. Any restrictions that should be delineated to assure safe, effective, or proper use of the drug. b. The above evidence-based criteria for mental health and substance use disorder drugs and drug classes shall be comparable to, and the P&T Committee shall apply them no more stringently with respect to such drugs, than those used for medical/surgical drugs and drug classes. All drugs or drug classes to be presented are reviewed using evidence based criteria from credible sources including -Peer-reviewed medical literature, -Accepted national treatment guidelines, -Drug compendia in common use, -Other authoritative medical sources. Expert opinion is obtained where necessary. The characteristics of	The same process is used to develop the medical necessity criteria for Mental Health/Substance Use Disorder drugs and medical/surgical drugs. PA Guidelines are developed by a designated Clinical PA Pharmacist according to clinical criteria approved at the quarterly P&T Committee meeting and formulary placement approved by Formulary Administration Services. Drug Selection Process 1. 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				Expert opinion is obtained where necessary. The characteristics of each drug (or drug class) evaluated included -Efficacy as well as relative efficacy compared to other similar medications. -Drug safety and relative risks of drug versus alternatives. -Cost considerations, including drug costs, comparative costs, and projected effect on other medical costs, where applicable. The Committee involves psychiatrists, pediatricians, and other mental health prescribing practitioners in the development of the formulary for psycho-pharmacologic drugs and pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step-therapy.	Expert opinion is obtained where necessary. The characteristics of each drug (or drug class) evaluated included -Efficacy as well as relative efficacy compared to other similar medications. -Drug safety and relative risks of drug versus alternatives. -Cost considerations, including drug costs, comparative costs, and projected effect on other medical costs, where applicable. The Committee involves psychiatrists, pediatricians, and other mental health prescribing practitioners in the development of the formulary for psycho-pharmacologic drugs and pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step-therapy.	Expert opinion is obtained where necessary. The characteristics of each drug (or drug class) evaluated included -Efficacy as well as relative efficacy compared to other similar medications. -Drug safety and relative risks of drug versus alternatives. -Cost considerations, including drug costs, comparative costs, and projected effect on other medical costs, where applicable. The Committee involves psychiatrists, pediatricians, and other mental health prescribing practitioners in the development of the formulary for psycho-pharmacologic drugs and pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step-therapy.
Rx Formulary Design & Management:				The Pharmacy and Therapeutics (P &T) Committee of [redacted] is responsible for review, guidance, and clinical recommendations for the therapeutic use of drugs included in [redacted]t's prescription drug formulary.	The Pharmacy and Therapeutics (P &T) Committee of [redacted] is responsible for review, guidance, and clinical recommendations for the therapeutic use of drugs included in [redacted]'s prescription drug formulary.	The Pharmacy and Therapeutics (P &T) Committee of [redacted] is responsible for review, guidance, and clinical recommendations for the therapeutic use of drugs included in [redacted] s prescription drug formulary.
Case Management Services & Medical Management of Specific Benefits:	None	None	None	Case Management does not approve or deny coverage of benefits. There are no specific benefits that are reviewed other than through the processes and medical necessity criteria noted above.	Case Management does not approve or deny coverage of benefits. There are no specific benefits that are reviewed other than through the processes and medical necessity criteria noted above.	Case Management does not approve or deny coverage of benefits. There are no specific benefits that are reviewed other than through the processes and medical necessity criteria noted above.
Process for assessing new technologies & treatments:	N/A	N/A	N/A	When there is a new technologies & treatments for which where there is no clear [redacted] MCG clinical guidelines or [redacted] cobranded coverage policy position, an evidence based medical inquiry is performed that is specific to the clinical concern in question. The medical inquiry is performed by reviewing the published peer reviewed evidence based literature as well as specialty society guidelines. The function of the inquiry is to assist the physician reviewer in considering the clinical appropriateness of the specific clinical request in question. Medical inquiry requests are reviewed by MTAC twice annually to determine if a medical coverage policy should be considered for development. In order for a technology to be considered for policy development through the MTAC, there must be a proposed clinical benefit for the intervention, FDA clearance or approval, if appropriate, anticipated significant requests for the service and concern about the use of the service being employed in circumstances where it may not be clinically appropriate. As part of the review process, FDA approval or clearance, as appropriate, is necessary, but not alone sufficient, for [redacted] to consider a technology to be proven. FDA approval or clearance does not apply to all services (e.g. procedures). However, when FDA approval or clearance, as appropriate, is present, [redacted] reviews English language peer reviewed publications, as well as relevant documents prepared by specialty societies and evidence-based review centers, such as the Agency for Health Care Research and Quality. Levels of evidence (referenced in the appendix below) are assigned to the publications based upon underlying study characteristics, including but not limited to incidence and prevalence of disease, study design, number of subjects, clinical outcomes of relevance, statistics used and significance, and assessment of flaws and bias. A research team performs a synthetic assessment of the literature in order to determine if there is a sufficiently evidence based proven relationship between the intervention and improved	When there is a new technologies & treatments for which where there is no clear [redacted] MCG clinical guidelines or [redacted] cobranded coverage policy position, an evidence based medical inquiry is performed that is specific to the clinical concern in question. The medical inquiry is performed by reviewing the published peer reviewed evidence based literature as well as specialty society guidelines. 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				health outcomes. This information is presented to the Committee who makes a final determination regarding coverage criteria.	health outcomes. This information is presented to the Committee who makes a final determination regarding coverage criteria.	health outcomes. This information is presented to the Committee who makes a final determination regarding coverage criteria.
Network Adequacy, provider network standards and reimbursement rates:	N/A	N/A	N/A	Providers applying for medical/surgical services are required to sign an agreement for participation, and complete the credentialing process prior to becoming a [redacted] participating provider, and are recredentialed within 36 months thereafter, to ensure they continue to meet our qualifications for participation. The criteria for participation is determined by business needs and by our credentialing policies and procedures, which is reviewed annually to reflect National Committee for Quality Assurance (NCQA), local, federal, and state standards and guidelines. The credentialing process includes a review of the standard application and independent verification of certain documentation submitted. Information submitted must be accurate, current, and complete. [redacted] requirements for credentialing include a completed signed and dated application, a completed, signed and dated authorization and release form (if not included in the application form), documented work history for the past 5 years (initial cred only), current unrestricted license to practice medicine, current unrestricted DEA certificate (if applicable), current unrestricted CDS certificate (if applicable), Board Certification (if applicable),verifiable education/training (if not board certified), unrestricted admitting privileges to at least one [redacted] participating hospital (if applicable), current professional liability insurance with required minimum coverage, acceptable history of professional liability claim experience, acceptable history relative to all types of disciplinary action by any hospital and health care institution and any licensing, regulatory or other professional organization. [redacted] will confirm that the provider continues to be in good standing with state and federal regulatory bodies at the time of initial credentialing, recredentialing and in between cycles, and, if applicable, is reviewed and approved by an accrediting body. In Connecticut, [redacted] leases its provider network from [redacted] [redacted] controls all in-network provider contracting. [redacted] cannot change admission standards to add additional providers to the network when there are known shortages of providers in a geographic region. However, [redacted] has a policy that states when a member is unable to locate an in-network provider within a reasonable* distance for treatment, then [redacted] will reimburse an out-of-network provider at the in-network cost sharing requisites. We will also contact the provider and attempt to make a Single Case Agreement (SCA) with the provider, using reasonable and customary rates, to cover the member's entire treatment, to assure the member will not be subject to any balance billing by the provider. Because [redacted] controls all network contracting, it creates all in-network rates and reimbursements and determines the allowable costs for each claim. [redacted] has no input on in-network rates and reimbursements. *"Reasonable distance" has specified definitions depending on the member's location in an urban, suburban or rural area, based on mileage and/or travel time.	Providers applying for medical/surgical services are required to sign an agreement for participation, and complete the credentialing process prior to becoming a [redacted] participating provider, and are recredentialed within 36 months thereafter, to ensure they continue to meet our qualifications for participation. 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Exclusions for failure to complete course of treatment:	None	None	None	N/A	N/A	N/A
Restrictions that limit duration or scope of benefits for services:	None	None	None	N/A	N/A	N/A

Restrictions on provider billing codes:	N/A	N/A	N/A	[redacted] uses [redacted]. to review our claims for appropriate claim editing and coding. We send our claims to [redacted] for coding and editing review prior to processing and paying the claims. If [redacted] identifies inappropriate coding or editing, [redacted] will release payment based on [redacted] findings. Providers can question and/or appeal the coding and editing findings and upon further review or providing additional information, [redacted] and [redacted] will review and may overturn the initial determination.	[redacted] uses [redacted] to review our claims for appropriate claim editing and coding. We send our claims to [redacted] for coding and editing review prior to processing and paying the claims. If [redacted] identifies inappropriate coding or editing, [redacted] will release payment based on [redacted] findings. Providers can question and/or appeal the coding and editing findings and upon further review or providing additional information, [redacted] and [redacted] will review and may overturn the initial determination.	[redacted] uses [redacted]. to review our claims for appropriate claim editing and coding. We send our claims to [redacted] for coding and editing review prior to processing and paying the claims. If [redacted] identifies inappropriate coding or editing, [redacted] will release payment based on [redacted] findings. Providers can question and/or appeal the coding and editing findings and upon further review or providing additional information, [redacted] and [redacted] will review and may overturn the initial determination.
Method for determining usual, customary and reasonable charges:	N/A	N/A	N/A	[redacted] uses [redacted] as our source for Reasonable and Customary Data. [redacted] considers R&C at the plan benefit level. We typically use the 80th percentile of R&C.	[redacted] uses [redacted] as our source for Reasonable and Customary Data. [redacted] considers R&C at the plan benefit level. We typically use the 80th percentile of R&C.	[redacted] uses [redacted] as our source for Reasonable and Customary Data. [redacted] considers R&C at the plan benefit level. We typically use the 80th percentile of R&C.

Part 2.

Disclosing a results analysis of all Evidentiary Standards, processes, strategies and other factors used in the development and qualification of each criteria used in the assessment of Medical Necessity and each NQTL applied under Mental Health, Substance Use Disorder and Medical/Surgical Benefits. Identifying any and all evidentiary standards and which are qualitative or quantitative in nature.
If there are no evidentiary standards being applied to support a specific criteria or factor, please provide a clear description of that criteria or factor;

[redacted] utilizes its own internally developed Coverage Policies (medical necessity criteria) and the MCG Guidelines when conducting medical necessity reviews of M/S and MH/SUD services and "The ASAM Criteria®" when conducting medical necessity reviews of SUD services.
For Emergency Services, [redacted] utilizes the Prudent Layperson Standard of the Affordable Care Act. This states the following:
The term "emergency medical condition" means a medical condition manifesting 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, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Severe dysfunction of any bodily organ or part
- Serious disfigurement

For [redacted] s own internally developed Coverage Policies, [redacted] 's Coverage Policy Unit (CPU), in partnership with [redacted] 's Medical Technology Assessment Committee("MTAC" "MTAC Committee" or the "Committee"), conducts evidence-based assessments of the medical literature and other sources of information pertaining to the safety and effectiveness of medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals. The MTAC Committee's evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in [redacted] 's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009:
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Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials.
Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies.
Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies.
Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature.The evidentiary standards, processes, strategies and other factors used considered in the design of all the NQTLs, for all Calssifications of M/H, SUD and Medical/Surical except for the Pharmacy Classification, are as follows:

- Cost of treatment/procedure
- Whether treatment type is a driver of high cost growth
- Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region
- Annualized claim volume for treatment type including total paid and denied claims
- Treatment types subject to a higher potential for fraud, waste and/or abuse
- Cost of UM and appeals for treatment type if subject to concurrent care review
- Projected return on investment and/or savings if treatment type is subjected to concurrent care review

If the benefit or value of utilizing the NQTL outweighs the administrative costs associated with utilizing the NQTL, the NQTL is put into place.
In considering evidentiary standards, processes, strategies and other factors in the design of all the NQTLs for the Pharmacy Classification, the The P&T Committee focuses only on the clinical merits of the drug. Pharmacoeconomics are not discussed at the P&T Meeting. The factors considered when establishing these NQTLs by the P&T Committee are based on sound scientific evidence and standards of practice that include but are not limited to:

- Assessing peer-reviewed medical literature
- Referencing published practice guidelines
- Comparing efficacy, side effects, and potential drug interactions among alternative drug therapies
- Assessing impact of formulary decisions to patient compliance

The same factors are considered for both medical/surgical conditions, behavioral health/mental conditions, and substance use disorders. In addition, step therapy is applied when it is determined that, for reasons of safety and/or efficacy, step therapy is recommended to promote appropriate use. Factors that are supplied from P&T Committee monographs include indication, pharmacology, dose and administration, special populations (pregnancy, female/male reproductive potential), pediatrics, hepatic impairment, renal impairment, adverse events, clinical trials, alternative drug therapies, place in therapy, optional clinical criteria, and formulary recommendation.

Part 3.

Provide all NQTL Comparative Analyses and results both "As-Written" and "In-Operation" (actual outcomes experienced from each NQTL) between MH, SUD and Med/Surg benefits, demonstrating that the Mental Health and Substance Use Disorder benefit practices are comparable and being applied no more stringently than to the equivalent Medical/Surgical benefits; please ensure that this summary includes all Six (6) Classifications: (1) In-Patient/INN (2) Out-Patient/INN (3) In-Patient/OON (4) Out-Patient/OON (5) Emergency Services (6) Pharmacy Services.

[redacted] has reviewed policies related to MH/SUD and medical/surgical services to ensure that NQTLs imposed on MH/SUD services are no more stringent than those applied to medical/surgical services, as written and in operation. Consistent with the NQTL requirement for comparability/stringency, [redacted] has confirmed that all the M/S services that meet the criteria for inclusion on the prior authorization or concurrent review lists are included on such lists, and that all of the MH/SUD services included on the lists also meet the criteria for inclusion. [redacted] "Consistency of Utilization Management Decision Making Around Medical Directors and Pharmacists (Inter-rater Reliability)" policy outlines our quality process for monitoring the consistency of utilization management decision making by Medical Directors. Moreover, [redacted] "Use and Application of Medical Necessity Criteria" policy outlines our process for monitoring consistent utilization review pertaining to mental health and substance use disorder levels of care ensuring they are clinically appropriate and consistent. To ensure consistency of reviews, cases/scenarios are selected for Medical Directors to participate in an inter-rater reliability (IRR) testing. The results of the IRR activity are aggregated and reporting is produced that includes the percentage of participation in the IRR activity, the percentage of consensus regarding the application of criteria, rationale, benefit information and determination information. The results report is reviewed and discussed to identify root causes of inconsistencies and opportunities to improve the medical review process, the application of criteria and increase consensus in medical decision-making over time. Annually, IRR results are reviewed and evaluated to develop and action plan and goals for the upcoming year.

In the past year, also [redacted] conducted an actual review of a randomized representative sample of denials for both M/S and MH/SUD utilization review requests. Approximately 60 cases were reviewed. The findings of the review are summarized as follows:

•All MH/SUD cases were reviewed by a peer reviewer prior to issuing a denial. This mandatory peer reviewer requirement applies to MH/SUD cases, affords a more advantageous review process to MH/SUD providers as compared to M/S providers, ensures that any denial is preceded by a peer-to-peer outreach not always offered to M/S providers.

•The type and nature of information requested and reviewed by both medical/surgical and MH/SUD reviewers was appropriate and consistent for the particular review.

•Both medical/surgical and MH/SUD reviewers consistently adhered to clinical guidelines and coverage policies when rendering an adverse determination.

The reviewers noted the case review, as well as the IRR process, concluded that utilization review was being applied, in operation, in a comparable and no more stringent manner for mental health/substance use disorder benefits as compared to medical/surgical benefits.

Regarding NQTLs under the prescription drug benefit, [redacted] performed analyses to determine that the processes and strategies used to design each NQTL, as written and in operation, for mental health/substance use disorder benefits are comparable to, and applied no more stringently than, the same for medical/surgical benefits. The first analysis included sampling a selection of criteria specific to drugs used to treat medical, mental health, and substance use disorder conditions. The sample included all eight criteria that apply to drugs used to treat mental health and substance use disorders and ten examples of criteria that apply to drugs used to treat medical conditions. [redacted] reviewed the criteria for coverage limited to certain diagnoses and other areas that would post parity concerns. The goal of this analysis was to determine if there were differences in requirements that applied to drugs used to treat medical conditions compared to drugs used to treat mental health and substance use disorder conditions. The analysis concluded that the same categories of requirements applied to both sets of drugs. The second analysis focused on prior authorization and appeals denial rates and turnaround times. These metrics were compared for reviews pertaining to drugs used to treat medical conditions compared to drugs used to treat mental health conditions and substance use disorders. No significant differences or parity concerns were identified. The third analysis aimed to confirm that NQTLs were applied consistently across classes of drugs used to treat medical conditions compared to classes of drugs used to treat mental health and substance use disorders. [redacted] reviewed all general therapeutic classes covered under the formulary to determine that there are not any classes of drugs to which each NQTL applied to all drugs under the class. One finding was that quantity limits apply to all medications within the smoking cessation class, but there were not any parity concerns due to a similar quantity limit across all opioids to prevent abuse. The other finding was that there is an age limit of 18+ years old on all drugs under the smoking cessation class; however, [redacted] determined that this was appropriate because smoking cessation products are not FDA approved or indicated for use by patients under the age of 18.

Part 4.

Disclose information to sufficently demonstrate consistent compliance with Sec. 38a-477ee(b),(3),(E)

See the results of the analyses described in Part 3 above.

Regarding operational parity compliance of all benefits except the prescription drug benefits, [redacted] has confirmed that its utilization management programs are applied comparably, and no more stringently, to MH/SUD benefits as compared to M/S benefits. While disparate outcomes of applying an NQTL to MH/SUD and M/S benefits do not necessarily evidence non-compliance, comparable outcomes like those described above can offer evidence of compliance with the NQTL requirement and support [redacted]'s conclusion that its application of utilization management NQTLs to MH/SUD benefits complies with the NQTL requirement.

Regarding operational parity compliance under the prescription drug benefit, [redacted] has confirmed that its analyses indicate that the insurer is in compliance with this Directive and the Mental Health Parity and Addiction Equity Act of 2008 and its implementing and related regulations.

Part 5.

CERTIFICATION

THE FOLLOWING CERTIFICATION MUST BE COMPLETED BY AN OFFICER OF THE COMPANY

I, [redacted], [redacted]
(Printed Name) (Title of Officer)
of [redacted], herby acknowledge that the information that he/she
(Company)
has provided is true and accurate on this 27 day of February, 2021 and that he/she has the authority to execute such instrument.

Signature of Corporate Officer [redacted]
(Signature)

[redacted]
(Print Name)