Federal Mental Health Parity and Addiction Equity Filing

Table 5: Non-Quantitative Treatment Limitations

Submit a separate form for each benefit plan design.

A. Plan Name: [redacted]		B. Date: 3/1/2021
C. Contact Name: [redacted]	D. Telephone Number: [redacted]	E. Email: [redacted]
F. Line of Business (HMO, EPO, POS, PPO): Connecticut HMO and PPO commercial plans		
G. Contract Type (large group, small group, individual): Large Group and Small Group		
H. Benefit Plan Effective Date: 1/1/2020 – 12/31/2020		I. Benefit Plan Design(s) Identifier(s):

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
A. Definition of Medical Necessity What is the definition of medical necessity?	[redacted] defines medical necessity as those health care services that a physician, exercising prudent clinical judgement, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:	Using the same definition, [redacted] ("[redacted]'s behavioral health benefits management vendor, defines medical necessity as those health care services that a physician, exercising prudent clinical judgement, would provide to a patient for the purpose of preventing, evaluating, diagnosing or	[redacted] uses the same medical necessity definition for medical/ surgical (Med/Surg) and mental health and substance use disorder (MH/SUD) benefits, and therefore, its processes meet and exceed the NQTL requirements of the Mental Health Parity and Addiction Equity Act ("MHPAEA").

[1] [redacted] was merged with and into [redacted] on July 1, 2020 with [redacted] as the surviving entity. As such, [redacted] is completing this form on behalf of [redacted] and its affiliate, [redacted] (collectively, [redacted] and [redacted] are referred to as [redacted])

	• in accordance with generally accepted standards of medical practice or state or federally mandated; • clinically appropriate, in terms of type, frequency, extent, site and duration; • considered effective for the patient's illness, injury or disease; • 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 as least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury or disease. For purposes of this definition, "Generally accepted standards of medical practice" means standards that are based on creditable scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.	treating an illness, injury, disease or its symptoms, and that are: • in accordance with generally accepted standards of medical practice or state or federally mandated; • clinically appropriate, in terms of type, frequency, extent, site and duration; • considered effective for the patient's illness, injury or disease; • 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 as least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury or disease. For purposes of this definition, "Generally accepted standards of medical practice" means standards that are based on creditable scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.	**Clinical Criteria is available at:** **Med/Surg:** [redacted] **MH/SUD:** [redacted] **Pharmacy Med/Surg and MH/SUD:** [redacted]

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
B. Prior-authorization Review Process Include all services for which prior- authorization is required. Describe any step- therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans. Inpatient, In-Network:	[redacted] requires prior authorization for certain inpatient services/procedures. These include: • Select non-emergent hospital inpatient admissions • Admissions to skilled nursing facilities (SNFs) acute • Admissions to skilled nursing facilities (SNFs) sub-acute • Inpatient rehabilitation admissions Select procedures, for example, joint surgeries, bariatric procedures, hysterectomy, and cholecystectomy for examples, require clinical documentation such as visit notes, PCP or treating provider statements, demonstrating that a member has unsuccessfully tried certain conservative treatment approaches HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-	[redacted] through [redacted] requires prior authorization for certain inpatient Mental Health/Substance use Disorder ("MH/SUD") services/procedures. These include: • Non emergent Inpatient MH/SUD Admissions • Admissions to residential treatment (MH/SUD) • Electroconvulsive therapy (ECT) when scheduled as inpatient • Substance use detoxification and treatment • Crisis stabilization There are no step-therapy or "fail first" requirements applied to these benefits and treatment plans are not required as part of the prior authorization process. HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving authorization (as defined by plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network.	**Process:** The Med/Surg and MH/SUD prior authorization policies and procedures for inpatient services, as written and as applied, are comparable and no more stringent for MH/SUD benefits than for Med/Surg benefits. Such utilization management policies and procedures consider similar factors, strategies and evidentiary standards in the design of the NQTL and comply with MHPAEA. For both [redacted] and [redacted] providers are responsible for obtaining prior authorization for those services requiring prior authorization. [redacted] and [redacted] use objective, evidence-based medical necessity criteria in making authorization determinations, including nationally recognized criteria, such as the clinical criteria developed by InterQual, the American Society of Addiction Medicine (ASAM), the American Academy of Child and Adolescent Psychiatry (AACAP), and the American Association of Community Psychiatrists (AACP). Authorization requests may be made electronically, telephonically or via fax. **Strategy:** For non-emergent inpatient levels of care, [redacted] and [redacted] each utilize prior authorization as a tool to ensure members receive medically appropriate care in the least restrictive setting that best meets the individual member's specific needs. When performing a prior authorization, clinical staff receive and review clinical information from the provider and apply medical necessity criteria to evaluate requests for specific services and authorize

	network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network.		medically necessary care in accordance with the individual member's benefit plan and clinical need. **Evidentiary standards and other factors:** A wide variety of factors are used in determining what Med/Surg and MH/SUD services require prior authorization, including utilization, cost, quality, clinical outcomes and efficiency, and market trends and fraud, waste and abuse (e.g. the variation in the length of stay and cost per episode of care, provider performance against quality metrics and efficacy of treatment). Examples of sources used to define such factors considered in designing NQTLs for Med/Surg and MH/SUD benefits may include recognized medical literature and published standards, clinical guidelines, evidence based empirical data and research studies, national accreditation standards, cost and trend data, quality and efficiency data, and internal claims and utilization data. Individuals responsible for making decisions related to reviewing and determining Med/surg utilization management best practices include board-certified physicians, med/surg specialists including, RN, ARPNs and PAs and other subject matter experts. For MH/SUD services, individuals responsible for determining utilization management best practices include board certified psychiatrists, addictionologists, psychiatric RNs, APRN, and PAs, psychologists and other subject matter experts. [redacted] and [redacted] both leverage similar data sets for the purpose of determining and evaluating NQTLs. This may include key indicator data such as cost, utilization (over and under) and readmission rates, as well as relevant HEDIS measures and quality indicators. Appeals (upheld and denied), grievances and clinical denial data are also monitored and used in assessing and evaluating use of NQTLs in the management of med/surg and MH/SUD benefits. Both [redacted] and [redacted] adhere to nationally recognized accreditation standards and maintain consistent processes, strategies, and evidentiary standards in the development of NQTLs) as evidenced by the organizations' respective National Committee for Quality Assurance (NCQA) accreditation. While compliance with and accreditation by NCQA is not required to demonstrate compliance in the development of NQTLs, it is indicative of best practices with respect to the implementation. The application of the utilization management tools and techniques for

			Med/Surg and MH/SUD benefits is based on comparable processes in compliance with MHPAEA.
Prior Authorization - Outpatient, In-Network: Office Visits:	No prior authorization is required for primary care visits. A primary care referral is required for HMO members to be seen by a medical specialist. Requiring a referral supports coordination of care between the PCP and medical specialists. HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving prior authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network.	No prior authorization is required for routine outpatient office visits. HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving prior authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network.	No authorization is required for outpatient primary care office visits or routine MH/SUD outpatient office visits, and therefore, the NQTL requirements under MHPAEA do not apply.
Prior Authorization - Outpatient, In-Network: Other Outpatient Items and Services:	[redacted] requires prior authorization for a select subset of other outpatient Med/Surg items and services: • Infusion and injectable medications • High end radiology • Speech therapy • Physical therapy, occupational therapy if services are expected to exceed the member's benefit limit. • Durable medical equipment • Molecular testing • Sleep testing • Outpatient day surgery	[redacted] through [redacted] requires prior authorization for a select subset of nonroutine outpatient MH/SUD items and services: • Electroconvulsive therapy (ECT) • Partial Hospitalization Programs • Intensive outpatient program • Psychological testing • Transcranial Magnetic Stimulation (TMS) • Applied Behavioral Analysis (ABA) skilled services	**Process:** The Med/Surg and MH/SUD prior authorization policies and procedures for other outpatient items and services, as written and as applied, are comparable and no more stringent for MH/SUD than for Med/Surg benefits. Such utilization management policies and procedures consider similar factors, strategies and evidentiary standards in the design of the NQTL and comply with MHPAEA. Providers are responsible for obtaining prior authorization for Med/Surg and MH/SUD services that require prior authorization. Authorization requests may be made electronically, telephonically or via fax.

	• Home Health services, (e.g. skilled nursing, physical therapy) • Interventional pain management • Invitro-fertilization (IVF) • Hospice services Select procedures, for example, IVF and interventional pain management, require clinical documentation such as visit notes, PCP or treating provider statements, demonstrating that a member has unsuccessfully tried certain conservative treatment approaches. Treatment plans are submitted as part of the home health and IVF authorization process. HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network.	There are no step-therapy or "fail first" requirements applied to these benefits Treatment plans are submitted as part of the ABA authorization process. HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network.	[redacted] and [redacted] use objective, evidence-based medical necessity criteria in making authorization determinations, including nationally recognized criteria, such as the clinical criteria developed by InterQual, ASAM, AACAP, and AACP. **Strategy:** For other outpatient items and services, [redacted] and [redacted] each utilize prior authorization as a tool to ensure members receive medically appropriate care in the most clinically effective setting that best meets the individual member's specific needs. When performing a prior authorization, clinical staff receive and review clinical information from providers and apply medical necessity criteria to evaluate requests for specific services and authorize medically necessary care in accordance with the individual member's benefit plan and clinical need. **Evidentiary standards and other factors:** A wide variety of factors are used in determining what Med/Surg and MH/SUD services require prior authorization, including utilization, cost, quality, clinical outcomes and efficiency, market trends and fraud, waste and abuse. Examples of sources used to define such factors considered in designing NQTLs for Med/Surg and MH/SUD benefits may include recognized medical literature and published standards, clinical guidelines, evidence based empirical data and research studies, national accreditation standards, cost and trend data, quality and efficiency data, and internal claims and utilization data. The evidentiary standards and other factors used in determining which outpatient non-office Med/Surg and MH/SUD benefits are subject to prior authorization include the review of objective data for variability in cost and quality of the services as well as provider discretion in determining the diagnosis and length of treatment and to ensure providers are demonstrating use of best practices to support efficacy of treatment. Individuals responsible for making decisions related to reviewing and determining Med/surg utilization management best practices include board-certified physicians, med/surg specialists including, RN, ARPNs and PAs and other subject matter experts. For MH/SUD services, individuals responsible for determining utilization management best practices include board certified psychiatrists, addictionologists, psychiatric RNs, APRN, and PAs, psychologists and other subject matter experts.

			[redacted] and [redacted] both leverage similar data sets for the purpose of determining NQTLs. These include but may not be limited to key indicator data such as cost, utilization (over and under) and readmission rates as well as relevant. HEDIS measures and quality indicators. Appeals (upheld and denied), grievances and clinical denial data are also monitored and used in assessing and evaluating use of NQTLs in the management of med/surg and MH/SUD benefits. Both [redacted] and [redacted] adhere to nationally recognized accreditation standards and maintain consistent processes, strategies, and evidentiary standards in the development of NQTLs as evidenced by the organizations' respective (NCQA accreditation. While compliance with and accreditation by NCQA is not required to demonstrate compliance in the development of NQTLs, it is indicative of best practices with respect to the implementation. The application of the utilization management tools and techniques for Med/Surg and MH/SUD benefits is based on comparable processes in compliance with MHPAEA.
Prior Authorization - Inpatient, Out-of-Network:	[redacted] requires prior authorization for certain inpatient, non-emergent out of network services • Select non-emergent hospital inpatient admissions • Admissions to skilled nursing facilities (SNFs) acute • Admissions to skilled nursing facilities (SNFs) sub-acute • Inpatient rehabilitation admissions Select procedures, for example, joint surgeries, bariatric procedures, hysterectomy, and cholecystectomy for examples, require clinical documentation such as visit notes, PCP or treating provider statements, demonstrating that a member has unsuccessfully tried certain conservative treatment approaches HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of	[redacted] through [redacted] requires prior authorization for certain inpatient, out of network non-emergent inpatient services: • Non-emergent Inpatient MH and SUD Admissions • Admissions to residential treatment (MH/SUD) • Electroconvulsive therapy (ECT) (when scheduled as IP) • Substance use detoxification and treatment • Crisis stabilization HMO members, per benefit design, may only access OON providers only under certain mitigating circumstances There are no step-therapy or "fail first" requirements applied to these benefits and treatment plans are not required as part of the prior authorization process. HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving	**Process:** The Med/Surg and MH/SUD utilization management policies and procedures for inpatient prior authorization, as written and as applied, are comparable and no more stringent for MH/SUD than for Med/Surg benefits. Such utilization polices and procedure consider similar factors, strategies and evidentiary standards in the design of the NQTL. For out-of-network Med/Surg and MH/SUD services, the member is responsible for obtaining any required prior authorization but can designate their provider to seek prior authorization on their behalf. [redacted] and [redacted] use objective, evidence-based, medical necessity criteria in making authorization determinations, including nationally recognized criteria, such as the clinical criteria developed by InterQual, ASAM, AACAP, and AACP. For members that do not have out of network benefits, authorization to seek care from a non-participating provider will be granted if services are not available within the plan's network and if such services meet the medical necessity requirements under the plan. Authorization requests may be made electronically, telephonically or via fax.

	network facility or provider without receiving authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network. For PPO members, failure to obtain authorization may result in a financial penalty to the member.	authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network.	**Strategy:** For non-emergent inpatient levels of care, [redacted] and [redacted] each utilize prior authorization as a tool to ensure members receive medically appropriate care in the least restrictive setting that best meets the individual member's specific needs. When performing a prior authorization, clinical staff receive and review clinical information from the provider and apply medical necessity criteria to evaluate requests for specific services and authorize medically necessary care in accordance with the individual member's benefit plan and clinical need. For inpatient out of network requests, both [redacted] and [redacted] utilize prior authorization to evaluate provider access, network adequacy and ensure quality of care and care coordination. **Evidentiary standards and other factors:** A wide variety of factors are used in determining what Med/Surg and MH/SUD services require prior authorization, including utilization, cost, quality, clinical outcomes and efficiency, market trends and fraud, waste and abuse (e.g. the variation in the length of stay and cost per episode of care, provider performance against quality metrics and efficacy of treatment). Examples of sources used to define such factors considered in designing NQTLs for Med/Surg and MH/SUD benefits may include recognized medical literature and published standards, clinical guidelines, evidence based empirical data and research studies, national accreditation standards, cost and trend data, quality and efficiency data, and internal claims and utilization data. For out of network providers, prior authorization is used to ensure facilities have the proper licensing and accreditation and that the requested services meet the appropriate program and treatment specifications. Individuals responsible for making decisions related to reviewing and determining Med/surg utilization management best practices include board-certified physicians, med/surg specialists including, RN, ARPNs and PAs and other subject matter experts. For MH/SUD services, individuals responsible for determining utilization management best practices include board certified psychiatrists, addictionologists, psychiatric RNs, APRN, and PAs, psychologists and other subject matter experts.

			[redacted] and [redacted] both leverage similar data sets for the purpose of determining NQTLs. These include but may not be limited to key indicator data such as cost, utilization (over and under) and readmission rates and geo-access as well as relevant HEDIS measures and quality indicators. Appeals (upheld and denied), grievances and clinical denial data are also monitored and used in assessing and evaluating use of NQTLs. Both [redacted] and [redacted] adhere to nationally recognized accreditation standards and maintain consistent processes, strategies, and evidentiary standards in the development of NQTLs as evidenced by the organizations' respective National Committee for Quality Assurance (NCQA) accreditation. While compliance with and accreditation by NCQA is not required to demonstrate compliance in the development of NQTLs, it is indicative of best practices with respect to the implementation The application of the utilization management tools and techniques for Med/Surg and MH/SUD benefits is based on comparable processes in compliance with MHPAEA.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
Prior Authorization - Outpatient, Out-of-Network: Office Visits:	Not applicable. Prior authorization for outpatient primary care office visits is not required. However, if the member is enrolled in a plan that does not include out of network benefits, then prior authorization is required to obtain out of network services (e.g. an HMO plan or a limited network plan that does not include the provider in question). There are no step-therapy or "fail first" requirements applied to these benefits and treatment plans are not required as part of the prior authorization process. HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network.	Not applicable. Prior authorization for outpatient routine office visits is not required. However, if the member is enrolled in a plan that does not include out of network benefits, prior authorization is required to obtain out of network services (e.g. an HMO plan or limited network plan that does not include the provider in question). There are no step-therapy or "fail first" requirements applied to these benefits and treatment plans are not required as part of the prior authorization process. HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network.	**Process, strategy, evidentiary standards and other factors:** Prior authorization for primary care Med/Surg and routine MH/SUD outpatient office visits is not required. However, if a member is enrolled in a plan that does not cover out of network services, prior authorization for out of network services will be required for both Med/Surg or MH/SUD out of network care. This requirement is based upon the member purchasing an HMO or limited network plan, which generally requires that all Med/Surg and MH/SUD services be provided by an in-network provider or select network of providers. [redacted] applies the same prior authorization requirement for out of network Med/Surg and MH/SUD benefit requests, and therefore, its processes meet and exceed the NQTL requirements of MHPAEA. For members who do not have out of network benefits, a request for authorization to seek care from a non-participating provider will be granted if services are not available within the plan's network and all other terms and conditions of coverage are met. In those circumstances where the plan generally excludes coverage for out of network services, prior authorization for outpatient, out of network Med/surg and MH/SUD office visits is used to verify member and provider eligibility, determine benefit availability and evaluate medical necessity and appropriateness of the proposed out of network service. Considerations include: • Access/availability of care concerns (wait time, distance, travel, or cultural, ethnic, language considerations) • Continuity of care for members in active treatment • Member's clinical presentation PPO members are not required to have a PCP and therefore direct their own services. They are encouraged to utilize their PCP or attending

			physician to coordinate services but can choose to go out of network for Med/Surg and MH/SUD services. Authorization requests for out of network Med/Surg and MH/SUD services may be made electronically, telephonically or via fax.
Prior Authorization - Outpatient, Out-of-Network: Other Items and Services:	Members are responsible for obtaining prior authorization for select outpatient other out of network Med/Surg items and services provided by non-network practitioners. Prior authorization is required for: • Infusion and injectable medications • High end radiology • Speech therapy • Physical therapy, occupational therapy if services are expected to exceed the member's benefit limit. • Durable medical equipment • Molecular testing • Sleep testing • Outpatient day surgery • Home Health services, (e.g. skilled nursing, physical therapy) • Interventional pain management • Invitro-fertilization (IVF) • Hospice services Select procedures, for example, IVF and interventional pain management, require clinical documentation such as visit notes, PCP or treating provider statements, demonstrating that a member has unsuccessfully tried certain conservative treatment approaches. Treatment plans are submitted as part of the home health and IVF authorization process. HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving authorization (as defined by the plan), the member will be financially responsible for the services rendered.	Members are responsible for obtaining prior authorization for select outpatient other, non-routine out of network MH/SUD use disorder other items and services provided by non-network practitioners. Prior authorization is required for: • Electroconvulsive therapy (ECT) • Transcranial Magnetic Stimulation • Partial Hospital programs • Intensive Outpatient programs • Psychological testing • Extended psychotherapy lasting 60 minutes or longer (53+ minutes CPT time rule) with or without medication management • Applied Behavioral Analysis (ABA) skilled services There are no step-therapy or fail first requirements applied to these benefits. Treatment plans are submitted as part of the ABA authorization process. HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network.	**Process** The Med/Surg and MH/SUD prior authorization policies and procedures for other outpatient items and services, as written and as applied, are comparable and no more stringent for MH/SUD than for Med/Surg benefits. Such utilization management policies and procedures consider similar factors, strategies and evidentiary standards in the design of the NQTL and comply with MHPAEA. For out-of-network Med/Surg and MH/SUD services, the member is responsible for obtaining any required prior authorization but can designate their provider to seek prior authorization on their behalf. [redacted] and [redacted] use objective, evidence-based, medical necessity criteria in making authorization determinations, including nationally recognized criteria, such as the clinical criteria developed by InterQual, ASAM, AACAP, and AACP. Authorization requests may be made electronically, telephonically or via fax. **Strategy:** For other outpatient items and services, [redacted] and [redacted] each utilize prior authorization as a tool to ensure members receive medically appropriate care in the most clinically effective setting that best meets the individual member's specific needs. When performing a prior authorization, clinical staff receive and review clinical information from providers and apply medical necessity criteria to evaluate requests for specific services and authorize medically necessary care in accordance with the individual member's benefit plan and clinical need. **Evidentiary standards and other factors:** A wide variety of factors are used in determining what Med/Surg and MH/SUD services require prior authorization, including utilization, cost, quality, clinical outcomes and efficiency, market trends and fraud, waste and abuse. Examples of sources used to define such factors considered in designing NQTLs for Med/Surg and MH/SUD benefits may include recognized medical literature and published standards,

	PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network. For PPO members, failure to obtain authorization may result in a financial penalty to the member.		clinical guidelines, evidence based empirical data and research studies, national accreditation standards, cost and trend data, quality and efficiency data, and internal claims and utilization data. The evidentiary standards and other factors used in determining which outpatient non-office Med/Surg and MH/SUD benefits are subject to prior authorization include the review of objective data for variability in cost and quality of the services as well as provider discretion in determining the diagnosis and length of treatment and to ensure providers are demonstrating use of best practices to support efficacy of treatment. Individuals responsible for making decisions related to reviewing and determining Med/surg utilization management best practices include board-certified physicians, med/surg specialists including, RN, ARPNs and PAs and other subject matter experts. For MH/SUD services, individuals responsible for determining utilization management best practices include board certified psychiatrists, addictionologists, psychiatric RNs, APRN, and PAs, psychologists and other subject matter experts. [redacted] and [redacted] both leverage similar data sets for the purpose of determining NQTLs. These include but may not be limited to key indicator data such as cost, utilization (over and under) and readmission rates as well as relevant. HEDIS measures and quality indicators. Appeals (upheld and denied), grievances and clinical denial data are also monitored and used in assessing and evaluating use of NQTLs in the management of med/surg and MH/SUD benefits. Both [redacted] and [redacted] adhere to nationally recognized accreditation standards and maintain consistent processes, strategies, and evidentiary standards in the development of NQTLs as evidenced by the organizations' respective NCQA accreditation. While compliance with and accreditation by NCQA is not required to demonstrate compliance in the development of NQTLs, it is indicative of best practices with respect to the implementation. The application of the utilization management tools and techniques for Med/Surg and MH/SUD benefits is based on comparable processes in compliance with MHPAEA. **General Prior Authorization Requirements for Members without Out of Network Coverage:** If a member is enrolled in a plan that does not cover out of network services, prior authorization for out of network services will also be

			required for both Med/Surg or MH/SUD out of network care. This requirement is based upon the member purchasing an HMO or limited network plan, which generally requires that all Med/Surg and MH/SUD services be provided by an in-network provider or select network of providers. [redacted] applies the same prior authorization requirement for out of network Med/Surg and MH/SUD benefit requests, and therefore, its processes meet and exceed the NQTL requirements of MHPAEA. For members who do not have out of network benefits, a request for authorization to seek care from a non-participating provider will be granted if services are not available within the plan's network and all other terms and conditions of coverage are met. In those circumstances where the plan generally excludes coverage for out of network services, prior authorization is used to verify member and provider eligibility, determine benefit availability and evaluate medical necessity and appropriateness of the proposed out of network service. Considerations include: • Access/availability of care concerns (wait time, distance, travel, or cultural, ethnic, language considerations) • Continuity of care for members in active treatment • Member's clinical presentation
C. Concurrent Review Process, including frequency and penalties for all services. Describe any step-therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans. Inpatient, In-Network:	[redacted] requires concurrent review for certain inpatient services/procedures. These include: • Select non-emergent hospital inpatient admissions • Admissions to skilled nursing facilities (SNFs) acute • Admissions to skilled nursing facilities (SNFs) sub-acute • Inpatient rehabilitation admissions There are no step-therapy or "fail first" requirements applied to these benefits and treatment plans are not required as part of the prior authorization process. If the procedure for concurrent review is not followed, the provider may not be reimbursed for the service.	[redacted] through [redacted] requires concurrent review for certain inpatient services/procedures. These include: • Non emergent Inpatient MH and SUD Admissions • Admissions to residential treatment (MH/SUD) • Electroconvulsive therapy (ECT) (when scheduled as IP) • Substance use detoxification and treatment • Crisis stabilization There are no step-therapy or "fail first" requirements applied to these benefits and treatment plans are not required as part of the prior authorization process. If the procedure for concurrent review is not followed, the provider may not be reimbursed for the service.	**Process:** The Med/Surg and MH/SUD concurrent authorization policies and procedures for inpatient in-network services, as written and as applied, are comparable and no more stringent for MH/SUD than for Med/Surg benefits. Such utilization management policies and procedures consider similar factors, strategies and evidentiary standards in the design of the NQTL and comply with MHPAEA. Providers are responsible for obtaining authorization for Med/Surg and MH/SUD services that require concurrent review. [redacted] and [redacted] use evidence-based standard medical necessity criteria in making authorization determinations, including nationally recognized criteria, such as the clinical criteria developed by InterQual, ASAM, AACAP, and AACP. For [redacted] and [redacted] concurrent review is conducted by a licensed clinical staff member and is directed at maintaining effectiveness of care. Clinical staff conduct concurrent review during an ongoing hospitalization to determine whether continued stay/treatment is within

			the member's coverage parameters and are medically appropriate. In addition, clinical staff assure that active treatment is occurring and that all elements of treatment and discharge and transition of care planning are being addressed. The frequency of concurrent review varies according to the specific clinical presentation and need. Determinations are based on the clinical information available to the treating physician/practitioner at the time of the concurrent review or at the time the clinical care was provided, and medical necessity criteria or other clinical guidelines required by contract or regulation or benefit plan provisions are applied. The reviewer will also consider the availability of community resources if needed to support treatment and transitions of care. Concurrent review requests may be made electronically, telephonically or via fax. **Strategy:** For non-emergent inpatient levels of care, concurrent review is focused on ensuring that the member continues to receive medically necessary care while in active treatment and to ensure proper discharge planning. Concurrent review can prevent variance in treatment and inconsistent health outcomes for members. **Evidentiary standards and other factors:** A wide variety of factors are used in determining what Med/Surg and MH/SUD services require concurrent review, including utilization, cost, quality, clinical outcomes and efficiency, and market trends (e.g. the variation in the length of stay, treatment and cost per episode of care, provider performance against quality metrics and efficacy of treatment). The evidentiary standards used in determining which inpatient benefits are subject to medical necessity review on a concurrent basis include, but are not limited to, objective data related to quality and cost, efficacy, market trend drivers, utilization and the probability of clinical improvement and effective health outcomes from continued inpatient care. Members receiving inpatient services are generally at high risk with complex clinical conditions. Concurrent review is a tool used to resolve barriers to discharge, ensure that the member obtains the appropriate level of care and to support successful transitions of care. Concurrent review is also used to monitor and act upon variability in quality of care to reduce risk of poor outcomes, readmissions and unnecessary medical expense.

			Individuals responsible for making decisions related to reviewing and determining Med/surg utilization management best practices include board-certified physicians, med/surg specialists including, RN, ARPNs and PAs and other subject matter experts. For MH/SUD services, individuals responsible for determining utilization management best practices include board certified psychiatrists, addictionologists, psychiatric RNs, APRN, and PAs, psychologists and other subject matter experts. [redacted] and [redacted] both leverage similar data sets for the purpose of determining NQTLs. This may include key indicator data such as cost, utilization (over and under) and readmission rates as well as relevant HEDIS measures and quality metrics. Appeals (upheld and denied), grievances and clinical denial data are also monitored and used in assessing and evaluating use of NQTLs in the management of Med/Surg and MH/SUD benefits. Both [redacted] and [redacted] adhere to nationally recognized accreditation standards and maintain consistent processes, strategies, and evidentiary standards in the development of NQTLs as evidenced by the organizations' respective NCQA accreditation. While compliance with and accreditation by NCQA is not required to demonstrate compliance in the development of NQTLs, it is indicative of best practices with respect to the implementation. The application of the utilization management tools and techniques for Med/Surg and MH/SUD benefits is based on comparable processes in compliance with MHPAEA.
Concurrent Review - Outpatient, In-Network: Office Visits:	Not applicable Concurrent review is not required for outpatient, in network office visits for Med/Surg services.	Not applicable. Concurrent review is not required for routine outpatient, in network office visits for MH/SUD services.	No concurrent review is required for outpatient, in network, Med/Surg and MH/SUD office visits, and therefore, the NQTL requirements under MHPAEA do not apply.
Concurrent Review - Outpatient, In-Network: Other Outpatient Items and Services:	[redacted] requires concurrent review for a select subset of other outpatient, in-network Med/Surg items and services: • Physical therapy, speech therapy and occupational therapy • Durable medical equipment • Home health services (e.g. skilled nursing, physical therapy) • Invitro-fertilization (IVF) • Hospice services	[redacted] through [redacted] requires concurrent review for a select subset of other outpatient, in-network MH/SUD services: • Electroconvulsive therapy (ECT) • Partial hospitalization programs • Intensive outpatient program • Applied Behavioral Analysis (ABA) skilled services	**Process:** The Med/Surg and MH/SUD concurrent authorization policies and procedures for other outpatient in-network items and services, as written and as applied, are comparable and no more stringent for MH/SUD than for Med/Surg benefits. Such utilization management policies and procedures consider similar factors, strategies and evidentiary standards in the design of the NQTL and comply with MHPAEA. Providers are responsible for obtaining authorization for Med/Surg and MH/SUD services that require concurrent review.

	IVF requires clinical documentation such as visit notes, PCP or treating provider statements, demonstrating that a member has unsuccessfully tried certain conservative treatment approaches. Treatment plans are submitted as part of the home health and IVF concurrent review process.	There are no step-therapy or fail first requirements applied to these benefits Treatment plans are submitted as part of the ABA concurrent review process.	[redacted] and [redacted] use evidence-based standard medical necessity criteria in making authorization determinations, including nationally recognized criteria, such as the clinical criteria developed by InterQual, ASAM, AACAP, and AACP. For [redacted] and [redacted] concurrent review is conducted by a licensed clinical staff member and is directed at maintaining effectiveness of care. This staff person conducts concurrent review during a course of treatment to determine whether continued authorization is within the member's coverage parameters and are medically appropriate. The frequency of concurrent review varies according to the specific clinical presentation and need. Determinations are based on the clinical information available to the treating physician/practitioner at the time of the concurrent review or at the time the clinical care was provided, and medical necessity criteria or other clinical guidelines required by contract or regulation or benefit plan provisions are applied. In making determinations, the clinical reviewer also considers the availability of community resources and the individual member's need. Concurrent review requests may be made electronically, telephonically or via fax. **Strategy:** For other outpatient items and services, concurrent review is focused on ensuring that the member continues to receive medically necessary care while in active treatment and that such care meets the member's healthcare needs. Concurrent review can prevent variance in treatment and inconsistent health outcomes for members. **Evidentiary standards and other factors:** A wide variety of factors are used in determining what Med/Surg and MH/SUD services require concurrent review, including utilization, cost, quality, clinical outcomes and efficiency, and market trends (e.g. the variation in the length of treatment and practice patterns, high variability in cost per episode of care, provider discretion in in determining the diagnosis and length of treatment, provider performance against quality metrics and efficacy of treatment). The evidentiary standards used in determining which inpatient benefits are subject to medical necessity review on a concurrent basis include, but are not limited to, objective data related to quality and cost, efficacy, market trend drivers, utilization and the probability of clinical improvement and effective health outcomes from continued outpatient care.

			Individuals responsible for making decisions related to reviewing and determining Med/surg utilization management best practices include board-certified physicians, med/surg specialists including, RN, ARPNs and PAs and other subject matter experts. For MH/SUD services, individuals responsible for determining utilization management best practices include board certified psychiatrists, addictionologists, psychiatric RNs, APRN, and PAs, psychologists and other subject matter experts. [redacted] and [redacted] both leverage similar data sets for the purpose of determining NQTLs. This may include key indicator data such as cost, utilization (over and under) and readmission rates as well as relevant. HEDIS measures and quality metrics. Appeals (upheld and denied), grievances and clinical denial data are also monitored and used in assessing and evaluating use of NQTLs in the management of med/surg and MH/SUD benefits. Both [redacted] and [redacted] adhere to nationally recognized accreditation standards and maintain consistent processes, strategies, and evidentiary standards in the development of NQTLs as evidenced by the organizations' respective (NCQA accreditation. While, compliance with and accreditation by NCQA is not required to demonstrate compliance in the development of NQTLs, it is indicative of best practices with respect to the implementation The application of the utilization management tools and techniques for Med/Surg and MH/SUD benefits is based on comparable processes in compliance with MHPAEA.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
Concurrent Review - Inpatient, Out-of-Network:	[redacted] requires concurrent review for non- emergent inpatient, out of network Med/surg admissions: • Select non-emergent hospital inpatient admissions • Admissions to skilled nursing facilities (SNFs) acute • Admissions to skilled nursing facilities (SNFs) sub-acute • Inpatient rehabilitation admissions There are no step-therapy or "fail first" requirements applied to these benefits and treatment plans are not required as part of the prior authorization process. HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network. For PPO members, failure to obtain authorization may result in a financial penalty to the member.	[redacted] through [redacted] requires concurrent review for non- emergent inpatient, out of network MH/SUD admissions: • Non-emergent Inpatient MH and SUD Admissions • Admissions to residential treatment (MH/SUD) • Substance use detoxification and treatment • Crisis stabilization There are no step-therapy or "fail first" requirements applied to these benefits and treatment plans are not required as part of the prior authorization process. HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network.	**Process**: The Med/Surg and MH/SUD concurrent authorization policies and procedures for inpatient out of network services, as written and as applied, are comparable and no more stringent for MH/SUD than for Med/Surg benefits. Such utilization management policies and procedures consider similar factors, strategies and evidentiary standards in the design of the NQTL and comply with MHPAEA. Clinical information collected during the review process includes information about the members treatment progress, current health status and proposed treatment plan. [redacted] and [redacted] use evidence-based standard medical necessity criteria in making authorization determinations, including nationally recognized criteria, such as the clinical criteria developed by InterQual, ASAM, AACAP, and AACP. For [redacted] and [redacted] concurrent review is conducted by a licensed clinical staff member and is directed at maintaining effectiveness of care. Clinical staff conduct concurrent review during an ongoing hospitalization to determine whether continued stay/treatment is within the member's coverage parameters and are medically appropriate. In addition, clinical staff assure that active treatment is occurring and that all elements of treatment and discharge and transition of care planning are being addressed. The frequency of concurrent review varies according to the specific clinical presentation and need. Determinations are based on the clinical information available to the treating physician/practitioner at the time of the concurrent review or at the time the clinical care was provided, and medical necessity criteria or other clinical guidelines required by contract or regulation or benefit plan provisions are applied. The

			reviewer will also consider the availability of community resources if needed to support treatment and transitions of care. Concurrent review requests may be made electronically, telephonically or via fax. **Strategy:** For non-emergent inpatient levels of care, concurrent review is focused on ensuring that the member continues to receive medically necessary care while in active treatment and to ensure proper discharge planning. Concurrent review can prevent variance in treatment and inconsistent health outcomes for members. **Evidentiary standards and other factors:** A wide variety of factors are used in determining what Med/Surg and MH/SUD services require concurrent review, including utilization, cost, quality, clinical outcomes and efficiency, and market trends (e.g. the variation in the length of stay, treatment and cost per episode of care, provider performance against quality metrics and efficacy of treatment). The evidentiary standards used in determining which inpatient benefits are subject to medical necessity review on a concurrent basis include, but are not limited to, objective data related to quality and cost, efficacy, market trend drivers, utilization and the probability of clinical improvement and effective health outcomes from continued inpatient care. Members receiving inpatient services are generally at high risk with complex clinical conditions. Concurrent review is a tool used to resolve barriers to discharge, ensure that the member obtains the appropriate level of care and to support successful transitions of care. Concurrent review is also used to monitor and act upon variability in quality of care to reduce risk of poor outcomes, readmissions and unnecessary medical expense. Individuals responsible for making decisions related to reviewing and determining Med/surg utilization management best practices include board-certified physicians, med/surg specialists including, RN, ARPNs and PAs and other subject matter experts. For MH/SUD services, individuals responsible for determining utilization management best practices include board certified psychiatrists, addictionologists, psychiatric RNs, APRN, and PAs, psychologists and other subject matter experts.

			[redacted] and [redacted] both leverage similar data sets for the purpose of determining NQTLs. This may include key indicator data such as cost, utilization (over and under) and readmission rates as well as relevant HEDIS measures and quality metrics. Appeals (upheld and denied), grievances and clinical denial data are also monitored and used in assessing and evaluating use of NQTLs in the management of Med/Surg and MH/SUD benefits. Both [redacted] and [redacted] adhere to nationally recognized accreditation standards and maintain consistent processes, strategies, and evidentiary standards in the development of NQTLs as evidenced by the organizations' respective NCQA accreditation. While compliance with and accreditation by NCQA is not required to demonstrate compliance in the development of NQTLs, it is indicative of best practices with respect to the implementation. The application of the utilization management tools and techniques for Med/Surg and MH/SUD benefits is based on comparable processes in compliance with MHPAEA.
Concurrent Review - Outpatient, Out-of-Network: Office Visits:	Not applicable. Concurrent review is not required for outpatient, out of network Med/Surg office visits.	Not applicable. Concurrent review is not required for routine outpatient, out of network MH/SUD office visits.	No concurrent review is required for Med/surg or MH/SUD outpatient out of network office visits, and therefore, the NQTL requirements under MHPAEA do not apply.
Concurrent Review - Outpatient, Out-of-Network: Other Items and Services:	[redacted] requires concurrent review for a select subset of other outpatient out of network Med/surg items and services: • Physical therapy, speech therapy and occupational therapy • Durable medical equipment • Home health services (e.g. skilled nursing, physical therapy) • Invitro-fertilization (IVF) • Hospice services There are no step-therapy or fail first requirements applied to these benefits IVF requires clinical documentation such as visit notes, PCP or treating provider statements, demonstrating that a member has unsuccessfully tried certain conservative treatment approaches HMO members, per benefit design, have access to a defined network and do not have coverage for services	[redacted] through [redacted] requires concurrent review for a select subset of other outpatient out of network MH/SUD items and services: • Electroconvulsive therapy (ECT) • Partial hospitalization programs • Intensive outpatient programs • Applied Behavioral Analysis (ABA) skilled services There are no step-therapy or fail first requirements applied to these benefits Treatment plans are submitted as part of the ABA concurrent review process HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an	**Process:** The Med/Surg and MH/SUD concurrent authorization policies and procedures for other outpatient in-network items and services, as written and as applied, are comparable and no more stringent for MH/SUD than for Med/Surg benefits. Such utilization management policies and procedures consider similar factors, strategies and evidentiary standards in the design of the NQTL and comply with MHPAEA. Clinical information collected during the review process includes information about the members treatment progress, current health status and proposed treatment plan. [redacted] and [redacted] use evidence-based standard medical necessity criteria in making authorization determinations, including nationally recognized criteria, such as the clinical criteria developed by InterQual, ASAM, AACAP, and AACP. For [redacted] and [redacted] concurrent review is conducted by a licensed clinical staff member and is directed at maintaining effectiveness of care. This staff person conducts concurrent review during a course of

	provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network. For PPO members, failure to obtain authorization may result in a financial penalty to the member.	out of network facility or provider without receiving authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network.	treatment to determine whether continued authorization is within the member's coverage parameters and are medically appropriate. The frequency of concurrent review varies according to the specific clinical presentation and need. Determinations are based on the clinical information available to the treating physician/practitioner at the time of the concurrent review or at the time the clinical care was provided, and medical necessity criteria or other clinical guidelines required by contract or regulation or benefit plan provisions are applied. In making determinations, the clinical reviewer also considers the availability of community resources and the individual member's need. Concurrent review requests may be made electronically, telephonically or via fax. **Strategy:** For other outpatient items and services, concurrent review is focused on ensuring that the member continues to receive medically necessary care while in active treatment and that such care meets the member's healthcare needs. Concurrent review can prevent variance in treatment and inconsistent health outcomes for members. For outpatient out of network requests, both [redacted] and [redacted] may use concurrent review to ensure that the requested services continue to meet quality of care expectations and program specifications. Concurrent review may also be used to support a member's step-down and discharge to in-network providers, and as a tool to evaluate provider access, network adequacy and ensure quality of care and coordination of care. **Evidentiary standards and other factors:** A wide variety of factors are used in determining what Med/Surg and MH/SUD services require concurrent review, including utilization, cost, quality, clinical outcomes and efficiency, and market trends (e.g. the variation in the length of treatment and practice patterns, high variability in cost per episode of care, provider discretion in in determining the diagnosis and length of treatment, provider performance against quality metrics and efficacy of treatment). The evidentiary standards used in determining which inpatient benefits are subject to medical necessity review on a concurrent basis include, but are not limited to, objective data related to quality and cost, efficacy, market trend drivers, utilization and the probability of clinical improvement and effective health outcomes from continued outpatient care.

			Individuals responsible for making decisions related to reviewing and determining Med/surg utilization management best practices include board-certified physicians, med/surg specialists including, RN, ARPNs and PAs and other subject matter experts. For MH/SUD services, individuals responsible for determining utilization management best practices include board certified psychiatrists, addictionologists, psychiatric RNs, APRN, and PAs, psychologists and other subject matter experts. [redacted] and [redacted] both leverage similar data sets for the purpose of determining NQTLs. This may include key indicator data such as cost, utilization (over and under) and readmission rates as well as relevant. HEDIS measures and quality metrics. Appeals (upheld and denied), grievances and clinical denial data are also monitored and used in assessing and evaluating use of NQTLs in the management of med/surg and MH/SUD benefits. Both [redacted] and [redacted] adhere to nationally recognized accreditation standards and maintain consistent processes, strategies, and evidentiary standards in the development of NQTLs as evidenced by the organizations' respective (NCQA accreditation. While, compliance with and accreditation by NCQA is not required to demonstrate compliance in the development of NQTLs, it is indicative of best practices with respect to the implementation The application of the utilization management tools and techniques for Med/Surg and MH/SUD benefits is based on comparable processes in compliance with MHPAEA.
D. Retrospective Review Process, including timeline and penalties. Inpatient, In-Network:	[redacted] conducts retrospective reviews for Med/surg inpatient services when payment is requested by a provider or member after the services have already been provided and authorization or notification was not obtained as required under the plan. Unless extenuating circumstances are identified, the request for payment will generally be administratively denied for failure to meet the authorization requirements of the plan. If extenuating circumstances are identified, a retrospective review will be conducted to determine whether the inpatient services were medically necessary as defined under the plan. Retrospective review may also be performed if payment is requested for an inpatient admission following emergency room treatment and [redacted] was not notified of such inpatient admission	[redacted] through [redacted] conducts retrospective reviews for MH/SUD inpatient services when payment is requested by a provider or member after the services have already been provided and authorization or notification was not obtained as required under the plan. Unless extenuating circumstances are identified, the request for payment will generally be administratively denied for failure to meet the authorization requirements of the plan. If extenuating circumstances are identified, a retrospective review will be conducted to determine whether the inpatient services were medically necessary as defined under the plan. Retrospective review may also be performed if payment is requested for an inpatient admission following emergency room treatment and [redacted]	**Process:** The Med/Surg and MH/SUD retrospective review policies and procedures for inpatient in-network services, as written and as applied, are comparable and no more stringent for MH/SUD than for Med/Surg benefits. Such utilization management policies and procedures consider similar factors, strategies and evidentiary standards in the design of the NQTL and comply with MHPAEA. The retrospective review process provides members or providers with an opportunity for a post-service review of a request for coverage when the administrative authorization or notification requirements of the plan have not been met. In these instances, the review will be initially focused on the reason that the participating provider failed to notify or obtain authorization from [redacted] or [redacted] for the service. Only if extenuating circumstances are identified will a clinical utilization review be conducted to determine whether the inpatient services were

	within the time period required under the plan. In situations where the plan's notification requirements could not be met, retrospective review may be used to evaluate a request for coverage, as well as to identify potential inappropriate utilization or quality issues. Members are held harmless for provider's failure to obtain authorization when required.	Pilgrim was not notified of such inpatient admission within the time period required under the plan. In situations where the plan's notification requirements could not be met, retrospective review may be used to evaluate a request for coverage, as well as to identify potential inappropriate utilization or quality issues. Members are held harmless for provider's failure to obtain authorization when required.	medically necessary as defined under the plan. [redacted] and [redacted] use evidence-based standard medical necessity criteria in making retrospective review determinations, including nationally recognized criteria, such as the clinical criteria developed by InterQual, ASAM, AACAP, and AACP. Members and providers have up to 180 days from the last date of service to request a retrospective review. If any part of the care cannot be covered, the case is forwarded to a Peer Reviewer to review the entire episode of care. The member or authorized representative is notified in writing of the coverage decision in accordance with applicable state law requirements. **Strategy:** [redacted] and [redacted] conduct inpatient in-network retrospective reviews to ensure proper use of benefits and adherence to policy as well as identify mitigating circumstances, if any, that might impact the failure to meet the authorization or notification requirements under the terms of the health plan. Retrospective review may be used to evaluate the request for an administrative and/or clinical coverage decision. **Evidentiary standards and other factors:** [redacted] and [redacted] use retrospective reviews as a primary tool for identifying potential inappropriate utilization, clinical appropriateness of treatment, proper use of benefits, quality concerns, practice pattern variability, and/or provider education needs regarding procedural requirements. Individuals responsible for making decisions related to reviewing and determining utilization management best practices for retrospective reviews include board-certified physicians, including psychiatrists, internal med/surg and behavioral health specialists and other subject matter experts. External expertise is consulted, as needed. [redacted] and [redacted] both leverage similar data sets for the purpose of determining NQTLs. These may include key indicator data such as claims analysis, quality indicators, appeals (upheld and denied), grievances and administrative denial data. Both [redacted] and [redacted] adhere to nationally recognized accreditation standards and maintain consistent processes, strategies, and evidentiary

			standards in the development of NQTLs as evidenced by the organizations' respective National Committee for Quality Assurance (NCQA) accreditation. While compliance with and accreditation by NCQA is not required to demonstrate compliance in the development of NQTLs, it is indicative of best practices with respect to the implementation. The application of the utilization management tools and techniques for Med/Surg and MH/SUD benefits is based on comparable processes in compliance with MHPAEA.
Retrospective Review - Outpatient, In-Network: Office Visits:	Not applicable. Authorization is not required for outpatient, in-network Med/Surg office visits.	Not applicable. Authorization is not required for outpatient, in-network mental health and substance use disorder office visits.	No authorization is required for outpatient primary care office visits or routine MH/SUD outpatient office visits, and therefore, the NQTL requirements under MHPAEA do not apply.
Retrospective Review - Outpatient, In-Network: Other Outpatient Items and Services:	[redacted] conducts retrospective reviews for Med/surg outpatient other items and services when payment is requested by a provider or member after the services have already been provided and authorization or notification was not obtained as required under the plan. Unless extenuating circumstances are identified, the request for payment will generally be administratively denied for failure to meet the authorization requirements of the plan. If extenuating circumstances are identified, a retrospective review will be conducted to determine whether the outpatient services were medically necessary as defined under the plan.	[redacted] through [redacted] conducts retrospective reviews for MH/SUD other outpatient services when payment is requested by a provider or member after the services have already been provided and authorization or notification was not obtained as required under the plan. Unless extenuating circumstances are identified, the request for payment will generally be administratively denied for failure to meet the authorization requirements of the plan. If extenuating circumstances are identified, a retrospective review will be conducted to determine whether the outpatient services were medically necessary as defined under the plan.	**Process:** The Med/Surg and MH/SUD retrospective review policies and procedures for in-network other outpatient items and services, as written and as applied, are comparable and no more stringent for MH/SUD than for Med/Surg benefits. Such utilization management policies and procedures consider similar factors, strategies and evidentiary standards in the design of the NQTL and comply with MHPAEA. The retrospective review process provides members or providers with an opportunity for a post-service review of a request for coverage when the administrative authorization or notification requirements of the plan have not been met. In these instances, the review will be initially focused on the reason that the participating provider failed to notify or obtain authorization from [redacted] or [redacted] for the service. Only if extenuating circumstances are identified will a clinical utilization review be conducted to determine whether the inpatient services were medically necessary as defined under the plan. [redacted] and [redacted] use evidence-based standard medical necessity criteria in making retrospective review determinations, including nationally recognized criteria, such as the clinical criteria developed by InterQual, ASAM, AACAP, and AACP. Members and providers have up to 180 days from the last date of service to request a retrospective review. If any part of the care cannot be covered, the case is forwarded to a Peer Reviewer to review the entire episode of care. The member or authorized representative is notified in writing of the coverage decision in accordance with applicable state law requirements.

			Strategy: [redacted] and [redacted] conduct inpatient in-network retrospective reviews to ensure proper use of benefits and adherence to policy as well as identify mitigating circumstances, if any, that might impact the failure to meet the authorization or notification requirements under the terms of the health plan. Retrospective review may be used to evaluate the request for an administrative and/or clinical coverage decision. **Evidentiary standards and other factors:** [redacted] and [redacted] use retrospective reviews as a primary tool for identifying potential inappropriate utilization, clinical appropriateness of treatment, proper use of benefits, quality concerns, practice pattern variability, and/or provider education needs regarding procedural requirements. Individuals responsible for making decisions related to reviewing and determining utilization management best practices for retrospective reviews include board-certified physicians, including psychiatrists, internal med/surg and behavioral health specialists and other subject matter experts. External expertise is consulted, as needed. [redacted] and [redacted] both leverage similar data sets for the purpose of determining NQTLs. These may include key indicator data such as claims analysis, quality indicators, appeals (upheld and denied), grievances and administrative denial data. Both [redacted] and [redacted] adhere to nationally recognized accreditation standards and maintain consistent processes, strategies, and evidentiary standards in the development of NQTLs as evidenced by the organizations' respective National Committee for Quality Assurance (NCQA) accreditation. While compliance with and accreditation by NCQA is not required to demonstrate compliance in the development of NQTLs, it is indicative of best practices with respect to the implementation. The application of the utilization management tools and techniques for Med/Surg and MH/SUD benefits is based on comparable processes in compliance with MHPAEA.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
Retrospective Review - Inpatient, Out-of-Network:	[redacted] conducts retrospective reviews for Med/surg inpatient services when payment is requested by a provider or member after the services have already been provided and authorization or notification was not obtained as required under the plan. Unless extenuating circumstances are identified, the request for payment will generally be administratively denied for failure to meet the authorization requirements of the plan. If extenuating circumstances are identified, a retrospective review will be conducted to determine whether the inpatient services were medically necessary as defined under the plan. Retrospective review may also be performed if payment is requested for an inpatient admission following emergency room treatment and [redacted] was not notified of such inpatient admission within the time period required under the plan. In situations where the plan's notification requirements could not be met, retrospective review may be used to evaluate a request for coverage, as well as to identify potential inappropriate utilization or quality issues. For PPO members, failure to obtain authorization may result in a financial penalty. HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an	[redacted] through [redacted] conducts retrospective reviews for MH/SUD inpatient services when payment is requested by a provider or member after the services have already been provided and authorization or notification was not obtained as required under the plan. Unless extenuating circumstances are identified, the request for payment will generally be administratively denied for failure to meet the authorization requirements of the plan. If extenuating circumstances are identified, a retrospective review will be conducted to determine whether the inpatient services were medically necessary as defined under the plan. Retrospective review may also be performed if payment is requested for an inpatient admission following emergency room treatment and [redacted] Pilgrim was not notified of such inpatient admission within the time period required under the plan. In situations where the plan's notification requirements could not be met, retrospective review may be used to evaluate a request for coverage, as well as to identify potential inappropriate utilization or quality issues. HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving authorization (as defined by the plan), the member will	**Process:** The Med/Surg and MH/SUD retrospective review policies and procedures for inpatient out of network services, as written and as applied, are comparable and no more stringent for MH/SUD than for Med/Surg benefits. Such utilization management policies and procedures consider similar factors, strategies and evidentiary standards in the design of the NQTL and comply with MHPAEA. The retrospective review process provides members or providers with an opportunity for a post-service review of a request for coverage when the administrative authorization or notification requirements of the plan have not been met. In these instances, the review will be initially focused on the reason that the out of network provider or member failed to notify or obtain authorization from [redacted] or [redacted] for the service. Only if extenuating circumstances are identified will a clinical utilization review be conducted to determine whether the inpatient services were medically necessary as defined under the plan. [redacted] and [redacted] use evidence-based standard medical necessity criteria in making retrospective review clinical determinations, including nationally recognized criteria, such as the clinical criteria developed by InterQual, ASAM, AACAP, and AACP. Members and providers have up to 180 days from the last date of service to request a retrospective review. If any part of the care cannot be covered, the case is forwarded to a Peer Reviewer to review the entire episode of care. The member or authorized representative is notified in writing of the coverage decision in accordance with applicable state law requirements.

	out of network facility or provider without receiving authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network,	be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network	**Strategy:** [redacted] and [redacted] conduct inpatient out of network retrospective reviews to ensure proper use of benefits and adherence to policy as well as identify mitigating circumstances, if any, that might impact the failure to meet the authorization or notification requirements under the terms of the health plan. Retrospective review may be used to evaluate the request for an administrative and/or clinical coverage decision. **Evidentiary standards and other factors:** [redacted] and [redacted] use retrospective reviews as a primary tool for identifying potential inappropriate utilization, clinical appropriateness of treatment, proper use of benefits, quality concerns, practice pattern variability, and/or provider education needs regarding procedural requirements. Individuals responsible for making decisions related to reviewing and determining utilization management best practices for retrospective reviews include board-certified physicians, including psychiatrists, internal med/surg and behavioral health specialists and other subject matter experts. External expertise is consulted, as needed. [redacted] and [redacted] both leverage similar data sets for the purpose of determining NQTLs. These may include key indicator data such as claims analysis, quality indicators, appeals (upheld and denied), grievances and administrative denial data. Both [redacted] and [redacted] adhere to nationally recognized accreditation standards and maintain consistent processes, strategies, and evidentiary standards in the development of NQTLs as evidenced by the organizations' respective NCQA accreditation. While compliance with and accreditation by NCQA is not required to demonstrate compliance in the development of NQTLs, it is indicative of best practices with respect to the implementation. The application of the utilization management tools and techniques for Med/Surg and MH/SUD benefits is based on comparable processes in compliance with MHPAEA.

Retrospective Review - Outpatient, Out-of-Network: Office Visits:	As noted above, prior authorization for outpatient primary care office visits is not required. However, if the member is enrolled in a plan that does not include out of network benefits, then prior authorization is required to obtain out of network services (e.g. an HMO plan or a limited network plan that does not include the provider in question). HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network.	As noted above, prior authorization for outpatient routine office visits is not required. However, if the member is enrolled in a plan that does not include out of network benefits, prior authorization is required to obtain out of network services (e.g. an HMO plan or limited network plan that does not include the provider in question). HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network.	**Process, strategy, evidentiary standards and other factors:** Prior authorization for primary care Med/Surg and routine MH/SUD outpatient office visits is not required. However, if a member is enrolled in a plan that does not cover out of network services, prior authorization for out of network services will be required for both Med/Surg or MH/SUD out of network care. This requirement is based upon the member purchasing an HMO or limited network plan, which generally requires that all Med/Surg and MH/SUD services be provided by an in-network provider or select network of providers. [redacted] applies the same prior authorization requirement for out of network Med/Surg and MH/SUD benefit requests, and therefore, its processes meet and exceed the NQTL requirements of MHPAEA. For members who do not have out of network benefits, a request for authorization to seek care from a non-participating provider will be granted if services are not available within the plan's network and all other terms and conditions of coverage are met. In those circumstances where the plan generally excludes coverage for out of network services, prior authorization for outpatient, out of network Med/surg and MH/SUD office visits is used to verify member and provider eligibility, determine benefit availability and evaluate medical necessity and appropriateness of the proposed out of network service. Considerations include: • Access/availability of care concerns (wait time, distance, travel, or cultural, ethnic, language considerations) • Continuity of care for members in active treatment • Member's clinical presentation PPO members are not required to have a PCP and therefore direct their own services. They are encouraged to utilize their PCP or attending physician to coordinate services but can choose to go out of network for Med/Surg and MH/SUD services. Authorization requests for out of network Med/Surg and MH/SUD services may be made electronically, telephonically or via fax. Members and providers have up to 180 days from the last date of service to request a retrospective review.
Retrospective Review - Outpatient, Out-of-Network: Other Items and Services:	[redacted] conducts retrospective reviews of Med/surg outpatient, out of network other items and services when payment is requested by a provider or member after the services have already been provided and authorization or notification was not obtained as	[redacted] through [redacted] conducts retrospective reviews of MH/SUD nonroutine outpatient, out of network other services when payment is requested by a provider or member after the services have already been provided and authorization or notification was not	**Process:** The Med/Surg and MH/SUD retrospective review policies and procedures for outpatient out of network other items and services, as written and as applied, are comparable and no more stringent for MH/SUD than for Med/Surg benefits. Such utilization management

	required under the plan. Unless extenuating circumstances are identified, the request for payment will generally be administratively denied for failure to meet the authorization or notification requirements of the plan. If extenuating circumstances are identified, a retrospective review will be conducted to determine whether the outpatient services were medically necessary as defined under the plan. For PPO members, failure to obtain authorization may result in a financial penalty to the member. HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network.	obtained as required under the plan. Unless extenuating circumstances are identified, the request for payment will generally be administratively denied for failure to meet the authorization or notification requirements of the plan. If extenuating circumstances are identified, a retrospective review will be conducted to determine whether the outpatient services were medically necessary as defined under the plan. HMO members, per benefit design, have access to a defined network and do not have coverage for services provided by a non-participating (out of network) provider except in limited circumstances, such as an emergency. If an HMO member receives care from an out of network facility or provider without receiving authorization (as defined by the plan), the member will be financially responsible for the services rendered. PPO members, per benefit design, may seek health care services from participating (in-network) and non-participating providers (out of network). Member Cost Sharing varies depending on whether the provider is in-network or out of network.	policies and procedures consider similar factors, strategies and evidentiary standards in the design of the NQTL and comply with MHPAEA. The retrospective review process provides members or providers with an opportunity for a post-service review of a request for coverage when the administrative authorization or notification requirements of the plan have not been met. In these instances, the review will be initially focused on the reason that the out of network provider or member failed to notify or obtain authorization from [redacted] or [redacted] for the service. Only if extenuating circumstances are identified will a clinical utilization review be conducted to determine whether the inpatient services were medically necessary as defined under the plan. [redacted] and [redacted] use evidence-based standard medical necessity criteria in making retrospective review clinical determinations, including nationally recognized criteria, such as the clinical criteria developed by InterQual, ASAM, AACAP, and AACP. Members and providers have up to 180 days from the last date of service to request a retrospective review. If any part of the care cannot be covered, the case is forwarded to a Peer Reviewer to review the entire episode of care. The member or authorized representative is notified in writing of the coverage decision in accordance with applicable state law requirements. **Strategy:** [redacted] and [redacted] conduct outpatient out of network other items and services retrospective reviews to ensure proper use of benefits and adherence to policy as well as identify mitigating circumstances, if any, that might impact the failure to meet the authorization or notification requirements under the terms of the health plan. Retrospective review may be used to evaluate the request for an administrative and/or clinical coverage decision. **Evidentiary standards and other factors:** [redacted] and [redacted] use retrospective reviews as a primary tool for identifying potential inappropriate utilization, clinical appropriateness of treatment, proper use of benefits, quality concerns, practice pattern variability, and/or provider education needs regarding procedural requirements.

			Individuals responsible for making decisions related to reviewing and determining utilization management best practices for retrospective reviews include board-certified physicians, including psychiatrists, internal med/surg and behavioral health specialists and other subject matter experts. External expertise is consulted, as needed. [redacted] and [redacted] both leverage similar data sets for the purpose of determining NQTLs. These may include key indicator data such as claims analysis, quality indicators, appeals (upheld and denied), grievances and administrative denial data. Both [redacted] and [redacted] adhere to nationally recognized accreditation standards and maintain consistent processes, strategies, and evidentiary standards in the development of NQTLs as evidenced by the organizations' respective NCQA accreditation. While compliance with and accreditation by NCQA is not required to demonstrate compliance in the development of NQTLs, it is indicative of best practices with respect to the implementation. The application of the utilization management tools and techniques for Med/Surg and MH/SUD benefits is based on comparable processes in compliance with MHPAEA.
E. Emergency Services	[redacted] does not require prior authorization, PCP referral or perform concurrent or retrospective review for Med/Surg. emergency services. Emergency services are covered when provided by either an in-network or out of network provider. If a member is admitted to a facility, the member or facility is responsible for notifying [redacted] within 2 business days of admission. This applies to all Med/Surg benefits.	[redacted] through [redacted] does not require prior authorization, PCP referral or perform concurrent or retrospective review for any MH/SUD emergency services. Emergency services are covered when provided by either an in-network or out of network provider. If a member is admitted to a facility, the member or facility is responsible for notifying [redacted] within 2 business days of admission. This applies to all MH/SUD benefits.	[redacted] and [redacted] cover emergency services that are medically necessary to screen and stabilize a member in a medical or behavioral health emergency. Members who believe they are having a medical or behavioral health emergency are encouraged to seek care at the nearest emergency facility. Admission from an emergency department to acute inpatient care does not require prior authorization or referral from a PCP. This does not preclude concurrent review of the appropriateness and medical necessity of the continued stay, following admission. Notification to the plan can be made by telephone, fax, or online. [redacted] and [redacted] use comparable processes, strategies, evidentiary standards or other factors in administering benefits for emergency services. The strategy behind the [redacted] and [redacted] notification requirement is to ensure that all members have access to appropriate medically necessary Med/Surg and MH/SUD services as described in the member's benefit plan, to manage health care costs, monitor quality of care, and to enable care management and care coordination. The evidentiary standards used in determining whether certain services require notification includes consideration of quality and clinical efficiency data, cost, trend and utilization data, and clinical outcomes.

F. Pharmacy Services Include all services for which prior-authorization is required, any step-therapy or "fail first" requirements, any other NQTLs. Tier 1:	[redacted]'s Prescription Drug Program includes a variety of unique commercial prescription drug formularies (Premium 3 Tier/4 Tier; Value 3 Tier/4 Tier/ 5 Tier). NQTLs for Tier 1,Tier 2, /Tier 3,Tier 4, and Tier 5 medications for Med/Surg benefits a include use of prior authorization, step therapy, dispensing limitations, and mandated generic substitutions. The following link provides information about the medications covered under [redacted]'s prescription drug program, including medications subject to utilization management requirements. [redacted] The selection process for formulary tier placement for both Med/Surg drugs and MH/SUD drugs is based on safety, efficacy and cost. Agents that are safer and/or more effective and cost less than existing higher tier agents are considered for coverage. Agents that are equally safe and effective but lower in cost will also be considered for lower tier placement. Agents offering marginal or incompletely defined increments in safety and/or efficacy but are higher cost will be considered on an individual basis, weighing the potential enhanced quality against the cost increase. Decisions on formulary tier placement are reviewed and approved by [redacted] Pharmacy and Therapeutics (P&T) Committee, and the [redacted] Formulary Tier Placement algorithm details the evaluation process for both Med/Surg drugs and MH/SUD drugs. [redacted] Formulary tier designations: Tier 1: Tier 1 includes the lower costing generic drugs which have been selected by [redacted] based on safety, efficacy and cost. Analysis is performed annually, and the Tier 1 list is updated accordingly based on P&T Committee review and approval.	[redacted]'s Prescription Drug Program includes a variety of unique commercial prescription drug formularies (Premium 3 Tier/4 Tier; Value 3 Tier/4 Tier/ 5 Tier). NQTLs for Tier 1,Tier 2, /Tier 3,Tier 4, and Tier 5 medications for MH/SUD benefits include use of prior authorization, step therapy, dispensing limitations, and mandated generic substitutions. The following link provides information about the medications covered under [redacted]'s prescription drug program, including medications subject to utilization management requirements. [redacted] The selection process for formulary tier placement for both Med/Surg drugs and MH/SUD drugs is based on safety, efficacy and cost. Agents that are safer and/or more effective and cost less than existing higher tier agents are considered for coverage. Agents that are equally safe and effective but lower in cost will also be considered for lower tier placement. Agents offering marginal or incompletely defined increments in safety and/or efficacy but are higher cost will be considered on an individual basis, weighing the potential enhanced quality against the cost increase. Decisions on formulary tier placement are reviewed and approved by [redacted] Pharmacy and Therapeutics (P&T) Committee, and the [redacted] Formulary Tier Placement algorithm details the evaluation process for both Med/Surg drugs and MH/SUD drugs. [redacted] Formulary tier designations: Tier 1: Tier 1 includes the lower costing generic drugs which have been selected by [redacted] based on safety, efficacy and cost. Analysis is performed annually, and	**Process:** The Med/Surg and MH/SUD pharmacy formulary design and utilization management policies and procedures, as written and as applied, are comparable and no more stringent for MH/SUD than for Med/Surg benefits. Such utilization management policies and procedures consider similar factors, strategies and evidentiary standards in the design of the NQTL and comply with MHPAEA. [redacted] Pharmacy Services along with the Pharmacy and Therapeutics (P&T) Committee manages the drug formulary process both clinically and contractually and provides accurate administration of the Formulary for [redacted] members. While [redacted]'s pharmacy benefits are administered by a pharmacy benefit manager, [redacted] determines the formulary design and the utilization management protocols that apply to its pharmacy benefits as described herein. . The P & T Committee membership consists of [redacted] employees and a majority of practicing physicians and mid-level specialists, primary care physicians and mid-level general medicine clinicians, and pharmacy specialists from a variety of clinical practice settings to adequately represent the needs of [redacted] members. The role of the P & T Committee is to advise on the clinical management of both Med/Surg and MH/SUD drug use, including recommendations pertaining to formulary drug selection, clinical practice guidelines, prior authorization guidelines, or coverage of specific drug therapies as they relate to medical necessity or appropriateness of use. **Strategy:** The processes, strategies and evidentiary standards behind [redacted]'s pharmacy benefit medical necessity standards and utilization management requirements ensure that all members have access to appropriate medically necessary, safe and effective Med/Surg and MH/SUD medications as described in the individual member's benefit plan, while managing health care costs. Coverage decisions for medications that require prior authorization are based on physician-expert approved, [redacted] defined clinical criteria incorporating evidence based medicine to support appropriate utilization and best clinical practices to avoid harm and reduce clinical errors.

	Tier 2: Tier 2 includes higher cost generic drugs which have been selected by [redacted] based on safety, efficacy and cost. Analysis is performed annually, and the Tier 2 list is updated accordingly based on P&T Committee review and approval. Tier 3: Tier 3 includes the non-preferred generic drugs and preferred brand drugs which have been selected by [redacted] based on safety, efficacy and cost. Analysis is performed biannually, and the Tier 3 list is updated accordingly based on P&T Committee review and approval. Tier 4: Tier 4 includes the non-preferred brand drugs and preferred specialty drugs which have been selected by [redacted] based on safety, efficacy and cost. Analysis is performed annually, and the Tier 4 list is updated accordingly based on P&T Committee review and approval. Tier 5: Tier 5 includes the non-preferred brand specialty drugs and non-preferred specialty drugs which have been selected by [redacted] based on safety, efficacy and cost. Analysis is performed annually, and the Tier 5 list is updated accordingly based on P&T Committee review and approval. **Note: Tier 5 designation applies to only benefit plans with the Value 5 Tier formulary.* New to Market (NTM) drug reviews for both Med/Surg and MH/SUD drugs are conducted quarterly, and formulary tier placement decisions are rendered within six months of drug launch. Pharmacy Services informs its provider customers of upcoming tier changes via provider newsletters. Members are notified in writing with a customized letter for adverse tier changes with a 60 day notice.	the Tier 1 list is updated accordingly based on P&T Committee review and approval. Tier 2: Tier 2 includes higher cost generic drugs which have been selected by [redacted] based on safety, efficacy and cost. Analysis is performed annually, and the Tier 2 list is updated accordingly based on P&T Committee review and approval. Tier 3: Tier 3 includes the non-preferred generic drugs and preferred brand drugs which have been selected by [redacted] based on safety, efficacy and cost. Analysis is performed biannually, and the Tier 3 list is updated accordingly based on P&T Committee review and approval. Tier 4: Tier 4 includes the non-preferred brand drugs and preferred specialty drugs which have been selected by [redacted] based on safety, efficacy and cost. Analysis is performed annually, and the Tier 4 list is updated accordingly based on P&T Committee review and approval. Tier 5: Tier 5 includes the non-preferred brand specialty drugs and non-preferred specialty drugs which have been selected by [redacted] based on safety, efficacy and cost. Analysis is performed annually, and the Tier 5 list is updated accordingly based on P&T Committee review and approval. **Note: Tier 5 designation applies to only benefit plans with the Value 5 Tier formulary.* New to Market (NTM) drug reviews for both Med/Surg and MH/SUD drugs are conducted quarterly, and formulary tier placement decisions are rendered within six months of drug launch. Pharmacy Services informs its provider customers of upcoming tier changes via provider newsletters. Members are notified in writing with a customized letter for adverse tier changes with a 60 day notice.	**Evidentiary standards and other factors:** The evidentiary standards and factors used include the review of published data from the medical literature (peer-reviewed journals, monographs and scientific abstracts), specialist consultant opinions, medical expert reviews, new information on covered drugs, FDA new drug approvals, and information provided by pharmaceutical manufacturers. The selection of drugs for prior authorization, step therapy or dispensing limitations is part of a detailed drug evaluation process set forth in the P&T Committee's Charter. This process identifies the evidentiary standards used by the Committee in its drug evaluation process that incorporates a review of published data from the medical literature, specialist consultant opinions, and information provided by pharmaceutical manufacturers. Below is a summary of the selection process used by the P&T Committee in implementing various utilization management programs for pharmacy benefits: <u>Selection of Drugs for Prior Authorization</u>: To ensure appropriate use, the P&T Committee may recommend prior authorization for coverage of some medications. The request will be evaluated utilizing Committee reviewed and approved guidelines. Coverage decisions for medications that require prior authorization are based on physician-expert approved criteria. [redacted]'s criteria incorporates evidence-based medicine to support appropriate utilization and best clinical practices to avoid harm and reduce clinical errors. The Committee will review criteria for prior authorization on an annual basis. <u>Selection of Drugs for Dispensing Limitations</u>: The P&T Committee may recommend that certain drugs be limited to a determined number of doses (*e.g.*, quantity limit) based on criteria including but not limited to safety, potential overdose hazard, abuse potential, or approximation of usual doses per month. <u>Selection of Drugs for Step-Therapy</u>: Where there is a logical succession of drug therapy for a particular Med/Surg or MH/SUD condition, step-therapy may be recommended. a. In such a succession of agents, the most cost-effective preferred agent might be required to be used first with the prescriber moving to another agent next if the first drug was not successful or the patient was an inappropriate candidate, or the patient had adverse effects.

			b. This process of moving to secondary agents may involve information from prescribers or may be automated by computer review of a patient drug history of which drug(s) had been tried previously.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
Tier 2:	See Section F/Pharmacy Services above.	See Section F/Pharmacy Services above.	See Section F/Pharmacy Services above.
Tier 3:	See Section F/Pharmacy Services above.	See Section F/Pharmacy Services above.	See Section F/Pharmacy Services above.
Tier 4:	See Section F/Pharmacy Services above.	See Section F/Pharmacy Services above.	See Section F/Pharmacy Services above.
G. Prescription Drug Formulary Design How are formulary decisions made for the diagnosis and medical necessary treatment of medical, mental health and substance use disorder conditions?	The [redacted] P&T Committee serves in an advisory capacity to [redacted] on matters pertaining to the clinical management of both medical/surgical and mental health/substance use disorder drug use, including recommendations pertaining to formulary drug selection, clinical practice guidelines, prior authorization guidelines, or coverage of specific drug therapies as they relate to medical necessity or appropriateness of use. The selection of drugs for prior authorization, step therapy or dispensing limitation is part of a detailed drug evaluation process set forth in the committee's Charter. This process identifies the evidentiary standards used by the Committee in its drug evaluation process that incorporates a review of published data from the medical literature, specialist consultant opinions, and information provided by pharmaceutical manufacturers. The Committee reviews and approves [redacted]'s Formulary on at least an annual basis to ensure:	The [redacted] P&T Committee serves in an advisory capacity to [redacted] on matters pertaining to the clinical management of both medical/surgical and mental health/substance use disorder drug use, including recommendations pertaining to formulary drug selection, clinical practice guidelines, prior authorization guidelines, or coverage of specific drug therapies as they relate to medical necessity or appropriateness of use. The selection of drugs for prior authorization, step therapy or dispensing limitation is part of a detailed drug evaluation process set forth in the committee's Charter. This process identifies the evidentiary standards used by the Committee in its drug evaluation process that incorporates a review of published data from the medical literature, specialist consultant opinions, and information provided by pharmaceutical manufacturers. The Committee reviews and approves [redacted]'s Formulary on at least an annual basis to ensure:	**Process:** The Med/Surg and MH/SUD pharmacy formulary design and utilization management policies and procedures, as written and as applied, are comparable and no more stringent for MH/SUD than for Med/Surg benefits. Such utilization management policies and procedures consider similar factors, strategies and evidentiary standards in the design of the NQTL and comply with MHPAEA. [redacted] Pharmacy Services along with the P&T Committee manages the drug formulary process both clinically and contractually and provides accurate administration of the Formulary for [redacted] members. While [redacted]'s pharmacy benefits are administered by a pharmacy benefit manager, [redacted] determines the formulary design and the utilization management protocols that apply to its pharmacy benefits as described herein. The P & T Committee membership consists of [redacted] employees and a majority of practicing physicians, including psychiatry, and mid-level specialists, primary care physicians and mid-level general medicine clinicians, and pharmacy specialists from a variety of clinical practice

	a. The coverage of drugs and therapeutic drug classes are in accordance with Committee policies, procedures and recommendations, and b. The presence of sufficient drugs and therapeutic drug classes to meet the medical and/or behavioral health needs of the patient population for which the formulary is intended, and c. The appropriateness of drug utilization management and control programs such as prior authorization, step therapy, generic substitution, quantity limits, and other drug utilization management and control activities that affect access to covered drugs. The Committee also reviews and approves [redacted]'s *Policy & Procedure for Pharmacy Exceptions* and the *Prescription Drug Program Management Overview* on at least an annual basis to ensure timely use of and access to medications.	a. The coverage of drugs and therapeutic drug classes are in accordance with Committee policies, procedures and recommendations, and b. The presence of sufficient drugs and therapeutic drug classes to meet the medical and/or behavioral health needs of the patient population for which the formulary is intended, and c. The appropriateness of drug utilization management and control programs such as prior authorization, step therapy, generic substitution, quantity limits, and other drug utilization management and control activities that affect access to covered drugs. The Committee also reviews and approves [redacted]'s *Policy & Procedure for Pharmacy Exceptions* and the *Prescription Drug Program Management Overview* on at least an annual basis to ensure timely use of and access to medications.	settings to adequately represent the needs of [redacted] members. The role of the P & T Committee is to advise on the clinical management of both medical/surgical and mental health/substance use disorder drug use, including recommendations pertaining to formulary drug selection, clinical practice guidelines, prior authorization guidelines, or coverage of specific drug therapies as they relate to medical necessity or appropriateness of use. **Strategy:** The processes, strategies and evidentiary standards behind [redacted]'s pharmacy benefit medical necessity standards and utilization management requirements ensure that all members have access to appropriate medically necessary, safe and effective Med/Surg and MH/SUD medications as described in the individual member's benefit plan, while managing health care costs. Coverage decisions for medications that require prior authorization are based on physician-expert approved, [redacted] defined clinical criteria incorporating evidence based medicine to support appropriate utilization and best clinical practices to avoid harm and reduce clinical errors. **Evidentiary standards and other factors:** The selection of drugs for prior authorization, step therapy or dispensing limitation is part of a detailed drug evaluation process set forth in the P & T Committee Charter. This process identifies the evidentiary standards used by the P&T Committee in its drug evaluation process that incorporates a review of published data from the medical literature such as peer to peer reviewed journals, monographs, and scientific abstracts, as well as specialist consultant opinions, medical expert reviews, new information on covered drugs, FDA new drug approvals and information provided by pharmaceutical manufacturers.
Describe the pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step therapy.	Clinical Pharmacy Specialists are charged with developing a formal written review for medications selected for Committee review. Evaluations focus on several factors including, but not limited to, scientific evidence in peer-reviewed medical literature, pharmacoeconomic studies which include quality of life issues, pharmacology, pharmacokinetics, safety profile, adverse effects, contraindications, clinical efficacy, drug-drug interactions, dosing, FDA approved indications, outcomes research data, clinical practice guidelines and comparison with current alternatives.	Clinical Pharmacy Specialists are charged with developing a formal written review for medications selected for Committee review. Evaluations focus on several factors including, but not limited to, scientific evidence in peer-reviewed medical literature, pharmacoeconomic studies which include quality of life issues, pharmacology, pharmacokinetics, safety profile, adverse effects, contraindications, clinical efficacy, drug-drug interactions, dosing, FDA approved indications, outcomes research data, clinical practice guidelines and comparison with current alternatives.	The Med/Surg and MH/SUD pharmacy formulary design and utilization management policies and procedures, as written and as applied, are comparable and no more stringent for MH/SUD than for Med/Surg benefits. Such utilization management policies and procedures consider similar factors, strategies and evidentiary standards in the design of the NQTL and comply with MHPAEA. **Process:** [redacted] Pharmacy Services along with the P&T Committee manages the drug formulary process both clinically and contractually and provides accurate administration of the Formulary for [redacted] members. While [redacted]'s pharmacy benefits are administered by a pharmacy benefit manager, [redacted] determines the formulary design and the utilization

	Selection of Drugs for Prior Authorization: To ensure appropriate use, the Committee may recommend Prior Authorization (PA) for coverage of some medications. The request will be evaluated utilizing Committee reviewed and approved guidelines. The Committee will review criteria for PA on an annual basis. Selection of Drugs for Dispensing Limitations: The Committee may recommend that certain drugs be limited to a determined number of doses (e.g., quantity limit) based on criteria including but not limited to safety, potential overdose hazard, abuse potential, or approximation of usual doses per month. Selection of Drugs for Step-Therapy: Where there is a logical succession of drug therapy for a particular medical or behavioral health condition, step-therapy may be recommended. In such a succession of agents, the most cost-effective preferred agent might be required to be used first with the prescriber moving to another agent next if the first drug was not successful or the member was an inappropriate candidate, or the member had adverse effects. This process of moving to secondary agents may involve information from prescribers or may be automated by computer review of a patient drug history of which drug(s) had been tried previously. Tier Placement supports the evaluation process based on safety, efficacy and cost. Agents that are safer and/or more effective and cost less than existing higher tier agents are considered for coverage. Agents that are equally safe and effective but lower in cost will also be considered for lower tier placement. Agents offering marginal or incompletely defined increments in safety and/or efficacy but are higher cost will be considered on an individual basis, weighing the potential enhanced quality against the cost increase.	Selection of Drugs for Prior Authorization: To ensure appropriate use, the Committee may recommend Prior Authorization (PA) for coverage of some medications. The request will be evaluated utilizing Committee reviewed and approved guidelines. The Committee will review criteria for PA on an annual basis. Selection of Drugs for Dispensing Limitations: The Committee may recommend that certain drugs be limited to a determined number of doses (e.g., quantity limit) based on criteria including but not limited to safety, potential overdose hazard, abuse potential, or approximation of usual doses per month. Selection of Drugs for Step-Therapy: Where there is a logical succession of drug therapy for a particular medical or behavioral health condition, step-therapy may be recommended. In such a succession of agents, the most cost-effective preferred agent might be required to be used first with the prescriber moving to another agent next if the first drug was not successful or the member was an inappropriate candidate, or the member had adverse effects. This process of moving to secondary agents may involve information from prescribers, or may be automated by computer review of a patient drug history of which drug(s) had been tried previously Tier Placement supports the evaluation process based on safety, efficacy and cost. Agents that are safer and/or more effective and cost less than existing higher tier agents are considered for coverage. Agents that are equally safe and effective but lower in cost will also be considered for lower tier placement. Agents offering marginal or incompletely defined increments in safety and/or efficacy but are higher cost will be considered on an individual basis, weighing the potential enhanced quality against the cost increase.	management protocols that apply to its pharmacy benefits as described herein. The P & T Committee membership consists of [redacted] employees and a majority of practicing physicians, including psychiatry, and mid-level specialists, primary care physicians and mid-level general medicine clinicians, and pharmacy specialists from a variety of clinical practice settings to adequately represent the needs of [redacted] members. The role of the P & T Committee is to advise on the clinical management of both medical/surgical and mental health/substance use disorder drug use, including recommendations pertaining to formulary drug selection, clinical practice guidelines, prior authorization guidelines, or coverage of specific drug therapies as they relate to medical necessity or appropriateness of use. **Strategy:** The processes, strategies and evidentiary standards behind [redacted]'s pharmacy benefit medical necessity standards and utilization management requirements ensure that all members have access to appropriate medically necessary, safe and effective Med/Surg and MH/SUD medications as described in the individual member's benefit plan, while managing health care costs. Coverage decisions for medications that require prior authorization are based on physician-expert approved, [redacted] defined clinical criteria incorporating evidence base medicine to support appropriate utilization and best clinical practices to avoid harm and reduce clinical errors **Evidentiary standards and other factors:** The evidentiary standards and factors used include the review of published data from the medical literature (peer-reviewed journals, monographs and scientific abstracts), specialist consultant opinions, medical expert reviews, new information on covered drugs, FDA new drug approvals, and information provided by pharmaceutical manufacturers.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
What disciplines, such as primary care physicians (internists and pediatricians) and specialty physicians (including psychiatrists) and pharmacologists, are involved in the development of the formulary for medications to treat medical, mental health and substance use disorder conditions.	A description of the P&T Committee members is included in Section F (Pharmacy Services) above and the P&T Committee Charter submitted as a supporting document. The membership includes representation of medical and behavioral health clinicians.	A description of the P&T Committee members is included in Section F (Pharmacy Services) above and the P&T Committee Charter submitted as a supporting document. The membership includes representation of medical and behavioral health clinicians.	A description of the P&T Committee members is included in Section F (Pharmacy Services) above and the P&T Committee Charter submitted as a supporting document. The membership includes representation of medical and behavioral health clinicians.
H. Case Management What case management services are available?	[redacted] offers transitional care management, complex case management (CCM) and medical behavioral integrated care management services for all members with primary medical conditions who are identified through a proprietary algorithm, who are referred by UM clinicians, caregivers, providers and members themselves.	[redacted] through [redacted] offers transitional care management, complex case management (CCM) and medical behavioral integrated care management services for all members with a primary Behavioral Health condition who are identified through a proprietary algorithm, who are referred by utilization management clinicians, caregivers, providers and members themselves.	[redacted] and [redacted] each offers case management services to members in order to assist them in obtaining high quality, cost effective care. These are offerings to members enrolled in an [redacted] benefit plan and do not impact the terms of Med/Surg and MH/SUD coverage under the plan. As such, case management is not an NQTL because it does not limit the scope or duration of Med/Surg or MH/SUD benefits.
What case management services are required?	No case management services are required.	No case management services are required.	Case management is not a mandatory program for members. Participation is voluntary and non-participation does not affect a member's coverage available under the benefit plan.
What are the eligibility criteria for case management services?	[redacted] has proprietary criterion to identify members who may benefit for care management services. Transitional care management: Care management is offered to members who are transitioning from inpatient, acute, sub-acute care setting to another care setting or to home.	[redacted] through [redacted] has proprietary criterion to identify members who may benefit for care management. Transitional care management: Care management is offered to members who are transitioning from inpatient or residential MH services or SUD inpatient	[redacted] and [redacted] offer case management to members who may need or benefit from assistance in managing their cares. The overall goal of case management is to help members regain optimum health or improved functional capability, in the appropriate setting and in a cost efficient manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up. The program described

	Medical Behavioral (MBI): Members are identified through health plan data when members are identified with chronic or at risk medical conditions that are not well managed where there is a co-occurring BH condition may be present and the member is actively managing and/or in treatment. Complex case management (CCM): utilizes a population health model for identifying and managing members with complex and emerging health needs. Data from behavioral claims, medical claims, pharmacy claims, and clinical data is leveraged to connect individuals with the right care at the right time based on condition combinations and level of severity. A focus on high-risk members with complex needs (oncology, chronic kidney disease) remains a core component of the model. Typically, complex members have multiple diagnoses and psychosocial needs that can significantly diminish their quality of life. [redacted] focuses on identifying and reaching out to at-risk members *before* they require more intensive medical services. Additionally the program accepts member referrals from[redacted] [redacted] clinicians, providers, caregivers and members themselves are eligible for services.	or residential levels of care to another care setting or to home. Medical Behavioral (MBI): Members are identified through health plan data encounters where there is a chronic or at risk medical conditions that is not well managed and there is the potential for an underlying or under treated BH condition. Complex case management (CCM): Identification of consumers whose clinical history includes higher levels of service and difficulties accessing after care treatment. Use of data show that specific categories of consumers - Stratification levels - are at significantly higher risk for severe and persistent mental illness along with increased utilization at higher levels of care. Typically, complex members have multiple diagnoses and psychosocial needs that can significantly diminish their quality of life. Members are identified and stratified in a way that enables[redacted] to intervene based on clinical opportunity. Data from behavioral claims, medical claims, pharmacy claims, and clinical data is leveraged to connect individuals with the right care at the right time based on condition combinations, level of severity and highly complex. Additionally, the program accepts member referrals from[redacted] and[redacted] clinicians, providers, caregivers and members themselves are eligible for services.	is modeled on and in compliance with NCQA Population Health Management standards. [redacted] and[redacted] meet all Complex Care Mgt. accreditation standards set forth by NCQA The programs include an annual Population Health Assessment; comprehensive evaluation review of the program and its outcome metrics (clinical, cost/utilization, and experience) and quarterly review of member case management files to ensure treatment follows evidence based best practices and opportunities for improvement are conducted.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
I. Process for Assessment of New Technologies Definition of experimental/investigational:	[redacted] generally defines experimental and investigational treatments as those treatments whose safety and efficacy has not been supported based on published peer-reviewed medical and scientific literature. The evidence of coverage defines Experimental, Unproven, or Investigational services and products as: Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests, will be deemed Experimental, Unproven, or Investigational by us under this Benefit Handbook for use in the diagnosis or treatment of a particular medical condition if either of the following is true: a. The product or service is not recognized in accordance with generally accepted evidence-based medical standards as being safe and effective for the use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted evidence-based medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to established peer review by qualified medical or scientific experts prior to publication. In the absence of any such reports, it will generally be determined that a service, procedure, device or drug is not safe and effective for the use in question. b. The products or services have not successfully completed a phase III clinical trial by the United States Food and Drug Administration (FDA) for the illness or condition being treated, or for the diagnosis for which it	[redacted] generally defines experimental and investigational treatments as those treatments whose safety and efficacy has not been supported based on published peer-reviewed medical and scientific literature. The evidence of coverage defines Experimental, Unproven, or Investigational services or products as: Any products or services, including, but not limited to, drugs, devices, treatments, procedures, and diagnostic tests, will be deemed Experimental, Unproven, or Investigational by us under this Benefit Handbook for use in the diagnosis or treatment of a particular medical condition if either of the following is true: a. The product or service is not recognized in accordance with generally accepted evidence-based medical standards as being safe and effective for the use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted evidence-based medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to established peer review by qualified medical or scientific experts prior to publication. In the absence of any such reports, it will generally be determined that a service, procedure, device or drug is not safe and effective for the use in question. b. The products or services have not successfully completed a phase III clinical trial by the United States Food and Drug Administration (FDA) for the illness or condition being treated, or for the diagnosis for which it	The Med/Surg and MH/SUD policies and procedures, as written and as applied, for determining what services and products are excluded under the plan as experimental, unproven or investigational are comparable and no more stringent for MH/SUD than for Med/Surg benefits. [redacted] does not delegate the administration of or determination of what is excluded under the plan as an experimental, unproven or investigational service or product. There is a single definition and process for determining what is considered experimental, unproven or investigational services and technologies for Med/surg and MH/SUD benefits. [redacted] considers the same factors, strategies and evidentiary standards in determining exclusions for Med/Surg and MH/SUD services and products as experimental, unproven or investigational, which meets and exceeds the requirements of MHPAEA.

	is being prescribed. (This does not include off-label uses of FDA approved drugs where use is recognized by established research documentation).	is being prescribed. (This does not include off-label uses of FDA approved drugs where use is recognized by established research documentation).	
Qualifications of individuals evaluating new technologies:	Evaluation new technologies occurs in the Technology Assessment Committee. Qualifications of the Committee members responsible for oversite of evaluating new technologies includes board-certified physicians (medical, surgical and behavioral health), pharmacists, business content experts and members of Medical Policy team. The [redacted] P&T Committee evaluates and determines drugs that may be considered experimental. These recommendations are shared with the Technology Assessment Committee.	Evaluation new technologies occurs in the Technology Assessment Committee. Qualifications of the Committee members responsible for oversite of evaluating new technologies includes board-certified physicians (medical, surgical and behavioral health), pharmacists, business content experts and members of Medical Policy team. The [redacted] P&T Committee evaluates and determines drugs that may be considered experimental. These recommendations are shared with the Technology Assessment Committee.	[redacted] 's Technology Assessment Committee is responsible for evaluating all medical devices, health care procedures (medical, surgical, mental health and substance use disorder) and medical drugs to determine whether or not a treatment is experimental or investigational.
Evidence consulted in evaluating new technologies:	The Committee utilizes an evidence-based approach using the following general criteria: • A review of well-designed published peer reviewed literature, or opinions and evaluations by national medical associations/consensus panels, or other accredited bodies must permit conclusions on the effect of the technology on health outcomes. • Evidence that the technology will improve net health outcomes and the beneficial effects of the health outcomes must outweigh any harmful effects on health outcomes. • Technology must be equally beneficial as any established alternatives and should improve health outcomes as much as or more than any established alternatives, and must be cost-effective • The technology must be attainable outside the investigational setting and • Technology must have final approval from appropriate governing regulatory bodies	The Committee utilizes an evidence-based approach using the following general criteria: • A review of well-designed published peer reviewed literature, or opinions and evaluations by national medical associations/consensus panels, or other accredited bodies must permit conclusions on the effect of the technology on health outcomes. • Evidence that the technology will improve net health outcomes and the beneficial effects of the health outcomes must outweigh any harmful effects on health outcomes. • Technology must be equally beneficial as any established alternatives and should improve health outcomes as much as or more than any established alternatives, and must be cost-effective • The technology must be attainable outside the investigational setting and • Technology must have final approval from appropriate governing regulatory bodies	**Process:** If a new service, medical drug, or technology is not listed or determination on coverage has not been made, the service and technology will be considered experimental/investigational until it is evaluated by [redacted] If a decision is made to evaluate the technology, the request is brought to the Committee. Individual consideration is available for members in the interim. **Strategy:** To ensure [redacted] members have access to services and/or technologies that are shown to improve health outcomes and that health outcomes outweigh any harmful effects on those outcomes and are cost-effective. **Evidentiary standards and other factors:** Evidentiary standards and factors considered include: • A review of well-designed published peer reviewed literature, or opinions and evaluations by national medical associations/consensus panels, or other accredited bodies must permit conclusions on the effect of the technology on health outcomes. • Evidence that the technology will improve net health outcomes and the beneficial effects of the health outcomes must outweigh any harmful effects on health outcomes.

	In addition, the following medical and scientific sources are considered throughout the process: • Peer-reviewed scientific studies published in medical journals that meet nationally recognized requirements for scientific manuscripts • Peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's (NIH) National Library of Medicine • Medical journals recognized by the Secretary of Health and Human Services • Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, such as: Federal Agency for Healthcare Research and Quality of National Institutes of Health, National Comprehensive Cancer Network, National Academy of Sciences or Centers for Medicare and Medicaid Services (CMS) Any national board recognized by the National Institutes of Health (NIH), Peer-reviewed abstracts, Medical Directories (e.g. Hayes Inc, ECRI Institute, UpToDate), U.S. Food and Drug Administration (FDA) and associated compendia If a new service, medical drug, or technology is not listed or determination on coverage has not been made, the service and technology will be considered experimental/investigational until it is evaluated by [redacted] Individual consideration is available for members in the interim.	In addition, the following medical and scientific sources are considered throughout the process: • Peer-reviewed scientific studies published in medical and psychiatric journals that meet nationally recognized requirements for scientific manuscripts • Peer-reviewed literature, biomedical compendia and other literature that meet the criteria of the National Institutes of Health's (NIH) National Library of Medicine • Substance Abuse and Mental Health Services Administration (SAMSHA), National Institute of Mental Health (NIMH), National Institute of Drug Abuse (NIDA), Medical journals recognized by the Secretary of Health and Human Services • Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, such as: Federal Agency for Healthcare Research and Quality of National Institutes of Health, National Comprehensive Cancer Network, National Academy of Sciences or Centers for Medicare and Medicaid Services (CMS) Any national board recognized by the National Institutes of Health (NIH), Peer-reviewed abstracts, Medical Directories (e.g. Hayes Inc, ECRI Institute, UpToDate), U.S. Food and Drug Administration (FDA) and associated compendia If a new service, medical drug, or technology is not listed or determination on coverage has not been made, the service and technology will be considered experimental/investigational until it is evaluated by [redacted] Individual consideration is available for members in the interim.	• Technology must be equally beneficial as any established alternatives and should improve health outcomes as much as or more than any established alternatives, and must be cost-effective • The technology must be attainable outside the investigational setting and • Technology must have final approval from appropriate governing regulatory bodies In addition, the following medical and scientific sources are considered throughout the process: • Peer-reviewed scientific studies published in medical journals that meet nationally recognized requirements for scientific manuscripts • Peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's (NIH) National Library of Medicine • Medical journals recognized by the Secretary of Health and Human Services • Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, such as: Federal Agency for Healthcare Research and Quality of National Institutes of Health, National Comprehensive Cancer Network, National Academy of Sciences or Centers for Medicare and Medicaid Services (CMS) Any national board recognized by the National Institutes of Health (NIH), Peer-reviewed abstracts, Medical Directories (e.g. Hayes Inc, ECRI Institute, UpToDate), U.S. Food and Drug Administration (FDA) and associated compendia [redacted] consults the same evidence sources for evaluating new technology and determining experimental/investigational services and technologies for all Med/surg and MH/SUD services.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
J. Standards for provider credentialing and contracting			
Is the provider network open or closed?	[redacted] maintains an open network for most medical/surgical services, however, there are instances from time to time where [redacted] will close its network to certain ancillary and non-physician health care providers in some or all of its service areas. Examples of the providers to which [redacted] may close its network include durable medical equipment providers, home care and home infusion providers, laboratories, skilled nursing facilities, rehabilitation facilities, sleep labs, and specialty pharmacy.	[redacted] through [redacted] maintains an open network in the New England States for facility and group/individual MH/SUD providers for network contracting who meet credentialing and quality requirements for inclusion. Network recruitment is prioritized by member experience regarding access as well as data on current network availability and density standards.	The factors [redacted] considers when deciding to close its Med/Surg network to certain provider types includes the network needs, including member access needs and network adequacy and access standards for each service area, the prevalence of fraud, waste and abuse, the prevalence of quality of care related issues, cost efficiency and the need to ensure the ability to manage the volume of network providers based upon [redacted]'s goals of providing high quality care to members and excellent customer service to members and network providers. Based upon the factors above, the processes, strategies and evidentiary standards used by [redacted] in determining whether to close its network to certain providers may include consideration of member input related to quality of care and access, network adequacy data, state and national accreditation standards, and information related to the prevalence of fraud, waste and abuse and quality of care issues in certain health care provider industries. [redacted] maintains an open network for MH/SUD services. There is no NQTL that applies to MH/SUD benefits with respect to the question of whether the plan has an open or closed network, and therefore, these requirements do not apply.
What are the credentialing standards for physicians?	To be credentialed, [redacted] requires that physicians provide the following: • A current valid license to practice in the state in which they provide care to [redacted] members and a current valid DEA certificate,	To be credentialed, as a physician (psychiatrist and addictionologists), [redacted] requires that the psychiatrist provide the following: • A current valid license to practice in the state in which they provide care to [redacted] members, and a current valid DEA certificate	**Process:** The Med/Surg and MH/SUD credentialing policies and procedures, as written and as applied, are comparable and no more stringent for MH/SUD than for Med/Surg benefits. Such credentialing policies and procedures consider similar factors, strategies and evidentiary standards in the design of the NQTL and comply with MHPAEA.

	• Board certification (as applicable), • Highest level of education and training attained, • Required malpractice coverage, • Malpractice history, • Relevant work history, • MCR/MCD sanctions, • Previous or current state sanctions of license restrictions and/ or • Limitations of scope of practice *State laws determine whether a clinician must hold a federal DEA or state CDS to prescribe controlled substances. Prescribing of controlled substances may also require a current and unrestricted state-controlled substance certificate (CDS), if applicable in the state.	• Board certification (as applicable), • Highest level of education and training attained, • Required malpractice coverage, • Malpractice history, • Relevant work history, • MCR/MCD sanctions, • Previous or current state sanctions of license restrictions • Limitations of scope of practice *State laws determine whether a clinician must hold a federal DEA or state CDS to prescribe controlled substances. Prescribing of controlled substances may also require a current and unrestricted state-controlled substance certificate (CDS), if applicable in the state.	Both [redacted] and [redacted] complete a standardized process of data collection and credential verification on physicians who wish to provide care to [redacted] members as contracted providers. The data components collected and the process for primary source verification are maintained in compliance with federal and state laws and current NCQA standards. **Strategy:** This process supports the development and maintenance of a highly-qualified network of physicians, accomplished by conducting a thorough assessment of the qualifications and performance of individual physicians seeking initial or continued affiliation with the plan. This review concludes with a decision to grant or deny affiliation to each candidate. **Evidentiary standards and other factors** Based on the above, the processes, strategies and evidentiary standards used by [redacted] and [redacted] the credentialing standards for physicians may include consideration of member input related to quality of care and access, network adequacy data, state and national accreditation standards, and information related to the prevalence of fraud, waste and abuse and quality of care issues in certain health care provider industries.
What are the credentialing standards for licensed non-physician providers? Specify type of provider and standards; e.g., nurse practitioners, physician assistants, psychologists, clinical social workers.	To be credentialed as a non-physician provider, the provider must provide [redacted] with the following: • A current valid license to practice in the state in which they provide care to [redacted] members, • Highest level of education and training attained, • Malpractice coverage, • Malpractice history, • Relevant work history, • MCR/MCD sanctions, • Previous or current state sanctions of license restrictions or • Limitations of scope of practice. If the provider is a prescriber, they must also provide a current valid DEA certificate, board certification (as applicable), This applies to all independently licensed non-physician providers, including nurse practitioners and	To be credentialed as a non-physician provider, the provider must provide [redacted] with the following: • A current valid license to practice in the state in which they provide care to [redacted] members, • Highest level of education and training attained, • Malpractice coverage, • Malpractice history, • Relevant work history, • MCR/MCD sanctions, • Previous or current state sanctions of license restrictions or • Limitations of scope of practice. If the provider is a prescriber, they must also provide a current valid DEA certificate, board certification (as applicable), This applies to all independently licensed non-physician providers	**Process:** Both [redacted] and [redacted] complete a standardized process of data collection and credential verification on non-physician licensed clinical staff who wish to provide care to [redacted] members as contracted providers. In addition, the data components collected and the process for primary source verification are maintained in compliance with federal and state laws and current NCQA standards. **Strategy:** This process supports the development and maintenance of a highly-qualified network of licensed non-physicians, accomplished by conducting a thorough assessment of the qualifications and performance of individual physicians seeking initial or continued affiliation with The Plan. This review concludes with a decision to grant or deny affiliation to each candidate. **Evidentiary standards and other factors** Based on the above, the processes, strategies and evidentiary standards used by [redacted] and [redacted] the credentialing standards for non-physicians may include consideration of member input related to

	physician assistants in certain specialties and/or where required by applicable state law.		quality of care and access, network adequacy data, state and national accreditation standards, and information related to the prevalence of fraud, waste and abuse and quality of care issues in certain health care provider industries.
What are the credentialing/contracting standards for unlicensed personnel; e.g., home health aides, qualified autism service professionals and paraprofessionals?	[redacted] credentials unlicensed personnel as "organizational providers" as part of a facility. [redacted] credentials facilities that may employ unlicensed personnel in accordance with federal and state laws and NCQA standards. The minimum credentialing requirements to be considered for inclusion in the [redacted] network of organizational providers includes: • Lists of Medicare/Medicaid certified providers prepared by CMS; • Letters from the State or Medicare/Medicaid fiscal intermediaries; • Letters to the provider from Medicare/Medicaid, CMS; • Current State licensure as a hospital or other facility type (where required); and • Accreditation by an approved accreditation body (e.g. JCAHO, CHAP, CARF, ACHC, AAAHC) If the Organizational provider is not accredited, the Organizational provider must have been surveyed by the appropriate state licensing board or CMS within the past three (3) years and had five or fewer deficiencies or has received documentation from the appropriate state licensing board or CMS that the provider's plan of correction for deficiency citations has been accepted, or in lieu of the survey report, the facility has received a letter from the appropriate state licensing board or CMS or applicable state agency which shows that the facility was reviewed and indicates that it passed inspection. If necessary, [redacted] may also perform a site visit	[redacted] credentials unlicensed personnel as "organizational providers" as part of a facility. [redacted] credentials facilities that may employ unlicensed personnel in accordance with federal and state laws and NCQA standards. The minimum credentialing requirements to be considered for inclusion in the [redacted] network of organizational providers includes: • Lists of Medicare/Medicaid certified providers prepared by CMS; • Letters from the State or Medicare/Medicaid fiscal intermediaries; • Letters to the provider from Medicare/Medicaid, CMS; • Current State licensure as a hospital or other facility type (where required); and • Accreditation by an approved accreditation body (e.g. JCAHO, CHAP, CARF, ACHC, AAAHC) If the Organizational provider is not accredited the Organizational provider must have been surveyed by the appropriate state licensing board or CMS within the past three (3) years and had five or fewer deficiencies or has received documentation from the appropriate state licensing board or CMS that the provider's plan of correction for deficiency citations has been accepted, or in lieu of the survey report, the facility has received a letter from the appropriate state licensing board or CMS or applicable state agency which shows that the facility was reviewed and indicates that it passed inspection. If necessary, [redacted] may also perform a site visit	**Process:** Both [redacted] and [redacted] credential unlicensed personnel as "organizational providers" as part of a facility and rather than credential non-licensed staff individually, credentials the facility that employ unlicensed personnel in accordance with federal and state laws and NCQA standards. **Strategy:** This process supports the development and maintenance of a highly-qualified network of facilities and non-licensed staff accomplished by conducting a thorough assessment of the qualifications and performance of individual physicians seeking initial or continued affiliation with the Plan. This review concludes with a decision to grant or deny affiliation to each candidate. **Evidentiary standards and other factors** Based on the above, the processes, strategies and evidentiary standards used by [redacted] and [redacted] the credentialing standards for non-licensed staff may include consideration of member input related to quality of care and access, network adequacy data, state and national accreditation standards, and information related to the prevalence of fraud, waste and abuse and quality of care issues in certain health care provider industries.

	[redacted] compares the most recent the appropriate state licensing board or CMS survey report to [redacted] standards to assess whether the provider is compliant with the standards. Examples of facility types include: • Acute Care Hospitals • Federally Qualified Health Centers • Acute Rehabilitation Hospitals • Skilled Nursing Facilities • Home Health Care Agencies • Freestanding Surgery Center	[redacted] compares the most recent the appropriate state licensing board or CMS survey report to [redacted] standards to assess whether the provider is compliant with the standards. Examples of facility types include: • Community Mental Health Centers • Rural Health Clinics • Federally Qualified Health Centers • Acute General Hospitals • Residential Treatment Centers • Home Health Care Agencies	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
K. Exclusions for Failure to Complete a Course of Treatment Does the Plan exclude benefits for failure to complete treatment?	For med/surg, benefits, select procedures require clinical documentation such as visit notes and treatment plans, PCP or treating provider statements, demonstrating that a member has unsuccessfully tried certain conservative treatment approaches or there is a medical contraindication to the required course of treatment. Examples of this include certain surgical procedures (hip and knee procedures, bariatric procedures), formulas and enteral nutrition, diabetes management services, high end imaging and infertility treatment. Medical necessity criteria and clinical guidelines that describe specific treatment protocols are evidence-based and support the use of best practices and cost effectiveness.	Not applicable. There are no "failure to complete treatment" policies and procedures applied to MH/SUD services.	The following description applies to Med/Surg benefits only. There are no benefit exclusions for failure to complete treatment that apply to MH/SUD benefits and therefore, MH/SUD benefits are not subject to this NQTL. Based on the foregoing, the processes, strategies, evidentiary standards and other factors are not (and cannot) be more stringent for MH/SUD benefits than for Med/Surg benefits, demonstrating compliance with MHPAEA. **Medical/Surgical Process** Medical necessity criteria and applicable clinical guidelines are used to determine the appropriate treatment protocols for specific procedures. Criteria is developed with input from clinical experts, including actively practicing experts int eh field and approved by the Clinical Medical Policy Committee. Providers must submit applicable clinical information ad history to demonstrate that the member has unsuccessfully tried certain more conservative treatment approaches. **Medical/Surgical Strategy** This strategy promotes of the use of the least invasive, efficacious and cost-effective procedure to ensure the best clinical outcomes for members with certain conditions. **Medical/Surgical Evidentiary standards and other factors** The evidentiary standards and factors used include the review of published data from the medical literature (peer-reviewed journals, monographs and scientific abstracts), specialist consultant opinions, medical expert reviews, new clinical guidelines.

L. Restrictions that limit duration or scope of benefits for services Does the Plan restrict the geographic location in which services can be received; e.g., service area, within California, within the United States?	Geographic restrictions apply to both Med/Surg and MH/SUD benefits in the same way and depend upon whether the plan includes in-network benefits only or in-network and out-of-network benefits. HMO plan members must use in-network providers within HPHC's service area for all covered Med/Surg and MH/SUD services, except in limited circumstances (e.g. emergency care). PPO plan members have in-network and out-of-network benefits and can obtain covered services from providers nationwide for all Med/Surg and MH/SUD services.	Geographic restrictions apply to both Med/Surg and MH/SUD benefits in the same way and depend upon whether the plan includes in-network benefits only or in-network and out-of-network benefits. HMO plan members must use in-network providers within [redacted]'s service area for all covered Med/Surg and MH/SUD services, except in limited circumstances (e.g. emergency care). PPO plan members have in-network and out-of-network benefits and can obtain covered services from providers nationwide for all Med/Surg and MH/SUD services.	There is no difference in the processes, strategies, evidentiary standards and other factors used for restricting geographic locations for Med/Surg and MH/SUD services, as any geographic restrictions are based solely on whether the plan is an HMO or PPO plan, not whether the service is an M/S or MH/SUD service. To the extent any geographic restriction applies to a plan, it applies to both M/S and MH/SUD services. Based on the foregoing, the processes, strategies, evidentiary standards and other factors are comparable and no more stringent for MH/SUD benefits than for Med/Surg benefits and comply with MHPAEA.
Does the Plan restrict the type(s) of facilities in which enrollees can receive services?	Enrollees are required to obtain covered M/S services from licensed medical/surgical providers rendering services within the lawful scope of the provider's license.	Enrollees are required to obtain covered MH/SUD services from licensed MH/SUD providers rendering services within the lawful scope of the provider's license.	There is no difference in the processes, strategies, evidentiary standards and other factors used for restricting the types of facilities in which enrollees can receive M/S and MH/SUD services, as all covered services must be received by a licensed provider acting within the lawful scope of their license regardless of whether the covered service is an Med/Surg or MH/SUD service. Based on the foregoing, the processes, strategies, evidentiary standards and other factors are comparable and no more stringent for MH/SUD benefits than for Med/Surg benefits and comply with MHPAEA.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
M. Does the Plan restrict the types of provider specialties that can provide certain M/S and/or MH/SUD benefits?	Enrollees are required to obtain covered M/S services from licensed Med/Surg providers rendering services within the lawful scope of the provider's license. For example, skilled nursing facility care must be obtained by an inpatient extended care facility, or part of one, that is operating pursuant to law to provide skilled nursing services.	Enrollees are required to obtain covered MH/SUD services from licensed MH/SUD providers rendering services within the lawful scope of the provider's license. For example, MH/SUD services must be provided by a licensed mental health professional, such as a psychiatrist, psychologist, or clinical social worker, or a facility licensed or approved by the applicable state health or mental health department that is primarily operating to render MH or SUD facility services.	There is no difference in the processes, strategies, evidentiary standards and other factors used for restricting the types of specialties in which enrollees can receive M/S and MH/SUD services, as all covered services must be received by a licensed provider acting within the lawful scope of their license regardless of whether the covered service is a Med/Surg or MH/SUD service. Based on the foregoing, the processes, strategies, evidentiary standards and other factors are comparable and no more stringent for MH/SUD benefits than for Med/Surg benefits and comply with MHPAEA.
N. Network Adequacy	[redacted] complies with applicable state and accreditation network adequacy standards to ensure sufficient Med/Surg providers are available to members enrolled in the plan. [redacted] takes additional the measures to ensure provider availability and access for its members. As part of [redacted]'s credentialing standards for admission to the network, providers must meet certain access and availability standards. [redacted]'s provider network policies establish the requirements for clinician availability and maximum time periods for scheduling Med/Surg appointments. As such, [redacted] contractually requires its network to meet and maintain such access and availability standards as a condition of network participation and to self-report changes in open panel status. [redacted] credentialing and participating provider standards ensure that members have access to qualified providers that are able to provide safe and effective care on a timely basis. [redacted] also offers telemedicine options as a means to increase member access to care.	[redacted] complies with applicable state and accreditation network adequacy standards to ensure sufficient MH/SUD providers are available to members enrolled in the plan. [redacted] takes additional the measures to ensure provider availability and access for its members. As part of [redacted]'s credentialing standards for admission to the network, providers must meet certain access and availability standards. [redacted]'s provider network policies establish the requirements for clinician availability and maximum time periods for scheduling MH/SUD appointments. As such, [redacted] contractually requires its network to meet and maintain such access and availability standards as a condition of network participation and to self-report changes in open panel status. [redacted] credentialing and participating provider standards ensure that members have access to qualified providers that are able to provide safe and effective care on a timely basis. [redacted] also offers telemedicine options as a means to increase member access to care. As an additional step, [redacted] initiated a program called the Express Access Network that encourages providers	[redacted] and [redacted] take the same measures to ensure provider availability and access for our members. Both companies meet state and accreditation network adequacy requirements and contractually require their network of providers to meet standards of availability and access as a condition for admission into the network and as a condition for continued participation in the network. [redacted] and [redacted] have comparable processes for ensuring timely access to care for members by leveraging credentialing and contracting standards as a requirement for network participation. These standards and programs all help ensure that members have timely access to care. Based on the foregoing, the processes, strategies, evidentiary standards and other factors are comparable and no more stringent for MH/SUD benefits than for Med/Surg benefits and comply with MHPAEA.

		to accelerate appointment timeframes beyond the standard (from ten business days to five business days) in order to increase access timeframes for members. Providers who are willing to meet these accelerated appointment timeframes are identified in the provider directory as taking appointment timeframes within five days. This works to increase member access and increase referrals for providers.	
O. In-Network Provider Reimbursement	[redacted] considers a wide array of factors in determining provider reimbursement rates for in-network professional services, which may include: • CMS published information, including CMS resource-based relative value scale (RBRVUs) • Geographic market • Provider education, training, license level, and experience • Market conditions, such as industry benchmarks and competitive landscape, including competitor networks and reimbursement levels • Practice size and affiliation • Service type and services covered • Historic base rates • Member access needs/demand for services • Provider supply/scarcity • Impact on total medical cost relative to market and health plan affordability • Quality and clinical efficiency Examples of sources that may be used by [redacted] to define the factors above include: • CMS RBRVUs • Other third party information assessing relativities • CMS published standards, data and information • Internal and external market and competitive analysis • Internal and external claims analysis • Cost growth benchmark data • Utilization data • Information on member access needs • Cost and premium trend data	[redacted] considers a wide array of factors in determining provider reimbursement rates for in-network professional services, which may include: • CMS published information, including CMS resource-based relative value scale (RBRVUs) • Geographic market • Provider education, training, license level, and experience • Market conditions, such as industry benchmarks and competitive landscape, including competitor networks and reimbursement levels • Practice size and affiliation • Service type and services covered • Historic base rates • Member access needs/demand for services • Provider supply/scarcity • Impact on total medical cost relative to market and health plan affordability • Quality and clinical efficiency Examples of evidentiary standards that may be used by [redacted] to define the factors above include: • CMS RBRVUs • Other third party information assessing relativities • CMS published standards, data and information • Internal and external market and competitive analysis • Internal and external claims analysis • Cost growth benchmark data • Utilization data • Information on member access needs • Cost and premium trend data	As demonstrated below, [redacted] and [redacted] have comparable processes for determining provider reimbursement for Med/Surg and MH/SUD services consistent with the requirements of MHPAEA. **Process and Strategy**: The fee schedules utilized by [redacted] and [redacted] for in-network professional provider reimbursement are developed using an analytical approach based on sound market-driven, economic principles aimed at appropriately compensating plan providers for health care services delivered to members, while also providing members with access to high quality, affordable, and clinically appropriate Med/Surg and MH/SUD services. The process used by [redacted] and [redacted] to develop reimbursement rates consists of annually updating its standard fee schedules using the factors and sources described in this section and potentially negotiating rates above the standard fee schedule. Using the prior year's standard fee schedule, each company applies the CMS RBRVUs, develops state-specific schedules to account for geographic differences, makes adjustments for license level distinctions, and accounts for other market conditions, including competitive landscape, provider supply and demand, member access needs, and impact on total medical cost relative to market and health plan affordability. In addition, adjustments may be made to comply with regulatory requirements. The evidentiary standards used in determining provider reimbursement are grounded in an objective analysis of local and national trends, governmental requirements, and patient needs.

	• Quality and clinical efficiency data • Internal subject matter experts	• Quality and clinical efficiency data • Internal subject matter experts	
P. Method for determining usual, customary and reasonable charges	[redacted] considers a wide array of factors in determining provider reimbursement rates for out of network professional services, which may include: • Benchmark reimbursement data • Geographic market • Provider education, training, license level, and experience • Market conditions and the competitive landscape • Service type and services covered Examples of evidentiary standards [redacted] may use to define the factors identified above include: • CMS published standards, data and information • All payer claims data and Fair Health data • Other third-party information assessing relativities • Internal and external market and competitive analysis • Internal and external claims analysis • Analysis of competitor networks and reimbursement levels	[redacted] considers a wide array of factors in determining provider reimbursement rates for out of network professional services, which may include: • Benchmark reimbursement data • Geographic market • Provider education, training, license level, and experience • Market conditions and the competitive landscape • Service type and services covered Examples of evidentiary standards [redacted] may use to define the factors identified above include: • CMS published standards, data and information • All payer claims data and Fair Health data • Other third-party information assessing relativities • Internal and external market and competitive analysis • Internal and external claims analysis • Analysis of competitor networks and reimbursement levels	As demonstrated below, [redacted] and [redacted] have comparable processes for determining provider reimbursement for out of network Med/Surg and MH/SUD services consistent with the requirements of MHPAEA. **Process and Strategy:** [redacted]'s and [redacted]'s strategy is to appropriately compensate providers for health care services delivered to members, while also providing members with access to high quality, affordable, and clinically appropriate Med/Surg and MH/SUD services. The evidentiary standards used in determining provider reimbursement are grounded in an analysis of local and national trends, governmental requirements, and patient needs. [redacted] and [redacted] generally have two methodologies for reimbursing out-of-network professional services: (1) use of Fair Health Organization data for out-of-network services received within the plan's service area and (2) use of CMS published rates for out-of-network services received outside of the plan's service area. Under the first methodology, [redacted] and [redacted] use information provided by an independent third-party organization called Fair Health to determine reimbursement rates. Fair Health collects information about what providers bill for services based on the zip code of the provider, the diagnosis, and the type of service provided. Reimbursement rates are determined by the 85th percentile of the Fair Health rate and are based on a specific type of service provided in a specific geographic area (zip code), as captured by the Fair Health database. Under the second methodology, [redacted] and [redacted] use a percentage (150%) of the CMS published rates for the same or similar services within the geographic area where the provider is located and may make adjustments in accordance with Medicare payment policies.
Q. Restrictions on provider billing codes	[redacted] has payment integrity processes intended to prevent and detect billing and payment errors, fraud, waste and abuse (e.g. unbundling).	[redacted] has payment integrity processes intended to prevent and detect billing and payment errors, fraud, waste and abuse (e.g. unbundling).	**Process and Strategy, and Evidentiary Standards**: The Med/Surg and MH/SUD payment integrity policies and procedures, as written and as applied, are comparable and no more stringent for MH/SUD than for Med/Surg benefits. Such policies and

			procedures consider similar factors, strategies and evidentiary standards in the design of the NQTL and comply with MHPAEA. [redacted] and [redacted] use claim billing and payment policies, claims auditing and other investigative measures to prevent and monitor billing errors, fraud, waste and abuse. The processes consist of prevention and detection measures, including claims data mining, use of algorithms to detect common billing errors and fraudulent or abusive billing activities, claims editing applications, clinical editing software, coding validation, payment policy development and management, data analysis, and other investigative measures including provider outreach and medical record reviews. Both [redacted] and [redacted] have fraud units that collaborate with and assist state and federal government enforcement agencies with investigations related to fraud, waste and abuse. The processes, strategies and evidentiary standards behind the [redacted] and [redacted] billing and payment policies is to ensure appropriate billing for health care services, the appropriate administration of benefits under the health plan, to maintain payment integrity and to prevent, manage and detect billing and payment errors, and fraud, waste and abuse. These processes are designed to help ensure that all members have access to safe and effective medically necessary Med/Surg and MH/SUD services, while tangentially helping to manage health care costs. This further ensures that the plan is managed efficiently and economically to achieve the its objectives, including safeguarding plan assets and preventing and detecting errors, fraud, waste and abuse. [redacted] and [redacted] consider various evidentiary standards and other factors in designing its payment integrity policies and procedures, including industry standards, CMS adopted standards and policies, competitive information, and trends in fraud, waste and abuse. **Med/Surg Payment Policies are available at:** [redacted] **MH/SUD Payment Policies are available at:** [redacted]