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: March 1, 2021
C. Contact Name: [redacted]	D. Telephone Number: [redacted]	E. Email: [redacted]
F. Line of Business (HMO, EPO, POS, PPO): **HMO**		
G. Contract Type (large group, small group, individual): **Large Group**		
H. Benefit Plan Effective Date: January 1, 2021		I. Benefit Plan Design(s) Identifier(s):[1]

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?	See the provided file: [redacted] Exhibit 01.Medical Necessity	Same as Medical/Surgical	See the provided file: [redacted] Exhibit 02.Final Medical Policy Creation NQTL

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 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:	See the provided file: [redacted] Exhibit 03.Precertification Prior Authorization List	See the provided file: [redacted] Exhibit 03.Precertification Prior Authorization List Note, we do not apply fail first criteria to mental health/substance use disorder services.	See the provided file: [redacted] Exhibit 04.Combined UM Review NQTL
Prior Authorization - Outpatient, In-Network: Office Visits:	See the provided file: [redacted] Exhibit 03.Precertification Prior Authorization List	See the provided file: [redacted] Exhibit 03.Precertification Prior Authorization List	See the provided file: [redacted] Exhibit 04.Combined UM Review NQTL
Prior Authorization - Outpatient, In-Network: Other Outpatient Items and Services:	See the provided file: [redacted] Exhibit 03.Precertification Prior Authorization List	See the provided file: [redacted] Exhibit 03.Precertification Prior Authorization List	See the provided file: [redacted] Exhibit 04.Combined UM Review NQTL
Prior Authorization - Inpatient, Out-of-Network:	N/A unless a referral is approved	N/A unless a referral is approved	

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:	N/A unless a referral is approved	N/A unless a referral is approved	
Prior Authorization - Outpatient, Out-of-Network: Other Items and Services:	N/A unless a referral is approved	N/A unless a referral is approved	
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:	If a certain number of days/visits has been authorized, [redacted] does not conduct concurrent review during that course of treatment to determine if any additional approved days remain medically necessary. Instead, concurrent review is only conducted when the provider determines that days/visits in addition to those previously approved are required.	If a certain number of days/visits has been authorized, [redacted] does not conduct concurrent review during that course of treatment to determine if any additional approved days remain medically necessary. Instead, concurrent review is only conducted when the provider determines that days/visits in addition to those previously approved are required.	See the provided file: [redacted] Exhibit 04.Combined UM Review NQTL

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 - Outpatient, In-Network: Office Visits:	If a certain number of days/visits has been authorized, [redacted] does not conduct concurrent review during that course of treatment to determine if any additional approved days remain medically necessary. Instead, concurrent review is only conducted when the provider determines that days/visits in addition to those previously approved are required.	If a certain number of days/visits has been authorized, [redacted] does not conduct concurrent review during that course of treatment to determine if any additional approved days remain medically necessary. Instead, concurrent review is only conducted when the provider determines that days/visits in addition to those previously approved are required.	See the provided file: [redacted] Exhibit 04.Combined UM Review NQTL
Concurrent Review - Outpatient, In-Network: Other Outpatient Items and Services:	If a certain number of days/visits has been authorized, [redacted] does not conduct concurrent review during that course of treatment to determine if any additional approved days remain medically necessary. Instead, concurrent review is only conducted when the provider determines that days/visits in addition to those previously approved are required.	If a certain number of days/visits has been authorized, [redacted] does not conduct concurrent review during that course of treatment to determine if any additional approved days remain medically necessary. Instead, concurrent review is only conducted when the provider determines that days/visits in addition to those previously approved are required.	See the provided file: [redacted] Exhibit 04.Combined UM Review NQTL
Concurrent Review - Inpatient, Out-of-Network:	Same as in-network if a referral was approved	Same as in-network if a referral was approved	Same as in-network
Concurrent Review - Outpatient, Out-of-Network: Office Visits:	Same as in-network if a referral was approved	Same as in-network if a referral was approved	Same as in-network

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 - Outpatient, Out-of-Network: Other Items and Services:	Same as in-network if a referral was approved	Same as in-network if a referral was approved	Same as in-network
D. Retrospective Review Process, including timeline and penalties. Inpatient, In-Network:	[redacted] will conduct a retrospective review after a service takes place such as when a claim is submitted and it is determined that the service is on our preauthorization list and a preauthorization was not requested. When a preauthorization review for a service is conducted, our claim system is coded to reflect that the service was approved or denied. Thus, when a claim for the service is received, the claim system will identify whether the service has already been reviewed and authorized or denied or whether the claim needs to be flagged for a clinical review (i.e., a retrospective review is conducted).	[redacted] will conduct a retrospective review after a service takes place such as when a claim is submitted and it is determined that the service is on our preauthorization list and a preauthorization was not requested. When a preauthorization review for a service is conducted, our claim system is coded to reflect that the service was approved or denied. Thus, when a claim for the service is received, the claim system will identify whether the service has already been reviewed and authorized or denied or whether the claim needs to be flagged for a clinical review (i.e., a retrospective review is conducted).	See the provided file: [redacted] Exhibit 04.Combined UM Review NQTL

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 - Outpatient, In-Network: Office Visits:	[redacted] will conduct a retrospective review after a service takes place such as when a claim is submitted and it is determined that the service is on our preauthorization list and a preauthorization was not requested. When a preauthorization review for a service is conducted, our claim system is coded to reflect that the service was approved or denied. Thus, when a claim for the service is received, the claim system will identify whether the service has already been reviewed and authorized or denied or whether the claim needs to be flagged for a clinical review (i.e., a retrospective review is conducted).	[redacted] will conduct a retrospective review after a service takes place such as when a claim is submitted and it is determined that the service is on our preauthorization list and a preauthorization was not requested. When a preauthorization review for a service is conducted, our claim system is coded to reflect that the service was approved or denied. Thus, when a claim for the service is received, the claim system will identify whether the service has already been reviewed and authorized or denied or whether the claim needs to be flagged for a clinical review (i.e., a retrospective review is conducted).	See the provided file: [redacted] Exhibit 04.Combined UM Review NQTL

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 - Outpatient, In-Network: Other Outpatient Items and Services:	[redacted] will conduct a retrospective review after a service takes place such as when a claim is submitted and it is determined that the service is on our preauthorization list and a preauthorization was not requested. When a preauthorization review for a service is conducted, our claim system is coded to reflect that the service was approved or denied. Thus, when a claim for the service is received, the claim system will identify whether the service has already been reviewed and authorized or denied or whether the claim needs to be flagged for a clinical review (i.e., a retrospective review is conducted).	[redacted] will conduct a retrospective review after a service takes place such as when a claim is submitted and it is determined that the service is on our preauthorization list and a preauthorization was not requested. When a preauthorization review for a service is conducted, our claim system is coded to reflect that the service was approved or denied. Thus, when a claim for the service is received, the claim system will identify whether the service has already been reviewed and authorized or denied or whether the claim needs to be flagged for a clinical review (i.e., a retrospective review is conducted).	See the provided file: [redacted] Exhibit 04.Combined UM Review NQTL
Retrospective Review - Inpatient, Out-of-Network:	Same as in-network	Same as in-network	Same as in-network
Retrospective Review - Outpatient, Out-of-Network: Office Visits:	Same as in-network	Same as in-network	Same as in-network
Retrospective Review - Outpatient, Out-of-Network: Other Items and Services:	Same as in-network	Same as in-network	Same as in-network

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).
E. Emergency Services	We do not require prior authorization for any emergency service. For medical services only, we conduct retrospective reviews for certain codes that have been determined to not generally be emergency situations to ensure the member received treatment in the correct setting. This code listing was approved by the Department. Additionally, if a member is admitted, they or their provider is requested to notify us as soon as possible so we can review the number of days medically necessary.	We do not do utilization review for any emergency service claims attributed to behavioral health conditions. However, if a member is admitted, they or their provider is requested to notify us as soon as possible so we can review the number of days medically necessary.	We treat MH/SUD conditions the same or better than medical/surgical conditions. For reviews done after a member is admitted as inpatient, please see the Retrospective Review responses.
F. Pharmacy Services Include all services for which prior-authorization is required, any step-therapy or "fail first" requirements, any other NQTLs. Tier 1: See provided file: [redacted] Exhibit 05.MH Parity Rx List 2020_FINAL	See the provided files: [redacted] Exhibit 05.MH Parity Rx List 2020_FINAL and [redacted] Exhibit 06.Final Drug Formulary NQTL	See the provided files: [redacted] Exhibit 05.MH Parity Rx List 2020_FINAL and [redacted] Exhibit 06.Final Drug Formulary NQTL	See the provided files: [redacted] Exhibit 05.MH Parity Rx List 2020_FINAL and [redacted] Exhibit 06.Final Drug Formulary NQTL
Tier 2:	See the provided files: [redacted] Exhibit 05.MH Parity Rx List 2020_FINAL and [redacted] Exhibit 06.Final Drug Formulary NQTL	See the provided files: [redacted] Exhibit 05.MH Parity Rx List 2020_FINAL and [redacted] Exhibit 06.Final Drug Formulary NQTL	See the provided files: [redacted] Exhibit 05.MH Parity Rx List 2020_FINAL and [redacted] Exhibit 06.Final Drug Formulary NQTL

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 3:	See the provided files: [redacted] Exhibit 05.MH Parity Rx List 2020_FINAL and [redacted] Exhibit 06.Final Drug Formulary NQTL	See the provided files: [redacted] Exhibit 05.MH Parity Rx List 2020_FINAL and [redacted] Exhibit 06.Final Drug Formulary NQTL	See the provided files: [redacted] Exhibit 05.MH Parity Rx List 2020_FINAL and [redacted] Exhibit 06.Final Drug Formulary NQTL
Tier 4:	See the provided files: [redacted] Exhibit 05.MH Parity Rx List 2020_FINAL and [redacted] Exhibit 06.Final Drug Formulary NQTL	See the provided files: [redacted] Exhibit 05.MH Parity Rx List 2020_FINAL and [redacted] Exhibit 06.Final Drug Formulary NQTL	See the provided files: [redacted] Exhibit 05.MH Parity Rx List 2020_FINAL and [redacted] Exhibit 06.Final Drug Formulary NQTL
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?	See the provided file: [redacted] Exhibit 06.Final Drug Formulary NQTL	See the provided file: [redacted] Exhibit 06.Final Drug Formulary NQTL	See the provided file: [redacted] Exhibit 06.Final Drug Formulary NQTL
Describe the pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step therapy.	See the provided file: [redacted] Exhibit 06.Final Drug Formulary NQTL	See the provided file: [redacted] Exhibit 06.Final Drug Formulary NQTL	See the provided file: [redacted] Exhibit 06.Final Drug Formulary NQTL

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.	See the provided file: [redacted] Exhibit 06.Final Drug Formulary NQTL	See the provided file: [redacted] Exhibit 06.Final Drug Formulary NQTL	See the provided file: [redacted] Exhibit 06.Final Drug Formulary NQTL
H. Case Management What case management services are available?	[redacted] provides case management for catastrophically ill or injured members who require extensive medical services and who have exceptional or complex needs. Case managers are responsible for evaluating and monitoring the efficiency, appropriateness and quality of all aspects of health care for members who have been accepted into the case management program. To achieve this objective, the case management program works in collaboration with the member's team of health care professionals to provide feedback, support and assistance during the utilization and case management process.	Behavioral Health Case Management is a comprehensive program supporting members of all ages who are impacted by their behavioral health condition. BH CM services include Post Discharge Management, Complex Case Management and Care Coordination. Members most appropriate for BH Case Management include those who are most at risk for readmission or likelihood of admission, high cost, high risk, chronic or comorbid conditions and need care coordination. The program assists members and their families with obtaining appropriate behavioral health treatment, offering community resources, providing education and telephonic support, and promoting provider collaboration.	See the provided file: [redacted] Exhibit 07.Final Case Management NQTL

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 case management services are required?	None	None	Case management is voluntary.
What are the eligibility criteria for case management services?	See Explanation	See Explanation	See the provided file: [redacted] Exhibit 07.Final Case Management NQTL
I. Process for Assessment of New Technologies Definition of experimental/investigational:	See the provided file: [redacted] Exhibit 08.Policy_Investigational	See the provided file: [redacted] Exhibit 08.Policy_Investigational	See the provided file: [redacted] Exhibit 07.Final Case Management NQTL
Qualifications of individuals evaluating new technologies:	See the provided file: [redacted] Exhibit 08.Policy_Investigational	See the provided file: [redacted] Exhibit 08.Policy_Investigational	We utilize the same process as utilized for medical necessity determinations. See the provided file: [redacted] Exhibit 02.Final Medical Policy Creation NQTL
Evidence consulted in evaluating new technologies:	See the provided file: [redacted] Exhibit 08.Policy_Investigational and Explanation	See the provided file: [redacted] Exhibit 08.Policy_Investigational and Explanation	We utilize the same process as utilized for medical necessity determinations. See the provided file: [redacted] Exhibit 02.Final Medical Policy Creation NQTL

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?	Our provider networks are open. They just need to agree to our standard terms of participation.	We do not have any closed networks for mental health or SUD providers. They just need to agree to our standard terms of participation.	All networks are open for all providers willing and able to meet our standard terms of participation,
What are the credentialing standards for physicians?	See Explanation	See Explanation	See the provided file: [redacted] Exhibit 09.Credentialing Program Summary_2020 v.3
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.	See Explanation	See Explanation	See the provided file: [redacted] Exhibit 09.Credentialing Program Summary_2020 v.3
What are the credentialing/contracting standards for unlicensed personnel; e.g., home health aides, qualified autism service professionals and paraprofessionals?	See Explanation	See Explanation	See the provided file: [redacted] Exhibit 09.Credentialing Program Summary_2020 v.3
K. Exclusions for Failure to Complete a			

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).
Course of Treatment Does the Plan exclude benefits for failure to complete treatment?	No, the plan does not exclude benefits due to failure to complete treatment.	No, the plan does not exclude benefits due to failure to complete treatment.	We treat medical/surgical and MH/SUD conditions the same.
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?	Services must be provided within the Connecticut service area unless it is an urgent or emergent condition.	Services must be provided within the Connecticut service area unless it is an urgent or emergent condition.	We treat medical/surgical and MH/SUD conditions the same.
Does the Plan restrict the type(s) of facilities in which enrollees can receive services?	The facility must meet the definition of a covered facility in the booklet, which generally requires appropriate licensure and accreditation.	The facility must meet the definition of a covered facility in the booklet, which generally requires appropriate licensure and accreditation.	We require all covered providers, whether facility based or in-network or not, to be licensed by the applicable state and be appropriately accredited. See provided file: [redacted] [redacted]Exhibit 13.Facility Definitions – Small Group and Large Group for defined terms in the Definitions section of the booklets: Facility, Hospital, Residential Treatment Center/Facility, and Skilled Nursing Facility.

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?	The provider must be operating within the scope of his/her license and meet the definition of a covered provider.	The provider must be operating within the scope of his/her license and meet the definition of a covered provider.	We treat medical/surgical and MH/SUD providers the same.

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).
N. Network Adequacy	See explanation	See explanation	PPO, HMO, on- and off-exchange networks are assessed annually for availability of providers throughout the state and appointment access to meet [redacted] standards. For behavioral health availability standards (ratio of members to each provider), all provider specialties are measured, unlike medical which measures PCPs, high volume and critical specialties only, using geo-access software that maps proximity of providers to members by zip code. Accessibility is measured by provider surveys, using appropriate sample sizes, which ask providers to confirm appointment wait times for non-life-threatening, urgent, and routine visits. Members are also surveyed for satisfaction with both availability of providers who meet their cultural, language and gender requirements, and appointment wait times, and any member complaints related to either availability or accessibility of providers are reviewed. Corrective actions are taken if any survey results show that provider access and availability falls below [redacted] standards. Similar information is provided to the State of Connecticut with slight differences in the measurement criteria as required by the State; both [redacted] standards and State mandated criteria are measured and reported on an annual basis.
O. In-Network Provider Reimbursement	See explanation	See explanation	See the provided file: [redacted] Exhibit 11.Final CT Provider Reimbursement NQT

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).
P. Method for determining usual, customary and reasonable charges	See provided file: [redacted] Exhibit 17.Maximum Allowed Amount – HMO Large Group	See provided file: [redacted] Exhibit 17.Maximum Allowed Amount – HMO Large Group	[redacted] does not base its out-of-network reimbursement on usual, customary and reasonable charges. See provided file: [redacted] Exhibit 10.Non Par Reimbursement Commercial
Q. Restrictions on provider billing codes	[redacted] does not impose any specific billing code restrictions on providers.	[redacted] does not impose any specific billing code restrictions on providers.	