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): All		
G. Contract Type (large group, small group, individual): All		
H. Benefit Plan Effective Date: 2020 Benefit Plans		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?	The definition of Medically Necessary is included in the member's Certificate of Coverage and applies to both M/S and MH/SUD. Medically Necessary - health care services that are all of the following as determined by us or our designee: • In accordance with Generally Accepted Standards of Medical Practice. • Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness,	The definition of Medically Necessary is included in the member's Certificate of Coverage and applies to both M/S and MH/SUD. Medically Necessary - health care services that are all of the following as determined by us or our designee: • In accordance with Generally Accepted Standards of Medical Practice. • Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.	The definition for "Medical Necessity" applies equally to M/S and MH/SUD benefits. There is no other, separately applicable definition of "Medical Necessity" or "Medically Necessary". Therefore, the plans are parity compliant in this regard, as they are comparable, and applied no more stringently to MH/SUD than to M/S. **ATTACHMENTS:** [redacted]

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	substance-related and addictive disorders, disease or its symptoms. • Not mainly for your convenience or that of your doctor or other health care provider. • Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms. Generally Accepted Standards of Medical Practice are standards that are based on credible 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. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us. We develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through [redacted] or the telephone number on your ID card. They are also available to Physicians and other health care professionals on [redacted]	• Not mainly for your convenience or that of your doctor or other health care provider. • Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms. Generally Accepted Standards of Medical Practice are standards that are based on credible 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. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us. We develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time) are available to Covered Persons through [redacted] or the telephone number on your ID card. They are also available to Physicians and other health care professionals on [redacted].	
B. Prior-authorization Review Process Include all services for which prior- authorization	**Inpatient Services requiring Prior Authorization.** Please refer to Addendum A for listing of the services that require prior authorization.	**Inpatient Services requiring Prior Authorization.** Please refer to Addendum A for listing of the services that require prior authorization.	For both M/S and MH/SUD, the goal of Prior Authorization is to ensure cost-effective and clinically effective treatment is delivered at the right time and in the right clinical setting to achieve a positive clinical outcome. The

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is required. Describe any step- therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans. Inpatient, In-Network:	**Why does the Plan require Prior Authorization?** The Plan uses Prior Authorization to accomplish the following goals: • Monitor and prevent potential overutilization and underutilization; • Manage high-cost and prolonged-duration services; • Ensure enrollee safety; • Determine the appropriate level of care; and • Determine whether the service or item is medically necessary. **Process for Obtaining Prior Authorization** For any inpatient service on the Prior Authorization list, the in-network provider is contractually responsible for obtaining the Prior Authorization. There may be some in-network benefits for which the member is responsible for obtaining Prior Authorization which are identified in the Plan document's Schedule of Benefits. The member is not ultimately financially responsible for failure to obtain Prior Authorization, unless the member is on a PPO Plan. For any inpatient service on the Prior Authorization List, the in-network facility must confirm, prior to rendering the service that the coverage approval is on file. The purpose of this protocol is to enable the facility and the member to have an informed pre-service conversation; in cases where it is determined that the service will not be covered the member can then decide whether to receive and pay for the service. When the in-network provider or member requests Prior Authorization, appropriately qualified clinical staff reviews the request utilizing the applicable clinical policies and/or guidelines, criteria, and Plan terms, and then renders a coverage determination. Both the providers and member are notified of the adverse determination consistent with state, federal and accreditation	**Why does the Plan require Prior Authorization?** The Plan uses Prior Authorization to accomplish the following goals: • Monitor and prevent potential overutilization and underutilization; • Manage high-cost and prolonged-duration services; • Ensure enrollee safety; • Determine the appropriate level of care; and • Determine whether the service or item is medically necessary. **Process for Obtaining Prior Authorization.** For any inpatient service on the Prior Authorization list, the in-network provider is contractually responsible for obtaining the Prior Authorization. There may be some in-network benefits for which the member is responsible for obtaining Prior Authorization which are identified in the Plan document's Schedule of Benefits. The member is not ultimately financially responsible for failure to obtain Prior Authorization, unless the member is on a PPO Plan. For any inpatient service on the Prior Authorization List, the in-network facility must confirm, prior to rendering the service that the coverage approval is on file. The purpose of this protocol is to enable the facility and the member to have an informed pre-service conversation; in cases where it is determined that the service will not be covered the member can then decide whether to receive and pay for the service. When the in-network provider or member requests Prior Authorization, appropriately qualified clinical staff reviews the request utilizing the applicable clinical policies and/or guidelines, criteria, and Plan terms, and then render a coverage determination. Both the providers and member are notified of the adverse determination consistent with state, federal and accreditation requirements and applicable appeal rights are provided.	processes and criteria utilized for prior authorization of MH/SUD treatments or services are comparable and applied no more stringently than, those designed and applied to M/S treatment or services. Parity compliance exists because both utilize evidence-based nationally recognized clinical guidelines when designing or determining whether to add or maintain a prior authorization requirement. Further, the processes and evidentiary standards used in application are comparable because both MH/SUD and M/S consider the type of treatment or service requested and the member's clinical presentation when applying clinical guidelines for the treatment or service. M/S and MH/SUD requests for authorization are evaluated by appropriately licensed and qualified medical or behavioral clinical staff. For both MH/SUD and M/S, the treating provider is required to provide clinical information. This information is reviewed by a medical professional with appropriate credentials necessary to confirm coverage and that the suggested treatment/service is clinically appropriate based on nationally recognized, evidence-based clinical guidelines and medical policies, standardized coverage determination guidelines (CDGs), and generally accepted, peer-reviewed medical literature. Based on the foregoing, the processes and evidentiary standards are comparable and no more stringently applied for MH/SUD. Further, the Plan may apply the following factors to determine whether Prior Authorization will be

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	requirements and applicable appeal rights are provided. **How are Prior Authorizations Submitted** Prior Authorization can be submitted electronically or by phone. **Staff Qualifications** M/S is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized** M/S staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. **Fail First Requirements** Fail first requirements could apply for certain inpatient surgeries, such as hip arthroplasty. **Timeframe to Respond.** M/S will follow all applicable state and federal laws and accreditation timeframe requirements.	**How are Prior Authorizations Submitted.** Prior Authorization can be submitted electronically or by phone. **Staff Qualifications** MH/SUD is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. RN, LPC, LISW, etc.) and all adverse determinations are made by [redacted] Medical Directors or PhDs. **Guidelines/Criteria Utilized.** MH/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as Level of Care Utilization System (LOCUS), Child and Adolescent Service Intensity Instrument (CASII), Early Childhood Service Intensity Instrument (ECSII) and American Society of Addiction Medicine (ASAM). **Fail First Requirements** MH/SUD does not apply fail first requirements to the inpatient level of care. **Timeframe to respond.** MH/SUD will follow all applicable state and federal laws and accreditation timeframe requirements.	applied to a particular benefit or service: A. The service or treatment is subject to material variation (*i.e.*, a statistically significant change identified internally through claims evaluation, reporting, and analytics and/or externally through published clinical evidence) by: level of care, site of service care, diagnosis, and/or provider/facility with respect to outcome, utilization, or cost; or B. Utilization patterns suggest evidence-based national clinical guidelines are not being followed consistently; or C. For new services, clinical indications are evolving and/or clinical evidence suggests the use of the service requires specified qualifying criteria for safe and effective treatment outcomes; and D. The value of applying Prior Authorization in terms of improved outcomes or reduced costs exceeds the administrative burden/cost in applying Prior Authorization. **ATTACHMENTS:** [redacted] Prior Authorization List Addendum A Schedule of Benefits: Summary of Benefits Table
Prior Authorization - Outpatient, In-Network: Office Visits:	Prior Authorization is not required for In-Network Office Visits.	Prior Authorization is not required for In-Network Office Visits.	The Plan is parity compliant, as neither M/S nor MH/SUD require Prior Authorization for In-network office visits

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
Prior Authorization - Outpatient, In-Network: Other Outpatient Items and Services:	**Outpatient Services Requiring Prior Authorization.** Please refer to Addendum A for listing of the services that require prior authorization. **Why does the Plan require Prior Authorization?** The Plan uses Prior Authorization to accomplish the following goals: • Monitor and prevent potential overutilization and underutilization; • Manage high-cost and prolonged-duration services; • Ensure enrollee safety; • Determine the appropriate level of care; and • Determine whether the service or item is medically necessary. **Process for Obtaining Prior Authorization** For any outpatient service on the Prior Authorization list, the in-network provider is contractually responsible for obtaining the Prior Authorization. There may be some in-network benefits for which the member is responsible for obtaining Prior Authorization which are identified in the Plan document's Schedule of Benefits. The member is not ultimately financially responsible for failure to obtain Prior Authorization, unless the member is on a PPO Plan. The requirement does not vary based on place of service, such as a provider's office or via approved virtual technology (i.e. telehealth). When a Prior Authorization is requested, appropriately qualified clinical staff reviews the request utilizing the applicable clinical policies and/or guidelines, criteria, and Plan terms, and then renders a coverage determination. Both the providers and member are notified of the adverse determination consistent with state/federal requirements and applicable appeal rights are provided.	**Outpatient Services Requiring Prior Authorization.** Please refer to Addendum A for listing of the services that require prior authorization. **Why does the Plan require Prior Authorization?** The Plan uses Prior Authorization to accomplish the following goals: • Monitor and prevent potential overutilization and underutilization; • Manage high-cost and prolonged-duration services; • Ensure enrollee safety; • Determine the appropriate level of care; and • Determine whether the service or item is medically necessary. **Process for Obtaining Prior Authorization.** For outpatient services, the in-network provider is contractually responsible for obtaining the Prior Authorization. There may be some in-network benefits for which the member is responsible for obtaining Prior Authorization which are identified in the Plan document's Schedule of Benefits. The member is not ultimately financially responsible for failure to obtain Prior Authorization, unless the member is on a PPO Plan. The requirement does not vary based on place of service, such as a provider's office or via approved virtual technology (i.e. telehealth). When a Prior Authorization is requested, appropriately qualified clinical staff reviews the request utilizing the applicable clinical policies and/or guidelines, criteria, and Plan terms, and then renders a coverage determination. Both the providers and member are notified of the adverse determination, consistent with state, federal and accreditation requirements and applicable appeal rights are provided. **How are Prior Authorizations Submitted.** Prior Authorization can be submitted electronically or by phone.	For both M/S and MH/SUD, the goal of Prior Authorization is to ensure cost-effective and clinically effective treatment is delivered at the right time and in the right clinical setting to achieve a positive clinical outcome. The processes and criteria utilized for prior authorization of MH/SUD treatments and services are comparable and applied no more stringently than, those designed and applied to M/S treatment or services. Parity compliance exists because both utilize evidence- based nationally recognized clinical guidelines when designing or determining whether to add or maintain a prior authorization requirement. Further, the processes and evidentiary standards used in application are comparable because both MH/SUD and M/S consider the type of treatment or service requested and the member's clinical presentation when applying clinical guidelines for the treatment or service. M/S and MH/SUD requests for authorization are evaluated by appropriately licensed and qualified medical or behavioral clinical staff. For both MH/SUD and M/S, the treating provider is required to provide clinical information. This information is reviewed by a medical professional with appropriate credentials necessary to confirm coverage and that the suggested treatment/service is clinically appropriate based on nationally recognized, evidence-based clinical guidelines and medical policies, standardized coverage determination guidelines (CDGs), and generally accepted, peer-reviewed medical literature. Based on the foregoing, the processes and evidentiary

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	How are Prior Authorizations Submitted Prior Authorization can be submitted electronically or by phone. **Staff Qualifications** M/S is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized** M/S staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. **Fail First Requirements** M/S may apply Fail First Requirements to certain codes covered under Outpatient Benefits, such as medical injectables for cancer drugs. **Timeframe to Respond** M/S will follow all applicable state and federal laws and accreditation timeframe requirements.	**Staff Qualifications** MH/SUD is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. RN, LPC, LISW, etc.) and all adverse determinations are made by [redacted] Medical Directors or PhDs. **Guidelines/Criteria Utilized.** MH/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria (LOCUS, CASII, ECSII, ASAM). **Fail First Requirements** MH/SUD may apply to certain codes covered under Outpatient Benefits, such as TMS (Transcranial Magnetic Stimulation) **Timeframe to respond.** M/S will follow all applicable state and federal laws and accreditation timeframe requirements.	standards are comparable and no more stringently applied for MH/SUD. **ATTACHMENTS:** [redacted] Prior Authorization List Addendum A Schedule of Benefits: Summary of Benefits Table
Prior Authorization - Inpatient, Out-of-Network:	**Inpatient Services requiring Prior Authorization.** Please refer to the Inpatient Services NQTL Medical Management Worksheet for listing of the services that require prior authorization. **Why does the Plan require Prior Authorization?** The Plan uses Prior Authorization to accomplish the following goals: • Monitor and prevent potential overutilization and underutilization; • Manage high-cost and prolonged-duration services; • Ensure enrollee safety; • Determine the appropriate level of care; and	**Inpatient Services requiring Prior Authorization.** Please refer to the Inpatient Services NQTL Medical Management Worksheet for listing of the services that require prior authorization. **Why does the Plan require Prior Authorization?** The Plan uses Prior Authorization to accomplish the following goals: • Monitor and prevent potential overutilization and underutilization; • Manage high-cost and prolonged-duration services; • Ensure enrollee safety; • Determine the appropriate level of care; and	For both M/S and MH/SUD, the goal of Prior Authorization is to ensure cost-effective and clinically effective treatment is delivered at the right time and in the right clinical setting to achieve a positive clinical outcome. The processes and criteria utilized for prior authorization of MH/SUD treatments and services are comparable and applied no more stringently than, those designed and applied to M/S treatment or services. Parity compliance exists because both utilize evidence-based nationally recognized clinical guidelines when designing or determining whether to add or maintain a prior authorization

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	• Determine whether the service or item is medically necessary. **Process for Obtaining Prior Authorization.** When the plan has out-of-network benefits and the member chooses to receive certain Covered Health Care Services from out-of-network providers, the member is responsible for obtaining prior authorization before receiving these services. The members obligation to obtain prior authorization is also applicable when an out-of-Network provider intends to admit the member to a Network facility or to an out-of-network facility. When a Prior Authorization is requested, appropriately qualified clinical staff reviews the request utilizing the applicable clinical policies and/or guidelines, criteria, and Plan terms, and then render a coverage determination. Both the providers and member are notified of the adverse determination consistent with state, federal or accreditations requirements and applicable appeal rights are provided. **Network Gaps:** A network gap request for services to be rendered by an out-of-network provider when the network lacks an appropriate provider to perform the specific service being requested. An appropriate provider is one either within the required mileage range or one who possesses the necessary clinical expertise. **Transition of Care (TOC):** A request for TOC is based on a benefit which allows a newly covered member who is receiving ongoing care a transition period before they are required to transfer from an out-of- network provider to an in-network provider and to receive network benefits for the transition period. **Continuity of Care (CoC):** A request for CoC is based on a benefit which allows a covered member to continue to receive services rendered by a provider who has terminated from the provider network. The member is given a defined period of time	• Determine whether the service or item is medically necessary. **Process for Obtaining Prior Authorization.** When the plan has out-of-network benefits and the member chooses to receive covered Behavioral Health Care Services from out-of-network providers, the member is responsible for obtaining prior authorization before receiving these services. The members obligation to obtain prior authorization is also applicable when an out-of-network provider intends to admit the member to a Network facility or to an out-of-network facility. When a Prior Authorization is requested, appropriately qualified clinical staff reviews the request utilizing the applicable clinical policies and/or guidelines, criteria, and Plan terms, and then render a coverage determination. Both the providers and member are notified of any adverse determination consistent with state, federal or accreditations requirements and applicable appeal rights are provided. **Network Gaps:** A network gap request for services to be rendered by an out-of-network provider when the network lacks an appropriate provider to perform the specific service being requested. An appropriate provider is one either within the required mileage range or one who possesses the necessary clinical expertise. **Transition of Care (TOC):** A request for TOC is based on a benefit which allows a newly covered member who is receiving ongoing care a transition period before they are required to transfer from an out-of- network provider to an in-network provider and to receive network benefits for the transition period. **Continuity of Care (CoC):** A request for CoC is based on a benefit which allows a covered member to continue to receive services rendered by a provider who has terminated from the provider network. The member is given a defined period of time	requirement. Further, the processes and evidentiary standards used in application are comparable because both MH/SUD and M/S consider the type of treatment or service requested and the member's clinical presentation when applying clinical guidelines for the treatment or service. M/S and MH/SUD requests for authorization are evaluated by appropriately licensed and qualified medical or behavioral clinical staff. For both MH/SUD and M/S, the treating provider is required to provide clinical information. This information is reviewed by a medical professional with appropriate credentials necessary to confirm coverage and that the suggested treatment/service is clinically appropriate based on nationally recognized, evidence-based clinical guidelines and medical policies, standardized coverage determination guidelines (CDGs), and generally accepted, peer-reviewed medical literature. Based on the foregoing, the processes and evidentiary standards are comparable and no more stringently applied for MH/SUD. Please note that, with regard to Fail First requirements for Inpatient Prior Authorization, MH/SUD is less stringent in that there is no such requirement. As indicated, Fail First requirements could apply to M/S. ATTACHMENTS: Schedule of Benefits: Summary of Benefits Table Inpatient Services NQTL Medical Management

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	in which to transition to an in-network provider while continuing to receive in-network benefits for services from the terminated provider. **Staff Qualifications** M/S is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized.** M/S staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. **How are Prior Authorizations Submitted.** Out-of-Network Prior Authorization can be obtained by calling the telephone number on the members ID card **Fail First Requirements** Fail first requirements could apply for certain inpatient surgeries, such as hip arthroplasty. **Timeframe to respond.** M/S will follow all applicable state and federal or accreditation timeframe requirements.	in which to transition to an in-network provider while continuing to receive in-network benefits for services from the terminated provider. **Staff Qualifications** MH/SUD is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. RN, LPC, LISW, etc.) and all adverse determinations are made by [redacted] Medical Directors or PhDs **Guidelines/Criteria Utilized.** MH/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria (LOCUS, CASII, ECSII, ASAM). **How are Prior Authorizations Submitted.** Out-of-Network Prior Authorization can be obtained by calling the telephone number on the members ID card **Fail First Requirements** MH/SUD does not apply fail first requirements to inpatient level of care. **Timeframe to respond.** MH/SUD will follow all applicable state and federal or accreditation timeframe requirements.	Worksheet
Prior Authorization - Outpatient, Out-of-Network: Office Visits:	When the plan has out-of-network benefits, prior authorization is not required for Out-of-Network Office Visits.	When the plan has out-of-network benefits, prior authorization is not required for Out-of-Network Office Visits.	Parity compliance exists because neither M/S nor MH/SUD require Prior Authorization for Outpatient, Out-of-Network Office Visits.
Prior Authorization - Outpatient, Out-of-Network: Other Items and Services:	**Outpatient Services requiring Prior Authorization.** Please refer to Addendum A for listing of the services that require prior authorization. **Why does the Plan require Prior Authorization?** The Plan uses Prior Authorization to accomplish the following	**Outpatient Services requiring Prior Authorization.** Please refer to Addendum A for listing of the services that require prior authorization. **Why does the Plan require Prior Authorization?** The Plan uses Prior Authorization to accomplish the following	M/S requires Prior Authorization for some outpatient services. Likewise, some MH/SUD outpatient services require Prior Authorization, but the vast majority of outpatient MH/SUD services do not require Prior Authorization. For both M/S and MH/SUD, the goal of Prior

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	goals: • Monitor and prevent potential overutilization and underutilization; • Manage high-cost and prolonged-duration services; • Ensure enrollee safety; • Determine the appropriate level of care; and • Determine whether the service or item is medically necessary. **Process for Obtaining Prior Authorization** For Plans that include out-of-network benefits, M/S requires the member to obtain Prior Authorization for some out-of-network outpatient services as noted on the Schedule of Benefits. An out-of-network provider may request Prior Authorization on behalf of the member. When a Prior Authorization is requested, appropriately qualified clinical staff reviews the request utilizing the applicable clinical policies and/or guidelines, criteria, and Plan terms, and then render a coverage determination. Both the providers and member are notified of the adverse determination consistent with state, federal or accreditation requirements and applicable appeal rights are provided. **Network Gaps**: A network gap request for services to be rendered by an out-of-network provider when the network lacks an appropriate provider to perform the specific service being requested. An appropriate provider is one either within the required mileage range or one who possesses the necessary clinical expertise. **Transition of Care (TOC):** A request for TOC is based on a benefit which allows a newly covered member who is receiving ongoing care a transition period before they are required to transfer from an out-of- network provider to an in-network provider and to receive network benefits for the transition period.	goals: • Monitor and prevent potential overutilization and underutilization; • Manage high-cost and prolonged-duration services; • Ensure enrollee safety; • Determine the appropriate level of care; and • Determine whether the service or item is medically necessary. **Process for Obtaining Prior Authorization.** For Plans that include out-of-network benefits, MH/SUD requires the member to obtain prior authorization for some out-of-network outpatient services as noted on the Schedule of Benefits. An out-of-network provider may request Prior Authorization on behalf of the member. When a Prior Authorization is requested, appropriately qualified clinical staff reviews the request utilizing the applicable clinical policies and/or guidelines, criteria, and Plan terms, and then render a coverage determination. Both the providers and member are notified of any adverse determination consistent with state, federal and accreditation requirements and applicable appeal rights are provided. **Network Gaps:** A network gap request for services to be rendered by an out-of-network provider when the network lacks an appropriate provider to perform the specific service being requested. An appropriate provider is one either within the required mileage range or one who possesses the necessary clinical expertise. **Transition of Care (TOC):** A request for TOC is based on a benefit which allows a newly covered member who is receiving ongoing care a transition period before they are required to transfer from an out-of- network provider to an in-network provider and to receive network benefits for the transition period. **Continuity of Care (CoC):** A request for CoC is based on a	Authorization is to ensure cost-effective and clinically effective treatment is delivered at the right time and in the right clinical setting to achieve a positive clinical outcome. The processes and criteria utilized for prior authorization of MH/SUD treatments and services are comparable and applied no more stringently than, those designed and applied to M/S treatment or services. Parity compliance exists because both utilize evidence- based nationally recognized clinical guidelines when designing or determining whether to add or maintain a prior authorization requirement. Further, the processes and evidentiary standards used in application are comparable because both MH/SUD and M/S consider the type of treatment or service requested and the member's clinical presentation when applying clinical guidelines for the treatment or service. M/S and MH/SUD requests for authorization are evaluated by appropriately licensed and qualified medical or behavioral clinical staff. For both MH/SUD and M/S, the treating provider is required to provide clinical information. This information is reviewed by a medical professional with appropriate credentials necessary to confirm coverage and that the suggested treatment/service is clinically appropriate based on nationally recognized, evidence-based clinical guidelines and medical policies, standardized coverage determination guidelines (CDGs), and generally accepted, peer-reviewed medical literature. Based on the foregoing, the processes and evidentiary standards are comparable and no more

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	Continuity of Care (CoC): A request for CoC is based on a benefit which allows a covered member to continue to receive services rendered by a provider who has terminated from the provider network. The member is given a defined period of time in which to transition to an in-network provider while continuing to receive in-network benefits for services from the terminated provider. **How are Prior Authorizations Submitted** Prior Authorization can be submitted electronically or by phone. **Staff Qualifications** M/S is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized** M/S staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. **Fail First Requirements** M/S may apply Fail First Requirements to certain codes covered under Outpatient Benefits, such as medical injectables for cancer drugs. **Timeframe to Respond** M/S will follow all applicable state and federal laws and accreditation timeframe requirements.	benefit which allows a covered member to continue to receive services rendered by a provider who has terminated from the provider network. The member is given a defined period of time in which to transition to an in-network provider while continuing to receive in-network benefits for services from the terminated provider. **How are Prior Authorizations Submitted.** Prior Authorization can be submitted electronically or by phone. **Staff Qualifications** MH/SUD is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. RN, LPC, LISW, etc.) and all adverse determinations are made by [redacted] Medical Directors or PhDs. **Guidelines/Criteria Utilized.** MH/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria (LOCUS, CASII, ECSII, ASAM). **Fail First Requirements** MH/SUD may apply Fail First requirements to certain codes covered under Outpatient Benefits such as, TMS (Transcranial Magnetic Stimulation) **Timeframe to respond.** MH/SUD will follow all applicable state and federal laws and accreditation timeframe requirements.	stringently applied for MH/SUD. **ATTACHMENTS:** Schedule of Benefits: Summary of Benefits Table Addendum A
C. Concurrent Review Process, including frequency and penalties for all services. Describe any step-therapy or "fail first" requirements and requirements for	**Services Requiring Concurrent Review.** Concurrent Review applies to services provided at an inpatient level of care or when an inpatient stay exceeds the expected number of days. Concurrent Review does not apply, however, when a facility has agreed to accept a flat rate per stay.	**Services Requiring Concurrent Review.** Concurrent Review applies to services provided at an inpatient level of care or when an inpatient stay exceeds the expected number of days. Concurrent Review does not apply, however, when a facility has agreed to accept a flat rate per stay. **Why does the Plan Conduct Concurrent Review?** Concurrent	For both M/S and MH/SUD, the goal of Concurrent Review is to ensure cost-effective and clinically effective treatment is delivered at the right time and in the right clinical setting to achieve a positive clinical outcome. The processes and criteria utilized for Concurrent Review of MH/SUD treatments or services are

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
submission of treatment request forms or treatment plans. Inpatient, In-Network:	**Why does the Plan Conduct Concurrent Review?** Concurrent Review is a component of the Plan's utilization management program. The Medical Director and other clinical staff review hospitalizations, other inpatient admissions for the following reasons: • to detect and better manage over- and under-utilization; • to determine whether the admission and continued stay are— o consistent with the member's coverage, o medically appropriate, and o consistent with evidence-based guidelines; • to contribute to decisions about discharge planning and case management; and • to identify opportunities for quality improvement and cases that are appropriate for referral to a disease management program, if applicable. **Process for Concurrent Review** Concurrent review begins after notification of admission and receipt of clinical information. A concurrent review may be conducted by telephone, on-site, and when available, facilities can provide clinical information via access to Electronic Medical Records ("EMR"). If the reviewer (a mid- level provider, such as a nurse for M/S benefits) believes that an admission or continued stay may not be covered, the facility will be asked for more information concerning the member's clinical condition, treatment and case management plan. The reviewer's assessment of whether an admission or continued stay is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines. When the Medical Director determines that an admission or continued stay at the facility is not medically necessary, and will not be covered, the member, facility and the physician will be notified consistent with state, federal and accreditation requirements and applicable appeal rights are provided.	Review is a component of the Plan's utilization management program. The Medical Director and other clinical staff review hospitalizations, other inpatient admissions for the following reasons: • to detect and better manage over- and under- utilization; • to determine whether the admission and continued stay are— • consistent with the member's coverage, • medically appropriate, and • consistent with evidence-based guidelines; • to contribute to decisions about discharge planning and case management; and • to identify opportunities for quality improvement and cases that are appropriate for referral to a disease management program, if applicable. **Process for Concurrent Review.** Concurrent review begins after notification of admission and receipt of clinical information. A concurrent review may be conducted by telephone, on-site, and when available, facilities can provide clinical information via access to Electronic Medical Records ("EMR"). If the reviewer (a mid- level provider, such as a clinical social worker for MH/SUD benefits) believes that an admission or continued stay may not be covered, the facility will be asked for more information concerning the member's clinical condition, treatment and case management plan. The reviewer's assessment of whether an admission or continued stay is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines. When the Medical Director determines that an admission or continued stay at the facility is determined to not be medically necessary, and therefore not covered, the member, facility and the physician will be notified consistent with state, federal and accreditation requirements and applicable appeal rights are provided.	comparable and applied no more stringently than, those designed and applied to M/S treatment or services. Parity compliance exists because both M/S and MH/SUD utilize evidence-based nationally recognized clinical guidelines when applying Concurrent Review requirements. Further, for both M/S and MH/SUD, clinicians (with appropriate M/S or MH/SUD qualifications) conduct the review pursuant to applicable nationally recognized clinical guidelines. The processes and evidentiary standards designed and applied by MH/SUD for Concurrent Review are comparable to those designed and applied by M/S, as both follow all applicable state and federal guidelines for the service. The suggested timeframes are comparable, and no more stringent for MH/SUD, as M/S and MH/SUD should notify as soon as reasonably possible. Therefore, as noted above, the Concurrent Review process for MH/SUD is comparable to, and no more stringently applied, than for M/S. **ATTACHMENTS:** Addendum A

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Admission Notification Requirements Notification can be submitted via online or the telephone number on the back of the members ID card. Notification should occur as soon as reasonably possible. **Staff Qualifications** M/S is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized** M/S staff make determinations by utilizing evidence-based medical policy and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. **Fail First Requirements** M/S does not apply Fail First Requirements to concurrent review for Inpatient Benefits. **Timeframe to Respond** M/S will follow all applicable state and federal law and accreditation timeframe requirements.	**Admission Notification Requirements.** Notification can be submitted via online or the telephone number on the back of the member's ID card. Notification should occur as soon as reasonably possible. **Staff Qualifications** MH/SUD is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. RN, LPC, LISW, etc.) and all adverse determinations are made by [redacted] Medical Directors or PhDs **Guidelines/Criteria Utilized. M**H/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria (LOCUS, CASII, ECSII, ASAM). Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. **Fail First Requirements** MH/SUD does not apply Fail First Requirements to concurrent review for Inpatient Benefits. **Timeframe to respond.** MH/SUD will follow all applicable state and federal laws and accreditation timeframe requirements.	
Concurrent Review - Outpatient, In-Network: Office Visits:	Concurrent Review does not apply to office visits.	Concurrent Review does not apply to office visits.	The Plan is parity compliant for this benefit category because no NQTL is applied to M/S and MH/SUD services for office visits.
Concurrent Review - Outpatient, In-Network: Other Outpatient Items and Services:	**Services Requiring Concurrent Review.** Please refer to Addendum A for listing of the services reviewed through Concurrent Review.	**Services Requiring Concurrent Review.** Please refer to Addendum A for listing of the services reviewed through Concurrent Review. **Why does the Plan Conduct Concurrent Review?** Outpatient	For both M/S and MH/SUD, the goal of Concurrent Review is to ensure cost-effective and clinically effective treatment is delivered at the right time and in the right clinical setting to achieve a positive clinical outcome. The processes and criteria utilized for Concurrent

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation

	Why does the Plan Conduct Concurrent Review? Outpatient Concurrent Review is a component of the Plan's utilization management program. The Medical Director and other clinical staff review services for the following reasons:
	
	• to detect and better manage over- and under-utilization;
	• to determine whether the service(s) are—
	  ○ consistent with the member's coverage,
	  ○ medically appropriate, and
	  ○ consistent with evidence-based guidelines;
	• to identify opportunities for quality improvement and cases that are appropriate for referral to a disease management program, if applicable.
	
	The criteria used to determine whether Concurrent Review applies to a given benefit are as follows:
	
	For Outpatient, services are concurrently reviewed to determine if the continued course of outpatient treatment will be covered where outpatient services are approved for a defined period and continued, or ongoing outpatient services are requested beyond the previously approved services.
	
	Process for Concurrent Review
	Concurrent Review for in-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending.
	
	The reviewer's assessment of whether a continuing course of outpatient treatment is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines and the terms of the Plan.
	
	When the Medical Director determines whether the continuing course of treatment is medically necessary, the member and provider will be notified of the determination consistent with
		Concurrent Review is a component of the Plan's utilization management program. The Medical Director and other clinical staff review services for the following reasons:
		
		• to detect and better manage over- and under- utilization;
		• to determine whether the service(s) are—
		  ○ consistent with the member's coverage,
		  ○ medically appropriate, and
		  ○ consistent with evidence-based guidelines;
		• to identify opportunities for quality improvement and cases that are appropriate for referral to a disease management program, if applicable.
		
		The criteria used to determine whether Concurrent Review applies to a given benefit are as follows:
		
		For Outpatient, services are concurrently reviewed to determine if the continued course of outpatient treatment will be covered where outpatient services are approved for a defined period and continued, or ongoing outpatient services are requested beyond the previously approved services.
		
		Process for Concurrent Review. Concurrent Review for in-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending.
		
		The reviewer's assessment of whether a continuing course of outpatient treatment is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines and the terms of the Plan.
		
		When the Medical Director determines whether the continuing course of treatment is medically necessary, the member and provider will be notified of the determination consistent with state, federal or accreditation requirements and applicable appeal rights are provided.
			Review of MH/SUD treatments or services are comparable and applied no more stringently than, those designed and applied to M/S treatment or services.
			
			Parity compliance exists because both M/S and MH/SUD utilize evidence-based nationally recognized clinical guidelines when applying Concurrent Review requirements. Further, for both M/S and MH/SUD, clinicians (with appropriate M/S or MH/SUD qualifications) conduct the review pursuant to applicable nationally recognized clinical guidelines.
			
			The processes and evidentiary standards designed and
			applied by MH/SUD for Concurrent Review are comparable to those designed and applied by M/S, as both follow all applicable state and federal guidelines for the service. The suggested timeframes are comparable, and no more stringent for MH/SUD, as M/S and MH/SUD should notify as soon as reasonably possible. Therefore, as noted above, the Concurrent Review process for MH/SUD is comparable to, and no more stringently applied, than for M/S.
			
			ATTACHMENTS:
			Addendum A

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	state, federal or accreditation requirements and applicable appeal rights are provided. **Notification Requirements** The plan would typically receive the service request before the current course of treatment ends. Authorization can be obtained via online or by telephone. **Staff Qualifications** M/S is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized** M/S staff make determination by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. **Fail First Requirements** M/S does not apply Fail First Requirements to concurrent review for outpatient benefits. **Timeframe to Respond** M/S will follow all applicable state and federal laws and accreditation timeframe requirements	**Notification Requirements** The plan would typically receive the service request before the current course of treatment ends. Authorization can be obtained via online or by telephone. **Staff Qualifications** MH/SUD is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. RN, LPC, LISW, etc.) and all adverse determinations are made by [redacted] Medical Directors or PhDs **Guidelines/Criteria Utilized** MH/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria (LOCUS, CASII, ECSII, ASAM). **Fail First Requirements** MH/SUD does not apply Fail First Requirements to concurrent review for outpatient benefits. **Timeframe to Respond** MH/SUD will follow all applicable state and federal laws and accreditation timeframe requirements	
Concurrent Review - Inpatient, Out-of-Network:	**Services Requiring Concurrent Review.** When the plan has out-of-network benefits, concurrent review applies to services provided at an inpatient level of care or when an inpatient stay exceeds the expected number of days. Clinical policies and guidelines, which rely on current evidence-based medicine and criteria, are used to determine if a service is medically necessary under the member's benefit plan. **Why does the Plan Conduct Concurrent Review?** Concurrent Review is a component of the Plan's utilization management program. The Medical Director and other clinical staff review	**Services Requiring Concurrent Review.** When the plan has out-of-network benefits, concurrent review applies to services provided at an inpatient level of care or when an inpatient stay exceeds the expected number of days, while considering the needs of the individual patient at the time of review and the treatment requested. Clinical policies and guidelines, which rely on current evidence-based medicine and criteria, are used to determine if a service is medically necessary under the member's benefit plan.	For both M/S and MH/SUD, the goal of Concurrent Review is to ensure cost-effective and clinically effective treatment is delivered at the right time and in the right clinical setting to achieve a positive clinical outcome. The processes and criteria utilized for Concurrent Review of MH/SUD benefits are comparable and applied no more stringently than, those designed and applied to M/S treatment or services. Parity compliance exists because both M/S and

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation

	hospitalizations, other inpatient admissions for the following reasons:
	
	• to detect and better manage over- and under-utilization;
	• to determine whether the admission and continued stay are—
	  o consistent with the member's coverage,
	  o medically appropriate, and
	  o consistent with evidence-based guidelines;
	• to contribute to decisions about discharge planning and case management; and
	• to identify opportunities for quality improvement and cases that are appropriate for referral to a disease management program, if applicable.
	
	Process for Concurrent Review
	When the plan has out-of-network benefits, concurrent review usually begins on the first business day following notification. A concurrent review may be conducted by telephone, on-site, and when available, facilities can provide clinical information via access to Electronic Medical Records ("EMR"). If the reviewer (a mid- level provider, such as a nurse for M/S benefits) believes that an admission or continued stay may not be covered, the facility will be asked for more information concerning the member's clinical condition, treatment and case management plan.
	
	The reviewer's assessment of whether an admission or continued stay is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines.
	
	When the Medical Director determines that an admission or continued stay at the facility is not medically necessary, and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided. An out-of-network provider may bill the member for non-reimbursable
		Why does the Plan Conduct Concurrent Review? Concurrent Review is a component of the Plan's utilization management program. The Medical Director and other clinical staff review hospitalizations, other inpatient admissions for the following reasons:
		• to detect and better manage over- and under- utilization;
		• to determine whether the admission and continued stay are—
		  o consistent with the member's coverage,
		  o medically appropriate, and
		  o consistent with evidence-based guidelines;
		• to contribute to decisions about discharge planning and case management; and
		• to identify opportunities for quality improvement and cases that are appropriate for referral to a disease management program, if applicable.
		
		Process for Concurrent Review. When the plan has out-of-network benefits, concurrent review usually begins on the first business day following notification. A concurrent review may be conducted by telephone, on-site, and when available, facilities can provide clinical information via access to Electronic Medical Records ("EMR"). If the reviewer (a mid-level provider, such as a clinical social worker for MH/SUD benefits) believes that an admission or continued stay may not be covered, the facility will be asked for more information concerning the member's clinical condition, treatment and case management plan.
		
		The reviewer's assessment of whether an admission or continued stay is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines.
		
		When the Medical Director determines that an admission or continued stay at the facility is not medically necessary, and will not be covered, the member, facility and the physician will be notified consistent with state, federal and accreditation
			MH/SUD utilize evidence-based nationally recognized clinical guidelines when designing or determining whether to add or maintain a Concurrent Review requirement. Further, for both M/S and MH/SUD, clinicians (with appropriate M/S or MH/SUD qualifications) conduct the review pursuant to applicable nationally recognized clinical guidelines.
			
			The processes and evidentiary standards designed and applied by MH/SUD for Concurrent Review are comparable to those designed and applied by M/S, as both follow all applicable state/federal guidelines for the service. The suggested timeframes are comparable, and no more stringent for MH/SUD, as M/S and MH/SUD should notify as soon as reasonably possible. Therefore, as noted above, the Concurrent Review process for MH/SUD is comparable to, and no more stringently applied, than for M/S.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	charges. **Admission Notification Requirements** Notification can be submitted via the telephone number on the back of the members ID card. Notification should occur as soon as reasonably possible. **Staff Qualifications** M/S is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized** M/S staff make determinations by utilizing evidence-based medical policy and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. **Fail First Requirements** M/S does not apply Fail First Requirements to concurrent review for Inpatient Benefits. **Timeframe to Respond** M/S will follow all applicable state and federal laws and accreditation timeframe requirements	requirements and applicable appeal rights are provided. An out-of-network provider may bill the member for non-reimbursable charges. **Admission Notification Requirements.** Notification can be submitted via the telephone number on the back of the members ID card. Notification should occur as soon as reasonably possible. **Staff Qualifications**. MH/SUD is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. RN, LPC, LISW, etc.) and all adverse determinations are made by [redacted] Medical Directors or PhDs **Guidelines/Criteria Utilized. M**H/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria (LOCUS, CASII, ECSII, ASAM). Other criteria may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. **Fail First Requirements** MH/SUD does not apply Fail First Requirements to concurrent review for Inpatient Benefits. **Timeframe to respond.** MH/SUD will follow all applicable state and federal laws and accreditation timeframe requirements.	
Concurrent Review - Outpatient, Out-of-Network: Office Visits:	Concurrent Review does not apply to office visits.	Concurrent Review does not apply to office visits.	Plan is parity compliant for this benefit category because no NQTL is applied to either M/S or MH/SUD office visits.
Concurrent Review - Outpatient, Out-of-Network: Other Items and Services:	**Services Requiring Concurrent Review.** Please refer Addendum A for listing of the services reviewed	**Services Requiring Concurrent Review.** Please refer to Addendum A for listing of the services reviewed through Concurrent Review.	For both M/S and MH/SUD, the goal of Concurrent Review is to ensure cost-effective and clinically effective treatment is delivered at the right time and in the right clinical setting to achieve a positive clinical outcome. The

	through Concurrent Review. **Why does the Plan Conduct Concurrent Review?** Outpatient Concurrent Review is a component of the Plan's utilization management program. The Medical Director and other clinical staff review services for the following reasons: • to detect and better manage over- and under-utilization; • to determine whether the service is - o consistent with the member's coverage, o medically appropriate, and o consistent with evidence-based guidelines; • to identify opportunities for quality improvement and cases that are appropriate for referral to a disease management program, if applicable. The criteria used to determine whether Concurrent Review applies to a given benefit are as follows: For Outpatient, services are concurrently reviewed to determine if the continued course of outpatient treatment will be covered where outpatient services are approved for a defined period and continued, or ongoing outpatient services are requested beyond the previously approved services. **Process for Concurrent Review** When the plan has out-of-network benefits, concurrent review for out-of-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending. If the reviewer believes that a continuing course of outpatient treatment may not be covered, the provider will be asked for more information concerning the treatment. The reviewer's assessment of whether a continuing course of outpatient treatment is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines and the terms of the Plan. When the Medical Director determines whether the continuing	**Why does the Plan Conduct Concurrent Review?** Outpatient Concurrent Review is a component of the Plan's utilization management program. The Medical Director and other clinical staff review services for the following reasons: • to detect and better manage over- and under- utilization; • to determine whether the service is - o consistent with the member's coverage, o medically appropriate, and o consistent with evidence-based guidelines; • to identify opportunities for quality improvement and cases that are appropriate for referral to a disease management program, if applicable. The criteria used to determine whether Concurrent Review applies to a given benefit are as follows: For Outpatient, services are concurrently reviewed to determine if the continued course of outpatient treatment will be covered where outpatient services are approved for a defined period and continued, or ongoing outpatient services are requested beyond the previously approved services. **Process for Concurrent Review.** When the plan has out-of-network benefits, concurrent review for out- of-network outpatient benefits begins when the Plan receives a request for coverage for a continuing course of outpatient treatment that was previously approved and is ending. If the reviewer believes that a continuing course of outpatient treatment may not be covered, the provider will be asked for more information concerning the treatment. The reviewer's assessment of whether a continuing course of outpatient treatment is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of nationally recognized clinical guidelines and the terms of the Plan. When the Medical Director determines whether the continuing course of treatment is medically necessary, the member and provider will be notified of the determination consistent with	processes and criteria utilized for Concurrent Review of MH/SUD benefits are comparable and applied no more stringently than, those designed and applied to M/S treatment or services. Parity compliance exists because both M/S and MH/SUD utilize evidence-based nationally recognized clinical guidelines when designing or determining whether to add or maintain a Concurrent Review requirement. Further, for both M/S and MH/SUD, clinicians (with appropriate M/S or MH/SUD qualifications) conduct the review pursuant to applicable nationally recognized clinical guidelines. The processes and evidentiary standards designed and applied by MH/SUD for Concurrent Review are comparable to those designed and applied by M/S, as both follow all applicable state/federal guidelines for the service. The suggested timeframes are comparable, and no more stringent for MH/SUD, as M/S and MH/SUD should notify as soon as reasonably possible. Therefore, as noted above, the Concurrent Review process for MH/SUD is comparable to, and no more stringently applied, than for M/S. **ATTACHMENTS:** Addendum A

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	course of treatment is medically necessary, the member and provider will be notified of the determination consistent with state, federal and accreditation requirements and applicable appeal rights are provided. An out-of-network provider may bill the member for non-reimbursable charges. **Notification Requirements** The plan would typically receive the service request before the current course of treatment ends. Authorization can be obtained by calling the telephone number on the members ID card. **Staff Qualifications** M/S is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized** M/S staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. **Fail First Requirements** M/S does not apply Fail First Requirements to concurrent review for outpatient benefits. **Timeframe to Respond** M/S will follow all applicable state and federal laws and accreditation timeframe requirements.	state, federal and accreditation requirements and applicable appeal rights are provided. An out-of-network provider may bill the member for non-reimbursable charges. **Notification Requirements.** The plan would typically receive the service request before the current course of treatment ends. Authorization can be obtained by calling the telephone number on the members ID card. **Staff Qualifications**. MH/SUD is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. RN, LPC, LISW, etc.) and all adverse determinations are made by [redacted] Medical Directors or PhDs **Guidelines/Criteria Utilized. M**H/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria (LOCUS, CASII, ECSII, ASAM). **Fail First Requirements** MH/SUD does not apply Fail First Requirements to concurrent review for outpatient benefits. **Timeframe to respond.** MH/SUD will follow all applicable state and federal laws and accreditation timeframe requirements.	
D. Retrospective Review Process, including timeline and penalties. Inpatient, In-Network:	**Services reviewed through Retrospective Review** **Inpatient In-Network Pre-Claim Retrospective Review** applies to services provided at an inpatient level of care or bed day when the Plan is notified of the inpatient stay after discharge. **Inpatient In-Network Post-Claim Retrospective Review**. If	**Services reviewed through Retrospective Review** **Inpatient In-Network Pre-Claim Retrospective Review** applies to services provided at an inpatient level of care or bed day when the Plan is notified of the inpatient stay after discharge. **Inpatient In-Network Post-Claim Retrospective Review**. If prior auth is required and no prior auth is on file, the claim is	Retrospective Review is used to detect and better manage over- and under-utilization and to determine whether the service or item, reviewed retrospectively is: 1) consistent with the member's coverage, 2) medically appropriate, and 3) consistent with evidence-based guidelines. The processes and criteria utilized for Retrospective Review are comparable for

	prior auth is required and no prior auth is on file, the claim is denied administratively for no-prior auth on file. However, if the in-network facility/physician has the medical-necessity addendum, the provider can request a medical necessity review post claim.
	
	Why does the Plan conduct Retrospective Reviews?
	Retrospective Review is a component of the Plan's utilization management program. The Medical Director and other clinical staff review hospitalizations and other inpatient admissions, for the following reasons:
	
	• to detect and better manage over- and under-utilization;
	• to determine whether the services reviewed are—
	  ○ consistent with the member's coverage,
	  ○ medically appropriate, and consistent with evidence-based guidelines.
	
	Process for Retrospective Review.
	Pre-Claim Retrospective Review
	(Plan receives notification post discharge) – the Plan performs a pre-claim retrospective review, for certain inpatient in-network cases, starting with the first day of the admission if the in-network facility did not notify the Plan or seek prior authorization for an admission and provides extenuating circumstances for a late notification of inpatient admissions. This review is conducted unless post-discharge review is prohibited by hospital contract. Notification of all review outcomes is communicated in accordance with applicable state, federal and accreditation requirements, and applicable appeal rights are provided.
	
	Post-Claim Retrospective Review
	If prior auth is required and no prior auth is on file, the claim is denied administratively for no-prior auth on file. However, if the in-network facility/physician has the med-nec addendum, the provider can request a medical necessity review post claim. Notification of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements and applicable appeal rights are provided.
		denied administratively for no-prior auth on file. The provider can then appeal for medical necessity review post claim.
		
		Why does the Plan conduct Retrospective Reviews?
		Retrospective Review is a component of the Plan's utilization management program. The Medical Director and other clinical staff review hospitalizations and other inpatient admissions, for the following reasons:
		
		• to detect and better manage over- and under- utilization;
		• to determine whether the services reviewed are—
		  ○ consistent with the member's coverage,
		  ○ medically appropriate, and consistent with evidence-based guidelines.
		
		Process for Retrospective Review.
		Pre-Claim Retrospective Review (Plan receives notification post discharge) – the Plan performs a pre- claim retrospective review, for certain inpatient in- network cases, starting with the first day after
		notification, if the in-network facility did not notify the Plan in a timely manner or seek prior authorization for the admission and provides extenuating circumstances for the late notification. The review is conducted unless post-discharge review is prohibited by hospital contract. Notification of all review outcomes is communicated in accordance with applicable state, federal and accreditation requirements, and applicable appeal rights are provided.
		
		Post-Claim Retrospective Review.
		If prior authorization was required and no prior authorization is on file, the claim is denied administratively for no-prior authorization on file. The provider can then appeal for medical necessity review post claim. Notification of all review outcomes is communicated in accordance with applicable state, federal and accreditation requirements and applicable appeal rights are provided.
		
		Notification Requirements by online or telephone for Pre-Claim Retrospective Review. For Post-Claim Retrospective Review
			MH/SUD and M/S, as each provides for review and decision-making regarding previously provided services and treatments.
			
			From a stringency perspective, both M/S and MH/SUD reviews are initiated similarly in terms of requiring a basis for delayed notification, as well as the standards applied for each. Therefore, as written and in operation, Retrospective Review for MH/SUD benefits is applied in a comparable and no more stringent manner than for M/S benefits.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Notification Requirements By online or telephone for Pre-Claim Retrospective Review. For Post-Claim Retrospective Review reconsiderations, the provider can notify the plan via phone, on-line or mail. **Staff Qualifications** M/S is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized** M/S staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. **Timeframe to Respond** M/S will follow all applicable state and federal laws and accreditation timeframe requirements	reconsiderations, the provider can notify the plan via phone, on-line or mail. **Staff Qualifications**. MH/SUD is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. RN, LPC, LISW, etc.) and all adverse determinations are made by [redacted] Medical Directors or PhDs. **Guidelines/Criteria Utilized. M**H/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria (LOCUS, CASII, ECSII, ASAM). **Timeframe to respond.** MH/SUD will follow all applicable state and federal laws and accreditation timeframe requirements.	
Retrospective Review - Outpatient, In-Network: Office Visits:	Retrospective Review is not applicable to office visits.	Retrospective Review is not applicable to office visits.	Plan is parity compliant for this benefit category because Retrospective Review is not applied to M/S or MH/SUD Outpatient, In-Network Office Visits.
Retrospective Review - Outpatient, In-Network: Other Outpatient Items and Services:	**Services reviewed through Retrospective Review** **Outpatient In network Post-service, Pre-claim Reviews** When the Plan is contacted by an in-network provider who was unable to obtain prior authorization due to a qualifying mitigating circumstance, a medical necessity review will be conducted. • Echocardiograms • Stress Echocardiograms • Diagnostic Catheterizations • Electrophysiology Implants • DME • Home Health	**Services reviewed through Retrospective Review** **Outpatient In network Post-service, Pre-claim Reviews** When the Plan is contacted by an in-network provider who was unable to obtain prior authorization due to a qualifying mitigating circumstance, a medical necessity review will be conducted. • Intensive Outpatient Treatment • Electro-Convulsive Treatment • Psychological Testing • Extended Treatment Sessions - (50+) minutes • ABA **Outpatient in network Post Service/Post Claim Denial**	Retrospective Review is used to detect and better manage over- and under-utilization and to determine whether the service or item, reviewed retrospectively is: 1) consistent with the member's coverage, 2) medically appropriate, and 3) consistent with evidence-based guidelines. The processes and criteria utilized for Retrospective Review are comparable for MH/SUD and M/S, as each provides for review and decision-making regarding previously provided services and treatments. From a stringency perspective, both M/S and

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation

	Outpatient in network Post Service/Post Claim Denial Reconsiderations Review Process. If prior auth is required and no prior auth is on file, the claim is denied administratively for no-prior auth on file. However, if the in-network facility/physician has the medical-necessity addendum, the provider can request a medical necessity review post claim. See the Prior Authorization List above.
	
	For med/surg, [redacted] will retrospectively review certain claims based on CPT, diagnosis, revenue codes, or dollar amount when there is no prior authorization requirement and when a pre-service review approval is not on file.
	• Experimental/Investigational
	• Unproven
	• Cosmetic
	• Clinical questions of contract coverage
	• Skilled care vs. Custodial
	
	Why does the Plan conduct Retrospective Reviews?
	Retrospective Review is a component of the Plan's utilization management program. The Medical Director and other clinical staff review services for the following reasons:
	
	• to detect and better manage over- and under-utilization;
	• to determine whether the services reviewed are—
	  ○ consistent with the member's coverage,
	  ○ medically appropriate, and consistent with evidence-based guidelines.
	
	Process for Retrospective Review.
	Pre-Claim Retrospective Review Post-service
	When the Plan is contacted by an in-network provider who was unable to obtain prior authorization due to a qualifying mitigating circumstance, a medical necessity review will be conducted for outpatient services.
		Reconsiderations Review Process. If prior auth is required and no prior auth is on file, the claim is denied administratively for no-prior auth on file. If the claim is denied, the provider can appeal for medical necessity review. See the Prior Authorization List above.
		
		Why does the Plan conduct Retrospective Reviews?
		Retrospective Review is a component of the Plan's utilization management program. The Medical Director and other clinical staff review services for the following reasons:
		
		• to detect and better manage over- and under- utilization;
		• to determine whether the services reviewed are—
		  ○ consistent with the member's coverage,
		  ○ medically appropriate, and consistent with evidence-based guidelines.
		
		Process for Retrospective Review.
		Pre-Claim Retrospective Review
		Post-service When the Plan is contacted by an in-network provider who was unable to obtain prior authorization due to a qualifying mitigating circumstance a medical necessity review will be conducted for outpatient services. For all other services, the in-network provider can provide this additional information upon appeal.
		
		When the Medical Director determines that the service was not medically necessary, the member and providers will be notified consistent with state, federal and accreditation requirements and applicable appeal rights are provided.
		
		Post-Claim Retrospective Review –
		If prior authorization is required and no prior authorization is on file, the claim is denied administratively for no-prior authorization on file. However, the in-network provider can then appeal for medical necessity review post claim. Otherwise, the claim will
			MH/SUD reviews are initiated similarly in terms of requiring a basis for delayed notification, as well as the standards applied for each. Therefore, as written and in operation, Retrospective Review for MH/SUD benefits is applied in a comparable and no more stringent manner than for M/S benefits.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	For all other services, the in-network provider can provide this additional information upon appeal. When the Medical Director determines that the service was not medically necessary, the member and providers will be notified consistent with state, federal and accreditation requirements and applicable appeal rights are provided. **Post-Claim Retrospective Review** If prior auth is required and no prior auth is on file, the claim is denied administratively for no-prior auth on file. However, if the in-network provider has the med-nec addendum, the provider can request a medical necessity review. Otherwise, the claim will administratively deny for no-prior auth on file. If the service is reviewed and determined to be not medically necessary, then the claim will deny in full and provide appeal rights. If there are extenuating circumstances for not obtaining a prior auth, the provider if the reviewer (a mid-level provider, such as a nurse for M/S benefits) believes that the service is not medically necessary, the provider will be asked for more information. When the Medical Director determines whether the service is medically necessary, the provider will be notified of the determination. If denied, then the notice will include appeal rights and follow all applicable state, federal or accreditation requirements. **Notification Requirements** By telephone or online for Pre-Claim Retrospective Review. For Post-Claim Retrospective Review reconsiderations, the provider can notify the plan via phone, on-line or mail. **Staff Qualifications** M/S is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized**	administratively deny for no-prior authorization on file. If the reviewer (a mid-level provider, such as a clinical social worker for MH/SUD benefits) believes that the service was not medically necessary, the provider will be asked for more information. If the service is reviewed and determined to be not medically necessary, then the claim will deny in full and provide appeal rights. Upon appeal, a Medical Director determines whether the service was medically necessary, and the provider will be notified of the determination. If denied, then the notice will include appeal rights and follow all applicable state, federal and accreditation requirements. **Notification Requirements** By telephone or online for Pre-Claim Retrospective Review. For Post-Claim Retrospective Review reconsiderations, the provider can notify the plan via phone, on-line or mail. **Staff Qualifications**. MH/SUD is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. RN, LPC, LISW, etc.) and all adverse determinations are made by [redacted] Medical Directors or PhDs **Guidelines/Criteria Utilized.** MH/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria (LOCUS, CASII, ECSII, ASAM). **Timeframe to respond.** MH/SUD will follow all applicable state and federal laws and accreditation timeframe requirements.	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	M/S staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. **Timeframe to Respond** M/S will follow all applicable state and federal laws and accreditation timeframe requirements		

Retrospective Review - Inpatient, Out-of-Network:	**Services reviewed through Retrospective Review**
	
	Inpatient OON Pre-Claim Retrospective Review applies to services provided at an inpatient level of care or bed day when the Plan is notified of the inpatient stay after discharge.
	
	Inpatient OON Post-Claim Retrospective Review. Plan documents require the member to obtain a prior authorization for out-of-network inpatient elective (non-emergency) services. If no prior authorization or notification is on file, a penalty would be applied to the member and appeal rights are offered unless there are extenuating circumstances.
	
	If no prior auth is on file for the Inpatient stay the claim is routed to MCR for Level of Care and/or Length of Stay review.
	
	Why does the Plan conduct Retrospective Reviews?
	Retrospective Review is a component of the Plan's utilization management program. The Medical Director and other clinical staff review hospitalizations and other inpatient admissions, for the following reasons:
	
	• to detect and better manage over- and under-utilization;
	• to determine whether the services reviewed are—
	  ○ consistent with the member's coverage,
	  ○ medically appropriate, and consistent with evidence-based guidelines.
	
	Pre-Claim Retrospective Review
		Services reviewed through Retrospective Review
		
		Inpatient OON Pre-Claim Retrospective Review applies to services provided at an inpatient level of care or bed day when the Plan is notified of the inpatient stay after discharge.
		
		Inpatient OON Post-Claim Retrospective Review. Plan documents require the member to obtain a prior authorization for out-of-network inpatient elective (non-emergency) services. If no prior authorization or notification is on file, but services are determined to have been medically necessary, a penalty would be applied to the member unless there are extenuating circumstances. If the claim is reviewed and is determined to not have been medically necessary, the claim would be clinically denied and appeal rights provided.
		
		Why does the Plan conduct Retrospective Reviews?
		Retrospective Review is a component of the Plan's utilization management program. The Medical Director and other clinical staff review hospitalizations and other inpatient admissions, for the following reasons:
		
		• to detect and better manage over- and under- utilization;
		• to determine whether the services reviewed are—
		  ○ consistent with the member's coverage,
		  ○ medically appropriate, and consistent with evidence-based guidelines.
		
		Pre-Claim Retrospective Review
		When the plan has out-of-network benefits, plan documents
			Retrospective Review is used to detect and better manage over- and under-utilization and to determine whether the service or item, reviewed retrospectively is: 1) consistent with the member's coverage, 2) medically appropriate, and 3) consistent with evidence-based guidelines. The processes and criteria utilized for Retrospective Review are comparable for MH/SUD and M/S, as each provides for review and decision-making regarding previously provided services and treatments.
			
			From a stringency perspective, both M/S and MH/SUD reviews are initiated similarly in terms of requiring a basis for delayed notification, as well as the standards applied for each. Therefore, as written and in operation, Retrospective Review for MH/SUD benefits is applied in a comparable and no more stringent manner than for M/S benefits.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	When the plan has out-of-network benefits, plan documents require the member to obtain a prior authorization for out-of-network inpatient elective (non-emergency) services. Also, Plan documents require the member to notify the Plan for an out-of-network inpatient admission (non-emergency related). If the member does not notify the Plan, the claim will deny (administrative denial) for no-notification and appeal rights are provided. When there are extenuating circumstances for not obtaining a prior authorization/notification, the member can provide this information upon appeal. **Post-Claim Retrospective Review** When the plan has out-of-network benefits, plan documents require the member to obtain a prior authorization for out-of-network inpatient elective (non-emergency) services. If no prior authorization or notification is on file, a penalty would be applied to the member and appeal rights are offered unless there are extenuating circumstances. Post-service, pre-claim reviews are conducted on inpatient services. A clinical coverage review will be done to determine whether the service is medically necessary, and payment may be withheld if the services are determined not to have been medically necessary. Notification of all review outcomes is communicated in accordance with applicable state, federal and accreditation requirements and applicable appeal rights are provided. Retrospective Review for inpatient, out-of-network benefits applies substantially the same process and uses the same criteria as Retrospective Review for inpatient, in-network benefits, with two differences. First, out-of-network providers and facilities have no obligation to cooperate with the Plan's requests for information, documents, or discussions for purposes of Retrospective Review. The Plan seeks the same types of clinical information from the out-of-network provider or facility. Second, the provider may bill non-reimbursable charges to the member.	require the member to obtain a prior authorization for out-of-network inpatient elective (non-emergency) services. Also, Plan documents require the member to notify the Plan for an out-of-network inpatient admission (non-emergency related). If the member does not notify the Plan, the claim will deny (administrative denial) for no-notification and appeal rights are provided. When there are extenuating circumstances for not obtaining a prior authorization/notification, the member can provide this information upon appeal. **Post-Claim Retrospective Review** When the plan has out-of-network benefits, plan documents require the member to obtain a prior authorization for out-of-network inpatient elective (non-emergency) services. If no prior authorization or notification is on file, a penalty would be applied to the member and appeal rights are offered unless there are extenuating circumstances. Post-service, pre-claim reviews are conducted on inpatient services. A clinical coverage review will be done to determine whether the service is medically necessary, and payment may be withheld if the services are determined not to have been medically necessary. Notification of all review outcomes is communicated in accordance with applicable state, federal and accreditation requirements and applicable appeal rights are provided. Retrospective Review for inpatient, out-of-network benefits applies substantially the same process and uses the same criteria as Retrospective Review for inpatient, in-network benefits, with two differences. First, out-of-network providers and facilities have no obligation to cooperate with the Plan's requests for information, documents, or discussions for purposes of Retrospective Review. The Plan seeks the same types of clinical information from the out-of-network provider or facility. Second, the provider may bill non-reimbursable charges to the member. **Notification Requirements** By calling the telephone number on the members ID card.	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Notification Requirements By calling the telephone number on the members ID card. **Staff Qualifications** M/S is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized** M/S staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. **Timeframe to Respond** M/S will follow all applicable state and federal laws and accreditation timeframe requirements	**Staff Qualifications** MH/SUD is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. RN, LPC, LISW, etc.) and all adverse determinations are made by [redacted] Medical Directors or PhDs **Guidelines/Criteria Utilized** MH/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria (LOCUS, CASII, ECSII, ASAM). **Timeframe to respond** MH/SUD will follow all applicable state and federal laws and accreditation timeframe requirements.	
Retrospective Review - Outpatient, Out-of-Network: Office Visits:	Retrospective Review is not applicable to office visits.	Retrospective Review is not applicable to office visits.	Plan is parity compliant for this benefit category because Retrospective Review is not applied to M/S or MH/SUD Outpatient, OON Office Visits.
Retrospective Review - Outpatient, Out-of-Network: Other Items and Services:	**Services reviewed through Retrospective Review** Services that do not require prior authorization can be subject to a retrospective clinical review based on [redacted] Medical Policies. For med/surg, [redacted] will retrospectively review certain claims based on CPT, diagnosis, revenue codes, or dollar amount when there is no prior authorization requirement and when a pre-service review approval is not on file. • Experimental/Investigational • Unproven • Cosmetic • Clinical questions of contract coverage • Skilled care vs. Custodial	**Services reviewed through Retrospective Review** Not Applicable – [redacted] requires the member to obtain a prior authorization for certain outpatient, out-of-network services.(as detailed above) There are no additional items or services that are subject to retrospective review beyond those specified above. **Why does the Plan conduct Retrospective Reviews?** Retrospective Review is a component of the Plan's utilization management program. The Medical Director and other clinical staff review services for the following reasons: • to detect and better manage over- and under- utilization; • to determine whether the services reviewed are— o consistent with the member's coverage, o medically appropriate, and consistent with evidence-	Retrospective Review is used to detect and better manage over- and under-utilization and to determine whether the service or item, reviewed retrospectively is: 1) consistent with the member's coverage, 2) medically appropriate, and 3) consistent with evidence-based guidelines. The processes and criteria utilized for Retrospective Review are comparable for MH/SUD and M/S, as each provides for review and decision-making regarding previously provided services and treatments. From a stringency perspective, both M/S and MH/SUD reviews are initiated similarly in terms of requiring a basis for delayed notification. However, with regard to Outpatient, Out of Network care, MH/SUD does not retrospectively

	Why does the Plan conduct Retrospective Reviews?
	Retrospective Review is a component of the Plan's utilization management program. The Medical Director and other clinical staff review services for the following reasons:
	
	• to detect and better manage over- and under-utilization;
	• to determine whether the services reviewed are—
	  ○ consistent with the member's coverage,
	  ○ medically appropriate, and consistent with evidence-based guidelines.
	
	Pre-Claim Retrospective Review Post-Service
	When the plan has out-of-network benefits, the Plan requires the member to obtain a prior authorization for select outpatient out-of-network services. If the service requires prior authorization, the claim will administratively deny for failure to obtain a prior authorization and appeal rights are provided. If there are mitigating circumstances for not obtaining a prior authorization, the member can provide this information upon appeal.
	
	Post-Claim Retrospective Review
	When the Plan requires prior authorization/notification and there is no prior authorization/notification on file when the claim is received, the claim is penalized administratively for lack of a prior authorization/notification on file when the plan has out-of-network benefits. If there are mitigating circumstances for not obtaining a prior authorization, the member can provide this information upon appeal. Notification of all review outcomes is communicated in accordance with applicable state, federal and accreditation requirements.
	
	Retrospective Review for outpatient, out-of-network benefits applies substantially the same process and uses the same criteria as Retrospective Review for outpatient, in-network benefits, with two differences. First, out-of-network providers and facilities have no obligation to cooperate with the Plan's requests for information, documents, or discussions for purposes of Retrospective Review. The Plan seeks the same types of clinical
		based guidelines.
		
		Pre-Claim Retrospective Review
		Post-service
		When the plan has out-of-network benefits, the plan requires the member to obtain a prior authorization for select outpatient out-of-network services. If the service requires prior authorization, the claim will administratively deny for failure to obtain a prior authorization and appeal rights are provided. If there are mitigating circumstances for not obtaining a prior authorization, the member can provide this information upon appeal.
		
		Post-Claim Retrospective Review
		When the Plan requires prior authorization/notification and there is no prior authorization/notification on file when the claim is received, the claim is penalized administratively for lack of a prior authorization/notification on file when the plan has out-of-network benefits. If there are mitigating circumstances for not obtaining a prior authorization, the member can provide this information upon appeal. Notification of all review outcomes is communicated in accordance with applicable state, federal and accreditation requirements.
		
		Retrospective Review for outpatient, out-of-network benefits applies substantially the same process and uses the same criteria as Retrospective Review for outpatient, in-network benefits, with two differences. First, out-of-network providers and facilities have no obligation to cooperate with the Plan's requests for information, documents, or discussions for purposes of Retrospective Review. The Plan seeks the same types of clinical information from the out-of-network provider or facility. Second, the provider may bill non-reimbursable charges to the member.
		
		Notification Requirements
		By calling the telephone number on the members ID card.
		
		Staff Qualifications.
		MH/SUD is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. RN, LPC, LISW, etc.) and all adverse determinations are
			review Items and Services other than those requiring Prior Authorization. . Therefore, as written and in operation, Retrospective Review for MH/SUD benefits is applied in a comparable and no more stringent manner than for M/S benefits.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	information from the out-of-network provider or facility. Second, the provider may bill non-reimbursable charges to the member. **Notification Requirements** By calling the telephone number on the members ID card. **Staff Qualifications** M/S is staffed by [redacted] clinical, non-clinical and administrative personnel. All clinical reviews are made by clinical staff (i.e. nurses, physicians, etc.) and all adverse determinations are made by physicians/Medical Directors. **Guidelines/Criteria Utilized** M/S staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria, such as MCG® and InterQual. **Timeframe to Respond** M/S will follow all applicable state and federal laws and accreditation timeframe requirements	made by [redacted] Medical Directors or PhDs **Guidelines/Criteria Utilized.** MH/SUD staff make determinations by utilizing evidence-based medical policy, standardized coverage determination guidelines (CDGs) and nationally recognized clinical guidelines and criteria (LOCUS, CASII, ECSII, ASAM). **Timeframe to respond.** MH/SUD will follow all applicable state and federal laws and accreditation timeframe requirements.	
E. Emergency Services	Prior Authorization, Concurrent Review and Retrospective Review are not performed on Emergency Services.	Prior Authorization, Concurrent Review and Retrospective Review are not performed on Emergency Services.	Plan is parity compliant for this benefit category because Prior Authorization is not required, and Concurrent Review and Retrospective Review are not performed, on Emergency Services.
F. Pharmacy Services Include all services for which prior-authorization is required, any step-therapy or "fail first" requirements, any other NQTLs. Tier 1:	Prescription drugs are subject to prior authorization, step therapy and supply/quantity limits. Please see the attached Drugs with Clinical Programs as of 7/1/19 and 5/1/20 which identify prescription drugs subject to NQTLs (such as step therapy and prior authorization). Tier - The tiers for Outpatient Prescription Drugs are defined as follows: Tier 1- Medications that provide the highest overall value. Mostly generic drugs. Some brand-name drugs may also be	Prescription drugs are subject to prior authorization, step therapy and supply/quantity limits. Please see the attached Drugs with Clinical Programs as of 7/1/19 which identifies prescription drugs subject to NQTLs (such as step therapy and prior authorization). Tier - The tiers for Outpatient Prescription Drugs are defined as follows: Tier 1- Medications that provide the highest overall value. Mostly generic drugs. Some brand-name drugs may also be included.	The plan uses prior authorization, step therapy and supply/quantity limits as NQTLS. Prior authorization requires a prescriber to provide information about why a member is taking a medication to determine how it may be covered by the plan. Step therapy requires prior authorization and may require a member to try one or more other prescription drugs before the prescription drug they are requesting may be covered. Supply/quantity limits specifies the largest quantity of a prescription drug covered per copayment or in a defined period of time,

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	included. Tier 2 -Medications that provide good overall value. A mix of brand-name and generic drugs. Tier 3 –Medications that provide the lowest overall value. Mostly brand-name drugs, as well as some generics. Tier 4 –Medications that provide the lowest overall value. Mostly brand-name drugs, as well as some generics. The PDLs generally contain preferred brand and generics on Tiers 1 and 2, with non-preferred on Tier 3/4. Prescription drugs are not subject to an NQTL based on their tier. Medical/surgical prescription drugs and mental health/substances use disorder prescription drugs are subject to the same NQTLs as based on the Clinical Programs Policy.	Tier 2 -Medications that provide good overall value. A mix of brand-name and generic drugs. Tier 3 –Medications that provide the lowest overall value. Mostly brand-name drugs, as well as some generics. Tier 4 –Medications that provide the lowest overall value. Mostly brand-name drugs, as well as some generics. The PDLs generally contain preferred brand and generics on Tiers 1 and 2, with non-preferred on Tier 3/4. Prescription drugs are not subject to an NQTL based on their tier. Medical/surgical prescription drugs and mental health/substances use disorder prescription drugs are subject to the same NQTLs as based on the Clinical Programs Policy.	and are based on FDA approved labeling and clinical evidence. The requirements for NQTLs, including prior authorization and step therapy or "fail first", for both M/S and MH/SUD prescription drugs help to ensure the clinically appropriate prescription drug is provided to the member. As detailed in the accompanying columns, the criteria utilized to administer the prior authorization and step therapy requirement is the same for MH/SUD and M/S. Parity compliant comparability is satisfied by use of the same factors and evidentiary standards to determine whether the requirement will apply for a particular prescription drug. Further, both M/S and MH/SUD utilize generally accepted types of data, evidentiary sources and trend analysis in order to create and maintain a prior authorization or step therapy requirement. In this way, the MH/SUD prior authorization and step therapy requirements, in design and application, are the same and no more stringent than those utilized for M/S. A list of prescription drugs to which prior authorization applies under the pharmacy benefit as of 12/31/20 in the attachments: [redacted] In addition, please find attached the Initial Tier Placement and Benefit Coverage Policy which explains how prescription drugs are assigned to

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
			tiers. The Policy applies to all drugs regardless of their use. For prescription drugs covered under the medical and pharmacy benefit for both M/S and MH/SUD drugs, [redacted] uses the same policies and procedures to create clinical criteria and to develop clinical policies. Furthermore, all documents are reviewed by one [redacted] Committee. There is no distinction between MH/SUD and M/S prescription drugs, and the processes are administered in the same fashion and not applied more stringently to MH/SUD prescription drugs. MHPAEA provides the "processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification." However, it does not require the outcomes and non-quantitative treatment limitations (NQTL) to be the same for every prescription drug. Attached is the current Clinical Programs Policy used to determine if a prescription drug should be subject to Prior Authorization. **ATTACHMENTS:** [redacted]

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
Tier 2:	Prescription drugs are subject to prior authorization, step therapy and supply/quantity limits.	Prescription drugs are subject to prior authorization, step therapy and supply/quantity limits.	Please refer to the response above to Tier 1.
Tier 3:	Prescription drugs are subject to prior authorization, step therapy and supply/quantity limits.	Prescription drugs are subject to prior authorization, step therapy and supply/quantity limits.	Please refer to the response above to Tier 1.
Tier 4:	Prescription drugs are subject to prior authorization, step therapy and supply/quantity limits.	Prescription drugs are subject to prior authorization, step therapy and supply/quantity limits.	Please refer to the response above to Tier 1.
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] Committee reviews and evaluates all NQTLs including clinical and therapeutic factors. The following are considered in the development of NQTLs for all prescription drugs: FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant. The [redacted] Committee assesses the prescription drug's place in therapy, and its relative safety and efficacy. The Committee reviews decisions consistent with published evidence relative to these factors development by a pharmacoeconomic work group which extensively reviews medical and outcomes literature and financial models which assess the impact of cost versus potential offsets from the use of a prescription drug such as decreases in hospital stays, reduction in lab tests, or medical utilization due to side effects.	The [redacted] Committee reviews and evaluates all NQTLs including clinical and therapeutic factors. The following are considered in the development of NQTLs for all prescription drugs: FDA approved product labeling, peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use and claims data analysis as relevant. The [redacted] Committee assesses the prescription drug's place in therapy, and its relative safety and efficacy. The Committee reviews decisions consistent with published evidence relative to these factors development by a pharmacoeconomic work group which extensively reviews medical and outcomes literature and financial models which assess the impact of cost versus potential offsets from the use of a prescription drug such as decreases in hospital stays, reduction in lab tests, or medical utilization due to side effects.	The PDL/formulary decisions made for both M/S and MH/SUD prescription drugs help to ensure that the clinically appropriate prescription drug is provided to the member. As detailed in the accompanying columns, the process, timeframes, staff qualifications and criteria utilized to administer the formulary decisions are the same for MH/SUD and M/S. Parity compliant comparability is satisfied by use of the same factors and evidentiary standards to determine whether the requirement will apply for a particular prescription drug. Further, both M/S and MH/SUD utilize generally accepted types of data, evidentiary sources and trend analysis in order to create and maintain a prior authorization requirement. In this way, the MH/SUD prior authorization requirements, in design and application, are the same and no more stringent than those utilized for M/S. The disciplines involved in the development of the PDL/formulary requirements for both M/S and MH/SUD prescription drugs all make up one

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
			[redacted]. **ATTACHMENTS:** [redacted]
Describe the pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step therapy.	The process applied by the plan for prescription drug formulary design is the same process used for MH/SUD and M/S prescription drugs using the same committee, work groups and factors. MH/SUD or M/S prescription drugs are assessed under the same process without regard to their primary indication. The clinical criteria (NQTLs) for MH/SUD and M/S prescriptions drugs are all based on the Clinical Programs Policy [redacted] The Policy lays out when prescription drugs will be subject to a NQTL such as prior authorization or step therapy and makes no distinction between MH/SUD and M/S prescription drugs. The Policy is administered in the same fashion and is not applied more stringently to M/S prescription drugs.	The process applied by the plan for prescription drug formulary design is the same process used for MH/SUD and M/S prescription drugs using the same committee, work groups and factors. MH/SUD or M/S prescription drugs are assessed under the same process without regard to their primary indication. The clinical criteria (NQTLs) for MH/SUD and M/S prescriptions drugs are all based on the Clinical Programs Policy [redacted] The Policy lays out when prescription drugs will be subject to a NQTL such as prior authorization or step therapy and makes no distinction between MH/SUD and M/S prescription drugs. The Policy is administered in the same fashion and is not applied more stringently to M/S prescription drugs.	The pharmacy management processes, including cost-control measures, therapeutic substitution, and step therapy for both M/S and MH/SUD prescription drugs help to ensure that the clinically appropriate prescription drug is provided to the member. As detailed in the accompanying columns, the processes and criteria utilized to administer the pharmacy management policies are the same between MH/SUD and M/S. Parity compliant comparability is satisfied by use of the same factors and evidentiary standards to determine whether the requirement will apply for a particular prescription drug. Further, both M/S and MH/SUD utilize generally-accepted types of data, evidentiary sources and trend analysis in order to create and maintain a pharmacy management process. In this way, the MH/SUD pharmacy management process requirements, in design and application, are the same and no more stringent than those utilized for M/S. A list of prescription drugs to which prior authorization applies under the pharmacy benefit as of 12/31/20 in the attachments: [redacted]

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
			In addition, please find attached the Initial Tier Placement and Benefit Coverage Policy which explains how prescription drugs are assigned to tiers. The Policy applies to all drugs regardless of their use. **ATTACHMENTS:** [redacted]
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.	The [redacted] Committee is comprised of a diversity of clinical disciplines including behavioral health. See attached listing of the specialties of the [redacted] Committee members as of January 2020.	The [redacted] Committee is comprised of a diversity of clinical disciplines including behavioral health. See attached listing of the specialties of the [redacted] Committee members as of January 2020.	The disciplines involved in the development of the PDL/formulary requirements for both M/S and MH/SUD prescription drugs all make up one [redacted]. **ATTACHMENTS:** [redacted]
H. Case Management What case management services are available?	Case management services are available for certain chronic disease. No limitations exist for case management services; therefore, case management is not considered to be a NQTL.	Case management services are available for certain chronic disease. No limitations exist for case management services; therefore, case management is not considered to be a NQTL.	As no limitations/denials exist for case management services for M/S or MH/SUD, case management is not considered an NQTL.
What case management services are required?	Case management services are not required by the Plan.	Case management services are not required by the Plan.	As no requirements exist for case management services for M/S or MH/SUD, case management is not considered an NQTL.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
What are the eligibility criteria for case management services?	There are no restrictions to the case management services.	There are no restrictions to the case management services.	As no restrictions exist for case management services for M/S or MH/SUD, case management is not considered an NQTL.
I. Process for Assessment of New Technologies Definition of experimental/investigational:	The Plan excludes services that are experimental or investigational to be effective for the treatment of the medical condition at issue. Determination of whether a service is experimental or investigational begins with the definition of "Experimental or Investigational" under the Plan terms and then application of applicable clinical policy and criteria to the specific service to evaluate whether the service is considered Experimental or Investigational. The following definition for Experimental or Investigational Service(s) is defined in the member's Certificate of Coverage and applies to both M/S and MH/SUD. **Experimental or Investigational Service(s)** Medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following: • Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use. • Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not Experimental or Investigational.) • The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the	The Plan excludes services that are experimental or investigational to be effective for the treatment of the behavioral health condition at issue. Determination of whether a service is experimental or investigational begins with the definition of "Experimental or Investigational" under the Plan terms and then application of applicable clinical policy and criteria to the specific service to evaluate whether the service is considered Experimental or Investigational. The following definition for Experimental or Investigational Service(s) is defined in the member's Certificate of Coverage and applies to both M/S and MH/SUD. **Experimental or Investigational Service(s)** – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following: · - Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use. · - Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not Experimental or Investigational.) · - The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to	The definition for Experimental or Investigational Service(s) is the same for, and applies equally to, M/S and MH/SUD benefits. There is no other, separately applicable definition of "Experimental or Investigational Service(s)". **ATTACHMENT:** [redacted]

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	FDA regulations, regardless of whether the trial is actually subject to FDA oversight. Exceptions: • Clinical trials for which Benefits are available as described under Clinical Trials in Section 1: Covered Health Care Services. • We may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if: o You are not a participant in a qualifying clinical trial, as described under Clinical Trials in Section 1: Covered Health Care Services: and o You have a Sickness or condition that is likely to cause death within one year of the request for treatment. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition. Drugs prescribed for the treatment of cancer on the ground that the drug is not approved by the United States Food and Drug Administration for a particular indication if that drug is recognized for treatment of the covered indication in a standard reference compendia or in substantially accepted peer-reviewed medical literature. Such drug coverage will also include all Medically Necessary services which are associated with the administration of the drug. . To determine whether a service is considered Experimental or Investigational under the terms of the Plan, the reviewers for M/S cases use medical policies which rely on current evidence-based medicine and criteria.	FDA oversight. Exceptions: · Clinical trials for which Benefits are available as described under Clinical Trials in Section 1: Covered Health Care Services. · We may, as we determine, consider anotherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if: § You are not a participant in a qualifying clinical trial, as described under Clinical Trials in Section 1: Covered Health Care Services: and § You have a Sickness or condition that is likely to cause death within one year of the request for treatment. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition. Drugs prescribed for the treatment of cancer on the ground that the drug is not approved by the United States Food and Drug Administration for a particular indication if that drug is recognized for treatment of the covered indication in a standard reference compendia or in substantially accepted peer-reviewed medical literature. Such drug coverage will also include all Medically Necessary services which are associated with the administration of the drug. To determine whether services are Experimental or Investigational, MH/SUD services are subject to Plan terms. To determine whether a service is considered Experimental or Investigational under the terms of the Plan, the reviewers for MH/SUD cases use medical policies which rely on current evidence- based medicine and criteria.	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
Qualifications of individuals evaluating new technologies:	Medical Technology Assessment Committee (MTAC) Members are [redacted] Medical Directors with diverse medical and surgical specialties and subspecialties from health plans, business segments, acquired entities, and clinical review units.	Clinical Technology Assessment Committee (CTAC) Members are [redacted] Medical Directors with diverse behavioral health specialties and subspecialties, independent behavioral health professionals with scientific expertise, and business segments representatives.	M/S and MH/SUD both maintain Technology Assessment Committees for M/S and MH/SUD services. The committees are comprised of qualified medical professionals, including Medical Directors and practitioners.
Evidence consulted in evaluating new technologies:	The Plan uses a hierarchy of clinical evidence to select or develop clinical guidelines and policies. In the administration of M/S benefits, the Plan uses the following hierarchy of clinical evidence: • Statistically Robust, well-designed randomized controlled trials; • Statistically Robust, well-designed cohort studies; • Multi-site observational studies; • Single-site observational studies; • In the absence of strong and compelling scientific evidence, medical policies may be based upon national consensus statements by recognized authorities. The following stratification describes the hierarchy of use of medical policies and clinical guidelines within [redacted]: • National guidelines and consensus statements • Centers for Medicare and Medicaid Services (CMS) National Coverage Decisions (NCDs); • Clinical position papers based upon rigorous review of scientific evidence or clinical registry data from professional specialty societies when their statements are based upon referenced clinical evidence. • [redacted] medical and drug policies supersede CMS National Coverage Determinations and Local Coverage Determinations (except for the Medicare and/or Medicaid population), internally developed guidelines, and externally-licensed guidelines such as [redacted] MCG®, and [redacted] Guidelines. • [redacted] medical and drug policies will be in compliance with Federal regulations including but not limited to Nondiscrimination in Health Programs and	The Plan uses a hierarchy of clinical evidence to select or develop clinical guidelines and policies. In the administration of MH/SUD benefits, the Plan uses the following hierarchy of clinical evidence: • Systematic reviews and meta analyses • Randomized controlled trials • Large non-randomized controlled trials • Large prospective trials • Comparative and cohort studies • Cross sectional studies • Retrospective studies • Surveillance studies • Case reviews/case series • Anecdotal/editorial statements • Professional opinion • In the absence of strong and compelling scientific evidence, Technology Assessments may include evidence from national consensus statements or publications by recognized authorities. • Once a Clinical Technology Assessment has been completed, [redacted] Clinical Policies are developed which outline the clinical findings of the Clinical Technology Assessment. No behavioral health service will be deemed unproven solely on the basis of a lack of randomized controlled trials, particularly for new or emerging medical technologies.	Decisions are grounded in nationally recognized standards and formal hierarchies of evidence that are comparable to, and no more stringent for MH/SUD than for M/S.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Activities, 81 Fed. Reg. 31376 (May 18, 2016) (codified at 45 C.F.R. pt. 92). • Expert opinion using Grades of Recommendation, Assessment, Development and Evaluation (GRADE) methodology as outlined in the Cochrane Handbook for Systematic Reviews of Interventions. Per Cochrane's Handbook, "…*The GRADE approach defines the quality of a body of evidence as the extent to which one can be confident that an estimate of effect or association is close to the quantity of specific interest. Quality of a body of evidence involves consideration of within-study risk of bias (methodological quality), directness of evidence, heterogeneity, precision of effect estimates and risk of publication bias, as described in Section 12.2.2. The GRADE system entails an assessment of the quality of a body of evidence for each individual outcome.*" • No health service will be deemed unproven solely on the basis of a lack of randomized controlled trials, particularly for new or emerging medical technologies. No medical policies will be developed by UnitedHealthcare based solely on expert opinion.		
J. Standards for provider credentialing and contracting Is the provider network open or closed?	The Plan has an open M/S network.	The Plan has an open MH/SUD network	Comparable processes and standards apply for M/S and MH/SUD, as each maintains an open network.
What are the credentialing standards for physicians?	The Plan uses the credentialing and recredentialing process to ensure its network of contracted providers, who require credentialing, and providers seeking to join the Plan's network, have the appropriate level of education/licensure/certification and satisfy additional qualifications in order to provide care to Plan members. To do this, the Plan applies the following factors to determine whether to credential a provider or facility, or, in other words, to determine whether they meet the standards to join, or maintain their status in, the Plan's network of participating providers:	The Plan uses the credentialing and recredentialing process to ensure its network of contracted providers, who require credentialing, and providers seeking to join the Plan's network, have the appropriate level of education/licensure/certification and satisfy additional qualifications in order to provide care to Plan members. To do this, the Plan applies the following factors to determine whether to credential a provider or facility, or, in other words, to determine whether they meet the standards to join, or maintain their status in, the Plan's network of participating providers:	The Plan uses the credentialing and recredentialing process to ensure its network of contracted physicians, and physicians seeking to join the Plan's network, have the appropriate level of education/licensure/certification and satisfy additional qualifications in order to provide care to Plan members. As detailed in the accompanying columns, the Plan uses credentialing processes and plans based on National Committee for Quality Assurance (NCQA) accreditation standards and applicable

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	• The provider or facility completes and attests to the accuracy of the content of the application; • The Plan verifies certain information in the application and notifies provider applicants of all defects rendering the application incomplete within a timeframe that is consistent with state, federal and accreditation standards. Please reference the [redacted] Credentialing Plan on the [redacted] to access the regulatory and accreditation timeframes. If the information is not received, the Plan will notify the provider applicant of the request for additional information consistent with state, federal and accreditation standards and outlined in the Credentialing Plan; and • The provider or facility continues to meet the requirements set forth in the credentialing plan while they are contracted with the Plan. Credentialing generally is not required for health care professionals who are permitted to furnish services only under the direct supervision of another provider or for hospital-based or facility-based health care professionals who provide services to members' incidental to hospital or facility services. The Plan does not credential unlicensed providers. The Plan uses credentialing processes and plans based on NCQA standards and applicable state or Federal regulatory requirements when determining whether to credential a provider for both M/S and MH/SUD providers and facilities. To successfully complete the credentialing process, both M/S and MH/SUD providers must meet the baseline criteria as applicable to the State and practicing specialty, which can be found in the Additional State and Federal Addendum to the [redacted] Credentialing Plan or the State addendum. Individual (and certain facility-based) providers must complete the CAQH application and applicable attestation. The Plan verifies the following credentialing requirements consistent with state, federal and accreditation standards (outlined in the	• The provider or facility completes and attests to the accuracy of the content of the application; • The Plan verifies certain information in the application and notifies provider applicants of all defects rendering the application incomplete within a timeframe that is consistent with state, federal and accreditation standards. Please reference the [redacted] Credentialing Plan on the website [redacted] to access the regulatory and accreditation timeframes. If the information is not received, the Plan will notify the provider applicant of the request for additional information consistent with state, federal and accreditation standards and outlined in the Credentialing Plan; and • The provider or facility continues to meet the requirements set forth in the credentialing plan while they are contracted with the Plan. Credentialing generally is not required for health care professionals who are permitted to furnish services only under the direct supervision of another provider or for hospital-based or facility-based health care professionals who provide services to members' incidental to hospital or facility services. The Plan does not credential unlicensed providers. The Plan uses credentialing processes and plans based on NCQA standards and applicable state or Federal regulatory requirements when determining whether to credential a provider for both M/S and MH/SUD providers and facilities. To successfully complete the credentialing process, both M/S and MH/SUD providers must meet the baseline criteria as applicable to the State and practicing specialty, which can be found in [redacted] Clinician and Facility Credentialing Plan or the State Addendum to Credentialing Policies. Individual (and certain facility-based) providers must complete the CAQH application and applicable attestation. The Plan verifies the following credentialing requirements consistent with	state or Federal regulatory requirements when determining whether to credential a provider for both M/S and MH/SUD providers and facilities. The Plan also has similar governance structures and follows similar processes for credentialing new and recredentialing existing physicians, delegated credentialing, and the ongoing monitoring of existing providers. As such, comparable processes are used to credential physicians interested in joining the Plan's networks for MH/SUD and M/S. Additionally, both M/S and MH/SUD benefits evaluate whether to credential a physician using NCQA and relevant state or federal requirements and comparable practices. Therefore, the test of comparability is met. Credentialing criteria are not applied more stringently to MH/SUD benefits under the Plan as written and in operation because both MH/SUD and M/S require physicians verify the same information before credentialing a physician.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Credentialing Plan) upon receipt of a completed application: • Required medical or professional degrees or training, including any additional post-graduate education or training within the scope of practice (e.g., a fellowship, etc.); • Current unrestricted licensure and/or certification; • Valid DEA certificate, Controlled Substance Certificate (CSC) or acceptable substitute; • Absence of Medicare/Medicaid sanctions; • Five-year work history with an explanation of gaps greater than 6-months; • Proof of insurance or state-approved alternative; • Malpractice history for the past five years; Absence of sanctions or limitations on licensure; • Status of hospital privileges, if applicable; • No prior denials or terminations within the past 24 months; • On recredentialing, data from any quality improvement activities; and Affirmative responses to disclosure questions on the application.	state, federal and accreditation standards (outlined in the Credentialing Plan) upon receipt of a completed application: • Required medical or professional degrees or training, including any additional post-graduate education or training within the scope of practice (e.g., a fellowship, etc.); • Current unrestricted licensure and/or certification; • Valid DEA certificate, Controlled Substance Certificate (CSC) or acceptable substitute; • Absence of Medicare/Medicaid sanctions; • Five-year work history with an explanation of gaps greater than 6-months; • Proof of insurance or state-approved alternative; • Malpractice history for the past five years; Absence of sanctions or limitations on licensure; • Status of hospital privileges, if applicable; • No prior denials or terminations within the past 24 months; • On recredentialing, data from any quality improvement activities; and Affirmative responses to disclosure questions on the application.	
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.	Same as above.	Same as above.	Same as above.
What are the credentialing/contracting standards for unlicensed personnel; e.g., home health aides, qualified autism service professionals and paraprofessionals?	Credentialing generally is not required for health care professionals who are permitted to furnish services only under the direct supervision of another provider or for hospital-based or facility-based health care professionals who provide services to members incidental to hospital or facility services. The Plan does not credential unlicensed providers.	Credentialing generally is not required for health care professionals who are permitted to furnish services only under the direct supervision of another provider or for hospital-based or facility-based health care professionals who provide services to members incidental to hospital or facility services. The Plan does not credential unlicensed providers.	Credentialing/contracting standards for unlicensed personnel are not applied more stringently to MH/SUD than to M/S under the plan. As indicated, neither MH/SUD nor M/S credential unlicensed providers, and comparable requirements are applied to professionals furnishing services under direct supervision or incident to hospital or facility services.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
K. Exclusions for Failure to Complete a Course of Treatment Does the Plan exclude benefits for failure to complete treatment?	The Plan does not exclude services for failure to complete a course of treatment for M/S benefits.	The Plan does not exclude services for failure to complete a course of treatment.	Plan is parity compliant for this NQTL because neither M/S nor MH/SUD exclude services for failure to complete a course of treatment.
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?	The Plan arranges for the provision of Covered Health Services through its Network of approved providers within the approved service area. With the exception of Emergency Healthcare Services, authorized post-stabilization care or other specific services authorized by the Plan, when the member is away from the Plan's licensed Service Area, in network covered medical or Hospital Services may not be available.	The Plan arranges for the provision of Covered Health Services through its Network of approved providers within the approved service area. With the exception of Emergency services or other specific services authorized by the Plan, when the members are outside of the Plan's licensed service area, in-network covered MH/SUD Services may not available.	Both M/S and MH/SUD apply geographic restrictions to benefit coverage which require the member to utilize a recognized network of providers. While those restrictions may be affected by inherent differences between M/S and MH/SUD in terms of provider availability or the nature of services, the restrictions are comparable in design, and a no more stringent operational methodology is applied to MH/SUD.
Does the Plan restrict the type(s) of facilities in which enrollees can receive services?	The Plan does not restrict the types of providers that can provide medical/surgical services as long as the services are within the scope of practice (SOP) for the rendering facility. The Plan may require the member to choose a designated provider for certain services (e.g., clinical trials, infertility).	The Plan does not restrict the types of facilities that can provide MH/SUD services, as long as the services are within the scope of practice (SOP) for the rendering facility.	Both M/S and MH/SUD require that services be within the scope of practice for the rendering facility. Beyond that, MH/SUD does not restrict the type of facility where services may be received. Therefore, the requirements are comparable in design, and are no more stringent for MH/SUD than for M/S.
M. Does the Plan restrict the types of provider specialties that can provide certain M/S and/or MH/SUD benefits?	The Plan does not restrict the types of providers that can provide medical/surgical services as long as the services are within the scope of practice (SOP) for the rendering provider as required under state SOP law. The Plan may require the member to choose a designated provider for certain services (e.g., clinical trials, infertility).	The Plan does not restrict the types of providers that can provide behavioral health services, as long as the services are within the scope of practice (SOP) for the rendering provider as required under state SOP law.	Both M/S and MH/SUD require that services be within the scope of practice for the rendering provider. Beyond that, MH/SUD does not restrict the type of provider from whom services may be received. Therefore, the requirements are comparable in design, and are no more stringent for MH/SUD than for M/S.
N. Network Adequacy	The Plan uses the Network Composition Criteria to ensure its network of contracted providers is sufficiently robust to meet regulatory network adequacy standards and provide care to Plan	The Plan uses the Network Composition Criteria to ensure its network of contracted providers is sufficiently robust to meet regulatory network adequacy standards and provide care to Plan	The Plan is parity compliant with regard to this policy element, as both M/S and MH/SUD utilize comparable factors, processes and

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	members. To do this, the Plan applies the following factors to determine how to build the Plan's network of participating providers: • Whether there are applicable state or federal "any willing provider" laws; • Whether there are applicable state or federal network adequacy standards; • Whether the provider or facility is interested in joining the Plan's network of participating providers; and • Whether the Plan needs additional providers or facilities in its network and/or whether other member, business, or organizational needs are satisfied by including additional, or a particular provider or facility in the network. Sources and evidentiary standards include the following: ➢ [redacted] standards are based on National Committee for Quality Assurance NCQA standards, which include: ➢ Centers for Medicare & Medicaid Services CMS ➢ 2021 CMS Final Letter to Issuers in Related External or Internal Links section. This is followed when state regulations specify "reasonable" and/or "sufficient" access to care providers or when regulation is silent. ➢ State specific standards when state regulations identify a quantifiable network adequacy measurement for geographic and numeric availability. ➢ 90% of enrollees are within maximum time and distance requirements as set forth in NCQA. The Plan determines the need for additional individual or group practitioners, facilities, or facility-based providers in its network based on regulatory requirements and/or whether business or organizational needs are satisfied by including additional, or a particular, provider or facility in the network. When determining whether to recruit providers in a given geographic market (such as a county or metropolitan area), the	members. To do this, the Plan applies the following factors to determine how to build the Plan's network of participating providers: • Whether there are applicable state or federal "any willing provider" laws; • Whether there are applicable state or federal network adequacy standards; • Whether the provider or facility is interested in joining the Plan's network of participating providers; and • Whether the Plan needs additional providers or facilities in its network and/or whether other member, business, or organizational needs are satisfied by including additional, or a particular provider or facility in the network. Sources and evidentiary standards include the following: ➢ [redacted] standards are based on National Committee for Quality Assurance NCQA standards, which include: ➢ Centers for Medicare & Medicaid Services CMS ➢ 2021 CMS Final Letter to Issuers in Related External or Internal Links section. This is followed when state regulations specify "reasonable" and/or "sufficient" access to care providers or when regulation is silent. ➢ State specific standards when state regulations identify a quantifiable network adequacy measurement for geographic and numeric availability. ➢ 90% of enrollees are within maximum time and distance requirements as set forth in NCQA. The Plan determines the need for additional individual or group practitioners, facilities, or facility-based providers in its network based on regulatory requirements and/or whether business or organizational needs are satisfied by including additional, or a particular, provider or facility in the network. When determining whether to recruit providers in a given geographic market (such as a county or metropolitan area), the	evidentiary standards to implement, monitor and maintain Network Adequacy. The design and application of Network Adequacy protocols are based on regulatory requirements and the need to provide members with access to appropriate care; the processes and standards are no more stringent for MH/SUD than for M/S.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Plan considers Network adequacy and access reports, which are prepared on a regular basis (no less than quarterly) and shared with the Plan's network teams for recruitment purposes to ensure regulatory requirements are met. If the Plan determines it does not meet network adequacy requirements for a specialty or provider type, the Plan will actively seek to add providers to the network in that specialty or provider type unless there is a known supply gap in provider type in the area. If there is a supply gap, the Plan language allows members to seek an exception and receives services from an out-of-network provider at the in-network benefit level. The Plan also considers out-of-network utilization reports run by the claims department and potential service gaps identified by clinical reviewers. If high out-of-network utilization is identified in a certain area or for a specific item or service, the Plan may attempt to contract with these providers or other providers in the area or that provide the items or services. When implementing a new Plan, the implementation team will run network disruption reports to determine whether new providers are needed to meet the needs of the new plan's membership. The Plan's Sales team may also notify the network team about a customer request to contract with a specific provider. In response, the network team will review adequacy and access reports and determine whether there are available in-network alternatives, whether it's necessary to expand or enhance the network panel and pursue a contract with the provider, as appropriate.	Plan considers Network adequacy and access reports, which are prepared on a regular basis (no less than quarterly) and shared with the Plan's network teams for recruitment purposes to ensure regulatory requirements are met. If the Plan determines it does not meet network adequacy requirements for a specialty or provider type, the Plan will actively seek to add providers to the network in that specialty or provider type unless there is a known supply gap in provider type in the area. If there is a supply gap, the Plan language allows members to seek an exception and receives services from an out-of-network provider at the in-network benefit level. The Plan also considers out-of-network utilization reports run by the claims department and potential service gaps identified by clinical reviewers. If high out-of-network utilization is identified in a certain area or for a specific item or service, the Plan may attempt to contract with these providers or other providers in the area or that provide the items or services. When implementing a new Plan, the implementation team will run network disruption reports to determine whether new providers are needed to meet the needs of the new plan's membership. The Plan's Sales team may also notify the network team about a customer request to contract with a specific provider. In response, the network team will review adequacy and access reports and determine whether there are available in-network alternatives, whether it's necessary to expand or enhance the network panel and pursue a contract with the provider, as appropriate.	
O. In-Network Provider Reimbursement	**Individual or Group Practitioner:** The Plan uses the Center for Medicare and Medicaid Services (CMS) resource-based relative value scale ("RVRBS") methodology as a base to negotiate fee schedules with physicians. When CMS RVRBS or other CMS fee sources are not available, the Plan uses other fee sources such as third-party resources, like the [redacted] database and rates/relativities	**Individual or Group Practitioner:** For MH/SUD, [redacted] reimburses providers based on a standard network fee schedule. The standard approach is to reimburse at 100% of the fee schedule. [redacted] standard fee schedule is developed using CMS national RVUs as a guide to develop the reimbursement rate to the providers. RVU is the Relative Value Unit used by the CMS RVRBS. The RVUs are obtained from the	**Individual or Group Practitioner:** The M/S and MH/SUD benefits are reimbursed using CMS based fee schedules. The RVRBS reimbursement method used to reimburse M/S network providers is based on the principle that payments for physician services should vary with the resource costs for providing those services

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	obtained through studies from third-party vendors, discussion with internal subject-matter experts on the services and other market information. Ultimately, rates are negotiated based on the above-identified factors. For M/S, default fee schedules are developed by geography typically at a state level. These schedules are routinely updated to ensure the CMS relativities by code are current and relevant to each specialty. Updates are based on updates from CMS which typically on an annual basis but could be more frequent. The default fee schedules are set at a competitive rate level that other similar medical professionals have accepted in the past and are reasonably expected to accept to participate in the Plan's network in the future. As a result, for M/S, default fee schedules generally are set below the mean or median rates because those rates are influenced by provider leverage/negotiation. For M/S, contracted providers will stay on the same fee schedule or payment appendix originally negotiated until either (i) the Plan updates to a more current base fee schedule or (ii) either party initiates renegotiation. Reimbursement for in-network individual providers and facilities are determined through a negotiated process. During contract negotiations, the Plan applies the following factors to determine reimbursement for in-network providers for both med/surg and MH/SUD services: • Applicable CMS or other rate-setting methodology and benchmark reimbursement data for the provider type; • Member access by geography and specialty; • Impact on total medical cost relative to market and affordability; • Market dynamics, including provider leverage, competitor networks, scarcity of provider type in the market, and the need for provider type in network; • Quality and efficiency; and/or • Provider type (rates may be adjusted for specialists, higher	CMS Physician Fee Schedule Final Rule, Addendum B, which is posted on the CMS.gov website. The RVU for a specific code represent the relative resources required to perform that service compared to other services. [redacted] utilizes a set of internally developed base rates as a starting point. RVU's are used to check the relativities among the codes to ensure they are properly aligned. Rates are then adjusted based on a variety of factors including, supply/demand geography, license level, and market conditions. [redacted] evaluates fee schedules on an annual basis (or more frequent depending upon updates from CMS) and any necessary adjustments are made to remain competitive in the marketplace. In addition, when an RVU is not available for a given code other sources are used by [redacted] to assess the relativities and ensure consistent alignment. The other data and information sources can include the [redacted] database and rates/relativities obtained through studies from third-party vendors, consultation with subject matter experts on the services, and other market information. Just like M/S, [redacted] physician rates are negotiable and [redacted] considers the factors identified above when negotiating rates with providers. Reimbursement for in-network individual providers and facilities are determined through a negotiated process. During contract negotiations, the Plan applies the following factors to determine reimbursement for in-network providers for both med/surg and MH/SUD services: • Applicable CMS or other rate-setting methodology and benchmark reimbursement data for the provider type; • Member access by geography and specialty; • Impact on total medical cost relative to market and affordability; • Market dynamics, including provider leverage, competitor networks, scarcity of provider type in the market, and the need for provider type in network; • Quality and efficiency; and/or • Provider type (rates may be adjusted for specialists, higher	and is intended to improve and stabilize the payment system while providing physicians an avenue to continuously improve it. The RVRBS, methodology payments are determined by the resource costs needed to provide service, with each service divided into three components: physician (provider) work, practice expense and professional liability insurance (PLI). The CMS RVU used as a basis to reimburse MH/SUD providers also considers relative value unit (RVU) (i.e., the RVUs for work, practice expense, and malpractice). Both the RVRBS methodology and RVU methodologies vary to account for geographic differences in cost. When a CMS rate is not available both M/S and BH/SUD networks supporting the Plan use third-party resources like the [redacted] database or studies from third-party vendors. internal subject-matter experts on the services and other market information. [redacted] uses 100% of the fee schedule as its standard approach, then adjusts for supply/demand, geography, license level, and market conditions, while M/S sets its fee schedule below the mean as a default and then adjusts to rates accepted in the market and considers leverage of the provider (supply/demand) and both MH/SUD and M/S reimbursement rates can be negotiated. The factors and processes used to set BH/SUD network provider rates are comparable to the process and factors used to set M/S network provider rates. M/S practices are more stringent than BH/SUD practices because the M/S rates reimbursement

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	acuity facility types or non-physician provider types like physician assistants or social workers). While some variation may exist for all services, In-Network Provider Reimbursement generally is based on external rate sources for services provided by the same provider type in the same geography and the additional negotiation factors as needed. **Facilities**: For M/S facilities—or in-network, inpatient or outpatient facility services—the Plan uses a combination of CMS methodologies (MS-DRG inpatient, APC for outpatient, Fee Schedules, Per Diems, Percentage Payment Rate (PPR), per visit/per unit, etc.) and proprietary methods to develop targeted rates based on geography and facility type and to negotiate fee schedules/structures with facilities.-The most common measures in setting reimbursement level are based on percentage of CMS and discount level. For M/S, market dynamics influence the target reimbursement range for the facility. The Plan looks at cost-to-charge ratio concepts within CMS filings, and considers what the facility needs to make a reasonable margin. The Plan also looks at external filing documents, including financials, and considers whether the facility's cost relativity to other facilities is not an outlier. In other words, the target reimbursement rates are based on allowing the facility to make a fair margin and to ensure the Plan is not disadvantaged by the rate looking at cost-to-charge.	acuity facility types or non-physician provider types like physician assistants or social workers). While some variation may exist for all services, In-Network Provider Reimbursement generally is based on external rate sources for services provided by the same provider type in the same geography and the additional negotiation factors as needed. **Facilities:** For MH/SUD, various inpatient and outpatient payment methodologies are used such as per diems. For in-network facility provider reimbursement for MH/SUD, [redacted] Network Contracting and Health Care Economics ("HCE") work together to develop network target rates by geography and facility type which are used by the contracting team to negotiate rates with facility providers and for services not contemplated in the standard outpatient fee schedules. These rates are derived from average market pricing in the state based upon utilization data, CMS guidelines, and other internal data. Inpatient MH/SUD rates are negotiated between the parties using the factors above, target rates are only used as a guideline.	rates are set below the average rate in a geography, remain that same for M/S providers, unless adjusted by the Plan or either party renegotiates and BH/SUD rates are set at 100% of the fees schedule for a geography, are review annually for updates and updates may likewise made by the plan. **Facilities** Both M/S and BH/SUD outpatient rates for facilities consider CMS methodologies, per diems, and other internal data. Both M/S and BH/SUD network facility outpatient targeted rates are established based on geography and facility type. These targeted rates are used by the M/S and MH/SUD contracting teams to negotiate an agreed to rate between the parties for outpatient services. For inpatient rates, the M/S consider a percentage of CMS, discount level, and market dynamics impacting the facility. Similarly, MH/SUD network teams for the plan use per diem and MS—DRG, developing target rates based on geography and facility type. Both MS and MH/SUD use the targeted rates to negotiate with the facility. Thus, the development of a rates considering geography and facility type is comparable. M/S network contracting also looks at filings made by the facility and considers whether the facilities cost relativity is an outlier compared to other facilities. Since M/S applies additional factors to reduce the margin of the facility from its cost-to-charge information, M/S network rate

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			setting is more stringent than MH/SUD because M/S adds another step to lower the reimbursement of provider for inpatient, in-network services. Accordingly, the Plan considers the NQTL to determine inpatient and outpatient, in-network services to be parity compliant.
P. Method for determining usual, customary and reasonable charges	Standard Out of Network Reimbursement applies one of the following reimbursement methodologies to pay OON claims: (1) a "reasonable and customary" ("UCR") standard; (2) a Maximum Non-Network Reimbursement Program ("MNRP") methodology; or (3) Extended Non-Network Reimbursement Program ("ENRP") methodology. Alternatively, the Plan may allow the Insurer to apply Shared Savings programs which may obtain a discount/negotiation to the provider's billed charges. Each benefit plan specifies which of the methodologies applies to all OON claims, both M/S and MH/SUD. For example, if a benefit plan uses UCR for OON inpatient and outpatient reimbursement, the UCR methodology applies to both M/S and MH/SUD benefits. We apply the same factors for each methodology for reimbursement of both M/S services and MH/SUD services. Note that UCR (usual, customary, and reasonable) is not sold as a standard out of network reimbursement option for Fully Insured Commercial Connecticut plans.	Standard Out of Network Reimbursement applies one of the following reimbursement methodologies to pay OON claims: (1) a "reasonable and customary" ("UCR") standard; (2) a Maximum Non-Network Reimbursement Program ("MNRP") methodology; or (3) Extended Non-Network Reimbursement Program ("ENRP") methodology. Alternatively, the Plan may allow the Insurer to apply Shared Savings programs which may obtain a discount/negotiation to the provider's billed charges. Each benefit plan specifies which of the methodologies applies to all OON claims, both M/S and MH/SUD. For example, if a benefit plan uses UCR for OON inpatient and outpatient reimbursement, the UCR methodology applies to both M/S and MH/SUD benefits. We apply the same factors for each methodology for reimbursement of both M/S services and MH/SUD services. Note that UCR (usual, customary, and reasonable) is not sold as a standard out of network reimbursement option for Fully Insured Commercial Connecticut plans.	Both M/S and MH/SUD services and treatments use the same methodology for determining out-of-network provider reimbursements, the MHPAEA comparability requirements are satisfied.
Q. Restrictions on provider billing codes	Providers can only bill for services (codes) within their scope of licensure/practice. In addition, provider agreements require providers to bill/code in accordance with national coding and billing guidelines, reimbursement policies, and contractual fee schedule requirements.	Providers can only bill for services (codes) within their scope of licensure/practice. In addition, provider agreements require providers to bill/code in accordance with national coding and billing guidelines, reimbursement policies, and contractual fee schedule requirements.	Plan is parity compliant for this NQTL because comparable restrictions apply that are no more stringent for MH/SUD than for M/S.