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], [redacted] Insurance Company, [redacted] [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 of HMO, PPO, EPO		
G. Contract Type (large group, small group, individual): Large Group		
H. Benefit Plan Effective Date: N/A – renewal dates vary based on a client's policy anniversary		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?	[redacted] employs the same definition of medical necessity to medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) benefits. [redacted] Medical Directors apply the definition of "medical necessity" set forth in the governing plan instrument or the definition required by state law.	[redacted] employs the same definition of medical necessity to medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) benefits. [redacted] Medical Directors apply the definition of "medical necessity" set forth in the governing plan instrument or the definition required by state law.	[redacted] utilizes its own internally developed Coverage Policies (medical necessity criteria) and the MCG™ Guidelines when conducting medical necessity reviews of M/S services, procedures, devices, equipment, imaging, diagnostic interventions; its own internally developed Coverage Policies and the MCG™ Care Guidelines when conducting medical necessity reviews of MH/SUD

	Notwithstanding the above, [redacted]'s standard definition of "medical necessity" is as follows: **Medically Necessary/Medical Necessity** Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization: • required to diagnose or treat an illness, Injury, disease or its symptoms; • in accordance with generally accepted standards of medical practice; • clinically appropriate in terms of type, frequency, extent, site and duration; • not primarily for the convenience of the patient, Physician or other health care provider; • not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment	Notwithstanding the above, [redacted] s standard definition of "medical necessity" is as follows: **Medically Necessary/Medical Necessity** Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization: • required to diagnose or treat an illness, Injury, disease or its symptoms; • in accordance with generally accepted standards of medical practice; • clinically appropriate in terms of type, frequency, extent, site and duration; • not primarily for the convenience of the patient, Physician or other health care provider; • not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment	services and technologies; and "The ASAM Criteria®" when conducting medical necessity reviews of SUD services and technologies. [redacted] s Coverage Policy Unit (CPU), in partnership with [redacted]'s Medical Technology Assessment Committee, conducts evidence-based assessments of the medical literature and other sources of information pertaining to the safety and effectiveness of medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals. The Medical Technology Assessment Committee's evidence-based medicine approach ranks the categories of evidence and assigns greater weight to categories with higher levels of scientific evidence as set forth below in [redacted]'s "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009: Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs. Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials. Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental

	of your Sickness, Injury, condition, disease or its symptoms; and • rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting. In determining whether health care services, supplies, or medications are Medically Necessary, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by [redacted] or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.	of your Sickness, Injury, condition, disease or its symptoms; and • rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting. In determining whether health care services, supplies, or medications are Medically Necessary, all elements of Medical Necessity must be met as specifically outlined in the individual's benefit plan documents, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by [redacted] or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.	studies). Also systematic reviews and meta-analyses of observational studies. Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies. Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature. The Medical Technology Assessment Committee (MTAC) establishes and maintains clinical guidelines and medical necessity criteria in the form of published Coverage Policies pertaining to the various medical and behavioral health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes. This includes Coverage Policies that address medical/surgical services determined to be experimental and investigational. While [redacted]'s Coverage Policies and vendor guidelines are reviewed at least once annually, re-review of Coverage Policies and/or topics for new Coverage Policies are identified through multiple channels including requests from the provider community, customers, frontline reviewers, CPU and the impetus of new, emerging and evolving

			technologies. [redacted] s summary of its medical necessity coverage policy development and application process, is consistent between M/S and MH/SUD. [redacted] applies the same evidence-based guidelines as the platform to define established standards of effective care in both M/S and MH/SUD benefits. Consistency in policy development, process and application evidences compliance with the NQTL requirement that the medical management process be applied comparably, and no more stringently, to MH/SUD services than to M/S services. Compliance is further demonstrated through [redacted]'s uniform definition of Medical Necessity for M/S and MH/SUD benefits. An "in operation" review of [redacted]'s application of the medical necessity NQTL, specifically approvals and denial information, for Prior Authorization, Retrospective Review, and Concurrent Review across benefit classifications revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, [redacted]

			concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits... In performing the operational analysis of the application of UM [redacted] reviewed the denials issued within the reporting periods for both M/S and MH/SUD within each classification of benefits and for prior authorization, concurrent review, and retrospective review.
Area	**Medical/Surgical Benefits**	**Mental Health/Substance Use Disorder Benefits**	**Explanation**
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
B. Prior-authorization Review Process Include all services for which prior-authorization is required. Describe any step-therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans. Inpatient, In-Network:	All non-emergent M/S inpatient services are subject to pre-service medical necessity review (prior authorization) including Inpatient, In-Network. When determining which M/S inpatient, In-Network benefits are subject to pre-service medical necessity review (prior authorization/precertification), [redacted] conducts a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure • Whether treatment type is a driver of high cost growth	All non-emergent MH/SUD inpatient services are subject to pre-service medical necessity review (prior authorization) including Inpatient, In-Network. When determining which MH/SUD inpatient In-Network benefits are subject to pre-service medical necessity review (prior authorization/precertification), [redacted] conducts a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure	[redacted] applies prior authorization NQTL consistently to M/S benefits and MH/SUD benefits across benefit classifications. For both in-network and out-of-network M/S and MH/SUD benefits, [redacted] requires prior-authorization of non-emergent in-patient services, and for some, but not all, outpatient services based upon the same array of factors which include the cost of treatment (i.e. unit cost and trended cost of services); high cost growth (i.e. high utilization relative to benchmark); variability in cost and quality; provider discretion in determining type and length of treatment; clinical efficacy of proposed course of treatment; and claim/treatment types subject to a higher percentage of fraud, waste and/or abuse.

	• Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for treatment type if subject to pre-service review • Projected return on investment and/or savings if treatment type is subjected to pre-service review If the benefit or value of conducting pre-service review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to pre-service medical necessity review (prior authorization). No M/S inpatient benefits are subject to fail-first and/or step therapy requirements.	• Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for treatment type if subject to pre-service review • Projected return on investment and/or savings if treatment type is subjected to pre-service review If the benefit or value of conducting pre-service review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to pre-service medical necessity review (prior authorization). No MH/SUD inpatient benefits are subject to fail-first and/or step therapy requirements.	The enrollee's treating provider submits a request for benefit authorization of an inpatient level of care electronically or by phone, fax or mail. The case is referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the inpatient level of care requested, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the inpatient level of care at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets medical necessity criteria for the inpatient level of care at issue (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). [redacted] typically authorizes 1-4 medical/surgical or MH/SUD inpatient days upon pre-service review. UM coverage determinations of medical/surgical services and MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Moreover, [redacted]'s methodology for determining which MH/SUD services within a classification of benefits are subject to prior authorization is comparable to, and applied no more stringently than, its methodology for determining which

			medical/surgical services within the same classification of benefits are subject to prior authorization. [redacted] s methodology for determining which medical/surgical services and which MH/SUD services within a classification of benefits are subject to prior authorization as written and in operation, as well as its pre-service medical necessity review processes applied to medical/surgical services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the same classification of benefits. [redacted] has assessed several components of its utilization management program for NQTL compliance, including the methodology for determining which services will be subject to utilization management, the process for reviewing utilization management requests, and the process for applying coverage criteria. Consistent with the NQTL requirement for comparability/stringency, [redacted] has confirmed that all of the M/S services that meet the criteria for inclusion on the prior authorization or concurrent review lists are included on such lists, and that all of the MH/SUD services included on the lists also meet the criteria for inclusion. An “in operation” review of [redacted]’s application

			of the Prior Authorization NQTL, specifically approvals and denial information, in the In-Patient, In-Network classification revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, [redacted] concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.
Prior Authorization - Outpatient, In-Network: Office Visits:	Outpatient, In-Network office visits do not require prior authorization.	Outpatient, In-Network office visits do not require prior authorization.	Outpatient, In-Network office visits for M/S and MH/SUD benefits do not require prior authorization.
Prior Authorization - Outpatient, In-Network: Other Outpatient Items and Services:	All non-emergent M/S outpatient services are subject to pre-service medical necessity review (prior authorization) including Outpatient, In-Network: Other Outpatient Items and Services. When determining which MH/SUD outpatient benefits are subject to pre-service medical necessity review (prior authorization/precertification), [redacted] conducts a cost-benefit analysis based upon the following factors:	All non-emergent MH/SUD outpatient services are subject to pre-service medical necessity review (prior authorization) including Outpatient, In-Network: Other Outpatient Items and Services. When determining which MH/SUD outpatient benefits are subject to pre-service medical necessity review (prior authorization/precertification), [redacted] conducts a cost-benefit analysis based upon the following factors:	[redacted] applies the prior authorization NQTL consistently to M/S benefits and MH/SUD benefits. For both in-network and out-of-network M/S and MH/SUD benefits [redacted] requires prior-authorization of non-emergent in-patient services, and for some, but not all outpatient services based upon the same array of factors which include the cost of treatment (i.e. unit cost and trended cost of services); high cost growth (i.e. high utilization relative to benchmark); variability in cost and quality; provider discretion in determining type and length of treatment; clinical efficacy of proposed course of treatment; and claim/treatment types subject to a

	• Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for treatment type if subject to pre-service review • Projected return on investment and/or savings if treatment type is subjected to pre-service review If the benefit or value of conducting pre-service review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to pre-service medical necessity review (prior authorization).	• Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for treatment type if subject to pre-service review • Projected return on investment and/or savings if treatment type is subjected to pre-service review If the benefit or value of conducting pre-service review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to pre-service medical necessity review (prior authorization). Based upon the above referenced methodology, [redacted] subjects certain	higher percentage of fraud, waste and/or abuse. The enrollee's treating provider submits a request for benefit authorization of an outpatient service electronically or by phone, fax or mail. The case is referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the outpatient service requested, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the outpatient service at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets medical necessity criteria for the outpatient service at issue (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). UM coverage determinations of medical/surgical services and MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Moreover, [redacted]'s methodology for determining which MH/SUD services within a classification of benefits are subject to prior authorization is comparable to, and applied no more stringently than, its methodology for determining which

	Based upon the above referenced methodology, [redacted] subjects certain non-routine outpatient services (typically those subject to higher cost and/or utilization) to pre-service medical necessity review (prior authorization). Examples of medical/surgical outpatient services subject to pre-service review include outpatient surgery, advanced radiology, chemotherapy, speech therapy, etc. No medical/surgical outpatient benefits are subject to fail-first and/or step therapy requirements	non-routine outpatient services (typically those subject to higher cost and/or utilization) to pre-service review (prior authorization). MH/SUD outpatient services subject to pre-service review include partial hospitalization, intensive outpatient services (IOP), Applied Behavior Analysis (ABA) and Transcranial Magnetic Stimulation (TMS). No MH/SUD outpatient benefits, are subject to fail-first and/or step therapy requirements	medical/surgical services within the same classification of benefits are subject to prior authorization. [redacted] s methodology for determining which medical/surgical services and which MH/SUD services within a classification of benefits are subject to prior authorization as written and in operation, as well as its pre-service medical necessity review processes applied to medical/surgical services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the same classification of benefits. An "in operation" review of [redacted]'s application of the Prior Authorization NQTL, specifically approvals and denial information, in the Outpatient, In-Network, All Other classification revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, [redacted] concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.

Prior Authorization - Inpatient, Out-of-Network:	All non-emergent M/S inpatient services are subject to pre-service medical necessity review (prior authorization/precertification) including Inpatient, Out-of-Network. When determining which M/S inpatient, In-Network benefits are subject to pre-service medical necessity review (prior authorization/precertification), [redacted] conducts a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for treatment type if subject to pre-service review • Projected return on investment and/or savings if treatment type is subjected to pre-service review	All non-emergent MH/SUD inpatient services are subject to pre-service medical necessity review (prior authorization/precertification) including Inpatient, Out-of-Network. When determining which MH/SUD inpatient In-Network benefits are subject to pre-service medical necessity review (prior authorization/precertification), [redacted] conducts a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for treatment type if subject to pre-service review • Projected return on investment and/or savings if treatment type is subjected to pre-service review If the benefit or value of conducting pre-	[redacted] applies prior authorization/precertification NQTL consistently to M/S benefits and MH/SUD Benefits. In both M/S and MH/SUD services. For both in-network and out-of-network M/S and MH/SUD benefits [redacted] requires prior-authorization of non-emergent in-patient services, and for some, but not all outpatient services based upon the same array of factors which include the cost of treatment (i.e. unit cost and trended cost of services); high cost growth (i.e. high utilization relative to benchmark); variability in cost and quality; provider discretion in determining type and length of treatment; clinical efficacy of proposed course of treatment; and claim/treatment types subject to a higher percentage of fraud, waste and/or abuse. The enrollee's treating provider submits a request for benefit authorization of an inpatient level of care electronically or by phone, fax or mail. The case is referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the inpatient level of care requested, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the inpatient level of care at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical

	If the benefit or value of conducting pre-service review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to pre-service medical necessity review (prior authorization). No medical/surgical inpatient are subject to fail-first and/or step therapy requirements.	service review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to pre-service medical necessity review (prior authorization). No MH/SUD inpatient and outpatient benefits are subject to fail-first and/or step therapy requirements.	information and determines whether the enrollee meets medical necessity criteria for the inpatient level of care at issue (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). [redacted] typically authorizes 1-4 medical/surgical or MH/SUD inpatient days upon pre-service review. UM coverage determinations of medical/surgical services and MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Moreover, [redacted]'s methodology for determining which MH/SUD services within a classification of benefits are subject to prior authorization is comparable to, and applied no more stringently than, its methodology for determining which medical/surgical services within the same classification of benefits are subject to prior authorization. [redacted] s methodology for determining which medical/surgical services and which MH/SUD services within a classification of benefits are subject to prior authorization as written and in operation, as well as its pre-service medical necessity review processes applied to medical/surgical services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the same classification of benefits.

			An “in operation” review of [redacted]’s application of the Prior Authorization NQTL, specifically approvals and denial information, in the In-Patient, Out-of-Network classification revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, [redacted] concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
Prior Authorization - Outpatient, Out-of-Network: Office Visits:	Office Visits are never subject to prior authorization, including - Outpatient, Out-of-Network: Office Visits.	Office Visits are never subject to prior authorization, including - Outpatient, Out-of-Network: Office Visits.	Outpatient, Out-of-Network, Office Visits for M/S and MH/SUD benefits do not require prior authorization. Because the prior authorization NQTL does not apply to MH/SUD benefits, no further analysis of compliance with the NQTL requirement is warranted.
Prior Authorization - Outpatient, Out-of-Network: Other Items and Services:	All non-emergent M/S outpatient services are subject to pre-service medical necessity review (prior authorization/precertification) including Outpatient, In-Network: Other Outpatient Items and Services. When determining which MH/SUD outpatient benefits are subject to pre-service medical necessity review (prior authorization/precertification), [redacted] conducts a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure	All non-emergent MH/SUD outpatient services are subject to pre-service medical necessity review (prior authorization/precertification) including Outpatient, In-Network: Other Outpatient Items and Services. When determining which MH/SUD outpatient benefits are subject to pre-service medical necessity review (prior authorization/precertification), [redacted] conducts a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure	[redacted] applies prior authorization/precertification NQTL consistently to M/S benefits and MH/SUD benefits. In both M/S and MH/SUD services, for both in-network and out-of-network M/S and MH/SUD benefits [redacted] requires prior-authorization of non-emergent in-patient services, and for some, but not all outpatient services based upon the same array of factors which include the cost of treatment (i.e. unit cost and trended cost of services); high cost growth (i.e. high utilization relative to benchmark); variability in cost and quality; provider discretion in determining type and length of treatment; clinical efficacy of proposed course of treatment; and claim/treatment types subject to a higher percentage of fraud, waste and/or abuse.

	• Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for treatment type if subject to pre-service review • Projected return on investment and/or savings if treatment type is subjected to pre-service review If the benefit or value of conducting pre-service review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to pre-service medical necessity review (prior authorization). Based upon the above referenced methodology, [redacted] subjects certain non-routine outpatient services (typically those subject to higher cost and/or utilization) to pre-service medical	• Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for treatment type if subject to pre-service review • Projected return on investment and/or savings if treatment type is subjected to pre-service review If the benefit or value of conducting pre-service review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to pre-service medical necessity review (prior authorization). Based upon the above referenced methodology, [redacted] subjects certain non-routine outpatient services (typically those subject to higher cost and/or	The enrollee's treating provider submits a request for benefit authorization of an outpatient service electronically or by phone, fax or mail. The case is referred to a nurse reviewer/care manager who collects and reviews the supporting clinical information for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for the outpatient service requested, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for the outpatient service at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets medical necessity criteria for the outpatient service at issue (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). UM coverage determinations of medical/surgical services and MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Moreover, [redacted]'s methodology for determining which MH/SUD services within a classification of benefits are subject to prior authorization is comparable to, and applied no more stringently than, its methodology for determining which medical/surgical services within the same

	necessity review (prior authorization). Examples of medical/surgical outpatient services subject to pre-service review include outpatient surgery, advanced radiology, chemotherapy, speech therapy, etc. No medical/surgical outpatient benefits are subject to fail-first and/or step therapy requirements	utilization) to pre-service review (prior authorization). MH/SUD outpatient services subject to pre-service review include partial hospitalization, intensive outpatient services (IOP), Applied Behavior Analysis (ABA) and Transcranial Magnetic Stimulation (TMS). No MH/SUD outpatient benefits, are subject to fail-first and/or step therapy requirements	classification of benefits are subject to prior authorization. [redacted] s methodology for determining which medical/surgical services and which MH/SUD services within a classification of benefits are subject to prior authorization as written and in operation, as well as its pre-service medical necessity review processes applied to medical/surgical services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the same classification of benefits. An "in operation" review of [redacted]'s application of the Prior Authorization NQTL, specifically approvals and denial information, in the "Outpatient, Out-of-Network, Other Items and Services" classification revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, [redacted] concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.

C. Concurrent Review Process, including frequency and penalties for all services. Describe any step-therapy or "fail first" requirements and requirements for submission of treatment request forms or treatment plans. Inpatient, In-Network:	When determining which M/S inpatient benefits are subject to concurrent care medical necessity review, [redacted] conducts a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for treatment type if subject to concurrent care review • Projected return on investment and/or savings if treatment type is subjected to concurrent care review If the benefit or value of conducting concurrent care review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to concurrent care medical necessity review.	When determining which MH/SUD inpatient benefits are subject to concurrent care medical necessity review, [redacted] conducts a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for treatment type if subject to concurrent care review • Projected return on investment and/or savings if treatment type is subjected to concurrent care review If the benefit or value of conducting concurrent care review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to concurrent	[redacted] applies the concurrent care review NQTL consistently to M/S benefits and MH/SUD benefits. In both M/S and MH/SUD services, concurrent care reviews are typically initiated by a nurse reviewer for M/S benefits or Care Manager (licensed behavioral health clinician) for MH/SUD benefits telephonically a day or two before the last covered/authorized day. In both M/S and MH/SUD benefits, the nurse reviewer/care manager collects the updated clinical information and/or reviews it for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for continued inpatient care, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets criteria for continued inpatient care (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). [redacted] typically authorizes 1-4 medical/surgical inpatient days upon concurrent care review. UM coverage determinations of medical/surgical services and MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider.

	No medical/surgical inpatient and benefits are subject to fail-first and/or step therapy requirements.	care medical necessity review. No MH/SUD inpatient benefits are subject to fail-first and/or step therapy requirements.	Moreover, [redacted]'s methodology for determining which MH/SUD services within a classification of benefits are subject to concurrent care review is comparable to, and applied no more stringently than, its methodology for determining which medical/surgical services within the same classification of benefits are subject to concurrent care review. No MH/SUD inpatient and outpatient benefits, are subject to fail-first and/or step therapy requirements, so further analysis of fail-first/step therapy requirement NQTL compliance is not warranted. An "in operation" review of [redacted]'s application of the Concurrent Review NQTL, specifically approvals and denial information, in the "Inpatient, In-Network" classification revealed no statistically significant discrepancies in medical necessity denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, [redacted] concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. [redacted] s methodology for determining which medical/surgical services and which MH/SUD

			services within a classification of benefits are subject to concurrent care review as written and in operation, as well as its concurrent care medical necessity review processes applied to medical/surgical services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the same classification of benefits.
Concurrent Review - Outpatient, In-Network: Office Visits:	Office Visits are not subject to concurrent review, including - Outpatient, In-Network: Office Visits	Office Visits are not subject to concurrent review, including - Outpatient, In-Network: Office Visits	Outpatient, In-Network, Office Visits for M/S and MH/SUD benefits do not require concurrent review. Because the concurrent review NQTL does not apply to MH/SUD benefits, no further analysis of compliance with the NQTL requirement is warranted.
Concurrent Review - Outpatient, In-Network: Other Outpatient Items and Services:	When determining which M/S inpatient benefits are subject to concurrent care medical necessity review, [redacted] conducts a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region	When determining which M/S inpatient benefits are subject to concurrent care medical necessity review, [redacted] conducts a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region	[redacted] applies the concurrent care review NQTL consistently to M/S benefits and MH/SUD benefits. In both M/S and MH/SUD services, concurrent care reviews are typically initiated by a nurse reviewer for M/S benefits or Care Manager (licensed behavioral health clinician) for MH/SUD benefits telephonically a day or two before the last covered/authorized day. In both M/S and MH/SUD benefits, the nurse reviewer/care manager collects the updated clinical information and/or reviews it for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for continued outpatient care, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not

	• Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for treatment type if subject to concurrent care review • Projected return on investment and/or savings if treatment type is subjected to concurrent care review If the benefit or value of conducting concurrent care review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to concurrent care medical necessity review. Based upon the above referenced methodology, [redacted] subjects certain non-routine outpatient services (typically those subject to higher cost and/or utilization) to concurrent care medical necessity review. Examples of medical/surgical outpatient surgical services subject to concurrent care review include home health care, chemotherapy, speech therapy, physical therapy, occupational therapy, etc.	• Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for treatment type if subject to concurrent care review • Projected return on investment and/or savings if treatment type is subjected to concurrent care review If the benefit or value of conducting concurrent care review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to concurrent care medical necessity review. Based upon the above referenced methodology, [redacted] subjects certain non-routine outpatient services (typically those subject to higher cost and/or utilization) to concurrent care medical necessity review. MH/SUD outpatient surgical services subject to concurrent care review include partial hospitalization, intensive outpatient services (IOP), Applied Behavior Analysis (ABA) and Transcranial Magnetic Stimulation (TMS).	appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets criteria for continued outpatient care (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). UM coverage determinations of medical/surgical services and MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Moreover, [redacted]'s methodology for determining which MH/SUD services within a classification of benefits are subject to concurrent care review is comparable to, and applied no more stringently than, its methodology for determining which medical/surgical services within the same classification of benefits are subject to concurrent care review. No MH/SUD outpatient benefits are subject to fail-first and/or step therapy requirements, so further analysis of fail-first/step therapy requirement NQTL compliance is not warranted. An "in operation" review of [redacted]'s application of the Concurrent Review NQTL, specifically approvals and denial information, in the "Outpatient,

	No medical/surgical outpatient benefits are subject to fail-first and/or step therapy requirements.	No MH/SUD outpatient benefits are subject to fail-first and/or step therapy requirements.	In-Network, Other Items and Services" classification revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, [redacted] concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. [redacted] s methodology for determining which medical/surgical services and which MH/SUD services within a classification of benefits are subject to concurrent care review as written and in operation, as well as its concurrent care medical necessity review processes applied to medical/surgical services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the same classification of benefits.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
Concurrent Review - Inpatient, Out-of-Network:	When determining which M/S inpatient benefits are subject to concurrent care medical necessity review, [redacted] conducts a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse	When determining which MH/SUD inpatient benefits are subject to concurrent care medical necessity review, [redacted] conducts a cost-benefit analysis based upon the following factors: • Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse	[redacted] applies the concurrent care review NQTL consistently to M/S benefits and MH/SUD benefits. In both M/S and MH/SUD services, concurrent care reviews are typically initiated by a nurse reviewer for M/S benefits or Care Manager (licensed behavioral health clinician) for MH/SUD benefits telephonically a day or two before the last covered/authorized day. In both M/S and MH/SUD benefits, the nurse reviewer/care manager collects the updated clinical information and/or reviews it for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for continued inpatient care, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for continued inpatient care, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets criteria for continued inpatient care (i.e. peer reviewer may

	• Cost of UM and appeals for treatment type if subject to concurrent care review • Projected return on investment and/or savings if treatment type is subjected to concurrent care review If the benefit or value of conducting concurrent care review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to concurrent care medical necessity review. No medical/surgical inpatient benefits are subject to fail-first and/or step therapy requirements.	• Cost of UM and appeals for treatment type if subject to concurrent care review • Projected return on investment and/or savings if treatment type is subjected to concurrent care review If the benefit or value of conducting concurrent care review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to concurrent care medical necessity review. No MH/SUD inpatient benefits, are subject to fail-first and/or step therapy requirements.	authorize or deny benefit authorization depending upon the information provided by the treating provider). [redacted] typically authorizes 1-4 medical/surgical inpatient days upon concurrent care review. UM coverage determinations of medical/surgical services and MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Moreover, [redacted]'s methodology for determining which MH/SUD services within a classification of benefits are subject to concurrent care review is comparable to, and applied no more stringently than, its methodology for determining which medical/surgical services within the same classification of benefits are subject to concurrent care review. No MH/SUD inpatient and outpatient benefits are subject to fail-first and/or step therapy requirements, so further analysis of fail-first/step therapy requirement NQTL compliance is not warranted. An “in operation” review of [redacted]’s application of the Concurrent Review NQTL, specifically approvals and denial information, in the “Inpatient, Out-of-Network, Other Items and Services” classification revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. While operational outcomes are

			not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, [redacted] concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. [redacted] s methodology for determining which medical/surgical services and which MH/SUD services within a classification of benefits are subject to concurrent care review as written and in operation, as well as its concurrent care medical necessity review processes applied to medical/surgical services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the same classification of benefits.
Concurrent Review - Outpatient, Out-of-Network: Office Visits:	Office Visits are not subject to concurrent review, including - Outpatient, Out-of-Network: Office Visits	Office Visits are not subject to concurrent review, including - Outpatient, Out-of-Network: Office Visits	Outpatient, Out-of-Network office visits for M/S and MH/SUD benefits do not require concurrent review. Because the concurrent review NQTL does not apply to MH/SUD benefits, no further analysis of compliance with the NQTL requirement is warranted.
Concurrent Review - Outpatient, Out-of-Network: Other Items and Services:	When determining which M/S inpatient benefits are subject to concurrent care medical necessity review, [redacted] conducts a cost-benefit analysis based upon the following factors:	When determining which M/S inpatient benefits are subject to concurrent care medical necessity review, [redacted] conducts a cost-benefit analysis based upon the following factors:	[redacted] applies the concurrent care review NQTL consistently to M/S benefits and MH/SUD Benefits. In both M/S and MH/SUD services, concurrent care reviews are typically initiated by a nurse reviewer for M/S benefits or Care Manager (licensed behavioral

	• Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for treatment type if subject to concurrent care review • Projected return on investment and/or savings if treatment type is subjected to concurrent care review If the benefit or value of conducting concurrent care review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to concurrent care medical necessity review. Based upon the above referenced methodology, [redacted] subjects certain non-routine outpatient services (typically those subject to higher cost and/or utilization) to concurrent care medical	• Cost of treatment/procedure • Whether treatment type is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, treatment type, provider type and/or geographic region • Annualized claim volume for treatment type including total paid and denied claims • Treatment types subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for treatment type if subject to concurrent care review • Projected return on investment and/or savings if treatment type is subjected to concurrent care review If the benefit or value of conducting concurrent care review of the treatment type outweighs the administrative costs associated with conducting the review, the treatment type is subject to concurrent care medical necessity review. Based upon the above referenced methodology, [redacted] subjects certain non-routine outpatient services (typically those subject to higher cost and/or utilization) to concurrent care medical	health clinician) for MH/SUD benefits telephonically a day or two before the last covered/authorized day. In both M/S and MH/SUD benefits, the nurse reviewer/care manager collects the updated clinical information and/or reviews it for medical necessity. If the nurse reviewer/care manager determines the enrollee meets criteria for continued outpatient care, he/she authorizes the services at issue. If the nurse reviewer/care manager assesses the enrollee does not appear to meet medical necessity criteria for continued outpatient care, he/she refers the case to a peer reviewer (e.g. Medical Director) who conducts a peer-to-peer review with the treating provider. The peer reviewer reviews the clinical information and determines whether the enrollee meets criteria for continued outpatient care (i.e. peer reviewer may authorize or deny benefit authorization depending upon the information provided by the treating provider). UM coverage determinations of medical/surgical services and MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Moreover, [redacted]'s methodology for determining which MH/SUD services within a classification of benefits are subject to concurrent care review is comparable to, and applied no more stringently than, its methodology for determining which medical/surgical services within the same classification of benefits are subject to concurrent

	necessity review. Examples of medical/surgical outpatient surgical services subject to concurrent care review include home health care, chemotherapy, speech therapy, physical therapy, occupational therapy, etc. No medical/surgical outpatient benefits are subject to fail-first and/or step therapy requirements.	necessity review. MH/SUD outpatient surgical services subject to concurrent care review include partial hospitalization, intensive outpatient services (IOP), Applied Behavior Analysis (ABA) and Transcranial Magnetic Stimulation (TMS). No MH/SUD outpatient benefits are subject to fail-first and/or step therapy requirements.	care review. No MH/SUD outpatient benefits are subject to fail-first and/or step therapy requirements, so further analysis of fail-first/step therapy requirement NQTL compliance is not warranted. An "in operation" review of [redacted]'s application of the Concurrent Review NQTL, specifically approvals and denial information, in the "Outpatient, Out-of-Network, Other Items and Services" classification revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, [redacted] concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. [redacted] s methodology for determining which medical/surgical services and which MH/SUD services within a classification of benefits are subject to concurrent care review as written and in operation, as well as its concurrent care medical necessity review processes applied to medical/surgical services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for

			MH/SUD services within a classification of benefits than for medical/surgical services within the same classification of benefits.
D. Retrospective Review Process, Including timeline and penalties. Inpatient, In-Network:	M/S In-Patient, In-Network benefits are subject to retrospective medical necessity review if prior authorization was not obtained via the pre-service or concurrent care review process. Enrollees may request a retrospective medical necessity review by submitting the request in writing with the supporting medical records electronically or by fax or mail. The request for retrospective review and supporting clinical information are referred to a nurse reviewer for review. If the nurse reviewer determines the enrollee met criteria for the services at issue, he/she authorizes the services at issue. If the nurse reviewer assesses the participant did not appear to meet medical necessity criteria for services at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) for determination. If the medical records support the participant met medical necessity criteria for the in-network or out-of-network services at issue, the services would be authorized. If the medical records do not support the enrollee met medical necessity criteria for the in-network or	MH/SUD In-Patient, In-Network benefits are subject to retrospective medical necessity review if prior authorization was not obtained via the pre-service or concurrent care review process. Enrollees may request a retrospective medical necessity review by submitting the request in writing with the supporting medical records electronically or by fax or mail. The request for retrospective review and supporting clinical information are referred to a nurse reviewer for review. If the nurse reviewer determines the enrollee met criteria for the services at issue, he/she authorizes the services at issue. If the nurse reviewer assesses the participant did not appear to meet medical necessity criteria for services at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) for determination. If the medical records support the participant met medical necessity criteria for the in-network or out-of-network services at issue, the services would be authorized. If the medical records do not support the enrollee met medical necessity criteria for the in-network or	UM coverage determinations of M/S services and MH/SUD services use the same processes, strategies, and evidentiary standards and are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Moreover, [redacted]'s methodology for determining which MH/SUD services within a classification of benefits are subject to retrospective review is comparable to, and applied no more stringently than, its methodology for determining which medical/surgical services within the same classification of benefits are subject to retrospective review. An "in operation" review of [redacted]'s application of the Retrospective Review NQTL, specifically approvals and denial information, in the "Inpatient, In-Network" classification revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently,

	out-of-network services at issue, the services would be denied as not medically necessary. For denials of in-network services, participating providers are contractually obligated to hold the enrollee harmless for the services at issue. For denials of out-of-network services, the enrollee would have the right to pursue the full internal and/or external appeal process.	out-of-network services at issue, the services would be denied as not medically necessary. For denials of in-network services, participating providers are contractually obligated to hold the enrollee harmless for the services at issue. For denials of out-of-network services, the enrollee would have the right to pursue the full internal and/or external appeal process.	[redacted] concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. [redacted]s methodology for determining which medical/surgical services and which MH/SUD services within a classification of benefits are subject to retrospective review as written and in operation, as well as its retrospective review processes applied to medical/surgical services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the same classification of benefits.
Retrospective Review - Outpatient, In-Network: Office Visits:	Outpatient, In-Network office visits do not require retrospective review.	Outpatient, In-Network office visits do not require retrospective review.	Outpatient, In-Network, Office Visits for M/S and MH/SUD benefits do not require retrospective review. Because the retrospective review NQTL does not apply to MH/SUD benefits, no further analysis of compliance with the NQTL requirement is warranted.
Retrospective Review - Outpatient, In-Network: Other Outpatient Items and Services:	M/S Outpatient, In-Network benefits are subject to retrospective medical necessity review if prior authorization was not obtained via the pre-service or concurrent care review process. Enrollees may request a retrospective medical necessity review by submitting the request in writing with the supporting medical records electronically or by fax or mail. The request for retrospective	MH/SUD Outpatient, In-Network benefits are subject to retrospective medical necessity review if prior authorization was not obtained via the pre-service or concurrent care review process. Enrollees may request a retrospective medical necessity review by submitting the request in writing with the supporting medical records electronically or by fax	UM coverage determinations of M/S services and MH/SUD services use the same processes, strategies, and evidentiary standards and are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Moreover, [redacted]'s methodology for determining which MH/SUD services within a classification of benefits are subject to retrospective medical necessity review is comparable to, and applied no more

	review and supporting clinical information are referred to a nurse reviewer for review. If the nurse reviewer determines the enrollee met criteria for the services at issue, he/she authorizes the services at issue. If the nurse reviewer assesses the participant did not appear to meet medical necessity criteria for services at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) for determination. If the medical records support the participant met medical necessity criteria for the in-network or out-of-network services at issue, the services would be authorized. If the medical records do not support the enrollee met medical necessity criteria for the in-network or out-of-network services at issue, the services would be denied as not medically necessary. For denials of in-network services, participating providers are contractually obligated to hold the enrollee harmless for the services at issue. For denials of out-of-network services, the enrollee would have the right to pursue the full internal and/or external appeal process.	or mail. The request for retrospective review and supporting clinical information are referred to a nurse reviewer for review. If the nurse reviewer determines the enrollee met criteria for the services at issue, he/she authorizes the services at issue. If the nurse reviewer assesses the participant did not appear to meet medical necessity criteria for services at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) for determination. If the medical records support the participant met medical necessity criteria for the in-network or out-of-network services at issue, the services would be authorized. If the medical records do not support the enrollee met medical necessity criteria for the in-network or out-of-network services at issue, the services would be denied as not medically necessary. For denials of in-network services, participating providers are contractually obligated to hold the enrollee harmless for the services at issue. For denials of out-of-network services, the enrollee would have the right to pursue the full internal and/or external appeal process.	stringently than, its methodology for determining which medical/surgical services within the same classification of benefits are subject to retrospective medical necessity review. An “in operation” review of [redacted]’s application of the Retrospective Review NQTL, specifically approvals and denial information, in the “Outpatient, In-Network, Other Items and Services” classification revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, [redacted] concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. [redacted] s methodology for determining which medical/surgical services and which MH/SUD services within a classification of benefits are subject to retrospective review as written and in operation, as well as its retrospective review processes applied to medical/surgical services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the same

			classification of benefits.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
Retrospective Review - Inpatient, Out-of-Network:	M/S In-Patient, Out-of-Network are subject to retrospective medical necessity review if prior authorization was not obtained via the pre-service or concurrent care review process. Enrollees may request a retrospective medical necessity review by submitting the request in writing with the supporting medical records electronically or by fax or mail. The request for retrospective review and supporting clinical information are referred to a nurse reviewer for review. If the nurse reviewer determines the enrollee met criteria for the services at issue, he/she authorizes the services at issue. If the nurse reviewer assesses the participant did not appear to meet medical necessity criteria for services at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) for determination.	MH/SUD In-Patient, Out-of-Network are subject to retrospective medical necessity review if prior authorization was not obtained via the pre-service or concurrent care review process. Enrollees may request a retrospective medical necessity review by submitting the request in writing with the supporting medical records electronically or by fax or mail. The request for retrospective review and supporting clinical information are referred to a nurse reviewer for review. If the nurse reviewer determines the enrollee met criteria for the services at issue, he/she authorizes the services at issue. If the nurse reviewer assesses the participant did not appear to meet medical necessity criteria for services at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) for determination.	UM coverage determinations of M/S services and MH/SUD services use the same processes, strategies, and evidentiary standards and are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Moreover, [redacted]'s methodology for determining which MH/SUD services within a classification of benefits are subject to retrospective review is comparable to, and applied no more stringently than, its methodology for determining which medical/surgical services within the same classification of benefits are subject to retrospective review. An "in operation" review of [redacted]'s application of the Retrospective Review NQTL, specifically approvals and denial information, in the "Inpatient, Out-of-Network" classification revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL

	If the medical records support the participant met medical necessity criteria for the in-network or out-of-network services at issue, the services would be authorized. If the medical records do not support the enrollee met medical necessity criteria for the in-network or out-of-network services at issue, the services would be denied as not medically necessary. For denials of in-network services, participating providers are contractually obligated to hold the enrollee harmless for the services at issue. For denials of out-of-network services, the enrollee would have the right to pursue the full internal and/or external appeal process.	If the medical records support the participant met medical necessity criteria for the in-network or out-of-network services at issue, the services would be authorized. If the medical records do not support the enrollee met medical necessity criteria for the in-network or out-of-network services at issue, the services would be denied as not medically necessary. For denials of in-network services, participating providers are contractually obligated to hold the enrollee harmless for the services at issue. For denials of out-of-network services, the enrollee would have the right to pursue the full internal and/or external appeal process.	requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, [redacted] concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. [redacted] s methodology for determining which medical/surgical services and which MH/SUD services within a classification of benefits are subject to retrospective review as written and in operation, as well as its retrospective review processes applied to medical/surgical services and for MH/SUD services as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the same classification of benefits.
Retrospective Review - Outpatient, Out-of-Network: Office Visits:	Outpatient, Out of Network office visits do not require retrospective review.	Outpatient, Out of Network office visits do not require retrospective review.	Outpatient, Out-of-Network, Office Visits for M/S and MH/SUD benefits do not require retrospective review. Because the retrospective review NQTL does not apply to MH/SUD benefits, no further analysis of compliance with the NQTL requirement is warranted.
Retrospective Review - Outpatient, Out-of-Network: Other Items and Services:	M/S out-Patient, Out-of-Network are subject to retrospective medical necessity review if prior authorization was not obtained via the pre-service or concurrent care review process. Enrollees may request a retrospective	MH/SUD out-Patient, Out-of-Network are subject to retrospective medical necessity review if prior authorization was not obtained via the pre-service or concurrent care review process. Enrollees may request a retrospective	UM coverage determinations of M/S services and MH/SUD services use the same processes, strategies, and evidentiary standards and are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider.

	medical necessity review by submitting the request in writing with the supporting medical records electronically or by fax or mail. The request for retrospective review and supporting clinical information are referred to a nurse reviewer for review. If the nurse reviewer determines the enrollee met criteria for the services at issue, he/she authorizes the services at issue. If the nurse reviewer assesses the participant did not appear to meet medical necessity criteria for services at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) for determination. If the medical records support the participant met medical necessity criteria for the in-network or out-of-network services at issue, the services would be authorized. If the medical records do not support the enrollee met medical necessity criteria for the in-network or out-of-network services at issue, the services would be denied as not medically necessary. For denials of in-network services, participating providers are contractually obligated to hold the enrollee harmless for the services at issue. For denials of out-of-network services, the enrollee would have the right to pursue the full internal and/or external appeal process.	medical necessity review by submitting the request in writing with the supporting medical records electronically or by fax or mail. The request for retrospective review and supporting clinical information are referred to a nurse reviewer for review. If the nurse reviewer determines the enrollee met criteria for the services at issue, he/she authorizes the services at issue. If the nurse reviewer assesses the participant did not appear to meet medical necessity criteria for services at issue, he/she refers the case to a peer reviewer (e.g. Medical Director) for determination. If the medical records support the participant met medical necessity criteria for the in-network or out-of-network services at issue, the services would be authorized. If the medical records do not support the enrollee met medical necessity criteria for the in-network or out-of-network services at issue, the services would be denied as not medically necessary. For denials of in-network services, participating providers are contractually obligated to hold the enrollee harmless for the services at issue. For denials of out-of-network services, the enrollee would have the right to pursue the full internal and/or external appeal process.	Moreover, [redacted]'s methodology for determining which MH/SUD services within a classification of benefits are subject to retrospective review is comparable to, and applied no more stringently than, its methodology for determining which medical/surgical services within the same classification of benefits are subject to retrospective review. An “in operation” review of [redacted]’s application of the Retrospective Review NQTL, specifically approvals and denial information, in the “Outpatient, Out-of-Network, Other Items and Services” classification revealed no statistically significant discrepancies in denial rates as-between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, [redacted] concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. [redacted] s methodology for determining which medical/surgical services and which MH/SUD services within a classification of benefits are subject to retrospective review as written and in operation, as well as its retrospective review processes applied to medical/surgical services and for MH/SUD services as written and in operation reflect they are comparable

			and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the same classification of benefits.
E. Emergency Services	Emergency medical/surgical services are not subject to prior authorization. Emergency services that are furnished by a provider qualified to provide emergency services to evaluate and stabilize an emergency medical condition, including ambulance services, are assigned to the emergency care classification of benefits. An emergency medical condition exists when a medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: • Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child; • Serious impairment to bodily function; or Serious dysfunction of any bodily organ or part.	Emergency MH/SUD services are not subject to prior authorization. Emergency services that are furnished by a provider qualified to provide emergency services to evaluate and stabilize an emergency medical condition, including ambulance services, are assigned to the emergency care classification of benefits. An emergency medical condition exists when a medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: • Serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child; • Serious impairment to bodily function; or Serious dysfunction of any bodily organ or part.	[redacted] s integrated medical and behavioral health plans have only one, single benefit for emergency room and urgent care. Accordingly, there are no differences between M/S and MH/SUD emergency room and urgent care 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:	[redacted] requires prior authorization, step therapy, or quantity limits for certain prescription drugs to ensure the prescribed drugs are medically necessary to treat the enrollee's condition. [redacted] uses the same medical necessity standard when reviewing coverage for both medical/surgical and MH/SUD drugs. [redacted]'s prior authorization, step therapy, or quantity limit requirements were developed without regard to whether the prescription drugs are prescribed to treat a medical condition or a MH/SUD condition. Some drugs are not covered on any formulary tier; these drugs may be referred to as "non-formulary" drugs. A drug may be designated as non-formulary or excluded for one of several possible reasons, whether it is an M/S or MH/SUD benefit. A drug may be designated as non-formulary because it is excluded from coverage by the benefit plan irrespective of medical necessity (e.g. the drug is not FDA-approved, or prescribed to treat a condition not covered by the benefit plan), or because the applicable formulary committee(s) determine after consideration of several clinical and non-clinical factors that it	Same as Medical/Surgical	[redacted] has confirmed that its utilization management programs are applied comparably, and no more stringently, to MH/SUD drugs as compared to M/S drugs. It's written policies governing formulary placement and application of utilization management do not distinguish between the processes, factors or standards that inform design and application of the formulary placement and utilization management NQTLs. Indeed, [redacted] uses one, combined policy to govern its formulary management and utilization management requirements across M/S and MH/SUD benefits, and, while uniformity in processes is not required by the NQTL requirements (only comparability), and uniformity in processes for designing and applying an NQTL can evidence comparability in the NQTL as-written. In terms of operational parity compliance, [redacted] confirmed that all drugs, whether MH/SUD or M/S drugs, that the P&T Committee designates must be covered are, in fact, covered on the formulary, and all drugs' coverage conform to other P&T Committee clinical parameters dictating the circumstances under which a drug can be preferred over another drug through tier placement or subject to step therapy requirements mandating use of one drug over another for coverage purposes. Moreover, [redacted] s coverage of MH/SUD and M/S drugs all conform to the aforementioned standards established for Tier 1, Tier 2, Tier 3, and, as applicable for policyholders that elect to offer a specialty drug tier, Tier 4 placement status, and drugs subject to a utilization management requirement,

	doesn't warrant coverage on the formulary. If the P&T Committee identifies a drug as "Exclude" or "Optional," for example, then the [redacted] VAC may designate the drug as non-formulary if it covers on the formulary a preferred covered alternative that is lower net cost option (inclusive of ingredient cost as sourced from claims/reimbursement information and available rebate revenue) to [redacted] as compared to therapeutic alternatives. Notably, [redacted] does not apply prior authorization or step therapy requirements to any drugs used to treat an opioid use disorder or alcohol use disorder. [redacted] does apply prior authorization or quantity limits to several MH/SUD drugs. Mental health drugs are generally considered to be controlled substances under federal law and, with the exception of drugs generally used to treat opioid use disorder and alcohol use disorder, [redacted] applies prior authorization to controlled substances such as opioids used for pain management. This approach is consistent with [redacted]'s application of prior authorization to controlled substances on the basis of identified safety risks, and regardless of whether the controlled substance is used to treat an M/S condition, such as pain management, or		including prior authorization, step therapy, and/or quantity limits, conform to the aforementioned standards established for inclusion in a utilization management program. That is, [redacted] does not apply a utilization management requirement to an MH/SUD drug that does not exhibit the factors/standards described in the preceding columns that, as-written, justify application of a utilization management requirement to a drug, and in terms of stringency of application of the NQTL no M/S drugs are omitted from a utilization management requirement if they exhibit the same factors/standards. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, [redacted] concludes that the NQTLs of formulary management and utilization management were applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. The application of the same NQTL standard across M/S and MH/SUD benefits demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the prescription drug classification of benefits.

	an MH/SUD condition such as ADHD or bipolar disorder. [redacted] applies prior authorization to M/S drugs for other reasons, such as specialty drug/high cost status (i.e. specialty drugs are subject to prior authorization), but these are rationales in addition to, and not exclusive of, the safety risk factor based on a drug's status as a controlled substance. [redacted] also applies step therapy to a number of brand drugs in certain MH/SUD and M/S therapeutic classes in order to incentivize the use of lower net cost (inclusive of ingredient cost and available manufacturer revenue) generic and/or preferred brand alternatives as identified through an analysis of claims/reimbursement information for the brand drugs.		

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
Tier 2:	Same as Tier 1	Same as Tier 1	Same as Tier 1
Tier 3:	Same as Tier 1	Same as Tier 1	Same as Tier 1
Tier 4:	Same as Tier 1	Same as Tier 1	Same as 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?	[redacted] offers a variety of prescription drug formularies comprised of generic, preferred and non-preferred brand name drugs, and specialty drugs. The coverage of drugs covered on [redacted]'s formularies are, subject to a client policyholder's election, determined by two internal/affiliated committees that perform different, but interrelated, functions: the Pharmacy & Therapeutics Committee ("P&T Committee"); and, the Value Assessment Committee (a/k/a	Same as M/S benefits.	[redacted] does not distinguish, in writing or in operation, between M/S and MH/SUD benefits in its prescription drug formulary design. Formulary tiers are designed based on reasonable factors, consistent with the requirements of 45 CFR §146.136. [redacted] has confirmed that its formulary management and utilization management processes are applied comparably, and no more stringently, to MH/SUD drugs as compared to M/S drugs. Specifically, all drugs, whether MH/SUD or M/S drugs, that the P&T Committee designates must be covered are, in fact, covered on the formulary, and all

	Business Decision Team). The P&T Committee is composed of voting external clinicians across a number of specialties that perform, among other responsibilities, clinical reviews of drugs to determine whether a drug must be covered on the formulary as a clinical matter. In rendering clinical findings on drugs, the P&T Committee assesses the FDA labeling and, as appropriate and available, clinical practice standards/trends and documentation like clinical literature and guidelines. The Value Assessment Committee is composed of representatives representing several functional areas of the combined company, including, for example, clinicians and representatives from our sales and economics areas, that have experience with formulary management or PBM/health plan operations, and is responsible for deciding - within the clinical parameters established by the P&T Committee - which drugs will be covered on the formularies offered by [redacted]. If the P&T Committee finds that a drug must be covered on the formulary as a clinical matter, then the Value Assessment Committee must place the drug on the formulary. If the P&T		drugs conform to other P&T Committee clinical parameters dictating the circumstances under which a drug can be preferred over another drug through tier placement or subject to step therapy requirements mandating use of one drug over another for coverage purposes. Moreover, [redacted]'s coverage of MH/SUD and M/S drugs all conform to the aforementioned standards established for Tier 1, Tier 2, Tier 3, and, as applicable for policyholders that elect to offer a specialty drug tier, Tier 4 placement status, and [redacted] s review evidences that the processes and standards used to determine whether to subject a drug to utilization review is not only comparable, but identical, across M/S and MH/SUD drugs. The same P&T and CHP VAC committee structure reviews M/S and MH/SUD drugs for formulary placement and whether to subject a drug to a prior authorization requirement, and pursuant to common policies and procedures. The process for reviewing drugs for coverage does not differ by whether the drug is used to treat a M/S condition or a MH/SUD condition. In terms of operational parity compliance, [redacted] has also assessed as follows across its formularies: a comparable percentage of MH/SUD drugs are covered on v. off-formulary as compared to M/S drugs; a comparable, and in some cases lower, percentage of MH/SUD drugs are subject to prior authorization or step therapy requirements as compared to M/S drugs; and a comparable, and, in fact, lower, percentage of MH/SUD drugs are covered on the non-preferred brand

	Committee determines that a drug may or may not be covered on the formulary as a clinical matter, then the Value Assessment Committee may consider other factors, including economic factors, when deciding whether to place the drug on the formulary. The [redacted] Health Plan Commercial Value Assessment Committee (CHP VAC) is the governing body accountable for making formulary decisions, including drug formulary placement decisions and application of utilization management ("UM") for the Company's commercial plans. In its decision criteria, the CHP VAC considers the following factors: • Pharmacy and Therapeutics ("P&T") Committee clinical evaluation and designation. The clinical P&T Committee's designations are based on reviews of a drug's safety and efficacy and place in therapy, using available clinical evidence such as FDA label information and available clinical literature and guidelines (e.g. federal regulatory publications or professional society publications). The P&T		tier (Tier 3) of the formularies offered by [redacted] as compared to the MH/SUD drugs covered on Tiers 1 and 2. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, [redacted] concludes that the NQTLs of formulary management and utilization management were applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. The application of the same NQTL standard across M/S and MH/SUD benefits demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the prescription drug classification of benefits.

		Committee assigns one of several clinical designations to a drug based on the drug's safety/efficacy and place in therapy: Access, Include, Optional, or Exclude. These designations dictate whether, from a clinical perspective a drug must be covered on the formulary, or, alternatively, may, but is not required to be, covered on the formulary, and whether a drug may be covered more favorably than therapeutically alternative drugs. A drug designated "Include" or "Access" must be covered to the extent medically necessary, and alternative drugs may not be preferred over it through application of tier placement or step therapy. A drug designated "Optional" may or may not be covered on the formulary, and may be subject to a step therapy protocol that requires the use of alternative drugs. • Pharmacoeconomic review • Economic implications to enrollees and [redacted]. When assessing potential formulary placement decisions, the CHP VAC reviews based on projected		

	drug expenditure information derived from available manufacturer revenue and claims costs whether a drug is a lower net cost option relative to any therapeutic alternatives. • Status of drug as a generic, brand, or specialty drug. A drug is identified as generic or brand based on an algorithm that considers drug indicators made available by an external vendor called First DataBank. A drug is identified as a specialty drug based on the presence of one more of the following characteristics: the requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes; the need for intensive patient training and compliance assistance to facilitate therapeutic goals; limited or exclusive specialty pharmacy distribution (if a drug is only available through limited specialty pharmacy distribution it is considered specialty, even if it doesn't have other specialty drug characteristics); or specialized		

	product handling and/or administration requirements. • Other business considerations (e.g. impact to enrollees) • Legal, regulatory, and accreditation requirements • Operational feasibility. Some drugs are not covered on any formulary tier; these drugs may be referred to as "non-formulary" drugs. A drug may be designated as non-formulary or excluded for one of several possible reasons, whether it is an M/S or MH/SUD benefit. A drug may be designated as non-formulary because it is excluded from coverage by the benefit plan irrespective of medical necessity (e.g. the drug is not FDA-approved, or prescribed to treat a condition not covered by the benefit plan), or because the applicable formulary committee(s) determine after consideration of several clinical and non-clinical factors that it doesn't warrant coverage on the formulary. If the P&T Committee identifies a drug as "Exclude" or "Optional," for example, then the [redacted] VAC may designate the drug as non-formulary if it covers on the formulary a preferred covered alternative that is lower net cost option (inclusive of ingredient cost as sourced from		

	claims/reimbursement information and available rebate revenue) to [redacted] as compared to therapeutic alternatives. Tier 1 of the formulary includes covered generic drugs. Tier 2 of the formulary includes covered preferred brand drugs. Tier 3 of the formulary includes covered non-preferred brand drugs. The brand or generic status of a drug is determined by reference to an algorithm that analyzes available drug indicators, currently including First DataBank's drug indicator file, and not by reference to the drug's status as an M/S or MH/SUD benefit. Once brand drug status is determined by application of the algorithm, a covered brand drug is typically placed on Tier 2 for one of several reasons, including, for example, if the drug lacks available generic alternatives or if [redacted] maintains a rebate arrangement for the brand drug, even if the brand drug has generic alternatives. Conversely, a covered brand drug is typically placed on Tier 3 if it either has available generic alternatives or [redacted] lacks a rebate arrangement for the brand drug. Tier 4, if elected by the client plan sponsor, includes specialty drugs identified based on application of the above-stated definition.		

Describe the pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step therapy.	[redacted] applies, in addition to the formulary management and utilization management requirements in its prior responses regarding NQTL application to prescription drug benefits, several kinds of NQTLs. These include, as previously described, formulary placement/tiering, and application of step therapy, prior authorization, and quantity limits for medical necessity. Certain NQTLs, such as exclusions for drugs obtained outside of the United States, apply uniformly across M/S and MH/SUD drugs. Of note, and consistent with Connecticut insurance law, [redacted] does not apply mandatory mail order requirements to any drugs, including M/S and MH/SUD drugs.	Same as Medical/Surgical Benefits.	In addition to [redacted]'s explanations for how its formulary management decisions, and decisions to apply utilization management to certain drugs, complies with the cited parity standard, [redacted] has also reviewed its utilization management process for compliance with the parity NQTL requirement. With respect to parity compliance as-written, [redacted] employed the same medical necessity standard and operational policies and procedures for reviewing utilization management approval requests. Similarly to its process for formulary management, [redacted] reviews coverage requests for MH/SUD and M/S drugs subject to a utilization management requirement using a uniform, consolidated process that leverages identical policies and procedures. A team called the Pharmacy Service Center reviews initial utilization review requests based on coverage criteria developed by a uniform approval process, and a team called the National Appeals Organization reviews any appeals of denied drug claims, regardless of whether a drug is an MH/SUD or M/S benefit. Both teams employ identical procedures, including turnaround time requirements for standard and expedited requests, the method by which prescribers can submit utilization management approval requests, the issuance of coverage approval or denial determinations to enrollees and prescribers, and quality/oversight protocols. [redacted] reviews non-formulary and step therapy coverage exception requests for any drug, whether a M/S or MH/SUD benefit, that is non-formulary or subject to a step therapy requirement. The coverage exception process ensures that enrollees for which the

			covered, preferred alternative drugs are clinically inappropriate can obtain coverage for drugs otherwise subject to non-formulary status or a step therapy requirement. If the enrollee's prescriber demonstrates that the non-formulary or, as applicable, drug subject to step therapy is medically necessary, generally by evidencing that the preferred drug(s) are inappropriate or were ineffective for treating the enrollee's condition, then [redacted] approves coverage of the requested drug as medically necessary regardless of the drug's status as an MH/SUD or M/S benefit. In terms of operational parity compliance, a review of utilization management data revealed comparable, and, in fact, lower, medical necessity denial rates for MH/SUD drugs subject to prior authorization, step therapy, a quantity limit, or non-formulary status, as compared to M/S drugs subject to the same utilization management requirements. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, [redacted] concludes that the NQTLs of formulary management and utilization management were applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. The application of the same NQTL standard across M/S and MH/SUD benefits demonstrates as written and in operation

			reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the prescription drug classification.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
What disciplines, such as primary care physicians (internists and pediatricians) and specialty physicians (including psychiatrists) and pharmacologists, are involved in the development of the formulary for medications to treat medical, mental health and substance use disorder conditions.	The clinical P&T committee assesses the utilization and appropriateness of therapeutic agents and provides the clinical parameters within which the CHP VAC's decisions regarding formulary placement and application of utilization management must occur. The P&T committee is comprised of 16 independent, external providers, including 14 physicians and two pharmacists representing the following clinical practice areas: internal medicine, pulmonology, geriatrics, pediatrics, OB/GYN, endocrinology, gastroenterology, oncology, dermatology, rheumatology, cardiology, pharmacy (geriatrics), pharmacy (general), psychiatry, and neurology.	The clinical P&T committee assesses the utilization and appropriateness of therapeutic agents and provides the clinical parameters within which the CHP VAC's decisions regarding formulary placement and application of utilization management must occur. The P&T committee is comprised of 16 independent, external providers, including 14 physicians and two pharmacists representing the following clinical practice areas: internal medicine, pulmonology, geriatrics, pediatrics, OB/GYN, endocrinology, gastroenterology, oncology, dermatology, rheumatology, cardiology, pharmacy (geriatrics), pharmacy (general), psychiatry, and neurology.	By including a psychiatrist on the clinical P&T committee, [redacted] ensures that comparable clinical expertise in treating MH/SUD conditions and M/S conditions is represented in the formulary decision-making process. While physicians, regardless of specialty, may be able to review the clinical safety/efficacy profile of an MH/SUD drug just as readily as M/S drugs used to treat conditions that the physician may not specialize in treating, [redacted] acknowledges the benefits to its formulary management process of including MH/SUD expertise on the clinical P&T Committee. In the context of NQTL compliance, the inclusion of a physician with appropriate MH/SUD treatment expertise on the clinical P&T Committee that assigns clinical designations to M/S and MH/SUD drugs evidences the comparability of the process by which formulary management decisions are made, in writing and in operation, across M/S and MH/SUD prescription drug benefits. Relatedly, it also helps to ensure for MH/SUD drugs the appropriate consideration of the factors and standards that inform

			[redacted] s formulary management decisions.
H. Case Management What case management services are available?	For [redacted] Enrollees with complex medical and/or behavioral health conditions, [redacted] provides voluntary case management services which includes providing educational information, assessment/evaluation, planning, facilitation, care coordination, discharge planning and other services to meet an individual's and family's comprehensive health care needs through communication and sharing available resources to promote optimal patient care.	[redacted] maintains active support and coaching programs for autism, eating disorders, intensive behavioral case management, opioid and pain management, substance use, and coaching support for parents and families with these disorders. Each program retains its own referral and eligibility criteria including self-referral which remains complimentary and voluntary. [redacted]'s CLIMB Program (a coaching program that uses a short-term, cognitive behavioral approach coupled with mindfulness and stress management techniques) is open to all enrollees who have the [redacted] Total Behavioral Health product that are 18 and over.	Participation in case management services is not required, and an enrollee's participation in case management services does not limit the scope or duration of benefits for either MH/SUD or M/S benefits. Consequently, case management does not function as an NQTL under the cited parity requirement.
What case management services are required?	Health plan enrollees are not required to participate in case management services. Case management services are completely voluntary. Because case management services are not designed to	Health plan enrollees are not required to participate in case management services. Case management services are completely voluntary. Because case management services are not designed to	Participation in case management services is not required, and an enrollee's participation in case management services does not limit the scope or duration of benefits for either MH/SUD or M/S benefits. . Consequently, case management does not function as an NQTL under the cited parity

	limit the scope of benefit coverage or the duration of treatment, case management services would not be considered a non-quantitative treatment limitation.	limit the scope of benefit coverage or the duration of treatment, case management services would not be considered a non-quantitative treatment limitation.	requirement.
What are the eligibility criteria for case management services?	Case management services are complimentary, voluntary services offered to eligible health plan enrollees with complex medical conditions. Health plan enrollees are not required to participate in case management services. Case management services are completely voluntary. Because case management services are not designed to limit the scope of benefit coverage or the duration of treatment, they are not considered a NQTL.	Case management services are complimentary, voluntary services offered to eligible health plan enrollees with complex MH/SUD health conditions. Health plan enrollees are not required to participate in case management services. Case management services are completely voluntary. Because case management services are not designed to limit the scope of benefit coverage or the duration of treatment, they are not considered a NQTL.	Participation in case management services is not required, and an enrollee's participation in case management services does not limit the scope or duration of benefits for either MH/SUD or M/S benefits. Consequently, case management does not function as an NQTL under the cited parity requirement. Notwithstanding the inapplicability of the NQTL requirement to [redacted] s voluntary case management program, [redacted] offers case management services to enrollees with either complex MH/SUD or M/S conditions.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
I. Process for Assessment of New Technologies Definition of experimental/investigational:	Experimental, investigational and unproven (EIU) services are medical, surgical, diagnostic, or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by [redacted] s Coverage Policy Unit (CPU), in partnership with [redacted]'s Medical Technology Assessment Committee, to be: • not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed; • not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;	Experimental, investigational and unproven services are psychiatric or substance abuse health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by [redacted]'s Coverage Policy Unit (CPU), in partnership with [redacted]'s Medical Technology Assessment Committee, to be: • not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed; • not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;	The definition of experimental/investigational/unproven services is the same for MS and MH/SUD. [redacted] collects, tracks and trends relevant metrics on a semi-annual basis for services within each classification of medical/surgical and MH/SUD benefits. Metrics may include initial EIU coverage denials, coverage denials upheld and overturned upon internal appeal and coverage denials upheld and overturned upon external appeal/review A review of claims data revealed comparable denial rates for MH/SUD claims, as compared to M/S claims, denied as experimental, investigational and unproven as compared to medical/surgical claims denied as experimental, investigational and unproven. An "in operation" review of [redacted]'s application of the Experimental, Investigational, and Unproven NQTL, specifically approvals and denial information, in the "Outpatient, Out-of-Network, Other Items and Services" classification revealed no statistically significant discrepancies in EIU denial rates as-

	• the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.	• the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.	between MH/SUD and M/S benefits. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, [redacted] concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. The application of the same NQTL standard across M/S and MH/SUD benefits demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the same classification of benefits.
Qualifications of individuals evaluating new technologies:	[redacted]'s Medical Technology Assessment Committee (MTAC) applies a consistent process in the development of evidence-based Coverage Policies for a wide variety of medical technologies. The MTAC committee is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines. The committee reviews FDA approval/clearance status, English language peer reviewed publications as	[redacted]'s Medical Technology Assessment Committee (MTAC) applies a consistent process in the development of evidence-based Coverage Policies for a wide variety of medical technologies. The MTAC committee is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines. The committee reviews FDA approval/clearance status, English language peer reviewed publications as	[redacted]'s MTAC evaluates all new technologies for medical/surgical and MH/SUD benefits. MTAC is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines. The use of MTAC for development of evidence based Coverage Policies for M/S and MH/SUD demonstrates as written and in operation reflect they are comparable and no more stringent for MH/SUD services.

	well as relevant documents prepared by specialty societies and evidence-based review centers. The committee uses principles of evidence-based medicine in its evaluation of clinical literature and in its deliberative process and in preparing published medical coverage polices. The MTAC committee develops criteria to assist medical directors in determining whether a service/device is deemed to be medically necessary or experimental, investigational or unproven.	well as relevant documents prepared by specialty societies and evidence-based review centers. The committee uses principles of evidence-based medicine in its evaluation of clinical literature and in its deliberative process and in preparing published medical coverage polices. The MTAC committee develops criteria to assist medical directors in determining whether a service/device is deemed to be medically necessary or experimental, investigational or unproven.	
Evidence consulted in evaluating new technologies:	[redacted] has a Medical Technology Assessment Committee (MTAC) that develops coverage policies. The committee is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines. MTAC also consults with internal [redacted] subject matter experts as part of the committee review process. Internal subject matter experts include, but may not be limited to, orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists, and psychiatrists. The committee uses principles of	[redacted] has a Medical Technology Assessment Committee (MTAC) that develops coverage policies. The committee is composed of physicians and nurses, and includes specialists from assorted medical and behavioral health disciplines. MTAC also consults with internal [redacted] subject matter experts as part of the committee review process. Internal subject matter experts include, but may not be limited to, orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internists, surgeons, urologists, pulmonologists, cardiologists, and psychiatrists. The committee uses principles of	[redacted] s methodology and processes for determining whether medical/surgical interventions and MH/SUD interventions within a classification of benefits are experimental, investigational and/or unproven are comparable and no more stringent for MH/SUD services within a classification of benefits than for medical/surgical services within the same classification of benefits as written and in operation.

	evidence-based medicine in its evaluation of clinical literature, in development of its reviews, in its deliberative process, and in preparing published medical coverage policies. Financial considerations do not drive decisions about medical appropriateness. As part of the review process, FDA approval or clearance, as appropriate, is necessary, but not sufficient, for [redacted] to consider a technology to be proven. FDA approval or clearance does not apply to all services (i.e. procedures). However, when FDA approval or clearance, as appropriate, is present, [redacted] reviews English language peer reviewed publications, as well as relevant documents prepared by specialty societies and evidence-based review centers, such as the Agency for Health Care Research and Quality. Levels of evidence (referenced in the appendix below) are assigned to the publications based upon underlying study characteristics, including but not limited to incidence and prevalence of disease, study design, number of subjects, clinical outcomes of relevance, statistics used and significance, and assessment of flaws and bias. A research team performs a	evidence-based medicine in its evaluation of clinical literature, in development of its reviews, in its deliberative process, and in preparing published medical coverage policies. Financial considerations do not drive decisions about medical appropriateness. As part of the review process, FDA approval or clearance, as appropriate, is necessary, but not sufficient, for [redacted] to consider a technology to be proven. FDA approval or clearance does not apply to all services (i.e. procedures). However, when FDA approval or clearance, as appropriate, is present, [redacted] reviews English language peer reviewed publications, as well as relevant documents prepared by specialty societies and evidence-based review centers, such as the Agency for Health Care Research and Quality. Levels of evidence (referenced in the appendix below) are assigned to the publications based upon underlying study characteristics, including but not limited to incidence and prevalence of disease, study design, number of subjects, clinical outcomes of relevance, statistics used and significance, and assessment of flaws and bias. A research team performs a	

	synthetic assessment of the literature in order to determine if there is a sufficiently evidence based proven relationship between the intervention and improved health outcomes. This information is presented to the committee who makes a final determination regarding coverage criteria. [redacted] considers other sources of internal and external information as part of its decision making process. For instance [redacted] welcomes input from health care professionals and other interested parties. Health care professionals may share their comments with the regional market medical executive representing a specific geography, account or subject matter issue. The information is reviewed, usually as part of the annual update process. The MTAC committee develops criteria to assist medical directors in determining whether a service/device is deemed to be medically appropriate or experimental, investigational or unproven.	synthetic assessment of the literature in order to determine if there is a sufficiently evidence based proven relationship between the intervention and improved health outcomes. This information is presented to the committee who makes a final determination regarding coverage criteria. [redacted] considers other sources of internal and external information as part of its decision making process. For instance [redacted] welcomes input from health care professionals and other interested parties. Health care professionals may share their comments with the regional market medical executive representing a specific geography, account or subject matter issue. The information is reviewed, usually as part of the annual update process. The MTAC committee develops criteria to assist medical directors in determining whether a service/device is deemed to be medically appropriate or experimental, investigational or unproven.	

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
J. Standards for provider credentialing and contracting			
Is the provider network open or closed?	[redacted] maintains an open network for M/S providers such that new providers looking to contract with [redacted] will be admitted if they meet [redacted]'s network admission criteria. When determining whether to admit a provider into its provider network, [redacted] takes into consideration an array of factors including, but not limited to provider type and/or specialty; geographic market; supply of provider type and/or specialty; demand for provider type and/or specialty; and provider licensure and/or certification. In the event [redacted] s medical network had a sufficient supply of a particular type and/or specialty of provider within a geographic region (i.e. zip code),	[redacted] maintains an open network for MH/SUD providers, such that new providers looking to contract with [redacted] will be admitted if they meet [redacted]'s network admission criteria. When determining whether to admit a provider into its provider network, [redacted] takes into consideration an array of factors including, but not limited to provider type and/or specialty; geographic market; supply of provider type and/or specialty; demand for provider type and/or specialty; and provider licensure and/or certification. In the event [redacted] s medical network had a sufficient supply of a particular type and/or specialty of provider within a geographic region (i.e. zip code),	First, [redacted] maintains an open network for both M/S and MH/SUD providers, such that new providers looking to contract with [redacted] will be admitted if they meet [redacted] s network admission criteria. [redacted] conducts an annual directory audit which includes a valid random sample to meet NCQA accreditation requirements.

	[redacted] closes its network to that provider type and/or specialty in that geographic region.	[redacted] closes its network to that provider type and/or specialty in that geographic region.	
What are the credentialing standards for physicians?	Credentialing Requirements for facilities: • Signed application • Signed agreement • Unrestricted license/state operating certificate • Accreditation • Acceptable history of Medicaid and Medicare sanction information • Acceptable history of malpractice claim experience • Proof of professional and general liability insurance coverage • Quality Assurance/Quality Improvement Program Credentialing Requirements for independently practicing practitioners: • Signed application • Signed agreement to participate • Unrestricted state license to practice	Credentialing Requirements for facilities: • Signed application • Signed agreement • Unrestricted license/state operating certificate • Accreditation • Acceptable history of Medicaid and Medicare sanction information • Acceptable history of malpractice claim experience • Proof of professional and general liability insurance coverage • Quality Assurance/Quality Improvement Program Credentialing Requirements for independently practicing practitioners: • Signed application • Signed agreement to participate • Unrestricted state license to practice	[redacted] s methodology for credentialing for medical/surgical providers and MH/SUD physician providers are the same. [redacted]'s credentialing standards for licensed physicians follows NCQA, CMS and state and federal requirements and guidelines for MS and MH/SUD providers. The credentialing application process is consistent between physicians providing M/S and MH/SUD services and the required licensing, experience, CAQH application and verifications are indistinguishable. No additional [redacted]-specific credentialing requirements are applied to either M/S or MH/SUD physician providers. Consistency in standards and process evidences compliance with the NQTL requirement. An "in operation" review of [redacted]'s credentialing applications approvals and denials of providers reviewed no disparate outcomes in credentialing approvals or denials as between M/S and MH/SUD physician providers. The average time it took [redacted] to review and approve (or deny) a credentialing application for both M/S and MH/SUD providers was 74 days; 90 day approval average for medical/surgical providers and 50 day approval average for MH/SUD providers. While operational outcomes are not determinative of NQTL compliance, and an insurer may comply with the NQTL

	• Valid unrestricted DEA and CDS certificate for practitioners choosing to prescribe controlled substances • In good standing at facility at which he/she has privileges • Verification of education, training, license and board certification • Acceptable history of Medicaid and Medicare sanction information • Acceptable history of sanctions (i.e. restrictions on license and/or scope of practice) • Acceptable history of malpractice claim experience • Proof of adequate professional liability insurance coverage	• Valid unrestricted DEA and CDS certificate for practitioners choosing to prescribe controlled substances • In good standing at facility at which he/she has privileges • Verification of education, training, license and board certification • Acceptable history of Medicaid and Medicare sanction information • Acceptable history of sanctions (i.e. restrictions on license and/or scope of practice) • Acceptable history of malpractice claim experience • Proof of adequate professional liability insurance coverage	requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement. Consequently, [redacted] concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. [redacted] has therefore concluded its contracting/credentialing methodologies and processes applied to medical/surgical providers and MH/SUD providers are comparable and no more stringently applied to MH/SUD providers.
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.	[redacted] follows NCQA, CMS, state and federal requirements and guidelines for each provider and/or specialty type. The standard credentialing process is used for both licensed physician providers and licensed non-physician providers. See process above.	[redacted] follows NCQA, CMS, state and federal requirements and guidelines for each provider and/or specialty type. The standard credentialing process is used for both licensed physician providers and licensed non-physician providers. See process above.	[redacted]'s credentialing standards for licensed non-physician providers follows NCQA, CMS and state and federal requirements and guidelines for MS and MH/SUD providers. The credentialing application process is consistent between M/S and MH/SUD and such required licensing, experience, CAQH application and verifications are distinguishable only by differences in regulatory requirements. No additional [redacted]-specific credentialing requirements are applied to either M/S or MH/SUD providers. Consistency in standards and process evidences compliance with the NQTL requirement.

What are the credentialing/contracting standards for unlicensed personnel; e.g., home health aides, qualified autism service professionals and paraprofessionals?	Unlicensed providers may not be directly contracted, but may render services under a fully contracted and credentialed individual (supervising provider) or entity. For example, Home Health Aides are not individually credentialed or contracted directly, the Home Health Agency is contracted and credentialed as an entity (facility or clinic). [redacted] does not contract directly with most of these types of providers but rather, with the entity they work for. If certifications are available for paraprofessionals, it is reviewed for credentialing purposes.	Unlicensed providers may not be directly contracted, but may render services under a fully contracted and credentialed individual (supervising provider) or entity. For example, Home Health Aides are not individually credentialed or contracted directly, the Home Health Agency is contracted and credentialed as an entity (facility or clinic). [redacted] does not contract directly with most of these types of providers but rather, with the entity they work for. If certifications are available for paraprofessionals, it is reviewed for credentialing purposes.	[redacted] does not distinguish between M/S and MH/SUD for purposes of credentialing unlicensed professionals and paraprofessionals. For M/S and MH/SUD, unlicensed providers may not be directly contracted or credentialed but may render services under a fully contracted and credentialed individual (supervising provider) or entity (clinic or facility) [redacted]'s credentialing standards for unlicensed professionals and paraprofessionals follows applicable NCQA, CMS and state and federal requirements and guidelines for MS and MH/SUD providers. The credentialing application process is consistent between M/S and MH/SUD and such required licensing, experience, CAQH application and verifications are distinguishable only by differences in regulatory requirements. No additional [redacted]-specific credentialing requirements are applied to either M/S or MH/SUD providers. Consistency in standards and process evidences compliance with the NQTL requirement.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
K. Exclusions for Failure to Complete a Course of Treatment Does the Plan exclude benefits for failure to complete treatment?	[redacted] does not exclude benefits for failure to complete treatment.	[redacted] does not exclude benefits for failure to complete treatment.	[redacted] does not exclude benefits for failure to complete treatment for M/S or MH/SUD Benefits. [redacted] s process is consistent between M/S and MH/SUD, so [redacted] does not apply such an NQTL to MH/SUD benefits that warrants analysis under the NQTL requirement.
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?	[redacted] has a National Network that includes providers within the United States. [redacted] s policies do not cover anything other than urgent or emergent services if rendered outside of the United States.	[redacted] has a National Network that includes providers within the United States. [redacted] s policies do not cover anything other than urgent or emergent services if rendered outside of the United States.	[redacted]'s geographic limitations on coverage for services apply uniformly across MH/SUD and M/S benefits...
Does the Plan restrict the type(s) of facilities in which enrollees can receive services?	In Network facilities must meet contracting/credentialing requirements. Services in facilities may need prior authorization and meet our medical necessity guidelines.	In Network facilities must meet contracting/credentialing requirements. Services in facilities may need prior authorization and meet our medical necessity guidelines.	[redacted] standardly covers medically necessary services rendered by licensed and/or certified healthcare providers for the treatment of medical/surgical conditions and MH/SUD conditions. Services determined by [redacted] not to be medically

			necessary would excluded under the terms of the plan.

Area	Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits	Explanation
	Summarize the plan's applicable NQTLs, including any variations by benefit.	Summarize the plan's applicable NQTLs, including any variations by benefit.	Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4).
M. Does the Plan restrict the types of provider specialties that can provide certain M/S and/or MH/SUD benefits?	Yes. Providers are required to work within the scope of their licenses.	Yes. Providers are required to work within the scope of their licenses.	[redacted] requires providers to work within the scope of their licenses for both M/S and MH/SUD benefits. The process is consistent between M/S and MH/SUD benefits. [redacted] does not, in writing or in operation, further restrict provision of MH/SUD benefits to certain types of specialties so long as the rendering provider is acting within the scope of the provider's license, and, in terms of stringency, [redacted] confirms that it does not waive for any M/S providers the requirement that the M/S provider act within the scope of the provider's license in order for services to be covered.
N. Network Adequacy	Assessing supply and demand of medical/surgical provider types and/or specialties and MH/SUD provider types and/or specialties are based upon the same indicators including, but not limited to, NCQA and NAIC network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or	Assessing supply and demand of medical/surgical provider types and/or specialties and MH/SUD provider types and/or specialties are based upon the same indicators including, but not limited to, NCQA and NAIC network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or	[redacted] has reviewed and merged, where appropriate, its M/S and MH/SUD network adequacy policies and procedures to ensure comparability across M/S and MH/SUD providers. These policies and procedures are reviewed at least annually to ensure the continued sufficiency of the standards in meeting enrollees' needs. [redacted] uses combined network adequacy policy and a similar reporting template is used for both M/S and MH/SUD benefits. Network adequacy standards for behavioral health

	distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; member satisfaction surveys; and member complaint data.	distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; member satisfaction surveys; and member complaint data.	providers are comparable to similar medical specialists. In most instances the behavioral network adequacy standards require a member to travel fewer miles to see a behavioral specialist as compared to a medical specialist, effectively making MH/SUD providers more accessible to members as compared to medical specialists. Currently, or both M/S and MH/SUD providers, at least 90% of enrollees are required to have the designated access to meet [redacted]'s network adequacy standard. [redacted] completed an analysis last year of its network adequacy requirements for the state's service area, and [redacted]'s medical and behavioral networks meet the company's established access to care standards in urban, suburban, and rural areas. And in the event a enrollee cannot secure a provider or appointment within a reasonable time/distance or with reasonable appointment availability [redacted] will authorize out-of-network services at the in-network benefit level. Enrollees are able to receive assistance in locating a provider or appointment by contacting the phone number on the back of their ID card. In the event the enrollee and/or a [redacted] representative cannot locate a provider/appointment within the acceptable time/distance standards a request can be made for out-of-network care. As an additional way of ensuring meaningful access to services, [redacted] also measures accessibility of care to behavioral providers annually using findings from enrollee surveys and complaints and by measuring results against the accessibility standards

			and metrics. [redacted] uses the continuous quality improvement (CQI) process to identify opportunities for improvement. In summary, a review of [redacted]'s network adequacy reports for CT revealed sufficient access to medical/surgical and BH/SUD. [redacted] meets adequacy and accessibility requirements for medical/surgical and behavioral providers. [redacted] standards are developed and administered based on comparable processes for both medical/surgical and MH/SUD providers and network access. Moreover, [redacted] s analysis of recent claims information revealed comparable out-of-network utilization across MH/SUD and M/S benefits in the Inpatient, Outpatient (Other Items and Services), and Outpatient (Office Visits) benefit classifications.
O. In-Network Provider Reimbursement	Medical/surgical in-network facility based services are reimbursed on an assigned diagnosis-related group (DRG) or case rate basis and on a per diem basis. [redacted]'s in-network provider reimbursement methodology for medical/surgical providers are based upon the same array of factors including, but not limited to:	MH/SUD in-network facility based services are reimbursed on a per diem basis based upon the competitive rate for the type of service (level of care) or procedure with the geographic market. [redacted]'s in-network provider reimbursement methodology for MH/SUD providers are based upon the same array of factors including, but not limited to:	As described in the preceding columns, [redacted]'s methodology and process for negotiating in-network provider reimbursements for medical/surgical services and MH/SUD services within a classification of benefits are comparable and no more stringent for MH/SUD services than for medical/surgical services within the same classification of benefits as written. [redacted] also follows a comparable process in determining payment rates for non-physician providers for both medical/surgical and MH/SUD benefits. In this process, variables including market demand, provider specialty and availability and frequency of requests for provider fee increases may

	• Geographic market (i.e. market rate and payment type for provider type and/or specialty) • Type of provider (i.e. hospital, clinic and practitioner) and/or specialty • Supply of provider type and/or specialty • Network need and/or demand for provider type and/or specialty • Medicare reimbursement rates • Training, experience and licensure of provider Assessing supply and demand of medical/surgical provider types and/or specialties are based upon the same indicators including, but not limited to NCQA and NAIC network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; member satisfaction surveys; and member complaint data.	• Geographic market (i.e. market rate and payment type for provider type and/or specialty) • Type of provider (i.e. hospital, clinic and practitioner) and/or specialty • Supply of provider type and/or specialty • Network need and/or demand for provider type and/or specialty • Medicare reimbursement rates • Training, experience and licensure of provider Assessing supply and demand of MH/SUD provider types and/or specialties are based upon the same indicators including, but not limited to NCQA and NAIC network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; member satisfaction surveys; and member complaint data.	result in differentials in reimbursement rates across medical/surgical and MH/SUD provider types. When a medical or behavioral provider requests participation in the [redacted] network(s) or when [redacted] identifies a provider to recruit into its network(s), the provider is presented with a contract proposal which describes the details of the entire agreement such as obligations of the physician, obligations of [redacted], term of the contract, reimbursement, and applicable state supplemental requirements. [redacted] will respond within 20 days of provider inquiry to join the [redacted] network. The provider either accepts the proposed contract or may request negotiated changes to [redacted]'s standard provider template and standard reimbursement rates. Revisions to the standard Provider contract terms and reimbursement rates are analyzed and negotiated by either a Recruiter or Contract Negotiator, with oversight from a Contracting Director. The same standard methodologies are used for both medical/surgical and MH/SUD rate negotiation and any substantial deviations from standard reimbursement rates must be justified and approved. [redacted] s in-network provider reimbursement methodology is based upon factors including, but not limited to: geographic market (i.e. market rate and payment type for provider type and/or specialty); type of provider (i.e. hospital, clinic and practitioner) and/or specialty; supply of provider type and/or

			specialty; network adequacy and current Medicare reimbursement rates. All staff participating in a contract negotiation are trained on internal [redacted] policies and procedures, and have access to necessary tools to negotiate and develop appropriate reimbursement rates based on standard methodologies, provider specific reimbursement requests and escalate for justification and approval of any deviations. Concurrent with the negotiation or immediately thereafter, provider credentialing will be completed by [redacted] (or other such delegate of credentialing). The provider must successfully meet [redacted] credentialing requirements before the contract may be fully executed and. CAQH is utilized to obtain most individual practitioner credentialing related information, expediting the credentialing process while [redacted] adhering to all state credentialing review timelines. Upon finalization, successful credentialing, the agreement is executed the provider's participation in the contracted [redacted] network(s) begins on the applicable effective date. An 'in operation" review of [redacted]'s medical/surgical and MH/SUD reimbursement rates revealed that M/S providers is reimbursed at a higher percentage of Medicare than MH/SUD. While there is a disparate outcome in the in-operational review of [redacted]'s medical/surgical and MH/SUD reimbursement rates that results from differences in local market dynamics, such outcome does not mean

			the in-practice NQTL standards are non-comparable or being applied more stringently to MH/SUD benefits. Because in-network provider reimbursement is a factor relevant to NQTL compliance insofar as it impacts accessibility to in-network providers and [redacted] s network admissions criteria, itself the relevant NQTL, [redacted] emphasizes that the comparable out-of-network utilization over the recent measurement period across MH/SUD and M/S benefits and the achievement of applicable network adequacy requirements for MH/SUD and M/S providers, respectively, evidences that any discrepancies in rates offered to MH/SUD providers is not affecting [redacted] s ability to admit a sufficient number of providers.
P. Method for determining usual, customary and reasonable charges	The following information can vary by client election and/or state compliance rules. The Company may use a program provided by a partner entity that utilizes one of three methods to establish appropriate reimbursement levels for covered charges with non-contracted providers. These include the following: 1. The partner companies have standing agreements with providers that establish discounted rates which [redacted] can access through its agreement with the partner company. This is an indirect discount agreement	The following information can vary by client election and/or state compliance rules. The Company may use a program provided by a partner entity that utilizes one of three methods to establish appropriate reimbursement levels for covered charges with non-contracted providers. These include the following: 1. The partner companies have standing agreements with providers that establish discounted rates which [redacted] can access through its agreement with the partner company. This is an indirect discount agreement	[redacted] has assessed the operational parity compliance of its out-of-network reimbursement methodology and has confirmed out-of-network reimbursement methodology applies comparably to MH/SUD benefits and no more stringently than M/S benefits received out-of-network. For example, [redacted] covers the full billed charges submitted by the MH/SUD providers at a comparable and, generally, higher rate than it pays the full billed charges for M/S providers as measured across inpatient and outpatient services paid for its entire book of business. Moreover, in the aggregate [redacted] generally pays to MH/SUD providers a higher reimbursement amount than M/S providers as measured as a discount off the providers' billed charges. [redacted] s methodology for determining out-of-

	where the provider remains non-contracted but agrees not to balance bill the member. 2. The partner company reviews claims received by [redacted] from non-contracted providers and negotiates with the provider on the plan's behalf for a claim-specific discount. This is a direct discount agreement where the provider remains non-contracted but agrees not to balance bill the member. 3. The partner company facilitates an electronic offer to the provider on the plan's behalf whereby a provider is reimbursed at a market rate, as determined by the partner company and deemed to have agreed to the reimbursement absent an objection by the provider. If the claim cannot be adjudicated utilizing one of the above methodologies then reimbursement will be based on the lesser of the covered billed charges or the client-elected Maximum Reimbursable Charge (MRC). A description of the MRC is included in the plan documents. The client may elect one of two Maximum Reimbursable Charge (MRC) options to determine the allowable	where the provider remains non-contracted but agrees not to balance bill the member. 2. The partner company reviews claims received by [redacted] from non-contracted providers and negotiates with the provider on the plan's behalf for a claim-specific discount. This is a direct discount agreement where the provider remains non-contracted but agrees not to balance bill the member. 3. The partner company facilitates an electronic offer to the provider on the plan's behalf whereby a provider is reimbursed at a market rate, as determined by the partner company and deemed to have agreed to the reimbursement absent an objection by the provider. If the claim cannot be adjudicated utilizing one of the above methodologies then reimbursement will be based on the lesser of the covered billed charges or the client-elected Maximum Reimbursable Charge (MRC). A description of the MRC is included in the plan documents. The client may elect one of two Maximum Reimbursable Charge (MRC) options to determine the allowable	network medical/surgical provider reimbursement rates and out-of-network MH/SUD provider reimbursement rates are comparable and applied no more stringently to MH/SUD providers than to medical/surgical providers as written. Consistency in the determination process evidences compliance with the NQTL requirement that the process be applied comparably, and no more stringently, to MH/SUD services than to M/S services.

	amount: • MRC1 • Based on a percentile of charges (U&C) as compiled in a national charges database. • Clients select an MRC1 percentile: 50th, 60th, 70th, 80th, etc. Standard offerings are 70th percentile for HMO and POS product claims and 80th percentile for PPO and EPO products claims. • Emergency services provided by health care professional will be reimbursed using the MRC1 80th percentile allowable amount. • Emergency services provided by an outpatient facility will be reimbursed using the PPACA allowable amount. • MRC2 • Based on methodologies and rates used by CMS to pay Medicare claims. • Clients can select the percentage of MRC2 paid to non-contracted health care professionals and facilities for non-emergency services. Standard percentages are 110 percent, 150 percent, 200 percent, and 300 percent.	amount: • MRC1 • Based on a percentile of charges (U&C) as compiled in a national charges database. • Clients select an MRC1 percentile: 50th, 60th, 70th, 80th, etc. Standard offerings are 70th percentile for HMO and POS product claims and 80th percentile for PPO and EPO products claims. • Emergency services provided by health care professional will be reimbursed using the MRC1 80th percentile allowable amount. • Emergency services provided by an outpatient facility will be reimbursed using the PPACA allowable amount. • MRC2 • Based on methodologies and rates used by CMS to pay Medicare claims. • Clients can select the percentage of MRC2 paid to non-contracted health care professionals and facilities for non-emergency services. Standard percentages are 110 percent, 150 percent, 200 percent, and 300 percent.	

	• Emergency services provided by health care professional will be reimbursed using the MRC1 80th percentile allowable amount. • Emergency services provided by an outpatient facility will be reimbursed using the PPACA allowable amount. • In the absence of a Medicare Fee Schedule rate, [redacted] may develop a reimbursement rate using methodologies similar to the ones used by Medicare. For out-of-network services: • Emergency services provided by health care professional will be reimbursed using the MRC1 80th percentile allowable amount. • Emergency services provided by an outpatient facility will be reimbursed using the PPACA allowable amount.	• Emergency services provided by health care professional will be reimbursed using the MRC1 80th percentile allowable amount. • Emergency services provided by an outpatient facility will be reimbursed using the PPACA allowable amount. • In the absence of a Medicare Fee Schedule rate, [redacted] may develop a reimbursement rate using methodologies similar to the ones used by Medicare. For out-of-network services: • Emergency services provided by health care professional will be reimbursed using the MRC1 80th percentile allowable amount. • Emergency services provided by an outpatient facility will be reimbursed using the PPACA allowable amount.	
Q. Restrictions on provider billing codes	[redacted] does not place restrictions on provider billing codes or place restrictions on medical/surgical providers that would limit the scope of their practice. Claims must be submitted with the correct/current procedure codes (CPT, HCPCS, and/or Revenue) and with the correct/current ICD-10-CM Diagnosis codes or applicable Centers for Medicare & Medicaid Services (CMS) medical	[redacted] does not place restrictions on provider billing codes or place restrictions on MH/SUD providers that would limit the scope of their practice. Claims must be submitted with the correct/current procedure codes (CPT, HCPCS, and/or Revenue) and with the correct/current ICD-10-CM Diagnosis codes or applicable Centers for Medicare & Medicaid Services (CMS) medical	[redacted] requires claims to be submitted with the correct/current procedure codes (CPT, HCPCS, and/or Revenue) and with the correct/current ICD-10-CM Diagnosis codes for both medical/surgical and MH/SUD providers. [redacted] does not place any additional restrictions on provider billing codes for medical/surgical or MH/SUD. Consistency in provider billing process evidences compliance with the NQTL requirement that the

	reporting code requirements. Appropriate billing instructions are set forth in the provider's contract.	reporting code requirements. Appropriate billing instructions are set forth in the provider's contract.	medical management process be applied comparably, and no more stringently, to MH/SUD services than to M/S services.