Connecticut Nonquantitative Treatment Limitation "NQTL" Report

To

Insurance and Real Estate Committee

The Attorney General

The Office of The Healthcare Advocate

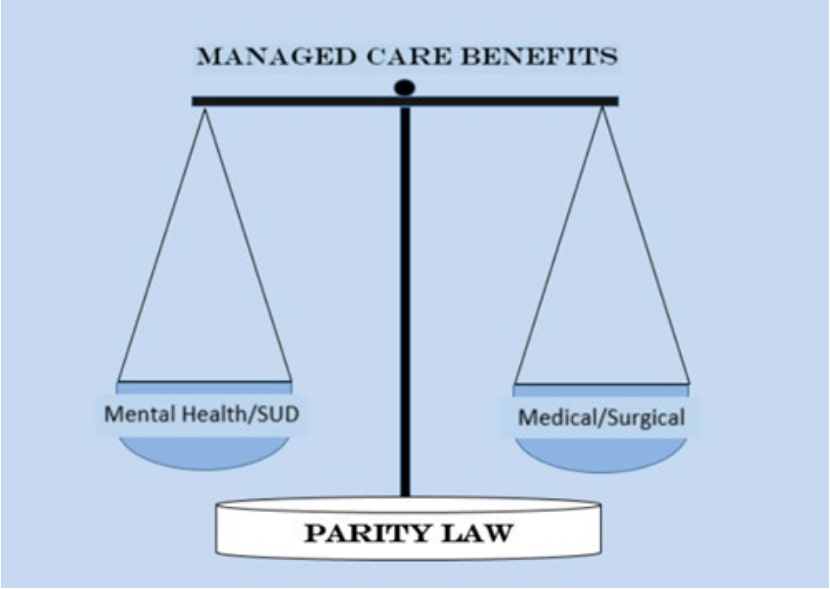
Office of Health Strategy

Presented by

Connecticut Insurance Department

Andrew N. Mais, Commissioner

April 14, 2023



Pursuant to CGS, Sec. 38a-477ee, the Connecticut Insurance Department is providing the 2023 report concerning nonquantitative treatment limitations submitted by pertinent insurers to the Commissioner ("Report").

The Report includes each NQTL report that the Insurance Commissioner received pursuant to Subsection (b) of 38a-477ee for calendar year 2022.

The data targets three (3) primary areas of disclosure:

(1) Processes used to develop and select medical necessity criteria for mental health and substance use disorder benefits and medical and surgical benefits.

(2) A description of all medically necessary and administrative nonquantitative treatment limitations (NQTL's) applied to mental health and substance use disorder benefits and medical and surgical benefits.

(3) Documentation of every evidentiary standard supporting each medical necessity criteria used within each NQTL, full disclosure of all factors used within each NQTL and comparative analysis of the NQTL "as-written" and the NQTL "in-operation", as designed and as applied to processes for mental health and substance use disorder, demonstrating that they are comparable and being no less stringently designed and applied to the similar medical and surgical benefits. This has been enhanced to include (3) critical areas for Mental Health Parity comparative review: (1) A prospective analysis on the as-written benefit limiting standards, (2) A concurrent or operational analysis on the in-practice benefit limiting processes, and (3) A retrospective analysis on the operational outcomes of the benefit limiting impacts.

This Report evaluates Benefit Limiting practices between mental health/substance use disorder benefits and medical/surgical benefits using Three (3) Parity Analysis Checkpoints, prospective analysis on the as-written benefit limiting outcomes, concurrent or operational analysis on the in-practice benefit limiting processes, and retrospective analysis on the operational outcomes of any benefit limiting impact whenever they produce substantially disparate outcome results.

We hope you find this report informative.

Respectfully,

Andrew N. Mais
Insurance Commissioner

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Connecticut Nonquantitative Treatment Limitation Annual Report-2023

I. Introduction

Pursuant to C.G.S. Section 38a-477ee, the Connecticut Insurance Department ("the Department") hereby submits its 2023 NQTL annual report to the General Assembly. Included are the various reports received by the Commissioner pursuant to Subsection (b) of CGS, Section 38a-477ee reflecting calendar year 2022 data.

II. Background

In 2019, the Connecticut legislature passed Public Act 19-159 (the "Act"), which, among other things, mandated that each health carrier was required to submit, not later than March 1, 2021 and annually thereafter, a report to the Commissioner, in a form and manner prescribed by the Commissioner, containing the following information for the calendar year immediately preceding:

(1) A description of the processes that such health carrier used to develop and select criteria to assess the medical necessity of (A) mental health and substance use disorder benefits, and (B) medical and surgical benefits;

(2) A description of all nonquantitative treatment limitations that such health carrier applied to (A) mental health and substance use disorder benefits, and (B) medical and surgical benefits; and

(3) The results of an analysis concerning the processes, strategies, evidentiary standards and other factors that such health carrier used in developing and applying the criteria and each nonquantitative treatment limitation, provided the commissioner is not permitted to disclose such results in a manner that is likely to compromise the financial, competitive or proprietary nature of such results.

In accordance with the Act, the results of such analysis shall, at a minimum:

(A) Disclose each factor that such health carrier considered, regardless of whether such health carrier rejected such factor, in designing each

nonquantitative treatment limitation and determining whether to apply such nonquantitative treatment limitation;

(B) Disclose any and all evidentiary standards, which standards may be qualitative or quantitative in nature, applied under a factor, and, if no evidentiary standard is applied under such a factor, a clear description of such factor;

(C) Provide comparative analyses, including the results of such analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the processes and strategies used to apply such nonquantitative treatment limitation, as written, to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, and the processes and strategies used to apply such nonquantitative treatment limitation, as written, to medical and surgical benefits;

(D) Provide comparative analyses, including the results of such analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, to medical and surgical benefits; and

(E) Disclose information that, in the opinion of the Insurance Commissioner, is sufficient to demonstrate that such health carrier, consistent with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, as amended from time to time, and regulations adopted thereunder, applied each nonquantitative treatment limitation comparably, and not more stringently, to mental health and substance use disorder benefits, and to medical and surgical benefits. Carriers are also required to demonstrate that they have complied with 38a-488c and 38a-514c, 38a-488a and 38a-514, 38a-510 and 38a-544, and (IV) the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Subsection (c) of CGS, Sec. 38a-477ee precludes the Commissioner from divulging the name or identity of any health carrier or entity that has contracted

with such health carrier, and mandates that such name or identity shall be given confidential treatment and not be made public by the Commissioner.

In addition to our statute applicable federal law, through the enactment of the Consolidation Appropriations Act imposed additional requirements. The Consolidated Appropriations Act of 2021 was enacted on December 27, 2020 (effective 2/2021). Section 203 of Title II of Division BB of the CAA amended Mental Health Parity and Addiction Equity Act, (MHPAEA), by expressly requiring group health plans and health insurance issuers imposing NQTLs on benefits to perform, demonstrate and document a comparative analysis of the design and application of any limitation on a benefits scope or duration.

This is an important update to MHPAEA because it significantly improved benefit comparability guidance for both the industry and the regulators. All stakeholders now have clear guidance on what is required and expected to demonstrate and perform a sufficient comparative analysis on benefit limiting practices and outcomes.

III. Description of Analysis

The federal MHPAEA defines nonquantitative treatment limitations as most commonly non-numeric standards that are designed and operationally applied in the management and delivery of healthcare. It is understood and recognized that these NQTL standards ultimately result in limiting the scope of Mental Health, Substance Use Disorder and Medical/Surgical benefits. The law establishes that NQTL's are an important tool in the management of healthcare, but it also specifically requires that these NQTL's be designed and applied comparably between Mental Health, Substance Use Disorder and Medical/Surgical benefits and that the health insurers document and demonstrate this comparative analysis. The expectation is that NQTL's components, such as prior-authorization or concurrent care review practices, would be applied to Mental Health and Substance Abuse Disorder benefits comparably and no more stringently than they would be applied to Medical/Surgical benefits. Finally, the federal law points out that these benefits can maintain comparable in-practice limiting standards that produce incongruent final operational outcomes because of justifiable clinical differences or experiences, but that these instances require an advanced comparative analysis demonstration.

The Department added Two (2) new targeted NQTL's for comparative analysis in this year's report; They are: (1) Network Adequacy and, (2) Provider Reimbursements.

This report requires health insurers to conduct (3) points in-time comparative benefit limiting reviews whenever they differ between similar benefit classifications within mental health/substance use disorder benefits and medical/surgical benefits : (1) A prospective analysis on all as-written benefit limiting standards, (2) A concurrent or operational analysis on all in-practice benefit limiting processes, and (3) A retrospective analysis on the operational outcomes of the benefit limiting impacts whenever actual outcome results are substantially disparate or non-comparative.

IV. Limitations of Analysis

The analysis is based on the 2022 health plan year and relies on information disclosed by the health carriers in their reports to the Department according to the Department revised Bulletin MC-24A.

V. Key Findings

While the data is limited to what was requested and what was disclosed, there are some observations to be made. Certain carriers provided sufficient information and supporting documentation regarding a reasoned discussion of findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as written, in operation and with the outcome results.

Overall, health carriers made significant improvements in their comparative analysis. However, in certain instances there was often a failure to provide to the Department's satisfaction, sufficient documentation demonstrating compliant parity analysis, in the following areas, in the overall pre-authorization and concurrent and retrospective claims denial rate between SUD, MH and Med/Surg benefits, in the rate of concurrent benefit claims between SUD benefits, MH benefits and Med/Surg benefits, and in the out-of-network and in-network claims rate between MH, SUD and Med/Surg benefits. In such situations, the Department undertook appropriate administrative action to

address insurers' shortcomings.Insurers have demonstrated a significant improvement to the depth and quality of their comparative review process analysis by having succinctly tied together all three (3) of the parity evaluation compliance checkpoints. Again, the full scope of a comparative benefit review involves three critical checkpoints for analysis: (1) A prospective analysis on all as-written benefit limiting standard differences, (2) A concurrent or operational analysis on all in-practice benefit limiting process differences, and (3) A retrospective analysis on the operational outcomes of the benefit limiting impacts whenever they produce substantially disparate outcome results.

VI. Detailed Findings

This discussion corresponds to the reports and charts attached as-Health Carrier Individual Reports-Exhibit A Submissions
The reader is encouraged to review those exhibits for full details.

Exhibit A (1)

Annual Mental Health and Substance Use Benefits Compliance Report

Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:

Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (13) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	***Medical/Surgical Benefits***
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.	As required by Conn. Gen. Stat. Sec. 38a-591c, the Company uses ASAM criteria for review of Mental Health/Substance Use Disorder (MH/SUD) services.	For Medical/Surgical services, the Company utilizes internally created medical polices and clinical guidelines and MCG.
In-Patient & In-Network NQTL Practices	Based on prior discussions with the DOI, Column A is reflective of the specific categories otherwise described within this as well as other NQTLs that may exist. The Company did not identify any inconsistencies or differences other than those set forth in this document.	Same as for MH/SUD.
In-Patient & Out-of-Network NQTL Practices	Based on prior discussions with the DOI, Column A is reflective of the specific categories otherwise described within this as well as other NQTLs that may exist. The Company did not identify any inconsistencies or differences other than those set forth in this document. It should be noted that HMO plans do not cover Out-of-Network benefits unless an out-of-network referral is approved.	Same as for MH/SUD.
Out-Patient & In-Network NQTL Practices	Based on prior discussions with the DOI, Column A is reflective of the specific categories otherwise described within this as well as other NQTLs that may exist. The Company did not identify any inconsistencies or differences other than those set forth in this document.	Same as for MH/SUD.
Out-Patient & Out-of-Network NQTL Practices	Based on prior discussions with the DOI, Column A is reflective of the specific categories otherwise described within this as well as other NQTLs that may exist. The Company did not identify any inconsistencies or differences other than those set forth in this document. It should be noted that HMO plans do not cover Out-of-Network benefits unless an out-of-network referral is approved.	Same as for MH/SUD.

Emergency Services/Benefits NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation. We do not do utilization review for any emergency service claims attributed to MH/SUD conditions. However, if a member is admitted, they or their provider is requested to notify us as soon as possible so we can review the number of days that are medically necessary.	Same as for MH/SUD.
Rx Formulary Design, Management and Pharmacy Services NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation. The Company maintains a single committee that reviews drugs for the formulary regardless of whether the drug is used to cover medical/surgical and MH/SUD conditions. The committee includes a psychiatrist. The same review process is used to determine whether to: 1) include a drug on the formulary; 2) identify a tier for the drug to be placed in; and 3) apply prior authorization, step therapy, and quantity limits.	Same as for MH/SUD.
Prior-Authorization NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation. All inpatient admissions are required to be prior authorized. For outpatient services, we apply the same factors, sources and processes for determining the services that appear on our prior authorization list. There is no prior authorization penalty applied to a MH/SUD service that is not prior authorized.	Same as for MH/SUD.
Concurrent Review Benefit NQTL Practices	There are no comparable inconsistencies or differences in the application, as written and in operation. The company does not initiate any concurrent reviews. Instead, the company conducts a continued stay/concurrent review when the treating provider/facility requests that the member's inpatient stay or outpatient treatment be approved for an ongoing stay in a facility or course of treatment due to the member's current medical condition. The same processes, strategies, evidentiary standards and other factors for continued stay/concurrent reviews for both MH/SUD and medical surgical benefits. Further, the company does not apply these processes, strategies, evidentiary standards and other factors more stringently to MH/SUD benefits.	Same as for MH/SUD.
Retrospective Review Benefit NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of retrospective review NQTL practices between medical/surgical and MH/SUD benefits. The company conducts a retrospective review when a claim is submitted and it is determined that the service is on our prior authorization list and a prior authorization was not requested. Additionally, the company will conduct a retrospective review for services for which it maintains a medical policy or clinical UM guideline and the service does not require a prior authorization. Because the company requires prior authorization of inpatient services, we expect to have very few retrospective reviews unless the provider fails to preauthorize care. In the case of outpatient services, we expect the numbers of retrospective reviews to be much higher for medical/surgical services. This is because the majority of the company's medical policies/clinical UM guidelines are for medical/surgical services. Also, a significant number of MH/SUD services are associated with outpatient office visits. Anthem does not maintain a medical policy/clinical UM guideline for those services so no utilization management review would be performed.	Same as for MH/SUD.

Clinical Procedure Coding, Billing Coding and Process NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation. The company relies on the same resources for coding our claims systems for the appropriate processing of claims, e.g. CMS, CPT Coding Manual, etc.	Same as for MH/SUD.
Case & Medical Management NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation. The company relies on the requirements of state and federal law and NCQA for its processes and procedures and routinely audits its staff to ensure those requirements are followed. As noted in previous discussions, the company's case management program for M/S and MH/SUD services should not be considered a non-quantitative treatment limitation. The voluntary case management program does not limit the scope and duration of benefits. Further, the voluntary case management program is separate and distinct from the UM process.	Same as for MH/SUD.
Network Adequacy & Provider Reimbursement Rates	Based on prior discussions with the DOI, Column A is reflective of the specific categories otherwise described within this as well as other NQTLs that may exist. The Company did not identify any inconsistencies or differences other than those set forth in this document.	Same as for MH/SUD.
(STEP-5): *A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.*	**The company did not identify any areas of concern with respect to its NQTL analysis. As noted above, we do have one area of disparity within the source of the medical policies used to review cases for medical necessity. The company is required by law to use ASAM for medical necessity reviews, so that disparity is compliant with MHPAEA. Therefore, the company is compliant with respect to the above NQTLs.**	

Exhibit A (2)

Annual Mental Health and Substance Use Benefits Compliance Report

Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:

Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (13) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	***Medical/Surgical Benefits***
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.	The only distinction in the Development, Modification or Addition of Medical Necessity Criteria as between M/S and MH/SUD services is the use of "The ASAM Criteria®" when conducting medical necessity reviews of SUD services. All MH/SUD services, whether in-network or out-of-network must be medically necessary. Services determined by the Company not to be medically necessary would excluded under the terms of the plan unless otherwise dictated by regulatory requirement or specific plan design. The Company performs utilization reviews for MH/SUD benefits. No separate entities review MH/SUD services for the Company. The Company employs the same definition of medical necessity to medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) benefits. The Company Medical Directors apply the definition of "medical necessity" set forth in the governing plan instrument or the definition required by state law. Notwithstanding the above, the Company'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;	The only distinction in the Development, Modification or Addition of Medical Necessity Criteria as between M/S and MH/SUD services is the use of "The ASAM Criteria®" when conducting medical necessity reviews of SUD services. All M/S services, whether in-network or out-of-network must be medically necessary. Services determined by the Company not to be medically necessary would excluded under the terms of the plan unless otherwise dictated by regulatory requirement or specific plan design. The Company performs utilization reviews for most medical/surgical (M/S) benefits. A separate Company reviews certain M/S services for the Company, another seperate Company reviews physical therapy and occupational therapy on behalf of the Company and both national and regional vendors to perform UM. All entities adhere to the Company's policies and procedures when performing utilization reviews, and all of the data provided is inclusive of utilization reviews of certain M/S services. The Company employs the same definition of medical necessity to (M/S) and mental health/substance use disorder (MH/SUD) benefits. The Company Medical Directors apply the definition of "medical necessity" set forth in the governing plan instrument or the definition required by state law. Notwithstanding the above, the Company's standard definition of "medical necessity" is as follows:

	• 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 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. • 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. 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, the Company Medical Director or Review Organization may rely on the clinical coverage policies maintained by the Company 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." Development of Clinical Criteria The Company utilizes its own internally developed Coverage Policies (medical necessity criteria) and the MCGTM Guidelines when conducting medical necessity reviews of MH services, procedures, devices, equipment, imaging, diagnostic interventions and the ASAM criteria for conducting medical necessity reviews of SUD services. The Company's Medical Technology Assessment Committee (MTAC) establishes and maintains clinical guidelines and medical necessity criteria in the form of published	"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 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. 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, the Company Medical Director or Review Organization may rely on the clinical coverage policies maintained by the Company 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." Development of Clinical Criteria The Company utilizes its own internally developed Coverage Policies (medical necessity criteria) and the MCGTM Guidelines when conducting medical necessity reviews of M/S services, procedures, devices, equipment, imaging, diagnostic interventions and its own internally developed Coverage Policies and the MCGTM Care Guidelines.

	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 MH/SUD services determined to be experimental and investigational. 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. While the Company'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. Also, the Company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Of note, the Company's most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits. Factors The Company maintains medical necessity criteria (also referred to as clinical criteria) for all behavioral health services. These criteria are either nationally recognized criteria sets, such as those developed by MCG, the American Society of Addiction Medicine ("ASAM") or are developed by the Company from the comparison of national, scientific and evidenced based criteria sets. The Company's Medical Technology Assessment Committee ("MTAC") reviews clinical research and guidelines for new clinical procedures and technologies to determine whether these services have demonstrated clinical efficacy or are still deemed experimental/investigational. The Company reviews medical and behavioral health national clinical practice guidelines on an annual and bi-annual basis to inform medical necessity criteria and the clinical decision process. The Company requires all services theoretically be medically necessary as a condition of coverage; therefore, Medical Necessity applies to all MH/SUD benefits in each benefit classification based on objective clinical criteria unless otherwise dictated by regulatory requirement or specific plan design. This is an industry standard for health insurance coverage. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved	The Company's 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 M/S services determined to be experimental and investigational. 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. While the Company'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. Also, the Company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Of note, the company's most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits. Factors The Company maintains medical necessity criteria (also referred to as clinical criteria) for all medical health services. 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	labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines. Sources and Evidentiary Standards The use of the various guidelines for clinical criteria/medical necessity (both external and internal) do not overlap and there is no hierarchical weight assigned to the standard, source, or guideline in any given review for clinical criteria. In other words, where a specific Company medical policy applies, that medical policy applies in whole without regard to other more general guidelines, like the ASAM Criteria or MCG Company's Coverage Policy Unit (CPU), in partnership with the Company's Medical Technology Assessment Committee (“MTAC”), 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 Company's MTAC is composed of physicians and nurses and includes specialists from both medical and behavioral health disciplines. Internal subject matter experts include, but are not limited to orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internist, surgeons, urologists, pulmonologists cardiologists, psychologists and psychiatrists. The Company-employed Medical Directors responsible for the development and/or review of medical necessity criteria of M/S and MH/SUD services include: Coverage Policy Author: The medical professionals who review and draft medical necessity coverage policies, in consultation with Coverage Policy SMEs, as part of the annual clinical review. These recommendations are offered to MTAC for discussion and ultimately require a vote of the majority to be accepted to go in to effect. The Committee may send it back for further review, reject recommendations, or propose an alternative, or any combination of those outcomes. The committee also discusses relevant health equity concerns. Coverage Policy SME: These are clinical subject matter experts – representing a range of clinical specialties, including, as relevant, MH/SUD experts (see the “Behavioral Health” clinicians listed in the “Coverage Policy SME” tab – consulted when drafting or reviewing coverage policies). The Company's MTAC’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 the Company’s “Levels of Scientific Evidence Table” adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 and evidenced in the Company’s Medical Technology Assessment and Coverage	each benefit classification based on objective clinical criteria unless otherwise dictated by regulatory requirement or specific plan design. This is an industry standard for health insurance coverage. 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. Sources and Evidentiary Standards The use of the various guidelines for clinical criteria/medical necessity (both external and internal) do not overlap and there is no hierarchical weight assigned to the standard, source, or guideline in any given review for clinical criteria. In other words, where a specific Company medical policy applies, that medical policy applies in whole without regard to other more general guidelines, like the ASAM Criteria or MCG Company's Coverage Policy Unit (CPU), in partnership with the Company's Medical Technology Assessment Committee (“MTAC”), 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 Company's MTAC is composed of physicians and nurses and includes specialists from both medical and behavioral health disciplines. Internal subject matter experts include, but are not limited to orthopedists, neurologists, neurosurgeons, OBGYNs, oncologists, primary care physicians, internist, surgeons, urologists, pulmonologists, cardiologists, psychologists and psychiatrists. The Company employed Medical Directors responsible for the development and/or review of medical necessity criteria of M/S and MH/SUD services include: Coverage Policy Author: The medical professionals who review and draft medical necessity coverage policies, in consultation with Coverage Policy SMEs, as part of the annual clinical review. These recommendations are offered to the Company's MTAC for discussion and ultimately require a vote of the majority to be accepted to go in to effect. The Committee may send it back for further review, reject recommendations, or propose an alternative, or any combination of those outcomes. The committee also discusses relevant health equity concerns. Coverage Policy SME: These are clinical subject matter experts – representing a range of clinical specialties, including, as relevant, MH/SUD experts (see the “Behavioral Health” clinicians listed in the “Coverage Policy SME” tab – consulted when drafting or reviewing coverage policies).

	Process for Determination of Medical Necessity Coverage Criteria Recommendations Policy (OPS-48): Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs. Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials. Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational studies. Level 4: Descriptive studies, case reports, case series, panel studies (non-experimental studies), and retrospective analyses of any kind. Also systematic reviews and meta-analyses of retrospective studies. Level 5: Professional/organizational recommendations when based upon a valid evidence-based assessment of the available literature. The Company's MTAC establishes and maintains medical necessity criteria in the form of published Coverage Policies pertaining to the various M/S and MH/SUD health services, therapies, procedures, devices, technologies and pharmaceuticals to be used for utilization management purposes.	The Company's MTAC'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 the Company's "Levels of Scientific Evidence Table" adapted from the Centre for Evidence Based Medicine, University of Oxford, March 2009 and evidenced in the Company's Medical Technology Assessment and Coverage Process for Determination of Medical Necessity Coverage Criteria Recommendations Policy (OPS-48): Level 1: Randomized Controlled Trials (RCT). Randomized, blinded, placebo-controlled, clinical trials and systematic reviews of RCTs and meta-analysis of RCTs. Level 2: Non-randomized controlled trials (an experimental study, but not an ideal design). Also systematic reviews and meta-analyses of non-randomized controlled trials. Level 3: Observational studies – e.g. cohort, case-control studies (non-experimental studies). Also systematic reviews and meta-analyses of observational
In-Patient & In-Network NQTL Practices	The Company applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.	The Company applies In-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.
In-Patient & Out-of-Network NQTL Practices	The Company applies In-Patient & Out-of-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.	The Company applies In-Patient & Out-of-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.
Out-Patient & In-Network NQTL Practices	The Company applies Out-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.	The Company applies Out-Patient & In-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.
Out-Patient & Out-of-Network NQTL Practices	The Company applies Out-Patient & Out-of-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.	The Company applies Out-Patient & Out-of-Network NQTL practices consistently to M/S benefits and MH/SUD benefits.
Emergency Services/Benefits NQTL Practices	The Company's integrated medical and behavioral health plans have only one, single benefit for emergency room and urgent care. Accordingly, there are no differences	The Company's integrated medical and behavioral health plans have only one, single benefit for emergency room and urgent care. Accordingly, there are no

	between how coverage for M/S and MH/SUD emergency room and urgent care services.	differences between how coverage for M/S and MH/SUD emergency room and urgent care services.
Rx Formulary Design, Management and Pharmacy Services NQTL Practices	The Company does not distinguish, in writing or in operation, between M/S and MH/SUD benefits in its prescription drug formulary design for its Standard, Value, Advantage, Performance, and Legacy formularies.	The Company does not distinguish, in writing or in operation, between M/S and MH/SUD benefits in its prescription drug formulary design for its Standard, Value, Advantage, Performance, and Legacy formularies.
Prior-Authorization NQTL Practices	**The only distinction in utilization management practices as between M/S and MH/SUD services is the Company's use of Peer-To-Peer reviewers for MH/SUD services.** **Peer to Peer Review Variation** With respect to MH/SUD benefits, and in contrast to the process for performing M/S benefit reviews, The Company ensures that any potential denial of MH/SUD benefits is preceded by a proactive offer to the provider of a peer-to-peer review for certain services including Inpatient and Outpatient All Other benefit classifications. The objectives of proactively seeking a peer-to-peer review is to minimize the risk of issuing a denial where, in fact, the enrollee's clinical situation warrants an approval for medically necessary care yet the provider's request may have incompletely or imprecisely stated the case for medical necessity, or, if a denial is nonetheless issued, mitigating disruption if the loss of coverage results in the enrollee moving to a different treatment type or level of care. This process is beneficial for the enrollee and results in greater approvals and fewer appeals of medical necessity denials. The Company's medical necessity review of MH/SUD services is guided by the ASAM Criteria, MCG and the Company's Clinical Coverage policies and plan documents approved for use in care management determinations. The Company's Peer-to-Peer review program is triggered when a care manager receives clinical information that does not appear to meet the ASAM Criteria, MCG and the Company's Clinical Coverage policies and plan documents for initial or prior authorization for level of care requested. In this instance, care managers may offer a lower level of care to ensure there is no delay or impediment to care where the medical necessity criteria is met. If that level of care is not accepted by the requesting provider (treating practitioner), the case is referred to Peer-to-peer review with a behavioral health physician reviewer. The Peer-to-Peer review is available for any coverage request for which the Company anticipates issuing a denial the Company incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a Company clinician proactively solicit a peer-to-peer review with the rendering provider. After	**The only distinction in utilization management practices as between M/S and MH/SUD services is the Company's use of Peer-To-Peer reviewers for MH/SUD services.** **Peer to Peer Review Variation** With respect to MH/SUD benefits, and in contrast to the process for performing M/S benefit reviews, the Company ensures that any potential denial of MH/SUD benefits is preceded by a proactive offer to the provider of a peer-to-peer review for certain services including Inpatient and Outpatient All Other benefit classifications. The objectives of proactively seeking a peer-to-peer review is to minimize the risk of issuing a denial where, in fact, the enrollee's clinical situation warrants an approval for medically necessary care yet the provider's request may have incompletely or imprecisely stated the case for medical necessity, or, if a denial is nonetheless issued, mitigating disruption if the loss of coverage results in the enrollee moving to a different treatment type or level of care. This process is beneficial for the enrollee and results in greater approvals and fewer appeals of medical necessity denials. The Company's medical necessity review of MH/SUD services is guided by the ASAM Criteria, MCG and the Company's Clinical Coverage policies and plan documents approved for use in care management determinations. The Company's Peer-to-Peer review program is triggered when a care manager receives clinical information that does not appear to meet the ASAM Criteria, MCG and the Company's Clinical Coverage policies and plan documents for initial or prior authorization for level of care requested. In this instance, care managers may offer a lower level of care to ensure there is no delay or impediment to care where the medical necessity criteria is met. If that level of care is not accepted by the requesting provider (treating practitioner), the case is referred to Peer-to-peer review with a behavioral health physician reviewer. The Peer-to-Peer review is available for any coverage request for which the Company anticipates issuing a denial the Company incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a

	completing the peer-to-peer review with the rendering provider, the Company Medical Director makes a decision to approve or deny the requested service, based on all of the clinical information provided. Peer-to-peer reviews that are declined by the requesting provider result in the Company Medical Director making a decision to approve or deny the requested service based on the clinical information that was submitted and obtained by the Company clinician. All reconsideration and appeal options are available if a case results in a denial, just as they are available for denials issues for an M/S request. If the Company's pro-active, volunteer Peer-to-Peer review were not applicable to MH/SUD services, and such services followed a similar process to the M/S benefit, services that were approved due to such Peer-to-Peer review, would have been much more likely to have resulted in a denial without additional information or discussion to meet clinical criteria. The provider has the right to decline the peer review and move forward retaining the same rights post-decision/denial. The Company's pro-active Peer-to-Peer review is more favorable to the enrollee and the rendering/requesting provide resulting in a less stringent, more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is, unless otherwise required by state law, conducted reactively, i.e., if the rendering provider outreaches to the Company.	Company clinician proactively solicit a peer-to-peer review with the rendering provider. After completing the peer-to-peer review with the rendering provider, the Company's Medical Director makes a decision to approve or deny the requested service, based on all of the clinical information provided. Peer-to-peer reviews that are declined by the requesting provider result in the Company Medical Director making a decision to approve or deny the requested service based on the clinical information that was submitted and obtained by the Company clinician. All reconsideration and appeal options are available if a case results in a denial, just as they are available for denials issues for an M/S request. If the Company's pro-active, volunteer Peer-to-Peer review were not applicable to MH/SUD services, and such services followed a similar process to the M/S benefit, services that were approved due to such Peer-to-Peer review, would have been much more likely to have resulted in a denial without additional information or discussion to meet clinical criteria. The provider has the right to decline the peer review and move forward retaining the same rights post-decision/denial. The Company’s pro-active Peer-to-Peer review is more favorable to the enrollee and the rendering/requesting provide resulting in a less stringent, more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is, unless otherwise required by state law, conducted reactively, i.e., if the rendering provider outreaches to the Company.
Concurrent Review Benefit NQTL Practices	**The only distinction in utilization management practices as between M/S and MH/SUD services is the Company's use of Peer-To-Peer reviewers for MH/SUD services.** **Peer to Peer Review Variation** With respect to MH/SUD benefits, and in contrast to the process for performing M/S benefit reviews, the Company ensures that any potential denial of MH/SUD benefits is preceded by a proactive offer to the provider of a peer-to-peer review for certain services including Inpatient and Outpatient All Other benefit classifications. The objectives of proactively seeking a peer-to-peer review is to minimize the risk of issuing a denial where, in fact, the enrollee’s clinical situation warrants an approval for medically necessary care yet the provider’s request may have incompletely or imprecisely stated the case for medical necessity, or, if a denial is nonetheless issued, mitigating disruption if the loss of coverage results in the enrollee moving to a different treatment type or level of care. This process is beneficial for the enrollee and results in greater approvals and fewer appeals of medical necessity denials.	**The only distinction in utilization management practices as between M/S and MH/SUD services is the Company's use of Peer-To-Peer reviewers for MH/SUD services.** **Peer to Peer Review Variation** With respect to MH/SUD benefits, and in contrast to the process for performing M/S benefit reviews, the Company ensures that any potential denial of MH/SUD benefits is preceded by a proactive offer to the provider of a peer-to-peer review for certain services including Inpatient and Outpatient All Other benefit classifications. The objectives of proactively seeking a peer-to-peer review is to minimize the risk of issuing a denial where, in fact, the enrollee’s clinical situation warrants an approval for medically necessary care yet the provider’s request may have incompletely or imprecisely stated the case for medical necessity, or, if a denial is nonetheless issued, mitigating disruption if the loss of coverage results in the enrollee moving to a different treatment type or level of care. This process is beneficial for the enrollee and results in greater approvals and fewer appeals of medical necessity denials.

	The Company's medical necessity review of MH/SUD services is guided by the ASAM Criteria, MCG and the Company's Clinical Coverage policies and plan documents approved for use in care management determinations. The Company's Peer-to-Peer review program is triggered when a care manager receives clinical information that does not appear to meet the ASAM Criteria, MCG and the Company's Clinical Coverage policies and plan documents for initial or prior authorization for level of care requested. In this instance, care managers may offer a lower level of care to ensure there is no delay or impediment to care where the medical necessity criteria is met. If that level of care is not accepted by the requesting provider (treating practitioner), the case is referred to Peer-to-peer review with a behavioral health physician reviewer. The Peer-to-Peer review is available for any coverage request for which the Company anticipates issuing a denial the Company incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a Company clinician proactively solicit a peer-to-peer review with the rendering provider. After completing the peer-to-peer review with the rendering provider, the Company Medical Director makes a decision to approve or deny the requested service, based on all of the clinical information provided. Peer-to-peer reviews that are declined by the requesting provider result in the Company Medical Director making a decision to approve or deny the requested service based on the clinical information that was submitted and obtained by the Company clinician. All reconsideration and appeal options are available if a case results in a denial, just as they are available for denials issues for an M/S request. If the Company's pro-active, volunteer Peer-to-Peer review were not applicable to MH/SUD services, and such services followed a similar process to the M/S benefit, services that were approved due to such Peer-to-Peer review, would have been much more likely to have resulted in a denial without additional information or discussion to meet clinical criteria. The provider has the right to decline the peer review and move forward retaining the same rights post-decision/denial. The Company's pro-active Peer-to-Peer review is more favorable to the enrollee and the rendering/requesting provide resulting in a less stringent, more advantageous process for MH/SUD claims because it is proactive, as compared to the process for M/S claims whereby any peer-to-peer review is, unless otherwise required by state law, conducted reactively, i.e., if the rendering provider outreaches to the Company.	The Company's medical necessity review of MH/SUD services is guided by the ASAM Criteria, MCG and the Company's Clinical Coverage policies and plan documents approved for use in care management determinations. The Company's Peer-to-Peer review program is triggered when a care manager receives clinical information that does not appear to meet the ASAM Criteria, MCG and the Company's Clinical Coverage policies and plan documents for initial or prior authorization for level of care requested. In this instance, care managers may offer a lower level of care to ensure there is no delay or impediment to care where the medical necessity criteria is met. If that level of care is not accepted by the requesting provider (treating practitioner), the case is referred to Peer-to-peer review with a behavioral health physician reviewer. The Peer-to-Peer review is available for any coverage request for which the Company anticipates issuing a denial the Company incorporates into its MH/SUD utilization review process a requirement that – prior to issuing a denial – a Company clinician proactively solicit a peer-to-peer review with the rendering provider. After completing the peer-to-peer review with the rendering provider, the Company Medical Director makes a decision to approve or deny the requested service, based on all of the clinical information provided. Peer-to-peer reviews that are declined by the requesting provider result in the Company Medical Director making a decision to approve or deny the requested service based on the clinical information that was submitted and obtained by the Company clinician. All reconsideration and appeal options are available if a case results in a denial, just as they are available for denials issues for an M/S request. 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Retrospective Review Benefit NQTL Practices	The Company applies the Retrospective Review NQTL comparably and no more stringently to MH/SUD benefits than to M/S benefits.	The Company applies the Retrospective Review NQTL comparably and no more stringently to MH/SUD benefits than to M/S benefits.
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	The Company applies Clinical Procedure Coding, Billing Coding and Process NQTL practices comparably and no more stringently to MH/SUD benefits than to M/S benefits.	The Company applies Clinical Procedure Coding, Billing Coding and Process NQTL practices comparably and no more stringently to MH/SUD benefits than to M/S benefits.
Case & Medical Management NQTL Practices	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. For Medical management see peer to peer review information in Prior auth and Concurrent.	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. For Medical management see peer to peer review information in Prior auth and Concurrent.
Network Adequacy & Provider Reimbursement Rates	The Company maintains an open network and will contract with any MH/SUD or M/S provider or facility requesting admission to the network. The Company does not limit parties with whom it will contract and negotiate rates. Provider admissions standards for entrance to the network is triggered by either a provider request or the Company's recruitment of the provider to join the network. The factors for the application of the NQTL are 1) the successful credentialing of the provider and 2) the execution of a provider contract, including reimbursement terms. A provider applicant must meet, at a minimum, the established discipline specific Credentialing Criteria for network participation. For example, depending on licensure level: the appropriate degree, state licensure, DEA (if applicable), State Controlled Substance Registration Certificate (where applicable), professional liability insurance, and other criteria related to professional training and work history. Additionally, providers are required to enter into a contract with the Company that includes negotiated reimbursement rates. Both the M/S and MH/SUD Provider Networks follow the same contracting process. The Company will respond within 20 days of provider inquiry to join the Company Provider Network. When a medical or behavioral provider requests participation in the Company network(s) or when Company identifies a provider to recruit into its network(s), the provider is presented with a standardized contract proposal which describes the details of the entire agreement such as including obligations of the physician, obligations of the Company, term of the contract, reimbursement, and applicable state supplemental requirements. Reimbursement Whether for initial negotiation or renegotiation, the Company uses its standard in-network provider reimbursement methodology for MH/SUD and M/S providers. Network adequacy deficiencies (Network Need) is always considered when	The Company maintains an open network and will contract with any MH/SUD or M/S provider or facility requesting admission to the network. The Company does not limit parties with whom it will contract and negotiate rates. Provider admissions standards for entrance to the network is triggered by either a provider request or the Company's recruitment of the provider to join the network. The factors for the application of the NQTL are 1) the successful credentialing of the provider and 2) the execution of a provider contract, including reimbursement terms. A provider applicant must meet, at a minimum, the established discipline specific Credentialing Criteria for network participation. For example, depending on licensure level: the appropriate degree, state licensure, DEA (if applicable), State Controlled Substance Registration Certificate (where applicable), professional liability insurance, and other criteria related to professional training and work history. Additionally, providers are required to enter into a contract with the Company that includes negotiated reimbursement rates. Both the M/S and MH/SUD Provider Networks follow the same contracting process. The Company will respond within 20 days of provider inquiry to join the Company Provider network. When a medical or behavioral provider requests participation in the Company network(s) or when the Company identifies a provider to recruit into its network(s), the provider is presented with a standardized contract proposal which describes the details of the entire agreement such as including obligations of the physician, obligations of the Company, term of the contract, reimbursement, and applicable state supplemental requirements. Reimbursement Whether for initial negotiation or renegotiation, the Company uses its standard in-network provider reimbursement methodology for MH/SUD and M/S providers. Network adequacy deficiencies (Network Need) is always considered when

	negotiating reimbursement rates. Standard reimbursement rates for inpatient and outpatient services for both M/S and MH/SUD providers are set based upon standard fee schedules, which are developed for facilities, physicians and non-physicians by state or region and reflect geographic variations within that state or region. Provider-specific fee schedules are developed based upon the professional or facility's negotiation request or business need, including the satisfaction of network adequacy requirements. Company's preferred standard is to reimburse the same rates across all plans/products. M/S contracts have the option to pay plans differently, while BH pays the same for all plans. This approach provides more favorable rates for MH/SUD providers. For example, BH pays the same rate for a Medicare provider as it does for a commercial provider. Rates may be negotiated differently depending upon plan if requested. In determining any rate in both the M/S and MH/SUD facility agreements, the Company supply and demand of provider types and/or specialties based upon the same indicators including, but not limited to NCQA 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; customer satisfaction surveys; and customer complaint data. That is, the Company's reimbursement rate development and negotiation processes are ultimately designed to ensure achievement of its adequacy standards for MH/SUD and M/S providers, and any departure from the standard fee schedules is informed by market demand, which may include, for example, the need to maintain, or achieve, network adequacy for a provider type in a particular geographic area. Provider Reimbursement – Outpatient Reimbursement rates for in-network M/S and MH/SUD outpatient services are determined as follows: (1) CMS (Medicare) RVU (relative value units); (2) Ingenix data derived from practitioner charges, where available is used to fill gaps on procedure codes that do not have a Medicare rate; (3) Clinical Lab and Pathology codes, where applicable; (4) Site of Service (SOS) (e.g. office, facility); (5) Geographical Practice Cost Index (GPCI). For both M/S and MH/SUD services where there is no CMS rate or RVU nor vendor benchmark available, the final rate for a service covered by the contract is determined to be (1) billed charges for the service; (2) negotiated discount off of billed charges for the service during the contracting process.	negotiating reimbursement rates. Standard reimbursement rates for inpatient and outpatient services for both M/S and MH/SUD providers are set based upon standard fee schedules, which are developed for facilities, physicians and non-physicians by state or region and reflect geographic variations within that state or region. Provider-specific fee schedules are developed based upon the professional or facility's negotiation request or business need, including the satisfaction of network adequacy requirements. The Company's preferred standard is to reimburse the same rates across all plans/products. M/S contracts have the option to pay plans differently, while MH/SUD pays the same for all plans. This approach provides more favorable rates for MH/SUD providers. For example, MH/SUD pays the same rate for a Medicare provider as it does for a commercial provider. Rates may be negotiated differently depending upon plan if requested. In determining any rate in both the M/S and MH/SUD facility agreements, the Company assesses supply and demand of provider types and/or specialties based upon the same indicators including, but not limited to NCQA 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; customer satisfaction surveys; and customer complaint data. 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For both M/S and MH/SUD services where there is no CMS rate or RVU nor vendor benchmark available, the final rate for a service covered by the contract is determined to be (1) billed charges for the service; (2) negotiated discount off of billed charges for the service during the contracting process.

	In terms of the process by which provider rates are negotiated, for both MH/SUD and M/S providers any revisions to the standard provider contract terms and reimbursement rates for both in network facility-based services and in-network outpatient services 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 M/S and MH/SUD rate negotiation and any substantial deviations from standard reimbursement rates must be justified and approved by more senior representatives in the respective contracting areas. All staff participating in contract negotiation are trained on internal Company 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 any deviations. Factors assessed to determine whether to vary from the standard fee schedule are derived from, where available, Medicare rates including whether the provider experiences a high volume of utilization, the populations served, and the dynamics of the geographic market in which the provider is located (e.g. whether the provider is needed to fill or prevent an adequacy deficiency, and the competitiveness and acceptability of the requested rate). Indeed, the MH/SUD provider contracting process ensures by policy the consideration of such factors in connection with rate negotiations so as to avoid inappropriately discrepant negotiation outcomes and/or avoidable adequacy deficiencies. Facility Reimbursement – Inpatient In-network facility-based services which are not reimbursed on an assigned diagnosis-related group (DRG) or case rate basis may generally be reimbursed on a per diem or discount basis. Currently, M/S has many more DRG contracts while a small minority of MH/SUD contracts are paid as DRG or case rate. Specifically, M/S paid just under 60% of admissions last year under DRGs and 20% as per-diem, and 20% as a percent of charges. MH/SUD are essentially 100% per-diem, as MH/SUD contracts do not have any significant case rates or percent of charges contracts. DRG (i.e. case rate) reimbursement rates generally do not exist for MH/SUD in-network inpatient services because unlike certain routine medical inpatient procedures (i.e. vaginal deliveries; cesarean deliveries; appendectomies, etc.), MH/SUD inpatient stays vary depending upon the unique clinical needs, circumstances and complexities of the individual patient (i.e. patient's insight or lack of insight into their illness; patient motivation to receive treatment; comorbidity, etc.) Per diem reimbursement for both M/S and MH/SUD facility-based services are based upon the following factors and accompanying evidentiary standards: (1) geographic	In terms of the process by which provider rates are negotiated, for both MH/SUD and M/S providers any revisions to the standard provider contract terms and reimbursement rates for both in network facility based services and in-network outpatient services 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 M/S and MH/SUD rate negotiation and any substantial deviations from standard reimbursement rates must be justified and approved by more senior representatives in the respective contracting areas. All staff participating in contract negotiation are trained on internal Company 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 any deviations. Factors assessed to determine whether to vary from the standard fee schedule are derived from, where available, Medicare rates including whether the provider experiences a high volume of utilization, the populations served, and the dynamics of the geographic market in which the provider is located (e.g. whether the provider is needed to fill or prevent an adequacy deficiency, and the competitiveness and acceptability of the requested rate). Indeed, the MH/SUD provider contracting process ensures by policy the consideration of such factors in connection with rate negotiations so as to avoid inappropriately discrepant negotiation outcomes and/or avoidable adequacy deficiencies. Facility Reimbursement – Inpatient In-network facility-based services which are not reimbursed on an assigned diagnosis-related group (DRG) or case rate basis may generally be reimbursed on a per diem or discount basis. Currently, M/S has many more DRG contracts while a small minority of MH/SUD contracts are paid as DRG or case rate. Specifically, M/S paid just under 60% of admissions last year under DRGs and 20% as per-diem, and 20% as a percent of charges. MH/SUD are essentially 100% per-diem, as MH/SUD contracts do not have any significant case rates or percent of charges contracts. DRG (i.e. case rate) reimbursement rates generally do not exist for MH/SUD in-network inpatient services because unlike certain routine medical inpatient procedures (i.e. vaginal deliveries; cesarean deliveries; appendectomies, etc.), MH/SUD inpatient stays vary depending upon the unique clinical needs, circumstances and complexities of the individual patient (i.e. patient's insight or lack of insight into their illness; patient motivation to receive treatment; comorbidity, etc.)

	market, which may be adjusted based upon Medicare Geographical Practice Cost Index ("GPCI"); (2) type of provider and/or specialty (e.g. physician practitioner v. non-physician practitioner v. facility); (3) supply of provider type and/or specialty; (4) network need and/or demand for provider type and/or specialty; (5) Medicare reimbursement rates for codes with assigned Medicare Relative Value Unit ("RVU"); and (6) Training, experience and licensure of providers billing for professional services under the facility agreement. The Company's methodology and process for negotiating in-network provider reimbursements for M/S and MH/SUD services within a classification of benefits are comparable and no more stringent for MH/SUD services than for M/S services within the same classification of benefits as written. The Company also follows a comparable process in determining payment rates for non-physician providers for both M/S and MH/SUD benefits. While there is variation in type of reimbursement methodology for facility reimbursement, the Company's Network Providers choose which methodology (DRG, Per Diem or Case Rate) will apply and the processes, factors and evidentiary standards applicable to each methodology is applied to M/S and MH/SUD providers consistently. In this process, variables including market demand, provider specialty and availability and frequency of requests for provider fee increases may result in differentials in reimbursement rates across medical/surgical and MH/SUD provider types.	Per diem reimbursement for both M/S and MH/SUD facility-based services are based upon the following factors and accompanying evidentiary standards: (1) geographic market, which may be adjusted based upon Medicare Geographical Practice Cost Index ("GPCI"); (2) type of provider and/or specialty (e.g. physician practitioner v. non-physician practitioner v. facility); (3) supply of provider type and/or specialty; (4) network need and/or demand for provider type and/or specialty; (5) Medicare reimbursement rates for codes with assigned Medicare Relative Value Unit ("RVU"); and (6) Training, experience and licensure of providers billing for professional services under the facility agreement. The Company's methodology and process for negotiating in-network provider reimbursements for M/S and MH/SUD services within a classification of benefits are comparable and no more stringent for MH/SUD services than for M/S services within the same classification of benefits as written. The Company also follows a comparable process in determining payment rates for non-physician providers for both M/S and MH/SUD benefits. While there is variation in type of reimbursement methodology for facility reimbursement, The Company's Network Providers choose which methodology (DRG, Per Diem or Case Rate) will apply and the processes, factors and evidentiary standards applicable to each methodology is applied to M/S and MH/SUD providers consistently. In this process, variables including market demand, provider specialty and availability and frequency of requests for provider fee increases may result in differentials in reimbursement rates across medical/surgical and MH/SUD provider types.
(STEP-5): *A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.*	**1. Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.** The Company has analyzed process, strategies, evidentiary standards and other factors used to apply Medical Necessity MH/SUD and M/S benefits and has determined compliance with parity requirements. The Company's medical necessity coverage policy development and application process is consistent between M/S and MH/SUD. The Company's Coverage Policy development and application is consistent. Coverage Policies 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, Coverage Policy Unit and the impetus of new, emerging and evolving technologies. Also, the company's routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) process is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. The application of the IRR process across MH/SUD and M/S benefits is itself evidence of the comparability of the Company's diligence in monitoring the utilization management process. Further, the aforementioned IRR results for MH/SUD and M/S benefits evidence comparability and equivalent stringency in the process of performing coverage reviews; specifically, the Company's most recent MH/SUD IRR exercise did not reveal a need to revise its coverage policies governing reviews of MH/SUD benefits as well as substantial agreement across reviewers who participated in the assessment.	

	The Company concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. The Company applies comparable evidence-based guidelines 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 the Company's uniform definition of Medical Necessity for M/S and MH/SUD benefits. In performing the operational analysis of the application of UM, the Company reviewed denial rates for both M/S and MH/SUD within each classification of benefits and for benefits subject to prior authorization, concurrent review, and retrospective review. **2. Prior-Authorization NQTL Practices** The Company 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, the Company requires prior authorization of non-emergent inpatient services and certain Outpatient services. In reaching this conclusion, the Company 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. The process by which prior authorization is applied to M/S and MH/SUD inpatient, in-network benefits is comparable and applied no more stringently to MH/SUD inpatient benefits. Coverage determinations of both M/S 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, the Company'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. The Company'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 in policy/procedure 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 the Company's application of the Prior Authorization NQTL, specifically approvals and denial information, in the In-Patient, In-Network and Out-of-Network classification, Outpatient, In-Network and Out-of-Network, All Other classification for a sampling of plans 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, the Company concludes that the NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.

Exhibit A (3)

Annual Mental Health and Substance Use Benefits Compliance Report

Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:

Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (13) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	***Medical/Surgical Benefits***
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of medical necessity criteria between medical/surgical and MH/SUD (while different medical necessity tools may be used; for example, LOCUS and Milliman, they're both nationally recognized tools for developing medical necessity criteria for the treatment of MH/SUD and Medical/Surgical benefits). Medically necessary means healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental Illness, substance use disorder, condition, disease or its symptoms that are all of the following as determined by the Plan or its designee, within the Plan's sole discretion. The services must be: • in accordance with Generally Accepted Standards of Medical Practice; • clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, mental illness, substance use disorder disease or its symptoms; • not mainly for your convenience or that of your doctor or other health care provider; and • not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms. Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes. If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Plan reserves the right to consult	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences in the application, as written and in operation, of medical necessity criteria between medical/surgical and MH/SUD (while different medical necessity tools may be used; for example, LOCUS and Milliman, they're both nationally recognized tools for developing medical necessity criteria for the treatment of MH/SUD and medical/surgical benefits).

	expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Plan's sole discretion. The Plan develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies as developed by the Plan are revised from time to time. The Plan publishes information concerning utilization review and our medical necessity criteria here: https://www.XXXXX.com/health-care-professionals/utilization-management.html Within that site, there is a section dedicated specially to the criteria used for behavioral health conditions, (i.e., LOCUS/CALOCUS, ABA and ASAM), which can be found here: https://www.XXXXX.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html We also publish clinical policy bulletins concerning services we may or may not cover, including behavioral health services that may be excluded on grounds that they are experimental and investigational, which detail the evidentiary bases for our coverage or exclusion determinations: https://www.XXXXX.com/health-care-professionals/clinical-policy-bulletins.html Covered Services: All MH/SUD and Medical/Surgical services Factors: Medical necessity applies to all medical/surgical and mental health/substance use disorder benefits in each MHPAEA category and is based on generally accepted standards of care. Processes, Strategies, Evidentiary Standards: Note-“Processes”, “strategies”, “evidentiary standards”, and “other factors” are terms of equivalence; none of which have to be individually articulated in order to be sufficient NQTL analysis. A plain reading interpretation of the MHPAEA Final Rule makes it clear that “any” (emphasis added) processes, strategies, evidentiary standards, or other factors” used in applying the MH/SUD NQTL can be compared to any process, strategy, evidentiary standard, or other factors used in applying the medical/surgical NQTL for the purposes of comparability and stringency analysis. See 29 CFR 2590.712(c)(4). Therefore, throughout all of these answers you will see content populated under the combine header of "process, strategy, or evidentiary standard"—some of which may be supported qualitatively or some of which may be supported quantitatively (e.g. “cost” as a factor to add a service to the NPL). MHPAEA provides that a plan may develop medical policies that limit care for mental health/substance use disorder benefits based on medical necessity as long as it does so for medical/surgical benefits and the “evidentiary standards are applied in a manner that is based on clinically appropriate standards of care for a condition”. 45 CFR 146.136(c)(4)(iii) (Example 4) The processes, strategies, and evidentiary standards include: • Evidence in the peer-reviewed published medical literature, • Evidence-based consensus statements, expert opinions of healthcare providers • Evidence-based guidelines from nationally recognized professional healthcare organizations and public health agencies. • Technology assessments and structured evidence reviews • Review of generally accepted national evidence-based guidelines from national medical professional	

	organizations, evidence-based evaluations by consensus panels, and technology evaluation bodies or criteria from professional associations such as: - Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and Medicare Benefit Policy Manual - MCG guidelines - American Society of Addiction Medicine (ASAM) Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition - Applied Behavior Analysis Medical Necessity Guide - InterQual guidelines (as required by contractual provisions) - Level of Care Utilization System (LOCUS) for adults 18 years old and above and the Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS/CASII) Review of generally accepted national quality standards, i.e.) National Committee for Quality Assurance, NQCA These processes, strategies, and evidentiary standards : are represented in our Clinical Polices and in our published Clinical Policy Bulletins (CPBs) https://www.XXXXX.com/health-care-professionals/clinical-policy-bulletins.html In determining whether a medical technology is medically necessary and established, the Clinical Policy Council will consider whether the following five criteria are met: • Whether the medical technology has final approval from the appropriate governmental regulatory bodies • Whether the scientific evidence permits conclusions about the effect of the medical technology on health outcomes • Whether the medical technology improves net health outcomes • Whether the medical technology is at least as beneficial as any established alternatives • Whether the medical technology is more costly (taking into account all health expenses incurred in connection with the medical technology) than any equally effective established alternatives No other evidentiary standards were considered and rejected. Comparability Analysis: The Plan's strategy regarding satisfaction of parity's NQTL requirements includes the utilization of an identical standard/definition of medical necessity. Medical and MH/SUD utilize appropriately applicable and generally accepted standards of practice to guide clinician with coverage determinations. For substance use disorder treatments, the Plan utilizes criteria developed by the American Society of Addiction Medicine (or ASAM) as a guideline to determine medical necessity. Every individual MH/SUD medical necessity determination is afforded independent clinical consideration based on the member's presentation. This point is made clear to Plan clinicians making medical necessity determinations in both the medical necessity tools utilized and in staff training. More information about LOCUS, CALOCUS/CASSII and ASAM criteria can be found on the Plan's website at https://www.XXXXX.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html	

	For medical treatments the Plan utilizes Milliman Care Guidelines (MCG) as a guideline to determine the medical necessity. As Written: The definition of “medical necessity” for both MH/SUD and medical/surgical share the same definition in our standard Certificates of coverage. Additionally, the Clinical Policy Bulletins (CPB) and evidence-based guidelines used in the medical necessity review process have been found to be aligned to generally accepted practice standards. This validation is completed by our Clinical Policy Council and approval by our chief medical officer or their designee. This process involves annual review of generally accepted national evidence-based guidelines. In Operation: The Plan monitors the application of the medical necessity NQTL through several initiatives: • Mental Health Parity (MHP) Task Force: Multi-disciplinary team that meets monthly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical/Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care. • Denial Rates: comparative rate of MH/SUD vs. medical/surgical denials due to precertification/concurrent reviews. Book of Business data will be formally reviewed by the MHP Task Force at least annually. • Internal Quality Reviews and Inter-Rater Reliability assessments: Clinical denials due to precertification reviews are conducted randomly throughout the year by the Plan's Clinical Services Team. The MHP Task Force will review the results of these audits at least annually. • Average length of stay (ALOS) reviews: comparative ALOS of MH/SUD vs. medical/surgical cases. Book of Business data will be formally reviewed by the MHP Task Force at least annually. • Complaints and appeals: The Plan's National Quality Oversight Committee, NQOC tracks and reviews trend rates of complaints and appeals at least annually. The MHP Task Force will review the results of these reviews at least annually. • Annual surveys: Comparative analysis of (Consumer Assessment of Healthcare Providers and Systems (CAHPs) survey, Qualified Health Plan Enrollee Experience Survey, XXXXX BH Practitioner Experience Survey, XXXXX BH Provider (Facility) Experience Survey, XXXXX BH Member Experience Survey, Physician Practice Survey and surveys • Review of NPL Committee Minutes Further detail on the criteria: LOCUS/CALOCUS The Plan utilizes LOCUS and CALOCUS, which nationally is recognized (by several courts, regulators, and various external stakeholders) as a generally accepted standard of care tool, to guide clinicians in the making medically necessary level of care determinations for our members. The Level of Care Utilization System (LOCUS) assessment was developed to help determine the resource intensity needs of individuals who receive adult mental health services. The LOCUS was developed by the American Association of Community Psychiatrists (AACP) in 1996. The LOCUS provides a system for assessment of needs	

	based on 6 evaluation parameters: • Risk of harm • Functional status • Medical, addictive & psychiatric co-morbidity • Recovery Environment • Treatment and recovery history • Engagement and recovery status The LOCUS assessment is reviewed and updated annually. There are multiple venues for regular input from all users as well as processes for continuous review and update of the tools themselves based on this input. Venues include: • National Council for Community Behavioral Healthcare/AACP LOCUS Advisory Committee • Deerfield Solutions • AACP/AACAP Committee for CALOCUS/CASII AACP Board of Directors Products and Service Plank CALOCUS/CASII The Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS/CASII) assessment provides a framework for defining the appropriate character and intensity of both services and resources to meet the needs of children and adolescents . CALOCUS/CASII was developed by the American Association of Community Psychiatrists in collaboration with the American Association of Child and Adolescent Psychiatry and closely mirrors the structure of the LOCUS. The CALOCUS/CASI provides a system for assessment of needs based on 6 evaluation parameters: • Risk of harm • Functional status • Co-Occurrence of Conditions: medical, substance use, developmental and psychiatric • Environmental stress • Environmental support • Resilience and/or Response to Services o Child and Adolescent Engagement in Service o Parent/Primary Caregiver Engagement in Services Similar to the LOCUS assessment, the CALOCUS/CASII assessment is reviewed and updated annually. There are multiple venues for regular input from all users as well as processes for continuous review and update of the tools themselves based on this input. Venues include: • National Council for Community Behavioral Healthcare/AACP LOCUS Advisory Committee • Deerfield Solutions • AACP/AACAP Committee for CALOCUS/CASII • AACP Board of Directors Products and Services Plank	

	ASAM For members seeking treatment for substance use disorders, the Plan utilizes the American Society of Addiction Medicine Criteria. The ASAM Criteria provides guidelines for evaluating the medical necessity of levels and types of care for substance use disorders. Many Courts and regulators consider ASAM a generally accepted, national standard for SUD treatment decisions. Some states, notably New York, New Jersey and Texas, require state-specific SUD level of care criteria. In those states, we use the criteria required by law. ASAM revises its criteria from time to time in keeping with its established best practices. Such practices can be found at https://www.asam.org/resources/the-asam-criteria/about Currently, the Plan is using the most recent version of the ASAM guidelines. MCG For medical/surgical health treatments, Aetna utilizes Milliman Care Guidelines, which nationally is a generally accepted standard of care tool, to guideline to clinicians in the making medically necessary level of care determinations for our members. Clinical Policy Bulletins (CPBs) The Clinical Policy Council evaluates the safety, effectiveness and appropriateness of medical technologies (e.g., drugs, devices, medical and surgical procedures used in medical care, and the organizational and supportive systems within which such care is provided) that are covered under our medical plans, or that may be eligible for coverage under our medical plans. In making this determination, the Clinical Policy Council will review and evaluate evidence in the peer-reviewed published medical literature, information from the U.S. Food and Drug Administration and other Federal public health agencies, evidence-based guidelines from national medical professional organizations, and evidence-based evaluations by consensus panels and technology evaluation bodies. The Clinical Policy council is comprised of pharmacists and medical directors from the Medical Policy Administration (MPA) department, National Accounts department, Behavioral Health department, Clinical Pharmacy department and regional Patient Management units. The Clinical Policy council usually convenes twice monthly. • Both new and revised CPB drafts undergo a comprehensive review process. This includes review by our Clinical Policy Council and external practicing clinicians, and approval by our chief medical officer or their designee. • Drafts of new and revised CPBs are distributed for review to members of the Clinical Policy Council prior to each meeting. Each new and revised draft CPB is placed on the Clinical Policy Council agenda and is discussed during the meeting. The Clinical Policy Council votes whether or not to recommend approval of each draft CPB. In addition, the Clinical Policy Council may recommend other revisions to a draft CPB. • The CPB draft may be revised based on the Clinical Policy Council's recommendations. CPB drafts are reviewed	

	by our Legal department and the head of the Medical Policy Administration department, and further revisions to draft CPBs may be made based on their recommendations. Draft CPBs are sent to the chief medical officer or their designee for review and final approval. Draft CPBs that are approved by the chief medical officer or their designee will be published on our websites within 60 days of the Clinical Policy council's recommendations. • CPBs are reviewed annually unless relevant new medical literature, guidelines, regulatory actions, or other relevant new information warrants more frequent review. Each time a CPB is updated, a comprehensive search of the peer-reviewed published medical literature is performed to determine if there is a change in the experimental and investigational status or medical necessity of medical technologies addressed in each CPB. If the Clinical Policy unit determines that new evidence or other information has emerged to warrant consideration of a change in our clinical policy, a revised CPB is prepared. If no new evidence has emerged that would warrant a change in position, the CPB may be updated with additional supporting background information and references. Each revised and updated CPB is submitted to the Clinical Policy Council for review and approval. • In developing our CPBs, for each medical technology selected for evaluation, the Clinical Policy unit conducts a comprehensive search of the peer-reviewed published medical literature indexed in the National Library of Medicine PubMed Database, assesses the regulatory status of the technology, reviews relevant evidence-based clinical practice guidelines and related documents indexed in the Agency for Healthcare Research and Quality (AHRQ) National Guideline Clearinghouse Database, and reviews relevant technology assessments indexed in the National Library of Medicine's Health Services/Technology Assessment Text (HSTAT) Database. Also, the opinions of relevant experts may be obtained where necessary. • Each CPB includes a policy statement and references to the medical literature and other sources used in developing the clinical policy. In addition, the CPB may include a background section that describes the medical technology and provides the rationale for our policy. • In addition, each CPB has a coding section that provides applicable International Classification of Diseases (ICD), Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes. The Plan has confirmed that the evidence-based guidelines and criteria for all Medical/Surgical and MH/SUD procedures, services, devices and therapies demonstrate that a consistent methodology for determining medical necessity, in policy and practice, is comparably and no more stringently applied with respect to MH/SUD benefits than those applied to Medical/Surgical benefits Summary: The Plan has confirmed that the evidence-based guidelines and criteria for all Medical/Surgical and MH/SUD procedures, services, devices and therapies demonstrate that a consistent methodology for determining medical necessity, in policy and practice, is comparably and no more stringently applied with respect to MH/SUD benefits than those applied to Medical/Surgical benefits. Plan Language: COC: Medically necessary, medical necessity The medical necessity requirements are in the Glossary section, where we define "medically necessary, medical necessity." That is where we also explain what our medical directors or a physician they assign consider when determining if a service is medically necessary.	

	Important note: We cover medically necessary, sex-specific covered services regardless of identified gender. Medical necessity and precertification requirements Your plan pays for its share of the expense for covered services only if the general requirements are met. They are: • The service is medically necessary • For in-network benefits, you get the service from a network provider • You or your provider precertifies the service when required Medically necessary, medical necessity Health care services that are state or federally mandated or we at we determine a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that we determine are: • In accordance with generally accepted standards of medical practice • Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease • Not primarily for the convenience of the patient, physician or other health care provider • Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease SOB: No reference	
In-Patient & In-Network NQTL Practices	The description in column A reflects a benefit classification, as such NQTLs that apply to this benefit classification are: Prior Authorization/Precertification, Concurrent Review, Medical Necessity Criteria, Sequenced Treatment, Benefit Exclusion including for experimental and investigational purposes, Network Provider Reimbursement, Network Facility Reimbursement, Plan Standards to Ensure Network Adequacy, and Physician Credentialing/Admission Standards. There are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.
In-Patient & Out-of-Network NQTL Practices	The description in column A reflects a benefit classification, as such NQTLs that apply to this benefit classification are: Prior Authorization/Precertification, Concurrent Review, Retrospective Review, Medical Necessity Criteria, Sequenced Treatment, Benefit Exclusion including for experimental and investigational purposes, Non-Participating Provider Reimbursement/UCR Determination, and Non-Participating Facility Reimbursement/UCR Determination. There are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.

Out-Patient & In-Network NQTL Practices	The description in column A reflects a benefit classification which the Plan subclassifies as Outpatient-Office Visit and Outpatient-All Other. NQTLs that apply to the Outpatient-Office Visit benefit classification are: Medical Necessity Criteria, Benefit Exclusion including for experimental and investigational purposes, Network Provider Reimbursement, Network Facility Reimbursement, Plan Standards to Ensure Network Adequacy, and Physician Credentialing/Admission Standards. NQTLs that apply to the Outpatient-All Other Benefit classification are: Prior Authorization/Precertification, Concurrent Review, Medical Necessity Criteria, Sequenced Treatment, Treatment Plan Requirement, Benefit Exclusion including for experimental and investigational purposes, Network Provider Reimbursement, Network Facility Reimbursement, Plan Standards to Ensure Network Adequacy, and Physician Credentialing/Admission Standards. There are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.
Out-Patient & Out-of-Network NQTL Practices	The description in column A reflects a benefit classification which the Plan subclassifies as Outpatient-Office Visit and Outpatient-All Other. NQTLs that apply to the Outpatient-Office Visit benefit classification are: Medical Necessity Criteria, Benefit Exclusion including for experimental and investigational purposes, Non-Participating Provider Reimbursement/UCR Determination, and Non-Participating Facility Reimbursement/UCR Determination. NQTLs that apply to the Outpatient-All Other Benefit classification are: Prior Authorization/Precertification, Concurrent Review, Retrospective Review, Medical Necessity Criteria, Sequenced Treatment, Treatment Plan Requirement, Benefit Exclusion including for experimental and investigational purposes, Non-Participating Provider Reimbursement/UCR Determination, and Non-Participating Facility Reimbursement/UCR Determination. There are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.
Emergency Services/Benefits NQTL Practices	The description in column A reflects a benefit classification, as such NQTLs that apply to this benefit classification are: Prior Authorization/Precertification, Retrospective Review, Medical Necessity Criteria, Benefit Exclusion including for experimental and investigational purposes, Network Provider Reimbursement, Network Facility Reimbursement, Non-Participating Provider Reimbursement/UCR Determination, Non-Participating Facility Reimbursement/UCR Determination, Plan Standards to Ensure Network Adequacy, and Physician Credentialing/Admission Standards. There are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences, as written or in operation, in the factors, processes, strategies and evidentiary standards used in the development of the limitations between medical/surgical and MH/SUD.

Rx Formulary Design, Management and Pharmacy Services NQTL Practices	The Plan's Commercial Advanced Control and Standard Opt-Out Formularies, and Exchange Formularies with the applied pharmacy prior authorization, step therapy and quantity limit UM programs, which are components of the prescription drug benefit NQTLs, are designed and applied consistently across all drugs and drug classes and do not discriminate against individuals based on age, expected length of life, disability, degree of medical dependency, quality of life, gender identity, medical or mental health diagnosis, or other health conditions. The NQTL coverage factors considered, evidentiary standards used to apply the factors, processes in the development, and implementation strategies, applied to drugs used to treat mental health and Substance Use Disorder (MH/SUD) conditions are comparable to, and are applied no more stringently than the NQTL coverage factors considers, evidentiary standards used to apply the factors, processes in the development and implementation strategies, used in applying the limitations to drugs used to treat medical or surgical (MED/SURG) conditions or disorders.	See the Mental Health & Substance Use Disorder Benefit response. The same factors are considered, evidentiary standards used to apply the factors, processes in the development, and implementation strategies, applied to drugs used in MH/SUD conditions as for drugs used in medical/surgical conditions.
Prior-Authorization NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of prior authorization/precertification NQTL practices between medical/surgical and MH/SUD. All UM factors, processes, strategies, and evidentiary standards, both MH/SUD and medical/surgical, are singularly developed in unison through the coordination efforts of the Parity Taskforce who leverages both MH/SUD and medical/surgical subject matter experts in factor development and ongoing review, and the National Precertification List (NPL) Committee—a group of clinicians and other subject matter experts representing both MH/SUD and medical/surgical expertise then applies these determinants. This Precertification Committee oversees the Plan's NPL, which physicians, hospitals and other health care professionals use for all plans to determine when medical/surgical or MH/SUD precertification is needed or required for each benefit classification for INN services. Covered Services: A detailed analytical framework is not provided for Inpatient because this NQTL applies to all non-palliative procedures, services, devices, and therapies for both medical/surgical and MH/SUD; as such administration of this NQTL is identical. For Medical/Surgical: All outpatient all other non-palliative procedures, services, devices, and therapies on the National Precertification List (NPL) https://www.XXXXX.com/health-care-professionals/precertification/precertification-lists.html For MH/SUD: All outpatient all other non-palliative procedures, services, devices, and therapies on the Behavioral Health Precertification List https://www.XXXXX.com/health-care-professionals/precertification/precertification-lists.html Factors: 1. All medical/surgical and MH/SUD procedures, services, devices, and therapies subject to the precertification NQTL must meet one or more of the following review methodologies specific to each of the identified factors: a. Cost-- Cost of treatment is satisfied when the average paid Medicare rate was at least $150 for the service being considered (based on the Plan's national paid Medicare claims experience) b. High cost growth -- whether, based on internal Plan claims data, the per member per month expense for the	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences in the application, as written and in operation, of prior authorization/precertification NQTL practices between medical/surgical and MH/SUD.

	services increased more than 10% in the most recent two-year period compared to an initial year baseline (for example, if the 2015 PMPM=$1.00, the 2016 PMPM=$2.00, and the 2017 PMPM=$3.00, then that would be a 200% trend increase over the two-year period - calculate by subtracting the 2015 PEPM from the 2017 PMPM and then divide by the 2015 PMPM) c. Variability in cost and practice is satisfied when internal claims data demonstrates that there is greater than three-fold variability in cost per unit, overall length of treatment, or overall number of services per treatment for the procedure, service, device, or therapy in the most recent 12-month period AND All medical/surgical and MH/SUD procedures, services, devices, and therapies subject to the precertification NQTL must meet both of the following review methodologies specific to each of the identified factors 2. There must be at least one evidenced-based criteria (EBC) available to assist clinicians with precertification decisions. EBC may be sourced from national medical professional organizations, evidence-based evaluations by consensus panels and technology evaluation bodies, or criteria from professional associations AND 3. Administrative inability to apply Claims Rules (Claims Rules are automated claims system controls that decide if coverage criteria is met). A procedure, drug or technology cannot feasibly be managed by Claim Rules alone due to either subjectivity or complexity of criteria *Note--as part of the intake completed for new services being added to the NPL, generally a forecasted ROI is produced (and such requirement is noted in the intake instructions). Such forecasted ROI helps mitigate the risk of a service satisfying the initial inclusion factors in year one but failing the retention framework in subsequent years. It is important to note that for both the inclusion framework or retention framework for the NPL all factors are equally applicable to the consideration of a medical/surgical service or MH/SUD service such that the in-writing component of parity is satisfied. Analysis for the Retention of a Service to the NPL: • After the first year and annually thereafter, the ROI is calculated, and a decision is made to retain or remove from the NPL primarily based on the following: – ROI 3:1 or greater - retain – ROI 2 to 2.9:1 – NPL committee discussion of extenuating factors (see below) – ROI </= 1.9:1 and NOT integral to NPL Group/Category (example, breast reduction code may independently have a low ROI, but it is part of a procedure group for which precertification is required) - committee discussion of extenuating factors (see below) * While ROI may be the primary factor used to determine retention of a service on the NPL, the NPL Committee may consider additional factors that concern the NPL Committee which are unrelated to medical cost (e.g. incorrect utilization, or need to retain services on list to make coverage determinations consistent with our Clinical Policy Bulletins)	

	• Extenuating factors: Extenuating factors are qualitative or quantitative points of consideration that, based on the expertise of the Plan's NPL Committee, warrant additional consideration (beyond the ROI) in connection with the retention or removal of a service from the NPL. Such extenuating factors may include High-cost growth (as calculated using the methodology described in the inclusion section above), variability in practice or cost (as calculated using the methodology described in the inclusion section above), Safety, incidence of occurrence, incorrect utilization, consistency with our Clinical Policy Bulletins, and End-to-end staff and system support for efficient management. Processes, Strategies, Evidentiary Standards: The processes, strategies, and evidentiary standards used to define the factors include the following: The methods and analysis used in the development of the precertification NQTL include: • Review of Medicare rates • Internal claims database analysis • Review of generally accepted national evidence-based guidelines from national medical professional organizations, evidence-based evaluations by consensus panels, and technology evaluation bodies or criteria from professional associations such as: • Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and Medicare Benefit Policy Manual • MCG guidelines • National Comprehensive Cancer Network NCCN) guidelines (Category 1 and 2A recommendations) • American Society of Addiction Medicine (ASAM) Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, most recent version • Applied Behavior Analysis Medical Necessity Guide • InterQual guidelines (as required by contractual provisions) • The Level of Care Utilization System (LOCUS) & Children and Adolescent Level of Care Utilization System (CALOCUS) • Review of generally accepted national quality standards, i.e.) National Committee for Quality Assurance, NCQA • Internal claims system review. Review of claims systems capabilities with Head of Operations to validate system functionality. No other evidentiary standards were considered and rejected. Comparability Analysis: • A review of Medicare paid per procedure rates demonstrate that that all procedures, services, devices and therapies, added to the NPL in 2021 met the cost threshold of $150. Additionally, the evidenced-based criteria factor and the factor-related to the inability to manage the service through claims rule were satisfied. • Confirmation of evidence-based guidelines and criteria for all Medical Surgical and MH/SUD procedures,	

	services, devices and therapies subject to the precertification NQTL and review of those guidelines demonstrates that a consistent methodology for the pre-certification NQTL was developed and applied, in policy and practice, comparably and no more stringently with respect to MH/SUD benefits than those applied to medical surgical benefits As Written: MH/SUD and medical/surgical Precertification/Concurrent/and Retrospective Review all share the same definition in our standard Certificate of coverage. Additionally, the Plan maintains one set of utilization management (UM) policies that are equally applicable to MH/SUD and medical/surgical. In Operation: The Plan monitors the application of the UM through several initiatives: • Mental Health Parity (MHP) Task Force: Multi-disciplinary team that meets monthly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care. • Denial Rates: comparative rate of MH/SUD vs. medical/surgical denials due to precertification/concurrent reviews. Book of Business data will be formally reviewed by the MHP Task Force at least annually. • Internal Quality Reviews and Inter-Rater Reliability assessments: Clinical denials due to precertification reviews are conducted randomly throughout the year by our Clinical Services Team. The MHP Task Force will review the results of these audits at least annually. • Average length of stay (ALOS) reviews: comparative ALOS of MH/SUD vs. medical/surgical cases. Book of Business data will be formally reviewed by the MHP Task Force at least annually. • Complaints and appeals: The Plan's National Quality Oversight Committee, NQOC tracks and reviews trend rates of complaints and appeals at least annually. The MHP Task Force will review the results of these reviews at least annually. • Annual surveys: Comparative analysis of (Consumer Assessment of Healthcare Providers and Systems (CAHPs) survey, Qualified Health Plan Enrollee Experience Survey, Aetna BH Practitioner Experience Survey, Aetna BH Provider (Facility) Experience Survey, Aetna BH Provider Member Experience Survey, Physician Practice Survey and surveys • Review of NPL Committee Minutes Summary: The Plan has confirmed that the criteria for all Medical Surgical and MH/SUD procedures, services, devices and therapies demonstrate that a consistent methodology for the determining which services will be subject to UM, in policy and practice, is comparably and no more stringently applied with respect to MH/SUD benefits than those applied to medical surgical benefits. Plan Language:	

	COC: Precertification You need pre-approval from us for some covered services. Pre-approval is also called precertification. In-network Your network physician is responsible for obtaining any necessary precertification before you get the care. Network providers cannot bill you if they fail to ask us for precertification. But if your physician requests precertification and we deny it, and you still choose to get the care, you will have to pay for it yourself. Out-of-network When you go to an out-of-network provider, you are responsible to get any required precertification from us. If you don't precertify: • Your benefits may be reduced, or the plan may not pay. See your schedule of benefits for details. • You will be responsible for the unpaid bills. • Your additional out-of-pocket expenses will not count toward your deductible or maximum out-of-pocket limit if you have any. Timeframes for precertification are listed below. For emergency services, precertification is not required, but you should notify us as shown. To obtain precertification, contact us. You, your physician or the facility must call us within these timelines: Non-emergency admission – Call at least 14 days before the date you are scheduled to be admitted Emergency admission – Call within 48 hours or as soon as reasonably possible after you have been admitted Urgent admission – Call before you are scheduled to be admitted Outpatient non-emergency medical services - Call at least 14 days before the care is provided, or the treatment or procedure is scheduled An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or injury. We will tell you and your physician in writing of the precertification decision, where required by state law. An approval is valid for 180 days as long as you remain enrolled in the plan. For an inpatient stay in a facility, we will tell you, your physician and the facility about your precertified length of stay. If your physician recommends that you stay longer, the extra days will need to be precertified. You, your physician, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. We will tell you and your physician in writing of an approval or denial of the extra days. If you or your provider request precertification and we don't approve coverage, we will tell you why and explain how you or your provider may request review of our decision. See the Claim decisions, grievances and appeal procedures section. Types of services that require precertification	

	Precertification is required for inpatient stays and certain outpatient services and supplies. Precertification is required for the following types of services and supplies: • Inpatient services and supplies o Gene-based, cellular and other innovative therapies (GCIT) o Stays in a hospital o Stays in a skilled nursing facility o Stays in a rehabilitation facility o Stays in a hospice facility o Stays in a residential treatment facility for treatment of mental health disorders and substance related disorders o Obesity (bariatric) surgery • Outpatient services and supplies o Applied behavior analysis o Complex imaging o Comprehensive infertility services and ART services o Cosmetic and reconstructive surgery o Emergency transportation by airplane o Gene-based, cellular and other innovative therapies (GCIT) o Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications) o Kidney dialysis o Outpatient back surgery not performed in a physician's office o Private duty nursing services o Sleep studies o Knee surgery o Wrist surgery o Transcranial magnetic stimulation (TMS) o Partial hospitalization treatment – mental health disorder and substance related disorders treatment diagnoses Sometimes you or your provider may want us to review a service that doesn't require precertification before you get care. This is called a predetermination, and it is different from precertification. Predetermination means that you or your provider requests the pre-service clinical review of a service that does not require precertification Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You can find the bulletins and other information at https://www.XXXXX.com/health-care-professionals/clinical-policy-bulletins.html. Certain prescription drugs are covered under the medical plan when they are given to you by your doctor or health care facility. The following precertification information applies to these prescription drugs:	

	For certain drugs, your provider needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are medically necessary Step therapy is a type of precertification where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. However, if you are in a pain management program, this requirement will not apply. Step therapy will not be required for any prescribed drug for longer than 60 days. At the end of the 60 day period, your physician or PCP may feel the use of the step therapy provision is ineffective, and prescribe a different medication. Contact us or go online to get the most up-to-date precertification requirements and list of step therapy drugs. Medical necessity and precertification requirements Your plan pays for its share of the expense for covered services only if the general requirements are met. They are: • The service is medically necessary • For in-network benefits, you get the service from a network provider • You or your provider precertifies the service when required Precertification, precertify Pre-approval that you or your provider receives from us before you receive certain covered services. This may include a determination by us as to whether the service is medically necessary and eligible for coverage. Step therapy A form of precertification under which certain prescription drugs are excluded from coverage, unless a first-line therapy drug is used first by you. The list of step therapy drugs is subject to change by us or an affiliate. An updated copy of the list of drugs subject to step therapy is available upon request or on our website at https://www.XXXXX.com/individuals-families/find-a-medication.html. SOB: Precertification covered services reduction This only applies to out-of-network covered services: Your certificate contains a complete description of the precertification process. You will find details in the Medical necessity and precertification section. If precertification for covered services isn't completed, when required, it can result in the following benefit reductions: • Covered services reduced by the lesser of 50% of the benefit that would have been payable or $500 You may have to pay an additional portion of the allowable amount because you didn't get precertification. This	

	portion is not a covered service and doesn't apply to your deductible or maximum out-of-pocket limit, if you have one	
Concurrent Review Benefit NQTL Practices	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of concurrent review benefit NQTL benefit practices between medical/surgical and MH/SUD. Concurrent review is a utilization review service performed by licensed healthcare professionals to evaluate the patient's care while in the hospital or while undergoing outpatient treatment. The intent is to determine medical necessity and appropriateness of treatment, assess appropriateness of level of care and treatment setting, determine benefits and eligibility identify the patient's discharge and continuing care plan, and identify and refer potential quality of care and patient safety concerns for additional review. All inpatient services, whether MH/SUD or medical/surgical, are subject to Concurrent Review; as such comparability analysis is not required for the Inpatient INN and OON classifications. Concurrent Review in the Outpatient-All Other INN and OON classifications, as further described below, is conducted for services listed on the National Precertification List or member precertification list (for OON) and for MH/SUD services on the Behavioral Health Precertification list or member precertification list. (See link for current precertification list: https://www.XXXXX.com/health-care-professionals/precertification/precertification-lists.html). Concurrent Review involves a review for continued medical necessity for dates of service beyond the initial precertification authorization and occurs with subsequent coverage requests so that no gaps in the authorization exist. This means that staff reviews all dates of service that do not have a coverage determination with a subsequent request for an extension of services. The Concurrent Review process includes a review for medical necessity and for the appropriate level of care that meets the member's clinical needs. We use standardized clinical guidelines, monitor the member's progress, review for potential quality of care concerns, and ensure there is an adequate discharge plan in place. If medical necessity is not evident, the case is sent for review to a medical director who may call the attending physician for additional information before rendering a coverage determination. For medical/surgical care, additional units (e.g. days, sessions) of care are authorized based on the individual needs of the member (i.e. clinical judgement based on complexity and severity) guided by care guidelines (which in many cases prescribe care pathways, treatments and lengths of stay), by facility contract, and clinical criteria. For MH/SUD, clinical judgment guided by clinical criteria dictates the number of additional units of care that are authorized. MH/SUD's use of clinical judgment guided by clinical criteria as the sole process/strategy for determinations of additional units of care authorized exceeds the expectations of "comparability" under NQTL testing. Clinical judgement, when applied with the appropriate stringency controls discussed below, is a strategy that is more favorable to members. The medical/surgical utilization management team similarly uses clinical judgement as a process/strategy; however, clinical judgement is further constrained by facility contract, and care guidelines (which in many cases prescribe care pathways, treatments and lengths of stay). For both BH and medical/surgical, "severity" and "complexity", as used within our UM policies, are determined primarily based on	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences in the application, as written and in operation, of concurrent review benefit NQTL benefit practices between medical/surgical and MH/SUD.

	the clinical judgement of expert reviewers and informed by the member's medical history, clinician progress notes, and discharge plans. The Plan relies on the following processes and strategies to ensure clinical judgement remains a process/strategy that exceeds the minimum requirements of Parity for MH/SUD concurrent review frequency determinations: comparison of denial rates and average length of stay, Internal Quality Reviews (IQR) and Inter-Rater Reliability (IRR) assessments, NCQA Health Plan Accreditation, and peer-to-peer clinical review. It should be noted that our book of business comparative analysis of UM denials rates and average length of stays demonstrate that on scale, MH/SUD benefits historically have significantly fewer denials per 1,000 admissions and longer average lengths of stays than medical surgical comparable benefits. Regarding IQR and IRR review, among other things, the intent is to identify both strengths and opportunities for improvement in the delivery of UM services, and to measure compliance with National Committee of Quality Assurance (NCQA) File Review standards (which evaluate both BH and medical surgical UM practice and are designated as "must pass" for recertification). A random sample of UM denials, which includes all lines of business and product types, is conducted periodically. The goal for each audit is an aggregate audit score of at least 95%. An NCQA File Review tool is used to complete the audits. Quantitative and qualitative feedback is provided by the audit process to induvial UM reviewers. The Medical Director Internal Quality Review is a process for re-adjudication of a claim in situations where a Senior Medical Director (SMD) or Medical Director (MD) auditor disagrees with a medical necessity determination made by a Medical Director (MD) and/or Physician Advisor (PA) and/or Clinician Advisor (CA). Our Peer-to-peer review process seeks to decrease the risk of inconsistencies in the operationalization of UM policies by allowing a treating practitioner, a clinician on behalf of the treating practitioner or a facility designated physician to discuss a clinical denial of coverage determination with a peer reviewer or behavioral health consultant psychiatrist/psychologist to mitigate the risk of operational disparities based on differences in the quantity/quality of written documentation the treating practitioner may provide. Covered Services: Outpatient-All Other Medical/Surgical: All outpatient all other non-palliative procedures, services, devices, and therapies on the National Precertification List (NPL) https://www.XXXXX.com/health-care-professionals/precertification/precertification-lists.html Outpatient All-Other MH/SUD: All outpatient all other non-palliative procedures, services, devices, and therapies on the Behavioral Health Precertification List https://www.XXXXX.com/health-care-professionals/precertification/precertification-lists.html Factors: Outpatient-All Other- Refer to Factors for Precertification NQTL.	

	Processes, Strategies, Evidentiary Standards: Outpatient-All Other- Refer to Processes, Strategies, Evidentiary Standards for Precertification NQTL Comparability Analysis: Outpatient-All Other-Refer to Comparability Analysis for Precertification NQTL As Written: Outpatient-All Other-Refer to As Written for Precertification NQTL In Operation: Outpatient-All Other- Refer to In Operation for Precertification NQTL Summary: The Plan has confirmed that the criteria for all Medical/Surgical and MH/SUD procedures, services, devices and therapies demonstrate that a consistent methodology for determining which services will be subject to UM, in policy and practice, is comparably and no more stringently applied with respect to MH/SUD benefits than those applied to Medical/Surgical benefits. Plan Language: COC: Concurrent care claim extension A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a hospital stay or adding a number of visits to a provider. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 15 days. Concurrent care claim reduction or termination A concurrent care claim reduction or termination occur when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an external review organization if the situation is eligible for external review. During this continuation period, you are still responsible for your share of the costs, such as copayments, coinsurance and deductibles that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period. SOB: No reference	
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	There are no clinical automated claims edits/policies applied to MH/SUD benefits. Therefore, a NQTL analysis is not required. There are no non-comparable inconsistencies or differences in the application, as written and in operation, of clinical procedure coding, billing coding and process practices between medical/surgical and MH/SUD.	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences in the application, as written and in

		operation, of clinical procedure coding, billing coding and process practices between medical/surgical and MH/SUD.
Case & Medical Management NQTL Practices	This entire section is not applicable. NQTLs are “treatment limitations” that are not numerical in nature but otherwise may limit the scope or duration of MH/SUD benefits. Case Management is a voluntary service to our members. There are no adverse consequences to the member if a member decides not to enroll or use information provided during case management. These are provided to help high risk members and those who support them to improve management of health conditions as well as improve impact on functioning and overall health. We outline in our Behavioral Health Case Management Program Policy NCS 415 (available upon request), “Eligible members have the right to participate or decline participation.” If a member decided not to participate in the case management program, or does not complete the care plan, benefits are not excluded or denied. We provided additional detail in 2022 which is still relevant to this year's annual filing which may be referred to if necessary.	This entire section is not applicable. NQTLs are “treatment limitations” that are not numerical in nature but otherwise may limit the scope or duration of MH/SUD benefits. Case Management is a voluntary service to our members. There are no adverse consequences to the member if a member decides not to enroll or use information provided during case management. These are provided to help high risk members and those who support them to improve management of health conditions as well as improve impact on functioning and overall health. We outline in our Behavioral Health Case Management Program Policy NCS 415 (available upon request), “Eligible members have the right to participate or decline participation.” If a member decided not to participate in the case management program, or does not complete the care plan, benefits are not excluded or denied. We provided additional detail in 2022 which is still relevant to this year's annual filing which may be referred to if necessary.
Network Adequacy & Provider Reimbursement Rates	There are no non-comparable inconsistencies or differences in the application, as written and in operation, of network adequacy & provider reimbursement rates NQTL practices between medical/surgical and MH/SUD. The following framework organizes the factors, sources, methods, analysis and stringency application applied to the inpatient and outpatient benefit classifications for NQTLs in the following categories: participating provider reimbursement, non-participating provider reimbursement, participating facility reimbursement, non-participating facility reimbursement and network adequacy. Participating Provider Reimbursement NQTL Negotiated charge is the amount a network provider has agreed to accept or that we have agreed to pay them or a third party vendor (including any administrative fee in the amount paid). Covered Services: All Med/Surg and MH/SUD services delivered in-network Factors: All factors are the same for medical/surgical and MH/SUD • Reimbursement rate indices (e.g. Medicare reimbursement rates)	See the Mental Health & Substance Use Disorder Benefits response as there are no non-comparable inconsistencies or differences in the application, as written and in operation, of network adequacy & participating and non-participating provider and facility reimbursement rate NQTL benefit practices between medical/surgical and MH/SUD.

	• Market dynamics (e.g. supply and demand) • Provider type (e.g. MD, NP) • Service type (e.g. counseling, initial assessment) Processes, Strategies, Evidentiary Standards: • Standard fee schedules: – Benchmarked from Medicare reimbursement rates – Developed for each market based on market analysis • Final negotiated rate – either standard rates or a negotiated fee schedule No other evidentiary standards were considered and rejected. Comparability Analysis: MH/SUD standard fee schedule rates can be higher but are not lower than medical rates for the same codes that can be used by BH and medical/surgical providers. The process to determine provider network reimbursement between Medical/Surgical and MH/SUD is as follows: Medical informs Behavioral Health that they are adjusting the standard rates for a given market. Medical supplies the new medical rates for the codes shared with the behavioral health fee schedule. BH will provide rates to medical for MH/SUD services in the BH Network. Behavioral Health will compare the rates to the medical rates. If the medical rate is the higher rate, Behavioral Health will adopt the medical rate. Behavioral Health will cascade the rate down to the lower level providers using the following CMS guidelines and commensurate with level of training : • MD's (MH/SUD and medical/surgical) & Clinical Psychologists receive 100% of the rate. • Nurse Practitioners, Physician Assistants and Certified Nurse Specialist (MH/SUD and medical/surgical) receives 85% of the new rate** • Drug and Alcohol Counselor, Licensed Professional Counselor, Marriage and Family Therapist, Pastoral Counselor, Social Worker receives 75% of the new rate*** • Audiologist, Registered Dietician, Genetic Counselor, Massage Therapist, Nutritionist, Respiratory Therapist receives 75% of the new rate ** If the existing MH/SUD rate is higher than 85% of the new rate, the already existing rate stays in place *** If the existing MH/SUD rate is higher than the 75% of the new rate, the already existing rate stays in place The rates are effective at the same time as the new medical rates. MH/SUD rates can be updated in addition to the rate updates triggered by the Medical rate updates. As Written: The Plan maintains uniform reimbursement practices that are equally applicable to MH/SUD and medical/surgical. In Operation: The Plan monitors the application of this NQTL through several initiatives: • Mental Health Parity (MHP) Task Force: Multi-disciplinary team that meets monthly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to	

	respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care. • Rates are updated, and new schedules are completed and reviewed by a different person to make sure they are accurate. The rates are reviewed on both Medical and BH by members of the enterprise senior network team as well as by members of the senior regional market team. Summary: The Plan has confirmed that the our practices and policies in developing our reimbursement rates demonstrate that a consistent methodology for determining these rates are equally applicable to MH/SUD and Medical/Surgical. Our standard market fee schedules is comparable in that the fee schedules would not pay a MH/SUD provider less than a med/surg provider for submission of the same billing code. Plan Language: COC: Negotiated charge For health coverage, this is either: • The amount a network provider has agreed to accept • The amount we agree to pay directly to a network provider or third party vendor (including any administrative fee in the amount paid) for providing services, prescription drugs or supplies to plan members. This does not include prescription drug services from a network pharmacy. We may enter into arrangements with network providers or others related to: • The coordination of care for members • Improving clinical outcomes and efficiencies Some of these arrangements are called: • Value-based contracting • Risk sharing • Accountable care arrangements These arrangements will not change the negotiated charge under this plan. For prescription drug services from a network pharmacy: The amount we established for each prescription drug obtained from a network pharmacy under this plan. This negotiated charge may reflect amounts we agreed to pay directly to the network pharmacy or to a third party vendor for the prescription drug, and may include a rebate, an additional service or risk charge set by us. We may receive or pay additional amounts from or to third parties under price guarantees. These amounts may not change the negotiated charge under this plan. SOB: No reference	

	Non-Participating Provider Reimbursement NQTL Allowable amount is the amount of an out-of-network provider's charge that is eligible for coverage. The allowable amount depends on the geographic area where members get the service or supply. Covered Services: All Med/Surg and MH/SUD services delivered out-of-network Factors: All factors are the same for medical/surgical and MH/SUD • Reasonable and Customary rates benchmarked from reimbursement rate indices • The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate • Generally accepted standards of medical and dental practice • The views of physicians and dentists practicing in the relevant clinical areas • The Plan's own data and/or databases and methodologies maintained by third parties. Processes, Strategies, Evidentiary Standards: • Rate hierarchy (i.e. a preset algorithm that generates the rate that will be paid based on certain factors) • Market analysis when rate hierarchy is not applicable • Final rate negotiated as part of the rate hierarchy process • Vendor contracts • Third-party claim and code review Comparability Analysis: The Plan compensates nonparticipating providers based on member's plan and benefit level subject to the lesser of either the billed charges or the allowable amount determined by a standard rate hierarchy that is the same for both MH/SUD and M/S. For our standard fully insured plans, our claim payment system follows these steps in attempting to price non-participating claims. If one step is unsuccessful, we move on to the next until the claim is successfully priced. These steps may vary by type of non-participating claim. First tier of hierarchy includes Single-case contracting (pre-service negotiations), second tier includes availability of a National Advantage Program (NAP) rate, third tier includes the Plan rate, fourth tier includes facility charge review, fifth tier includes ad hoc NAP post-service negotiations, and sixth tier involves non-par reasonable/default rate. Where reimbursement is based on the Plan's OON schedules then: • MD's (MH/SUD and medical/surgical) & Clinical Psychologists receive 100% of the rate • All other provider types receives 85% of the new rate As Written: The Plan maintains uniform reimbursement practices that are equally applicable to MH/SUD and medical/surgical.	

	In Operation: The Plan monitors the application of this NQTL through: • Mental Health (MHP) Task Force: Multi-disciplinary team that meets monthly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care. Summary: The Plan has confirmed that the our practices and policies in developing our reimbursement rates demonstrate that a consistent methodology for determining these rates are equally applicable to MH/SUD and Medical/Surgical. Plan Language: COC: Allowable amount This is the amount of an out-of-network provider's charge that is eligible for coverage. You are responsible for all charges above this amount. The allowable amount depends on the geographic area where you get the service or supply. Allowable amount doesn't apply to involuntary services. These are services or supplies that are: • Provided at a network facility by an out-of-network provider • Not available from a network provider • An emergency service The table below shows the method for calculating the allowable amount for specific services or supplies: Service or supply: — Allowable amount is based on: • Professional services and other services or supplies not mentioned below — Reasonable amount rate 50%-400% of Medicare allowed rate • Services of hospitals and other facilities — Reasonable amount rate 50%-400% of Medicare allowed rate • Prescription drugs — 50%-200% of average wholesale price (AWP) • Prescription drugs for gene-based, cellular and other innovative therapies (GCIT) — 50%-200% of average wholesale price (AWP) Important note: See Special terms used, below, for a description of what the allowable amount is based on. If the provider bills less than the amount calculated using a method above, the allowable amount is what the provider bills.	

	If your ID card displays the National Advantage Program (NAP) logo, your cost share may be lower when you get care from a NAP provider. These are out-of-network providers and third party vendors who have contracts with us but are not network providers. When you get care from a NAP provider, your out-of-network cost share applies. Special terms used: • Our out-of-network rates (AONR) are our standard rates used to begin contract talks with providers in a specific geographic area. For areas where we don't maintain AONR, we use 50%-400% of the Medicare allowed rates. • Average wholesale price (AWP) is the current average wholesale price of a prescription drug as listed in the Facts & Comparisons®, Medi-Span daily price updates or any other similar publication we choose to use. • Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility provider's estimated costs for the service and leave the provider with a reasonable profit. This means for: * Hospitals and other facilities that report costs or cost to charge ratios to The Centers for Medicare & Medicaid Services (CMS), the FCR rate is based on what the facilities report to CMS * Facilities that don't report costs or cost to charge ratios to CMS, the FCR rate is based on a statewide average of these facilities We may adjust the formula as needed to maintain the reasonableness of the allowable amount. For example, we may make an adjustment if we determine that in a state the charges of a specific type of facility are much higher than charges of facilities that report to CMS. • Geographic area is normally based using the first three digits of a zip code. If we believe we need more data for a particular service or supply, we may base rates on a wider geographic area such as the entire state. • Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees without taking into account adjustments for specific provider performance. We update our system with these when revised within 30-180 days of receiving them from CMS. If Medicare doesn't have a rate, we use one or more of the items below to determine the rate for a service or supply: * The method CMS uses to set Medicare rates * How much other providers charge or accept as payment * How much work it takes to perform a service * Other things as needed to decide what rate is reasonable We may make the following exceptions: * For inpatient services, our rate may exclude amounts CMS allows for operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) programs * Our rate may exclude other payments that CMS may make directly to hospitals or other providers and backdated adjustments * For anesthesia, our rate may be at least 100%-350% of the rate CMS establishes * For lab, our rate may be 5%-75% of the rate CMS establishes	

	* For DME, our rate may be 25%-75% of the rate CMS establishes For medications that are paid as a medical benefit instead of a pharmacy benefit, our rate may be 50%-100% of the rates CMS establishes. When the allowable amount is based on a percentage of the Medicare allowed rate, it is not affected by adjustments or incentives given to providers under Medicare programs. • Prevailing charge rate is the 50th-95th percentile value reported in a database prepared by FAIR Health®, a non-profit company. FAIR Health may change these periodically. We update our systems within 30-180 days of receiving them from FAIR Health. If the database becomes unavailable, we may substitute a different, comparable database. If the alternate data source doesn't contain a value for a service or supply, we will base the allowable amount on the Medicare allowed rate. • Reasonable amount rate means your plan has established a rate amount as follows: Service or supply: — Reasonable amount is: • Professional services — 50th-95th percentile value reported in a database prepared by FAIR HEALTH • Inpatient and outpatient hospital charges — 50%-500% of Medicare allowed rate The FCR rate What the provider bills •Inpatient and outpatient charges that are not from a hospital — 50%-500% of Medicare allowed rate The FCR rate What the provider bills Our reimbursement policies We have the right to apply our reimbursement policies to all out-of-network services including involuntary services. This may affect the allowable amount. When we do this, we consider: • The length and difficulty of a service • Whether additional expenses are needed, when multiple procedures are billed at the same time • Whether an assistant surgeon is needed • If follow up care is included • Whether other conditions change or make a service unique • Whether any of the services described by a claim line are part of or related to the primary service provided, when a charge includes more than one claim line • The educational level, licensure or length of training of the provider We base our reimbursement policies on our review of: • CMS National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding	

	practices are and aren't appropriate • Generally accepted standards of medical and dental practice • The views of physicians and dentists practicing in relevant clinical areas We use commercial software to administer some of these policies. Policies may differ for professional services and facility services. SOB: No Reference Participating Facility Reimbursement NQTL Covered Services: All Med/Surg and MH/SUD services delivered in-network Factors: All factors are the same for medical/surgical and MH/SUD • market dynamics (e.g. supply and demand, volume with Aetna) • Scope and complexity of services provided • the Plan's membership presence within region Processes, Strategies, Evidentiary Standards: • Benchmarked from Medicare Inpatient Psychiatric Facility Prospective Payment System • Market analysis • Negotiated reimbursement models (e.g. per diem versus DRG) • Final rate negotiated from standard target ranges Comparability Analysis: Prior to negotiating such rates with a particular facility provider, the Plan has developed a set of standard target rates based on the average rates paid for similar services in a particular market. These target rates are updated annually based on average rate increases. Rates are then negotiated on the basis of these target ranges, rather than a set fee schedule. In general, the majority of rates negotiated with freestanding facilities fall within a targeted rate range differential to the average as a whole. As Written: The Plan maintains uniform reimbursement practices that are equally applicable to MH/SUD and medical/surgical. In Operation: The Plan monitors the application of this NQTL through: • Mental Health Parity (MHP) Task Force: Multi-disciplinary team that meets monthly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of	

	care. Summary: The Plan has confirmed that the our practices and policies in developing our reimbursement rates demonstrate that a consistent methodology for determining these rates are equally applicable to MH/SUD and Medical/Surgical. Plan Language: COC: Refer to Participating Provider Reimbursement COC SOB: No reference Non-Participating Facility Reimbursement NQTL Covered Services: All Med/Surg and MH/SUD services delivered out-of-network Factors: All factors are the same for medical/surgical and MH/SUD • Reasonable and Customary rates benchmarked from reimbursement rate indices Processes, Strategies, Evidentiary Standards: • Rate hierarchy (i.e. a preset algorithm that generates the rate that will be paid based on certain factors) • Market analysis when rate hierarchy is not applicable • Final rate negotiated as part of the rate hierarchy process Comparability Analysis: The Plan compensates nonparticipating providers based on member's plan and benefit level subject to the lesser of either the billed charges or the allowable amount determined by a standard rate hierarchy that is the same for both MH/SUD and M/S. For our standard fully insured plans, our claim payment system follows these steps in attempting to price non-participating claims. If one step is unsuccessful, we move on to the next until the claim is successfully priced. These steps may vary by type of non-participating claim. First tier of hierarchy includes Single-case contracting (pre-service negotiations), second tier includes availability of a National Advantage Program (NAP) rate, third tier includes the Plan rate, fourth tier includes facility charge review, fifth tier includes ad hoc NAP post-service negotiations, and sixth tier involves non-par reasonable/default rate Where reimbursement is based on the Plan's OON schedules then: • MD's (MH/SUD and medical/surgical) & Clinical Psychologists receive 100% of the rate • All other provider types receives 85% of the new rate	

	As Written: The Plan maintains uniform reimbursement practices that are equally applicable to MH/SUD and medical/surgical. In Operation: The Plan monitors the application of this NQTL through several initiatives: • Mental Health Parity (MHP) Task Force: Multi-disciplinary team that meets bi- weekly to establish parity compliance protocols; clarify interpretation of parity regulations, FAQs, and related requirements; and to respond to internal and external parity questions and requests. Subgroups comprised of both Behavioral Health and Medical Surgical Clinical and other administrative personnel meet more frequently and as needed to ensure compliance in specific policy and operational areas, i.e.) network management, clinical management by level of care Summary: The Plan has confirmed that the our practices and policies in developing our reimbursement rates demonstrate that a consistent methodology for determining these rates are equally applicable to MH/SUD and Medical/Surgical. Plan Language: COC: Refer to Non-Participating Provider Reimbursement COC SOB: No reference Network Adequacy NQTL The Plan maintains sufficient numbers and types of primary care, behavioral health and specialty care practitioners in its network. The Plan maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners (SCP) and monitors how effectively this network meets the needs and preferences of its membership. The Plan establishes mechanisms to provide access to appointments for primary care services, behavioral healthcare services and specialty care services. The Plan provides and maintains appropriate access to primary care services, behavioral healthcare services and specialty care services. Covered Services: All Med/Surg and MH/SUD services delivered in-network Factors: All factors are the same for medical/surgical and MH/SUD Processes, Strategies, Evidentiary Standards: • Our standards approved by NCQA in accrediting the Plan. The Plan has NCQA accreditation as a Health Plan and a Managed Behavioral Healthcare Organization (“The Plan 's NCQA Standards”) • Network adequacy indicators are based on NCQAs NET 1 (AVAILABILITY OF PRACTITIONERS) and NET 2 (ACCESSIBILITY OF SERVICES) • State specific Network Adequacy as appliable Comparability Analysis: The same standards are used to define and monitor minimum requirements for network composition, ensure compliance with applicable state and federal regulatory standards, and to ensure compliance with applicable accreditations standards for both M/S and MH/SUD.	

	As Written: The Plan maintains uniform network adequacy practices that are equally applicable to MH/SUD and medical/surgical. In Operation: The Plan monitors the application of this NQTL through several initiatives: • Oversight of network adequacy reporting by the National Quality Oversight Committee NQOC. o A qualitative and quantitative analysis by product/product line is performed using network adequacy data which includes member complaints/grievances and appeals, accessibility, availability, out of network requests, and member experience data (CAHPS or member experience survey). • Network adequacy complaints/grievances and appeals at or in excess of .01 per thousand member months will trigger an additional review. The rate per thousand member months shall be calculated as follows: [# of complaints or appeals)/(monthly total for 12 months of membership/1000)] • Out-Of-Network requests for and utilization services will be reported at the product line-level per thousand members. The rate per thousand members shall be calculated as follows: [# of Out-of-Network requests)/1,000 enrollees] (membership/1000). Summary: The same standards are used to define and monitor minimum requirements for network composition, ensure compliance with applicable state and federal regulatory standards, and to ensure compliance with applicable accreditations standards for both M/S and MH/SUD. Plan Language: COC & SOB: No Reference	
(STEP-5): *A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.*	**The Plan has confirmed that the criteria for all Medical/Surgical and MH/SUD procedures, services, devices and therapies demonstrate that a consistent methodology for determining which services will be subject to NQTLs, in policy and practice, is comparably and no more stringently applied with respect to MH/SUD benefits than those applied to Medical/Surgical benefits.**	

Exhibit A (4)

Annual Mental Health and Substance Use Benefits Compliance Report

Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:

Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (13) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	***Medical/Surgical Benefits***
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.	Carrier did not identify any substantial disparities in its practices related to the development, modification or addition of medical necessity criteria, its medical appropriateness and level of care treatment practices suggesting a more restrictive practice was applied, either as written or in operation, to MH/SUD benefits as compared to Med/Surg benefits. Clinical criteria used to review medical necessity of MH/SUD services is different from the criteria used to review medical necessity of Med/Surg benefits. This not reflective of a more restrictive process, but instead, is due to the difference in clinical conditions that apply to MH/SUD and Med/Surg services. There is no substantial difference in Carrier's practices related to the development and use of medical necessity criteria, which is managed through Medical Management committees staffed with clinical experts and other business professionals responsible for developing, reviewing, assessing, and approving the clinical criteria used to make MH/SUD and Med/Surg medical necessity decisions (reviewed annually or more frequently, as appropriate). Carrier's plans use the same definition of medical necessity for MH/SUD and Med/Surg benefits and such definition is consistent with how it is defined under applicable Connecticut law. Carrier uses objective, evidenced-based clinical criteria developed externally and internally for both MH/SUD and Med/Surg medical necessity determinations. For MH/SUD benefits, nationally recognized ASAM, LOCUS, CASSII, CALOCUS-CASII and ECSII external criteria is used. When externally developed MH/SUD criteria is not available, internally developed evidence-based criteria is used for MH/SUD utilization reviews. For Med/Surg medical necessity reviews, Carriers uses internally developed evidence-based clinical criteria and nationally recognized, evidence-based external criteria published by InterQual. Internally evidence-based criteria is developed based upon analysis of published peer reviewed literature, input from internal clinicians and/or actively practicing clinicians and experts, and feedback from relevant business units. Staff making utilization management determinations participate in annual inter-rater-reliability (IRR) audits to ensure clinical policies, criteria and benefits are applied consistently and appropriately to ensure in-operation compliance. The most recent results on the overall rate of inter-rater reliability for MH/SUD utilization review determinations showed that 98.8% exceeded the target goal of 90%. These results indicate a high degree of consistency in MH/SUD	Same as response in MH/SUD column.

	utilization management decision making. For Med/Surg utilization management, staff must achieve a passing score of 85% or greater, and the most recent data showed that Med/Surg staff achieved a passing score of 85% or higher during their initial testing or as a result of individualized coaching and retesting. In addition, to the above, the Carrier reviewed the total 2022 claim outcomes for services rendered to Connecticut members, including both administrative and clinical claim outcomes, for Med/Surg and MH/SUD services. The overall percentage of Med/Surg claims approved/paid was 84.7% and the overall percentage of MH/SUD claims approved/paid was 88%. These results further support that the Carrier's application of NQTLs is comparable and no more stringent for MH/SUD benefits than it is for Med/Surg benefits.	
In-Patient & In-Network NQTL Practices	Responses below apply to Inpatient In-Network NQTLs applicable to the subcategories in this report.	Responses below apply to Inpatient In-Network NQTLs applicable to the subcategories in this report.
In-Patient & Out-of-Network NQTL Practices	Responses below apply to Inpatient Out-of-Network NQTLs applicable to the subcategories in this report.	Responses below apply to Inpatient Out-of-Network NQTLs applicable to the subcategories in this report.
Out-Patient & In-Network NQTL Practices	Responses below apply to Outpatient In-Network NQTLs applicable to the subcategories in this report.	Responses below apply to Outpatient In-Network NQTLs applicable to the subcategories in this report.
Out-Patient & Out-of-Network NQTL Practices	Responses below apply to Outpatient Out-of-Network NQTLs applicable to the subcategories in this report.	Responses below apply to Outpatient Out-of-Network NQTLs applicable to the subcategories in this report.
Emergency Services/Benefits NQTL Practices	Carrier did not identify any substantial disparities in the comparative analyses of the 2022 emergency services data suggesting a more restrictive practice was applied, either as written or in operation, to MH/SUD benefits as compared to Med/Surg benefits. Emergency services do not require authorization either for MH/SUD or for Med/Surg services. Carrier applies the same notice requirement (2 business days) for notification of MH/SUD and Med/Surg inpatient admissions following emergency services. Carrier’s 2022 data showed all MH/SUD emergency services were covered and 92% of Med/Surg emergency services were covered by Carrier.	Same as response in MH/SUD column.
Rx Formulary Design, Management and Pharmacy Services NQTL Practices	Carrier's policies and procedures related to the formulary design and utilization management of pharmacy benefits consider similar factors, strategies and evidentiary standards, and are, as written and as applied, comparable and no more stringent for MH/SUD benefits than for medical/surgical benefits. Examples of factors considered include generally accepted standards of clinical practice (e.g. as reflected in FDA approvals and indications, drug compendia, relevant medical society guidance), clinical efficacy, safety (e.g. adverse effects of drugs, contraindications, drug interactions, dosing and dispensing standards, potential for overdose and abuse), potential for fraud, waste and abuse, cost effectiveness, utilization, potential value for meaningful results from utilization management activity	Same as response in MH/SUD column.

	relative to the administrative cost, and comparison with alternatives. Examples of evidentiary standards and sources used to define such factors, include recognized medical literature, published clinical guidelines and standards, information published by pharmaceutical manufacturers (e.g. package inserts, drug compendia), safety profile of medication, evidence-based empirical data, research studies and other relevant medical literature discussing the drug, FDA approval and indications, state and federal requirements, cost and trend data, and feedback from practicing clinicians, pharmacy specialists and other subject matter experts. The processes, strategies and evidentiary standards behind Carrier's pharmacy benefit utilization management requirements ensure that members have access to appropriate medically necessary, safe and effective MH/SUD and Med/Surg medications as described in the plan. With respect to formulary design, the majority of the MH/SUD prescriptions are offered on the lower cost tiers, which provides more access and minimizes the financial burden for members who need these prescriptions. For example, Carrier's 2022 formulary showed that more than half of the MH/SUD prescriptions are in Tier 1 or Tier 2, while less than half of Med/Surg prescriptions are in Tier 1 or Tier 2. In addition, no disparities have been identified that suggest a more stringent utilization management process was applied to MH/SUD prescriptions as compared to Med/Surg prescriptions. The total drugs subject to utilization management (step therapy or prior authorization) on Carrier's formularies are comparable, with 11.73% of MH/SUD drugs on the 4 Tier formulary requiring step therapy or prior authorization and 16.71% of Med/Surg drugs requiring step therapy or prior authorization; and with 13.23% of MH/SUD drugs on the 5 Tier formulary requiring step therapy or prior authorization and 15.25% of Med/Surg drugs requiring step therapy or prior authorization of this formulary. The 2022 results further support that the Carrier's application of NQTLs is comparable and no more stringent for MH/SUD pharmacy benefits than it is for Med/Surg pharmacy benefits.	
Prior-Authorization NQTL Practices	Carrier's policies and procedures related to its NQTLs, as written and as applied, are comparable and no more stringent for MH/SUD benefits than for med/surg benefits. In designing and applying utilization management protocols, Carrier considers similar factors, strategies and evidentiary standards. Examples of factors (which are not weighted) considered include clinical appropriateness/clinical efficacy, variation in utilization patterns including underutilization or overutilization relative to clinical benchmarks, and the potential value for meaningful results from utilization management activity relative to the administrative cost. In addition, examples of evidentiary standards and sources used to define such factors, include recognized medical literature, evidence-based empirical data and research studies, quality and clinical efficiency data, state and federal requirements, publications by government sources and/or professional societies, utilization data, cost and trend data, and internal and external subject matter expert feedback. Carrier uses prior authorization to verify member eligibility, facilitate the appropriate utilization of services and facilitate coordination of care prior to services being provided. Prior authorization is used as a tool to ensure members receive medically appropriate care in accordance with the member's benefit plan. Carrier did not identify any substantial disparities in the comparative analyses of the 2022 prior authorization utilization management protocol suggesting a more restrictive prior authorization review process was applied, either as written or in	Same as response in MH/SUD column.

	operation, to MH/SUD benefits as compared to Med/Surg benefits. Carrier's 2022 clinical utilization review data (excluding pharmacy) showed there were 4406 total prior authorization requests (in-network and out-of-network combined), such that 94% were for Med/Surg services and 6% were for MH/SUD services. Carrier's approval rate for such prior authorization requests showed that 97% of the MH/SUD requests were approved and 84% of the Med/Surg prior authorization requests were approved.	
Concurrent Review Benefit NQTL Practices	Carrier's policies and procedures related to its NQTLs, as written and as applied, are comparable and no more stringent for MH/SUD benefits than for med/surg benefits. In designing and applying utilization management protocols, Carrier considers similar factors, strategies and evidentiary standards. Examples of factors (which are not weighted) considered include clinical appropriateness/clinical efficacy, variation in utilization patterns including underutilization or overutilization relative to clinical benchmarks, and the potential value for meaningful results from utilization management activity relative to the administrative cost. In addition, examples of evidentiary standards and sources used to define such factors, include recognized medical literature, evidence-based empirical data and research studies, quality and clinical efficiency data, state and federal requirements, publications by government sources and/or professional societies, utilization data, cost and trend data, and internal and external subject matter expert feedback. Carrier uses concurrent review to assess the continued medical necessity and appropriateness of utilization of services during care, and to facilitate coordination of care as appropriate, while service is ongoing. Concurrent review ensures the member continues to receive medically necessary care while in active treatment and to ensure proper discharge and transition of care planning. Carrier did not identify any substantial disparities in the comparative analyses of the 2022 concurrent reviews suggesting a more restrictive concurrent review process was applied, either as written or in operation, to MH/SUD benefits as compared to Med/Surg benefits. Carrier's 2022 clinical utilization review data (excluding pharmacy) showed there were significantly fewer concurrent reviews for MH/SUD services as compared to Med/Surg services. Specifically, of the 464 total concurrent reviews, 94% were for Med/Surg services and 6% were for MH/SUD services. Further, Carrier's data showed that 97% of concurrent reviews for MH/SUD services were approved and 84% of concurrent reviews were approved for Med/Surg services.	Same as response in MH/SUD column.
Retrospective Review Benefit NQTL Practices	Carrier's policies and procedures related to its NQTLs, as written and as applied, are comparable and no more stringent for MH/SUD benefits than for medical/surgical benefits. In designing and applying utilization management protocols, Carrier considers similar factors, strategies and evidentiary standards. Examples of factors (which are not weighted) considered include clinical appropriateness/clinical efficacy, variation in utilization patterns including underutilization or overutilization relative to clinical benchmarks, and the potential value for meaningful results from utilization management activity relative to the administrative cost. In addition, examples of evidentiary standards and sources used to define such factors, include recognized medical literature, evidence-based empirical data and research studies, quality and clinical efficiency data, state and federal requirements, publications by government sources and/or professional societies, utilization data, cost and trend data, and internal and external subject matter expert feedback.	Same as response in MH/SUD column.

	The retrospective review process provides members or providers with an opportunity for a post-service review of a request for coverage when the administrative authorization or notification requirements of the plan have not been met. Retrospective reviews are conducted to identify potential inappropriate utilization, clinical appropriateness of treatment, quality concerns, and/or provider education needs regarding procedural requirements. Carrier did not identify any substantial disparities in the comparative analyses of the 2022 retrospective reviews suggesting a more restrictive retrospective review process was applied, either as written or in operation, to MH/SUD benefits as compared to Med/Surg benefits. Carrier's 2022 clinical utilization review data (excluding pharmacy) showed there were significantly fewer retrospective reviews for MH/SUD as compared to Med/Surg services. Specifically, of the total 276 retrospective reviews, 94% were for Med/Surg services and 6% were for MH/SUD services. Further, Carrier's data showed a 94% approval rate of retrospective reviews for MH/SUD services and a 23% approval rate for Med/Surg services.	
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	Carrier did not identify any substantial disparities in its practices related to the clinical procedure coding, billing coding and process NQTL practices. The Carrier's claims processing systems are configured based on industry standard claim processing methodologies. Carrier uses a variety of sources to configure claims systems for the appropriate processing of MH/SUD and Med/Surg claims, including the American Medical Association, the Centers for Medicare & Medicaid Services, the CPT Coding Manual and the Healthcare Common Procedures Coding system code set.	Same as response in MH/SUD column.
Case & Medical Management NQTL Practices	Medical Management NQTLs: Please refer back to responses above under RX/Formulary Design, Prior Authorization, Concurrent Review, and Retrospective Review NQTLs. Carrier did not identify any substantial disparities in the comparative analyses of the 2022 utilization management reviews suggesting a more restrictive utilization management process was applied, either as written or in operation, to MH/SUD benefits as compared to Med/Surg benefits. Carrier considers the same factors and sources in designing its NQTLs and follows comparable processes in administering its MH/SUD and Med/Surg benefits. Carrier also considers the same factors and sources in developing clinical criteria used to perform utilization management reviews. When combining all utilization review protocols, Carrier's average approval rate for MH/SUD services was higher than the average approval rate for Med/Surg services. In addition, of the 58 total internal clinical appeals received, 93% were Med/Surg appeals and 7% were MH/SUD appeals, with a consistent approval rate for MH/SUD and Med/Surg services (50% approval rate for MH/SUD appeals and 47% approval rate for Med/Surg appeals). There were no clinical external clinical appeals filed for MH/SUD benefits and there was 1 external clinical appeal filed for Med/Surg benefits. This further demonstrates there were no substantial disparities in the utilization management procedures, including appeals, suggesting a more restrictive process, either as written or as applied, for MH/SUD benefits than for Med/Surg benefits. The low percentage of MH/SUD appeals also suggests accuracy and consistency in the initial utilization management process for such services, which is further corroborated by the Carrier's IRR scores. <u>Case Management:</u> The Carrier's Case Management practices are not an NQTL under MHPAEA because they do not result in benefit determinations and do not limit the scope or duration of benefits. Case Management services are available to members on a voluntary basis, and Case Management is separate and distinct from the Plan's Utilization	Same as response in MH/SUD column.

	Management program. The Plan's Case Management practices do not impose or influence a modification of a benefit determination or its scope or duration because Case Management is focused on educating members about best practices to manage their conditions, including with respect to transitions of care, coordination of care, medication adherence, necessary referrals, and follow-up appointments. For example, the Plan's Case Management teams will reach out to members who were recently discharged from the hospital to ensure that the members understand their discharge instructions and have any necessary medications. Case Management will also assist members with obtaining any required resources, such as medical equipment and supplies and appropriate home care. Case Management may also help members with getting referrals and appointments. The Carrier's Case Management program does not adversely impact the scope of care, treatment, or benefits delivered any differently than if patients had not participated in the case management practice.	
Network Adequacy & Provider Reimbursement Rates		
(STEP-5): *A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.*	Based on the foregoing, Carrier has demonstrated that its processes, strategies, evidentiary standards and other factors used to design and apply the NQTLs identified in this report, both as written and in operation, are comparable and no more stringently applied for MH/SUD benefits than for Med/Surg benefits. In designing and applying such NQTLs, Carrier considers similar factors, strategies and evidentiary standards and administers such NQTLs in a comparable manner. The following key points were considered in reaching Carrier's conclusion: 1. Following the definition under applicable Connecticut law, Carrier uses the same definition of medical necessity for MH/SUD and Med/Surg utilization reviews and uses objective, externally and internally developed evidence-based clinical criteria to make MH/SUD and Med/Surg utilization review decisions. Carrier follows consistent processes in the design of utilization management protocols and development of clinical criteria used in connection with such protocols. 2. Carrier's IRR testing demonstrated that clinical staff making utilization management decisions for MH/SUD benefits was high and exceeded the testing goals, demonstrating in-operation consistency and comparability with the written policies and plan terms related to NQTLs. 3. Carrier's overall rate of approved/paid claim outcomes for clinical and administrative claims were consistent among MH/SUD and Med/Surg services (slightly higher for MH/SUD claims). 4. Carrier's overall approval rates for the various types of utilization review determinations were higher for MH/SUD benefits than for Med/Surg benefits. 5. Carrier applies the same notification process for MH/SUD and Med/Surg emergency services and showed that emergency services were paid for all MH/SUD emergency services and that 92% of Med/Surg emergency services were paid. 6. Carrier's pharmacy benefit formulary tiering showed MH/SUD drugs generally on lower, less expensive tiers and consistency in the utilization management processes (prior authorization and step therapy) for pharmacy benefits, including consistency in outcomes data related to such utilization management protocols.	

Exhibit A (5)

Annual Mental Health and Substance Use Benefits Compliance Report

Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:

Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (13) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	***Medical/Surgical Benefits***
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.	MH/SUD medical necessity clinical determinations are made using externally developed, evidence-based clinical criteria (aka medical necessity criteria) such as American Society of Addiction Medicine (ASAM) Criteria®, Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System-Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) and Early Childhood Service Intensity Instrument (ECSII) guidelines as well as internally developed objective, evidence-based, behavioral clinical policies. Where available, MH/SUD uses externally developed evidence-based clinical criteria (e.g., ASAM®, LOCUS, CALOCUS-CASII and ECSII). When MH/SUD technologies (e.g., services, interventions, etc.) fall outside the scope of externally developed clinical criteria, internally developed, evidence-based, behavioral clinical policies are used when making clinical coverage determinations. The Clinical Technology Assessment Committee (CTAC) assesses externally developed clinical criteria and develops and approves behavioral clinical policies for MH/SUD services. CTAC uses scientifically based clinical evidence and the Hierarchy of Clinical Evidence in its development, assessment, and approval processes. CTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective services for MH/SUD members. CTAC is comprised of, but is not limited to, behavioral health medical directors, senior leaders of clinical operations and representatives from the clinical quality improvement department, utilization management, clinical	External clinical criteria and sources used are appropriate for M/S (MCG). Both MH/SUD and M/S primarily use external criteria. M/S uses evidence-based, medical internal policy. MH/SUD uses other evidenced-based sources when external criteria are silent on a specific diagnosis/treatment and/or when a diagnosis/treatment is new or emerging and not addressed in existing external criteria (i.e., ®, ASAM, LOCUS, CASII, CALOCUS-CASII, ECSII).

	operations, appeals, legal, compliance, network strategy, and provider experience teams. The Clinical Quality and Operations Committee (CQOC) reviews and validates behavioral clinical policies/clinical criteria endorsed by CTAC.	
In-Patient & In-Network NQTL Practices	Both MH/SUD and M/S require authorization for in-network (INN) inpatient admissions. The list of services varies based on the inherent nature of MH/SUD and M/S inpatient services. Inpatient INN MH/SUD: • MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment	Both M/S and MH/SUD require authorization for inpatient admissions. The list of services varies based on the inherent nature of M/S and MH/SUD inpatient provider types. • Hospital admissions that are elective or not the result of an emergency • Acute Inpatient • Rehabilitation facility admissions • Skilled nursing facility admissions • Sub-acute care admissions
In-Patient & Out-of-Network NQTL Practices	Both MH/SUD and M/S require authorization for out-of-network (OON) inpatient admissions. The list of services varies based on the inherent nature of MH/SUD and M/S inpatient services. Inpatient OON MH/SUD: • MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment	Both M/S and MH/SUD require authorization for inpatient admissions. The list of services varies based on the inherent nature of M/S and MH/SUD inpatient provider types. • Hospital admissions that are elective or not the result of an emergency • Acute Inpatient • Rehabilitation facility admissions • Skilled nursing facility admissions • Sub-acute care admissions
Out-Patient & In-Network NQTL Practices	Both MH/SUD and M/S require authorization for certain in-network (INN) outpatient services. Outpatient INN MH/SUD: • Partial Hospitalization/Day Treatment • Intensive Outpatient • Applied Behavioral Analysis (ABA) • Transcranial Magnetic Stimulation (TMS) • Electroconvulsive Therapy (ECT) • Psychological Testing	Both MH/SUD and M/S require authorization for certain out-of-network (OON) outpatient services. Outpatient OON M/S: • Advanced Radiology • Cardiology • Musculoskeletal surgery and interventional pain management • Ambulatory Surgery • Home Care

Out-Patient & Out-of-Network NQTL Practices	Both MH/SUD and M/S require prior authorization for certain out-of-network (OON) outpatient services. Outpatient OON MH/SUD: • Partial Hospitalization/Day Treatment • Intensive Outpatient • Applied Behavioral Analysis (ABA) • Transcranial Magnetic Stimulation (TMS) • Electroconvulsive Therapy (ECT) • Psychological Testing	Both MH/SUD and M/S require authorization for certain out-of-network (OON) outpatient services. Outpatient OON M/S: • Advanced Radiology • Cardiology • Musculoskeletal surgery and interventional pain management • Ambulatory Surgery • Home Care
Emergency Services/Benefits NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S.	No distinction in any NQTL practice between MH/SUD and M/S.
Rx Formulary Design, Management and Pharmacy Services NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S.	No distinction in any NQTL practice between MH/SUD and M/S.
Prior-Authorization NQTL Practices	Both MH/SUD and M/S have inpatient and outpatient services subject to prior authorization. Inpatient MH/SUD: • MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment	M/S and MH/SUD require prior authorization for certain outpatient services. Requests for ongoing services after the end of the initial prior authorization require review. This review is labeled prior authorization for most M/S and concurrent review for Partial Hospitalization (PHP) and Intensive Outpatient (IOP), but is essentially the same process.
Concurrent Review Benefit NQTL Practices	Both MH/SUD and M/S have inpatient and outpatient services subject to concurrent review. Inpatient MH/SUD: • MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment Note: (Applies to all inpatient services for facilities reimbursed on a per diem basis.)	M//S and MH/SUD require prior authorization for certain outpatient services. Requests for ongoing services after the end of the initial prior authorization require review. This review is labeled prior authorization for most M/S and concurrent review for Partial Hospitalization (PHP) and Intensive Outpatient (IOP), but is essentially the same process.

Retrospective Review Benefit NQTL Practices	Both MH/SUD and M/S have inpatient and outpatient services subject to retrospective review. Inpatient MH/SUD: • MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment Outpatient MH/SUD: • Partial Hospitalization/Day Treatment • Intensive Outpatient • Applied Behavioral Analysis (ABA) • Transcranial Magnetic Stimulation (TMS) • Electroconvulsive Therapy (ECT) • Psychological Testing	Both MH/SUD and M/S have inpatient and outpatient services subject to retrospective review. • Within 6 months of date of service with no claim on file • MH Non-Emergent Acute Inpatient • Acute Inpatient non-emergent and emergent • Skilled Nursing Facility (SNF) • Long Term Acute Care hospitalizations (LTAC) • Acute Inpatient Rehabilitation Facility (IRF) admissions • All outpatient services including post-acute services such as home health care, and ambulance. • Intensive Outpatient (IOP)
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	No distinction in any NQTL practice between MH/SUD and M/S.	No distinction in any NQTL practice between MH/SUD and M/S.
Case & Medical Management NQTL Practices	MH/SUD and M/S do not require participation in any of its supportive case management programs and non-participation does not limit benefits or services in any way. Therefore, case management services are not a treatment limitation (NQTL).	MH/SUD and M/S do not require participation in any of its supportive case management programs and non-participation does not limit benefits or services in any way. Therefore, case management services are not a treatment limitation (NQTL).
Network Adequacy & Provider Reimbursement Rates	MH/SUD assesses network adequacy based on access standards that are in accordance with Centers for Medicare & Medicaid Services (CMS) and/or applicable state laws. When determining whether to recruit providers in a given geographic market (such as a county or metropolitan area), MH/SUD considers network adequacy and access reports. Network adequacy and access reports are prepared on a regular basis and shared with network teams for recruitment purposes to ensure regulatory network access requirements are met. If MH/SUD determines it does not meet network adequacy requirements for a specialty or provider type, within set time and distance thresholds as determined by state or federal requirements, the network team will actively seek to add providers to the network in that specialty or provider type. If there is a supply gap, Plan language	If M/S determines it does not meet network adequacy requirements for a specialty or provider type, the plan will actively seek to add providers to the network in that provider type or specialty. If a member contacts the Customer Service team for assistance locating an in-network provider and the Customer Service Representative (CSR) cannot locate an in-network provider, the CSR notifies the plan's clinical case management staff/Care Management. Care Management assesses the request, and if necessary, notifies the Out of Network Negotiation team to negotiate a single case agreement with an out of network provider. Regarding Provider Reimbursement Rates, while all other comparatives of process remain consistent across MH/SUD and MS, the plan's M/S factors include CMS Resource-Based Relative Value

	allows members to seek an exception and receive services from an out-of-network (OON) provider at the in-network (INN) benefit level Regarding Provider Reimbursement Rates, no distinction noted in any NQTL practice between MH/SUD and M/S.	Scale (RBRVS) using Relative Value Units (RVUs) to define the value of the service or procedure relative to all services and procedures on the scale. The value of the service is based upon the following factors: 1) Provider Work (work), 2) Provider Expense (PE), 3) Provider Malpractice Insurance Expense (MP), 4) Geographic Practice Cost Indices (GCPI), 5) Conversion Factor (CF). The plan's comparative analysis of Provider Reimbursement rates indicate relative parity across the provider license types for comparable services performed by physicians, versus non-physicians (mid-levels).
(STEP-5): *A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.*	**The Plan performed a comparative analysis and concluded the factors, evidentiary standards, and source information used to apply MH/SUD NQTLs subjected to this parity review evidenced in the Exhibit A submission are comparable to, and applied no more stringently than, the factors, evidentiary standards and source information used to apply M/S.**	

Exhibit A (6)

Annual Mental Health and Substance Use Benefits Compliance Report

Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences

Description:

Please aggregate or consolidate any subsidiary blocks of business and any Individual, Small Group and Large Group lines of health plans together.

	For each of the (13) Categories in the 1st Column, Document and Describe any Sub-Category practices that limit benefits only when they are different within the similarly Mapped Classifications and when compared between the two benefits. Do this following all of the 5-Steps	
	Non-Quantitative Treatment Limitation & Medical Necessity Criteria Differences Between the Benefits	
	Mental Health & Substance Use Disorder Benefits	***Medical/Surgical Benefits***
Development, Modification or Addition of Medical Necessity Criteria. Medical Appropriateness and Level of Care Treatment Practices.	The Clinical Technology Assessment Committee (CTAC) assesses externally developed clinical criteria and develops and approves behavioral clinical policies for MH/SUD services. CTAC uses scientifically based clinical evidence and the Hierarchy of Clinical Evidence in its development, assessment, and approval processes. CTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective services for MH/SUD members. CTAC is comprised of, but is not limited to, behavioral health medical directors, senior leaders of clinical operations and representatives from the clinical quality improvement department, utilization management, clinical operations, appeals, legal, compliance, network strategy, and provider experience teams. The Clinical Quality and Operations Committee (CQOC) reviews and validates behavioral clinical policies/clinical criteria endorsed by CTAC. MH/SUD assesses evidence from the following when developing behavioral clinical policies/clinical criteria: • Scientifically based clinical evidence • Peer-reviewed literature • Hierarchy of Clinical Evidence: - Systematic reviews and meta-analyses - Randomized controlled trials - Large non-randomized controlled trials - Large prospective trials	The Medical Technology Assessment Committee (MTAC) assesses externally developed clinical criteria and develops and approves medical clinical policies for M/S services. MTAC uses scientifically based, clinical evidence and the Hierarchy of Clinical Evidence in its development, assessment, and approval processes. MTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective services for M/S members. MTAC is comprised of, but not limited to, medical directors with diverse medical and surgical specialties and sub-specialties, representatives from business segments, legal services, medical policy development and operations teams, and other guests, as required. The National Medical Care Management Committee (NMCMC) reviews and validates medical clinical policies/clinical criteria endorsed by MTAC. M/S assesses evidence from the following when developing or approving medical clinical policies/clinical criteria: • Scientifically based clinical evidence • Peer-reviewed literature • Hierarchy of Clinical Evidence: - Statistically robust, well-designed randomized controlled trials - Statistically robust, well-designed cohort studies - Multi-site observational studies - Single-site observational studies

	- Comparative and cohort studies - Cross sectional studies - Retrospective studies - Surveillance studies - Case reviews/case series - Anecdotal/editorial statements - Professional opinions Anecdotal/editorial statements and professional opinions are only used to support adoption of behavioral clinical policies /clinical criteria when no other source is available. In the absence of strong and compelling scientific evidence, behavioral clinical policies may be based upon: • National consensus statements • Publications by recognized authorities such as government sources and/or professional societies The M/S and MH/SUD Hierarchies of Clinical Evidence are comparable. Both use the following categories of sources (with source-specific differences if the source is specific to M/S or MH/SUD): • Well-designed evidence-based studies • Observational studies • Case studies • Consensus statements • Clinical and professional opinion papers MTAC and CTAC committees both assess the safety and effectiveness of technologies used for the treatment of health care conditions based upon the scientific evidence. CTAC's technology assessment process for MH/SUD technologies, including CTAC's Hierarchy of Clinical Evidence, is comparable to, and applied no more stringently than, MTAC's technology assessment process for M/S technologies including MTAC's Hierarchy of Clinical Evidence. When assessing the safety and efficacy of technologies used to treat M/S and MH/SUD conditions, both MTAC and CTAC first look at any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled, trials and cohort studies. CTAC will also look at systematic reviews and meta-analyses,	In the absence of strong and compelling scientific evidence, medical clinical policies may be based upon: • National guidelines and consensus statements • Centers for Medicare and Medicaid Services (CMS) National Coverage Decisions (NCDs) • Clinical position papers based upon rigorous review of scientific evidence or clinical registry data from professional specialty societies when their statements are based upon referenced clinical evidence, e.g., American College of Physicians (ACP), The Society for Post-Acute and Long-Term Care Medicine (AMDA), American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), American College of Cardiology (ACC), etc. The M/S and MH/SUD Hierarchies of Clinical Evidence are comparable. Both use the following categories of sources (with source-specific differences if the source is specific to M/S or MH/SUD): • Well-designed evidence-based studies • Observational studies • Case studies • Consensus statements • Clinical and professional opinion papers MTAC and CTAC committees both assess the safety and effectiveness of technologies used for the treatment of health care conditions based upon the scientific evidence. When assessing the safety and efficacy of technologies used to treat M/S and MH/SUD conditions, both MTAC and CTAC first look at any strong and compelling scientific evidence such as statistically robust, well-designed, randomized, controlled, trials and cohort studies. In addition, MTAC will look at multi-site observational studies and single site observational studies. When assessing the safety and efficacy of technologies used to treat MH/SUD, more evidentiary sources are included in the MH/SUD Hierarchy of Evidence than what is included in the M/S Hierarchy of Evidence. The MH/SUD Hierarchy of Evidence considers evidence from more areas when determining whether a treatment, service or technology is safe/effective. This means there is more "opportunity" (i.e., more evidentiary sources are available) to substantiate the efficacy and safety of a treatment, service or technology used to treat MH/SUD than there is for M/S.

	large prospective trials, cross-sectional studies, retrospective studies, surveillance studies, case reviews/case series, anecdotal/editorial statements, and professional opinions. When assessing the safety and efficacy of technologies used to treat MH/SUD, more evidentiary sources are included in the MH/SUD Hierarchy of Evidence than what is included in the M/S Hierarchy of Evidence. The MH/SUD Hierarchy of Evidence considers evidence from more areas when determining whether a treatment, service or technology is safe/effective. This means there is more “opportunity” (i.e., more evidentiary sources are available) to substantiate the efficacy and safety of a treatment, service or technology used to treat MH/SUD than there is for M/S.	
In-Patient & In-Network NQTL Practices	Based on the Plan's analysis, no differences were identified.	Based on the Plan's analysis, no differences were identified.
In-Patient & Out-of-Network NQTL Practices	Based on the Plan's analysis, no differences were identified.	Based on the Plan's analysis, no differences were identified.
Out-Patient & In-Network NQTL Practices	Based on the Plan's analysis, no differences were identified.	Based on the Plan's analysis, no differences were identified.
Out-Patient & Out-of-Network NQTL Practices	Based on the Plan's analysis, no differences were identified.	Based on the Plan's analysis, no differences were identified.
Emergency Services/Benefits NQTL Practices	Prior Authorization, Concurrent Review and Retrospective Review are not performed on MH/SUD Emergency services. Emergency services for MH/SUD, as defined by the prudent layperson standard (and as defined by the state), are covered without medical necessity.	Prior Authorization and Concurrent Review are not performed on M/S Emergency services. Emergency services for M/S, as defined by the prudent layperson standard (and as defined by the state), are covered without medical necessity.

Rx Formulary Design, Management and Pharmacy Services NQTL Practices	**Prescription Drug List (PDL) Design** The Pharmacy & Therapeutics (P&T) Committee assesses a MH/SUD prescription drug's place in therapy, and its relative safety and efficacy, in order to provide a clinical recommendation/designation used in determining coverage and tier assignment. For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop clinical policies through a single P&T Committee. Findings The Plan reviewed the number of MH/SUD prescription drugs by tier on a tri-annual basis. The findings of the Prescription Drug Tier Analysis (see data below) indicated the percent of prescription drugs by tiers for MH/SUD prescription drug services were comparable to the percent of prescription drugs by tiers for M/S prescription drug services. Data is for (January, May, and September 2021). The Plan also notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance. The following are results of each analysis in 2021: • January 2021 – - 58.9% of MH/SUD drugs are on Tiers 1 and 2 • May 2021 – - 59.1% of MH/SUD drugs are on Tiers 1 and 2 • September 2021 – - 60.0% of MH/SUD drugs are on Tiers 1 and 2 These evaluations were based on the Advantage PDL, which is the most commonly used PDL. Prescription Drug Prior Authorization / Step Therapy / Quantity Limits For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop MH/SUD drug policies through a single Pharmacy & Therapeutics (P&T) Committee. The findings of the prescription drug prior authorization or step therapy outcomes analysis for each Plan (see data below) indicated the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for MH/SUD prescription drugs were comparable to the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for M/S prescription drugs.	**Prescription Drug List (PDL) Design** The Pharmacy & Therapeutics (P&T) Committee assesses a M/S prescription drug's place in therapy, and its relative safety and efficacy, in order to provide a clinical recommendation/designation used in determining coverage and tier assignment. For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop clinical policies through a single P&T Committee. Findings The Plan reviewed the number of M/S prescription drugs by tier on a tri-annual basis. The findings of the Prescription Drug Tier Analysis (see data below) indicated the percent of prescription drugs by tiers for MH/SUD prescription drug services were comparable to the percent of prescription drugs by tiers for M/S prescription drug services. Data is for (January, May, and September 2021). The Plan also notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance. The following are results of each analysis in 2021: • January 2021 – - 54.0% of M/S drugs are on Tiers 1 and 2 • May 2021 – - 53.6% of M/S drugs are on Tiers 1 and 2 • September 2021 – - 53.7% of M/S drugs are on Tiers 1 and 2 These evaluations were based on the Advantage PDL, which is the most commonly used PDL. Prescription Drug Prior Authorization / Step Therapy / Quantity Limits For all prescription drugs covered under the pharmacy benefit, the Plan uses the same policies and procedures to create clinical criteria and develop M/S drug policies through a single Pharmacy & Therapeutics (P&T) Committee. The findings of the prescription drug prior authorization or step therapy outcomes analysis for each Plan (see data below) indicated the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for MH/SUD prescription drugs were comparable to the percentage of prescription drugs subject to prior authorization, step therapy, and/or quantity limits for M/S prescription drugs. Data is for (January, May, and September 2022). The Plan notes that the U.S.

	Data is for (January, May, and September 2022). The Plan notes that the U.S. Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance. The following are results of each analysis in 2022: • January 2022 – 30.6% (182) of MH/SUD drugs are subject to prior authorization, step therapy, and/or quantity limits • May 2022 – 32.5% (197) of MH/SUD drugs are subject to prior authorization, step therapy, and/or quantity limits • September 2022 – 32.7% (201) of MH/SUD drugs are subject to prior authorization, step therapy, and/or quantity limits In January of 2022 a discrepancy in report logic was identified that had resulted in an under-reporting of quantity limits in the past. Now corrected, the increase in reported quantity limits is driving an increase in overall prior authorization/step therapy/quantity limit programs for MH/SUD products (30.6%) vs non-MH/SUD products (19.6%). This discrepancy prompted further analysis of 2022 data, which indicated: • A higher percentage of quantity limits on MH/SUD products is seen for multiple reasons, including the following: - Smaller pool of MH/SUD products (594) vs. non-MH/SUD products (7,722) to evaluate (Generic Product Identifier [GPI] 14) - Many MH/SUD products have a high number of strengths -- Each strength and dosage form count towards the overall percentages -- When evaluated at a GPI 12 to control for multiple product strengths, MH/SUD products with a 'Quantity Limit only' make up 16.9% of all MH/SUD products and non-MH/SUD products are at 5.9% ---This represents a significant reduction compared to the GPI 14 analysis (MH/SUD 23.9%, Non-MH/SUD 6.4%) - Prevention of diversion for high-risk MH/SUD categories (e.g., stimulants, SUD treatment) -- At the GPI 14 level, 52.4% of MH/SUD products are considered higher risk for diversion vs. 4.5% of non-MH/SUD products (e.g., opioids, sleep disorder agents) -- When evaluated at a GPI 12 to control for multiple product strengths, 38.3% of all MH/SUD products are at a higher risk of diversion vs. only 2.5% of non-MH/SUD products	Department of Labor has indicated generally that outcomes data are not dispositive of parity compliance. The following are results of each analysis in 2022: • January 2022 – 19.6% (1,513) of M/S drugs are subject to prior authorization, step therapy, and/or quantity limits • May 2022 – 19.8% (1,532) of M/S drugs are subject to prior authorization, step therapy, and/or quantity limits • September 2022 – 20.4% (1,577) of M/S drugs are subject to prior authorization, step therapy, and/or quantity limits In January 2022, a discrepancy in report logic was identified that had resulted in an under-reporting of quantity limits in the past. Now corrected, the increase in reported quantity limits is driving an increase in overall prior authorization/step therapy/quantity limit programs for MH/SUD products (30.6%) vs. non-MH/SUD products (19.6%). This discrepancy prompted further analysis of 2022 data, which found: • A higher percentage of quantity limits on MH/SUD products is seen for multiple reasons, including the following: - Smaller pool of MH/SUD products (594) vs. non-MH/SUD products (7,722) to evaluate (Generic Product Identifier [GPI] 14) - Many MH/SUD products have a high number of strengths --Each strength and dosage form count towards the overall percentages --When evaluated at a GPI 12 to control for multiple product strengths, MH/SUD products with a 'Quantity Limit only' make up 16.9% of all MH/SUD products and non-MH/SUD products are at 5.9% ---This represents a significant reduction compared to the GPI 14 analysis (MH/SUD 23.9%, Non-MH/SUD 6.4%) - Prevention of diversion for high-risk MH/SUD categories (e.g., stimulants, SUD treatment) --At the GPI 14 level, 52.4% of MH/SUD products are considered higher risk for diversion vs. 4.5% of non-MH/SUD products (e.g., opioids, sleep disorder agents) --When evaluated at a GPI 12 to control for multiple product strengths, 38.3% of all MH/SUD products are at a higher risk of diversion vs. only 2.5% of non-MH/SUD products • Quantity limits is the driving factor for the overall higher percentage of clinical programs for MH/SUD products (32.5% vs 19.8% for non-MH/SUD)

	• Quantity limits is the driving factor for the overall higher percentage of clinical programs for MH/SUD products (32.5% vs 19.8% for non-MH/SUD) The Plan notes that the percentage of MH/SUD drugs subject to prior authorization, step therapy, and/or quantity limits is higher than the percentage of M/S drugs subject to prior authorization, step therapy, and/or quantity limits. The Plan concluded the contributing factors of having a smaller pool of MH/SUD products to evaluate, the broader range of doses for MH/SUD products, and the increased risk of abuse and diversion of MH/SUD products explain the variance. The Plan concluded this does not indicate a parity concern, but rather is an indicator of patient safety in disbursing MH/SUD drugs.	The Plan notes that the percentage of MH/SUD drugs subject to prior authorization, step therapy, and/or quantity limits is higher than the percentage of M/S drugs subject to prior authorization, step therapy, and/or quantity limits. The Plan concluded the contributing factors of having a smaller pool of MH/SUD products to evaluate, the broader range of doses for MH/SUD products, and the increased risk of abuse and diversion of MH/SUD products explain the variance. The Plan concluded this does not indicate a parity concern, but rather is an indicator of patient safety in disbursing MH/SUD drugs.
Prior-Authorization NQTL Practices	**Prior Authorization IP and OP INN**: Timeframe to submit. The timeframe for the provider or member to submit the prior authorization request was reviewed and it was determined that MH/SUD was no more stringent. As outlined in the Plan's Administrative Guide, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated. Unplanned or emergency admissions are not subject to prior authorization. M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews may be made by clinical staff (i.e., nurses, physicians, etc.) and all adverse determinations are made by a physician or other appropriate health care professionals. **Prior Authorization IP and OP OON:** The timeframe for the member to submit the prior authorization requirement was reviewed and it was determined that MH/SUD was no more stringent. Per the member's Plan documents, the timeframes vary depending upon the services requested from as soon as possible to six months prior to the OON service. Unplanned or emergency services are not subject to prior authorization. M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews may be made by clinical staff (i.e., nurses, physicians, etc.) and all adverse determinations are made by a physician or other appropriate health care professionals. IP INN M/S Services Subject to Prior Authorization OHI and OHP: • Arthroplasty • Bariatric Surgery • Breast Reconstruction (non-mastectomy)	**Prior Authorization IP and OP INN**: Timeframe to submit. The timeframe for the provider or member to submit the prior authorization request was reviewed and it was determined that MH/SUD was no more stringent. As outlined in the Plan's Administrative Guide, providers must submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service, unless otherwise stated. Unplanned or emergency admissions are not subject to prior authorization. M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews may be made by clinical staff (i.e., nurses, physicians, etc.) and all adverse determinations are made by a physician or other appropriate health care professionals. **Prior Authorization IP and OP OON:** The timeframe for the member to submit the prior authorization requirement was reviewed and it was determined that MH/SUD was no more stringent. Per the member's Plan documents, the timeframes vary depending upon the services requested from as soon as possible to six months prior to the OON service. Unplanned or emergency services are not subject to prior authorization. M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews may be made by clinical staff (i.e., nurses, physicians, etc.) and all adverse determinations are made by a physician or other appropriate health care professionals. IP INN M/S Services Subject to Prior Authorization OHI and OHP: • Arthroplasty • Bariatric Surgery • Breast Reconstruction (non-mastectomy) • Cardiology • Cerebral Seizure Monitoring – Inpatient Video EEG

	• Cardiology • Cerebral Seizure Monitoring – Inpatient Video EEG • Chemotherapy Services • Clinical Trials • Congenital Heart Disease • Cosmetic and Reconstructive Procedures • Dental services • Digestive System • Eye, Ear, Nose and Throat • End-stage renal disease (ESRD) dialysis services • Foot Surgery • Gender Dysphoria Treatment • Genital Organs • Hospice • Hysterectomy • Inpatient admissions – post-acute services • Musculoskeletal System • Nervous System • Obstetrical Procedures • Orthognathic Surgery • Orthopedic Surgeries • Respiratory System • Sleep Disorder Tests/Treatment • Spine Surgery • Transplants • Urinary System • Ventricular Assist Devices OP INN M/S Services Subject to Prior Authorization OHI and OHP: • Arthroplasty • Arthroscopy • Bariatric • Breast Reconstruction (non-mastectomy) • Cancer supportive care • Cardiology • Cardiovascular System • Cartilage Implants	• Chemotherapy Services • Clinical Trials • Congenital Heart Disease • Cosmetic and Reconstructive Procedures • Dental services • Digestive System • Eye, Ear, Nose and Throat • End-stage renal disease (ESRD) dialysis services • Foot Surgery • Gender Dysphoria Treatment • Genital Organs • Hospice • Hysterectomy • Inpatient admissions – post-acute services • Musculoskeletal System • Nervous System • Obstetrical Procedures • Orthognathic Surgery • Orthopedic Surgeries • Respiratory System • Sleep Disorder Tests/Treatment • Spine Surgery • Transplants • Urinary System • Ventricular Assist Devices OP INN M/S Services Subject to Prior Authorization OHI and OHP: • Arthroplasty • Arthroscopy • Bariatric • Breast Reconstruction (non-mastectomy) • Cancer supportive care • Cardiology • Cardiovascular System • Cartilage Implants • Chemotherapy Services • Clinical Trials

	• Chemotherapy Services • Clinical Trials • Cochlear Implants and Other Auditory Implants • Congenital Heart Disease • Continuous Glucose Monitoring • Cosmetic and reconstructive procedures • Dental Services • Diagnostic and Therapeutic Procedures • Digestive System • Durable Medical Equipment (DME) over $500 • Endocrine System • End-stage renal disease (ESRD) dialysis services • Eye, Ear, Nose and Throat • Foot Surgery • Functional Endoscopic Sinus Surgery (FESS) • Gastroenterology • Gender Dysphoria Treatment • Genetic Testing/Lab Services • Genital Organs • Hearing/Audio/Vision • Hemic and Lymphatic System • Home Health Care • Hospice • Hyperbaric Oxygen Treatment • Hysterectomy (abdominal and laparoscopic surgeries) • Infertility • Injectable Medications • Integumentary System • Medical and Surgical Supplies • Medicine Services and Procedures • Musculoskeletal System • Nervous System • Non-Emergency Air Transport • Obstetrical Procedures • Orthognathic Surgery • Orthopedic Surgeries • Orthotics and Prosthetics over $500	• Cochlear Implants and Other Auditory Implants • Congenital Heart Disease • Continuous Glucose Monitoring • Cosmetic and reconstructive procedures • Dental Services • Diagnostic and Therapeutic Procedures • Digestive System • Durable Medical Equipment (DME) over $500 • Endocrine System • End-stage renal disease (ESRD) dialysis services • Eye, Ear, Nose and Throat • Foot Surgery • Functional Endoscopic Sinus Surgery (FESS) • Gastroenterology • Gender Dysphoria Treatment • Genetic Testing/Lab Services • Genital Organs • Hearing/Audio/Vision • Hemic and Lymphatic System • Home Health Care • Hospice • Hyperbaric Oxygen Treatment • Hysterectomy (abdominal and laparoscopic surgeries) • Infertility • Injectable Medications • Integumentary System • Medical and Surgical Supplies • Medicine Services and Procedures • Musculoskeletal System • Nervous System • Non-Emergency Air Transport • Obstetrical Procedures • Orthognathic Surgery • Orthopedic Surgeries • Orthotics and Prosthetics over $500 • Pain Management

	• Pain Management • Potentially unproven services (including experimental/investigational and/or linked services) • Prostate Procedures • Physical, Occupational, Speech and Respiratory Therapy (PT/OT/ST/RT) • Radiation Therapy • Radiology • Respiratory System • Rhinoplasty • Routine Foot Care • Sinuplasty • Site of Service – Office-based program • Site of Service – Outpatient hospital • Sleep Disorder Tests/Treatment • Spine Surgery • Stimulators • Therapeutic Radiopharmaceuticals • Transplants • Urinary System • Uterine Fibroid MR-Guided Focus Ultrasound • Vagus Nerve Stimulation • Vein Procedures IP INN M/S Services Subject to Prior Authorization UHIC: • Arthroplasty • Bariatric Surgery • Breast Reconstruction (non-mastectomy) • Cardiology • Cerebral Seizure Monitoring – Inpatient Video EEG • Chemotherapy Services • Clinical Trials • Congenital Heart Disease • Cosmetic and Reconstructive Procedures • End-stage renal disease (ESRD) dialysis services • Foot Surgery • Gender Dysphoria Treatment • Hysterectomy	• Potentially unproven services (including experimental/investigational and/or linked services) • Prostate Procedures • Physical, Occupational, Speech and Respiratory Therapy (PT/OT/ST/RT) • Radiation Therapy • Radiology • Respiratory System • Rhinoplasty • Routine Foot Care • Sinuplasty • Site of Service – Office-based program • Site of Service – Outpatient hospital • Sleep Disorder Tests/Treatment • Spine Surgery • Stimulators • Therapeutic Radiopharmaceuticals • Transplants • Urinary System • Uterine Fibroid MR-Guided Focus Ultrasound • Vagus Nerve Stimulation • Vein Procedures IP INN M/S Services Subject to Prior Authorization UHIC: • Arthroplasty • Bariatric Surgery • Breast Reconstruction (non-mastectomy) • Cardiology • Cerebral Seizure Monitoring – Inpatient Video EEG • Chemotherapy Services • Clinical Trials • Congenital Heart Disease • Cosmetic and Reconstructive Procedures • End-stage renal disease (ESRD) dialysis services • Foot Surgery • Gender Dysphoria Treatment • Hysterectomy • Inpatient admissions – post-acute services

	• Inpatient admissions – post-acute services • Orthognathic Surgery • Sleep Apnea Procedures and Surgeries • Spinal Surgery • Transplant • Ventricular Assist Devices OP INN M/S Services Subject to Prior Authorization UHIC: • Arthroplasty • Arthroscopy • Bariatric • Bone Growth Stimulator • Breast Reconstruction (non-mastectomy) • Cancer supportive care • Cardiology • Cardiovascular • Cartilage Implants • Chemotherapy Services • Clinical Trials • Cochlear Implants and Other Auditory Implants • Congenital Heart Disease • Continuous Glucose Monitoring • Cosmetic and reconstructive procedures • Durable Medical Equipment (DME) over $1,000 • End-stage renal disease (ESRD) dialysis services • Foot Surgery • Functional Endoscopic Sinus Surgery (FESS) • Gender Dysphoria Treatment • Genetic and molecular testing to include BRCA gene testing • Home Health Care – Non-nutritional • Hysterectomy (abdominal and laparoscopic surgeries) • Infertility • Injectable Medications • MR-guided focused ultrasound (MRgFUS) to treat uterine fibroid • Non-Emergency Air Transport • Orthognathic Surgery • Orthotics over $1,000	• Orthognathic Surgery • Sleep Apnea Procedures and Surgeries • Spinal Surgery • Transplant • Ventricular Assist Devices OP INN M/S Services Subject to Prior Authorization UHIC: • Arthroplasty • Arthroscopy • Bariatric • Bone Growth Stimulator • Breast Reconstruction (non-mastectomy) • Cancer supportive care • Cardiology • Cardiovascular • Cartilage Implants • Chemotherapy Services • Clinical Trials • Cochlear Implants and Other Auditory Implants • Congenital Heart Disease • Continuous Glucose Monitoring • Cosmetic and reconstructive procedures • Durable Medical Equipment (DME) over $1,000 • End-stage renal disease (ESRD) dialysis services • Foot Surgery • Functional Endoscopic Sinus Surgery (FESS) • Gender Dysphoria Treatment • Genetic and molecular testing to include BRCA gene testing • Home Health Care – Non-nutritional • Hysterectomy (abdominal and laparoscopic surgeries) • Infertility • Injectable Medications • MR-guided focused ultrasound (MRgFUS) to treat uterine fibroid • Non-Emergency Air Transport • Orthognathic Surgery • Orthotics over $1,000 • Pain Management and Injection

	• Pain Management and Injection • Physical Therapy/Occupational Therapy (PT/OT) • Potentially unproven services (including experimental/investigational and/or linked services) • Prostate Procedures • Prosthetics over $1,000 • Radiation Therapy • Radiology • Rhinoplasty • Sinuplasty • Site of Service – Office-based program • Site of Service – Outpatient hospital • Site of Service – Outpatient hospital expansion • Sleep Apnea Procedures & Surgeries • Sleep Studies • Spinal Cord Stimulators • Spinal Surgery • Stimulators – not related to spine • Therapeutic Radiopharmaceuticals • Transplant • Vein Procedures IP OON M/S Services Subject to Prior Authorization OHI: • Bariatric Surgery • Clinical Trials • Cosmetic and Reconstructive Procedures; including Breast Reconstruction (Non-Mastectomy) • Hospice • Inpatient Admissions - Inpatient Stay and Post-Acute Services • Pregnancy - Maternity Services - Maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery and stays for Complications of Pregnancy exceeding 96 hours for a cesarean section delivery • Skilled Nursing Facility/Inpatient Rehabilitation Facility Services • Temporomandibular Joint Services • Transplant • Ventricular Assist Devices	• Physical Therapy/Occupational Therapy (PT/OT) • Potentially unproven services (including experimental/investigational and/or linked services) • Prostate Procedures • Prosthetics over $1,000 • Radiation Therapy • Radiology • Rhinoplasty • Sinuplasty • Site of Service – Office-based program • Site of Service – Outpatient hospital • Site of Service – Outpatient hospital expansion • Sleep Apnea Procedures & Surgeries • Sleep Studies • Spinal Cord Stimulators • Spinal Surgery • Stimulators – not related to spine • Therapeutic Radiopharmaceuticals • Transplant • Vein Procedures IP OON M/S Services Subject to Prior Authorization OHI: • Bariatric Surgery • Clinical Trials • Cosmetic and Reconstructive Procedures; including Breast Reconstruction (Non-Mastectomy) • Hospice • Inpatient Admissions - Inpatient Stay and Post-Acute Services • Pregnancy - Maternity Services - Maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery and stays for Complications of Pregnancy exceeding 96 hours for a cesarean section delivery • Skilled Nursing Facility/Inpatient Rehabilitation Facility Services • Temporomandibular Joint Services • Transplant • Ventricular Assist Devices OP OON M/S Services Subject to Prior Authorization OHI:

	OP OON M/S Services Subject to Prior Authorization OHI: • Bariatric Surgery • Breast Pumps • Clinical Trials • Cosmetic and Reconstructive Procedures; including Breast Reconstruction (Non-Mastectomy) • Diabetes Equipment - Before obtaining DME over $1000 • Durable Medical Equipment (DME) • Formulas/Specialized Foods • Genetic Testing/BRCA Gene Testing • Hearing Aids over $1000 • Home health care - non-nutritional • Infertility • Lab, X-Ray, and Diagnostics - For Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram • Lab, X-Ray, and Major Diagnostics - For CT, PET scans, MRI, MRA, and nuclear medicine, including nuclear cardiology • Non-emergency Air Transport • Orthodontia • Orthotics • Pain Management • Pharmaceutical Products – For IV infusions only • Preimplantation Genetic Testing (PGT) and Related Services • Prosthetics • Rehabilitation services [and Chiropractic Treatment] – Physical therapy, occupational therapy, Manipulative Treatment, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, cognitive rehabilitation therapy, and vision therapy • Scopic Procedures • Surgery - Outpatient - For all outpatient surgeries: blepharoplasty, cardiac catheterization, cochlear implants, uvulopalatopharyngoplasty, pacemaker insertion, pain management procedures, vein procedures, spine surgery, total joint replacements, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery • Therapeutic Treatments - Outpatient - Services that require prior authorization: Dialysis, chemotherapy, IV infusion, radiation oncology, intensity modulated radiation therapy, hyperbaric oxygen therapy and MR-guided focused ultrasound	• Bariatric Surgery • Breast Pumps • Clinical Trials • Cosmetic and Reconstructive Procedures; including Breast Reconstruction (Non-Mastectomy) • Diabetes Equipment - Before obtaining DME over $1000 • Durable Medical Equipment (DME) • Formulas/Specialized Foods • Genetic Testing/BRCA Gene Testing • Hearing Aids over $1000 • Home health care - non-nutritional • Infertility • Lab, X-Ray, and Diagnostics - For Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram • Lab, X-Ray, and Major Diagnostics - For CT, PET scans, MRI, MRA, and nuclear medicine, including nuclear cardiology • Non-emergency Air Transport • Orthodontia • Orthotics • Pain Management • Pharmaceutical Products – For IV infusions only • Preimplantation Genetic Testing (PGT) and Related Services • Prosthetics • Rehabilitation services [and Chiropractic Treatment] – Physical therapy, occupational therapy, Manipulative Treatment, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, cognitive rehabilitation therapy, and vision therapy • Scopic Procedures • Surgery - Outpatient - For all outpatient surgeries: blepharoplasty, cardiac catheterization, cochlear implants, uvulopalatopharyngoplasty, pacemaker insertion, pain management procedures, vein procedures, spine surgery, total joint replacements, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery • Therapeutic Treatments - Outpatient - Services that require prior authorization: Dialysis, chemotherapy, IV infusion, radiation oncology, intensity modulated radiation therapy, hyperbaric oxygen therapy and MR-guided focused ultrasound • Transplant services (including evaluation)

	• Transplant services (including evaluation) IP OON M/S Services Subject to Prior Authorization OHP: • Bariatric Surgery • Clinical Trials • Cosmetic and Reconstructive Procedures; including Breast Reconstruction (Non-Mastectomy) • Hospice • Inpatient Admissions - Inpatient Stay and Post-Acute Services • Pregnancy - Maternity Services - Maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery and stays for Complications of Pregnancy exceeding 96 hours for a cesarean section delivery • Skilled Nursing Facility/Inpatient Rehabilitation Facility Services • Spine Surgery • Temporomandibular Joint Services • Transplant • Ventricular Assist Devices OP OON M/S Services Subject to Prior Authorization OHP: • Bariatric Surgery • Breast Pumps • Clinical Trials • Cosmetic and Reconstructive Procedures; including Breast Reconstruction (Non-Mastectomy) • Diabetes Equipment - Before obtaining DME over $1000 • Durable Medical Equipment (DME) • Formulas/Specialized Foods • Genetic Testing/BRCA Gene Testing • Hearing Aids over $1000 • Home health care - non-nutritional • Infertility • Lab, X-Ray and Diagnostics - For Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram • Lab, X-Ray and Major Diagnostics - For CT, PET scans, MRI, MRA, and nuclear medicine, including nuclear cardiology • Non-emergency Air Transport • Orthodontia	IP OON M/S Services Subject to Prior Authorization OHP: • Bariatric Surgery • Clinical Trials • Cosmetic and Reconstructive Procedures; including Breast Reconstruction (Non-Mastectomy) • Hospice • Inpatient Admissions - Inpatient Stay and Post-Acute Services • Pregnancy - Maternity Services - Maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery and stays for Complications of Pregnancy exceeding 96 hours for a cesarean section delivery • Skilled Nursing Facility/Inpatient Rehabilitation Facility Services • Spine Surgery • Temporomandibular Joint Services • Transplant • Ventricular Assist Devices OP OON M/S Services Subject to Prior Authorization OHP: • Bariatric Surgery • Breast Pumps • Clinical Trials • Cosmetic and Reconstructive Procedures; including Breast Reconstruction (Non-Mastectomy) • Diabetes Equipment - Before obtaining DME over $1000 • Durable Medical Equipment (DME) • Formulas/Specialized Foods • Genetic Testing/BRCA Gene Testing • Hearing Aids over $1000 • Home health care - non-nutritional • Infertility • Lab, X-Ray and Diagnostics - For Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram • Lab, X-Ray and Major Diagnostics - For CT, PET scans, MRI, MRA, and nuclear medicine, including nuclear cardiology • Non-emergency Air Transport • Orthodontia • Orthotics

	• Orthotics • Pain Management • Pharmaceutical Products – For IV infusions only • Preimplantation Genetic Testing (PGT) and Related Services • Prosthetics • Rehabilitation services [and Chiropractic Treatment] – Physical therapy, occupational therapy, Manipulative Treatment, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, cognitive rehabilitation therapy, and vision therapy • Scopic Procedures • Spine Surgery • Surgery - Outpatient - For all outpatient surgeries: blepharoplasty, cardiac catheterization, cochlear implants, uvulopalatopharyngoplasty, pacemaker insertion, pain management procedures, vein procedures, spine surgery, total joint replacements, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery • Therapeutic Treatments - Outpatient - Services that require prior authorization: Dialysis, chemotherapy, IV infusion, radiation oncology, intensity modulated radiation therapy, hyperbaric oxygen therapy and MR-guided focused ultrasound • Transplant services (including evaluation) IP OON M/S Services Subject to Prior Authorization UHIC: • Bariatric Surgery • Clinical Trials • Cosmetic and Reconstructive Procedures; including Breast Reconstruction (Non-Mastectomy) • Hospice Care • Inpatient Admissions - Inpatient Stay and Post-Acute Services • Pregnancy - Maternity Services - Maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery and stays for Complications of Pregnancy exceeding 96 hours for a cesarean section delivery • Skilled Nursing Facility/Inpatient Rehabilitation Facility Services • Temporomandibular Joint (TMJ) Services • Transplant • Ventricular Assist Devices OP OON M/S Services Subject to Prior Authorization UHIC: • Bariatric Surgery	• Pain Management • Pharmaceutical Products – For IV infusions only • Preimplantation Genetic Testing (PGT) and Related Services • Prosthetics • Rehabilitation services [and Chiropractic Treatment] – Physical therapy, occupational therapy, Manipulative Treatment, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, cognitive rehabilitation therapy, and vision therapy • Scopic Procedures • Spine Surgery • Surgery - Outpatient - For all outpatient surgeries: blepharoplasty, cardiac catheterization, cochlear implants, uvulopalatopharyngoplasty, pacemaker insertion, pain management procedures, vein procedures, spine surgery, total joint replacements, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery • Therapeutic Treatments - Outpatient - Services that require prior authorization: Dialysis, chemotherapy, IV infusion, radiation oncology, intensity modulated radiation therapy, hyperbaric oxygen therapy and MR-guided focused ultrasound • Transplant services (including evaluation) IP OON M/S Services Subject to Prior Authorization UHIC: • Bariatric Surgery • Clinical Trials • Cosmetic and Reconstructive Procedures; including Breast Reconstruction (Non-Mastectomy) • Hospice Care • Inpatient Admissions - Inpatient Stay and Post-Acute Services • Pregnancy - Maternity Services - Maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery and stays for Complications of Pregnancy exceeding 96 hours for a cesarean section delivery • Skilled Nursing Facility/Inpatient Rehabilitation Facility Services • Temporomandibular Joint (TMJ) Services • Transplant • Ventricular Assist Devices OP OON M/S Services Subject to Prior Authorization UHIC: • Bariatric Surgery • Breast Pumps

	• Breast Pumps • Clinical Trials • Cosmetic and Reconstructive Procedures; including Breast Reconstruction (Non-Mastectomy) • Diabetes Equipment- Before obtaining DME over $1000 • Durable Medical Equipment (DME) • Formulas/Specialized Foods • Genetic Testing/BRCA Gene Testing • Hearing Aids over $1000 • Home health care - non-nutritional • Infertility • Lab, X-Ray and Diagnostics - For Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram • Lab, X-Ray and Major Diagnostics - For CT, PET scans, MRI, MRA, and nuclear medicine, including nuclear cardiology • Non-emergency Air Transport • Orthodontia • Orthotics • Pain Management and Injections • Pharmaceutical Products – IV Infusions only • Prosthetics • Rehabilitation services [and Chiropractic Treatment] – Physical therapy, occupational therapy, Manipulative Treatment, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, cognitive rehabilitation therapy, and vision therapy • Scopic Procedures - Outpatient Diagnostic and Therapeutic • Surgery - Outpatient - For all outpatient surgeries: Blepharoplasty, cardiac catheterization, cochlear implants, uvulopalatopharyngoplasty, pacemaker insertion, pain management procedures, vein procedures, spine surgery, total joint replacements, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery • Therapeutic Treatments - Outpatient - Services that require prior authorization: dialysis, chemotherapy, IV infusion, radiation oncology, intensity modulated radiation therapy, hyperbaric oxygen therapy, and MR-guided focused ultrasound Transplant services (including evaluation)	• Clinical Trials • Cosmetic and Reconstructive Procedures; including Breast Reconstruction (Non-Mastectomy) • Diabetes Equipment- Before obtaining DME over $1000 • Durable Medical Equipment (DME) • Formulas/Specialized Foods • Genetic Testing/BRCA Gene Testing • Hearing Aids over $1000 • Home health care - non-nutritional • Infertility • Lab, X-Ray and Diagnostics - For Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram • Lab, X-Ray and Major Diagnostics - For CT, PET scans, MRI, MRA, and nuclear medicine, including nuclear cardiology • Non-emergency Air Transport • Orthodontia • Orthotics • Pain Management and Injections • Pharmaceutical Products – IV Infusions only • Prosthetics • Rehabilitation services [and Chiropractic Treatment] – Physical therapy, occupational therapy, Manipulative Treatment, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, cognitive rehabilitation therapy, and vision therapy • Scopic Procedures - Outpatient Diagnostic and Therapeutic • Surgery - Outpatient - For all outpatient surgeries: Blepharoplasty, cardiac catheterization, cochlear implants, uvulopalatopharyngoplasty, pacemaker insertion, pain management procedures, vein procedures, spine surgery, total joint replacements, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery • Therapeutic Treatments - Outpatient - Services that require prior authorization: dialysis, chemotherapy, IV infusion, radiation oncology, intensity modulated radiation therapy, hyperbaric oxygen therapy, and MR-guided focused ultrasound • Transplant services (including evaluation)
Concurrent Review Benefit NQTL Practices	**Concurrent Review INN IP and OP:**	**Concurrent Review INN IP and OP:**

	The Plan's National Network Manual (for MH/SUD) was reviewed for timeliness of notification. The timeframe for the provider or member to notify of an admission was reviewed and determined that MH/SUD was no more stringent. INN MH/SUD facilities must notify the Plan within one business day after an admission unless a longer period is required by contract or state-specific requirements. MH/SUD is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews are made by clinical staff (i.e., physicians, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors (or Psychologists for outpatient services). **Concurrent Review OON IP and OP:** MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews are made by clinical staff (i.e., physicians, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors. OP INN MH/SUD Services Subject to Concurrent Review OHI, OHP, and UHIC: • Partial Hospitalization (PHP)/Day Treatment • Intensive Outpatient (IOP) IP INN MH/SUD Services Subject to Concurrent Review OHI, OHP, and UHIC: • MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment OP OON MH/SUD Services Subject to Concurrent Review OHI, OHP, and UHIC: Partial Hospitalization (PHP)/Day Treatment Intensive Outpatient (IOP) IP OON MH/SUD Services Subject to Concurrent Review OHI, OHP, and UHIC: • MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment	The Plan's Administrative Guide (for M/S) was reviewed for timeliness of notification. The timeframe for the provider or member to notify of an admission was reviewed and determined that MH/SUD was no more stringent. INN M/S facilities must notify the Plan within 24 hours for week-day admissions, unless otherwise indicated. M/S is staffed by clinical, non-clinical, and administrative personnel. Clinical reviews may be made by clinical staff (i.e., nurses, physicians, etc.) and all adverse determinations are made by a physician or other appropriate health care professionals. **Concurrent Review OON IP and OP:** M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews may be made by clinical staff (i.e., nurses, physicians, etc.) and all adverse determinations are made by a physician or other appropriate health care professionals. OP INN M/S Services Subject to Concurrent Review OHI and OHP: • Cancer supportive care • Cardiology • Chemotherapy Services • Continuous Glucose Monitoring • Diagnostic and Therapeutic Procedures • Durable Medical Equipment (DME) over $500 • End-stage renal disease (ESRD) dialysis services • Home Health Care • Hospice • Injectable Medications • Medical and Surgical Supplies • Pain Management • Physical, Occupational, Speech and Respiratory Therapy (PT/OT/ST/RT) • Radiation Therapy • Therapeutic Radiopharmaceuticals IP INN M/S Services Subject to Concurrent Review OHI and OHP: • Arthroplasty • Bariatric Surgery • Breast Reconstruction (non-mastectomy) • Cardiology • Cerebral Seizure Monitoring – Inpatient Video EEG • Chemotherapy Services • Clinical Trials

		• Congenital Heart Disease • Cosmetic and Reconstructive Procedures • Dental services • Digestive System • Eye, Ear, Nose and Throat • End-stage renal disease (ESRD) dialysis services • Foot Surgery • Gender Dysphoria Treatment • Genital Organs • Hospice • Hysterectomy • Inpatient admissions – post-acute services • Musculoskeletal System • Nervous System • Obstetrical Procedures • Orthognathic Surgery • Orthopedic Surgeries • Respiratory System • Sleep Disorder Tests/Treatment • Spine Surgery • Transplants • Urinary System • Ventricular Assist Devices OP INN M/S Services Subject to Concurrent Review UHIC: • Cancer supportive care • Cardiology • Chemotherapy Services • Continuous Glucose Monitoring • Durable Medical Equipment (DME) over $1,000 • End-stage renal disease (ESRD) dialysis services • Injectable Medications • Pain Management and Injection • Physical Therapy/Occupational Therapy (PT/OT) • Radiation Therapy • Therapeutic Radiopharmaceuticals

		IP INN M/S Services Subject to Concurrent Review UHIC: • Arthroplasty • Bariatric Surgery • Breast Reconstruction (non-mastectomy) • Cardiology • Cerebral Seizure Monitoring – Inpatient Video EEG • Chemotherapy Services • Clinical Trials • Congenital Heart Disease • Cosmetic and Reconstructive Procedures • End-stage renal disease (ESRD) dialysis services • Foot Surgery • Gender Dysphoria Treatment • Hysterectomy • Inpatient admissions – post-acute services • Orthognathic Surgery • Sleep Apnea Procedures and Surgeries • Spinal Surgery • Transplant • Ventricular Assist Devices • IP OON M/S Services Subject to Concurrent Review OHI, OHP, and UHIC: • Applies to all inpatient services for facilities reimbursed on a per diem basis OP OON M/S Services Subject to Concurrent Review OHI: • Diabetes Equipment - DME over $1000 • Durable Medical Equipment (DME) • Formulas/Specialized Foods • Home Health Care -Non-Nutritional • Pain Management and Injections • Rehabilitation services [and Chiropractic Treatment] – Physical therapy, occupational therapy, Manipulative Treatment, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, cognitive rehabilitation therapy, and vision therapy • Therapeutic Treatments - Outpatient - Services that require prior authorization: Dialysis, chemotherapy, IV infusion, radiation oncology, intensity modulated radiation therapy, hyperbaric oxygen therapy and MR-guided focused ultrasound

		OP OON M/S Services Subject to Concurrent Review OHP: • Diabetes Equipment - DME over $1000 • Durable Medical Equipment (DME) • Formulas/Specialized Foods • Home Health Care -Non-Nutritional • Pain Management and Injections • Rehabilitation services [and Chiropractic Treatment] – Physical therapy, occupational therapy, Manipulative Treatment, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, cognitive rehabilitation therapy, and vision therapy • Therapeutic Treatments - Outpatient - Services that require prior authorization: Dialysis, chemotherapy, IV infusion, radiation oncology, intensity modulated radiation therapy, hyperbaric oxygen therapy and MR-guided focused ultrasound OP OON M/S Services Subject to Concurrent Review UHIC: • Diabetes Equipment - DME over $1000 • Durable Medical Equipment (DME) • Formulas/Specialized foods • Home Health Care -Non-Nutritional • Pain Management and Injections • Rehabilitation services [and Chiropractic Treatment] – Physical therapy, occupational therapy, Manipulative Treatment, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, cognitive rehabilitation therapy, and vision therapy • Therapeutic Treatments - Outpatient - Services that require prior authorization: dialysis, chemotherapy, IV infusion, radiation oncology, intensity modulated radiation therapy, hyperbaric oxygen therapy, and MR-guided focused ultrasound
Retrospective Review Benefit NQTL Practices	**Retrospective Review Services Subject to NQTL:** The Plan conducts retrospective review when a MH/SUD service requires authorization, but the OON provider did not obtain authorization and the reason for lack of authorization meets criteria for an exception. The Plan may conduct retrospective review when the MH/SUD services indicated on a claim do not match an authorization that was previously provided. **Retrospective Review IP and OP INN:** Timeframe to submit. The Plan's Administrative Guide (for M/S) and National Network Manual (for MH/SUD) were reviewed for requirements related to timeliness	**Retrospective Review Services Subject to NQTL:** The Plan conducts retrospective review when a M/S service requires authorization, but the OON provider did not obtain authorization and the reason for lack of authorization meets criteria for an exception. The Plan may conduct retrospective review when the M/S services indicated on a claim do not match an authorization that was previously provided. The Plan may conduct retrospective review for M/S OON inpatient services where prior authorization was required but was not obtained **Retrospective Review IP and OP INN:**

	of notification to the Plan and it was determined that MH/SUD was no more stringent. MH/SUD providers have 180 days after the service is rendered to request a review. MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews may be made by clinical staff (i.e., physicians, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors (or Psychologists for outpatient). **Retrospective Review IP and OP OON:** The timeframe for the member to submit the retrospective requirement was reviewed and it was determined that MH/SUD was no more stringent. MH/SUD members have 180 days after the service is rendered to request a review. MH/SUD is staffed by clinical, non-clinical and administrative personnel. Clinical reviews may be made by clinical staff (i.e., physicians, nurses, licensed master's level behavioral health clinicians, etc.) and all adverse determinations are made by Medical Directors.	Timeframe to submit. The Plan's Administrative Guide (for M/S) and National Network Manual (for MH/SUD) were reviewed for requirements related to timeliness of notification to the Plan and it was determined that MH/SUD was no more stringent. M/S providers must notify the Plan within the requirements outlined in the provider contract. M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews may be made by clinical staff (i.e., nurses, physicians, etc.) and all adverse determinations are made by a physician or other appropriate health care professionals. **Retrospective Review IP and OP INN:** The timeframe for the member to submit the retrospective requirement was reviewed and it was determined that MH/SUD was no more stringent. M/S members must notify the Plan within timely filing requirements. M/S is staffed by clinical, non-clinical and administrative personnel. Clinical reviews may be made by clinical staff (i.e., nurses, physicians, etc.) and all adverse determinations are made by a physician or other appropriate health care professionals.
Clinical Procedure Coding, Billing Coding and Process NQTL Practices	The Plan's analysis determined that the process of how coding edits and reimbursement policies are developed and applied are the same.	The Plan's analysis determined that the process of how coding edits and reimbursement policies are developed and applied are the same.
Case & Medical Management NQTL Practices	Medical Case Management is a collaborative process between a member, that member's treating providers, and the Plan to improve the member's functional health and well-being and support the member's recovery. Such programs seek to achieve this goal by proactively engaging members before their health declines and helping them avoid escalation to higher levels of care (for example inpatient hospitalization). Case management is a voluntary member-facing program that does not include coverage determinations. Medical Case Management does not modify or influence a benefit determination. Case Managers do not make or recommend medical necessity determinations, do not direct treatment, or place treatment limitations based on program participation or lack thereof.	Medical Case Management is a collaborative process between a member, that member's treating providers, and the Plan to improve the member's functional health and well-being and support the member's recovery. Such programs seek to achieve this goal by proactively engaging members before their health declines and helping them avoid escalation to higher levels of care (for example inpatient hospitalization). Case management is a voluntary member-facing program that does not include coverage determinations. Medical Case Management does not modify or influence a benefit determination. Case Managers do not make or recommend medical necessity determinations, do not direct treatment, or place treatment limitations based on program participation or lack thereof.
Network Adequacy & Provider Reimbursement Rates	**Network Management** Based on the Plan's analysis, no differences were identified. **Reimbursement Rates - INN Facilities** For both M/S and MH/SUD facilities, the Plan uses the same process to propose reimbursement rate(s) for INN facility services. Both M/S and MH/SUD INN facility reimbursements are established through mutually negotiated rates based on facility	**Network Management** Based on the Plan's analysis, no differences were identified. **Reimbursement Rates - INN Facilities** For both M/S and MH/SUD facilities, the Plan uses the same process to propose reimbursement rate(s) for INN facility services. Both M/S and MH/SUD INN facility reimbursements are established through mutually negotiated rates based on facility

	type, services or programs provided, market dynamics including facility leverage, supply and demand of program or service type within the geographic market(s), facility volume, and/or facility proposed rate relative to market pricing. Both M/S and MH/SUD negotiated facility reimbursements are informed by market research. Current industry norms for MH/SUD facility-based services are more narrowly limited to the per diem reimbursement model only. Based on the key distinction in the variety of industry standard reimbursement models available for M/S facility-based services as compared to the dominant model, per diem reimbursement for MH/SUD facility-based reimbursement, a comparison of M/S and MH/SUD facility-based reimbursement rates could not be completed. The Plan continues to collaborate with MH/SUD facility-based providers to explore development of value-based reimbursement models. **Reimbursement Rates - INN Professional Services** Based on the Plan's analysis, no differences were identified. **Reimbursement Rates - OON Emergency** Based on the Plan's analysis, no differences were identified. **Reimbursement Rates - OON Inpatient and Outpatient** Based on the Plan's analysis, no differences were identified.	type, services or programs provided, market dynamics including facility leverage, supply and demand of program or service type within the geographic market(s), facility volume, and/or facility proposed rate relative to market pricing. Both M/S and MH/SUD negotiated facility reimbursements are informed by market research. The Plan determined that M/S facility-based services are reimbursed under a variety of different reimbursement models, including MS-DRG, case rates, per diem rates, and value-based models. Based on the key distinction in the variety of industry standard reimbursement models available for M/S facility-based services as compared to the dominant model, per diem reimbursement for MH/SUD facility-based reimbursement, a comparison of M/S and MH/SUD facility-based reimbursement rates could not be completed. The Plan continues to collaborate with MH/SUD facility-based providers to explore development of value-based reimbursement models. **Reimbursement Rates - INN Professional Services** Based on the Plan's analysis, no differences were identified. **Reimbursement Rates - OON Emergency** Based on the Plan's analysis, no differences were identified. **Reimbursement Rates - OON Inpatient and Outpatient** Based on the Plan's analysis, no differences were identified.
(STEP-5): *A Summary & Conclusionary Statement justifying how performing this comparative analysis required by the subsequent steps has led the Health Carrier to conclude that it is parity compliant.*	The Plan conducted a comparative analysis of the strategies, processes, factors, evidentiary standards, and source information for the NQTLs. The findings of the comparative analysis confirmed the strategies, processes, factors, evidentiary standards, and source information used by MH/SUD were comparable to, and applied no more stringently than the strategies, processes, factors, evidentiary standards, and source information used by M/S both “as written” and "in operation." The Plan concluded the methodologies used by MH/SUD were comparable to, and applied no more stringently than, the methodologies used by M/S.	