TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS AND INSURANCE
CHAPTER 6. DEPARTMENT OF INSURANCE
ARTICLE 13. MENTAL HEALTH PARITY

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R20-6-1301. Definitions

The definitions in A.R.S. § 20-3501 and the following definitions apply to this Article:

"Arizona Mental Health Parity Act" means the statutes found at A.R.S. §§ 20-3501 through 20-3505.

"Coverage unit" has the meaning prescribed at 45 C.F.R. § 146.136(a) "Coverage unit."

"Department" means the Arizona Department of Insurance and Financial Institutions.

"Financial requirements (FR)" has the meaning at 45 C.F.R. § 146.136(a) "Financial requirements."

"Health care insurer" has the meaning prescribed at A.R.S. § 20-3501(2).

"Health plan" has the meaning prescribed at A.R.S. § 20-3501(3).

"HHS MHPAEA tool" means the Mental Health Parity tool offered by the U.S. Department of Health and Human Services.

"Inpatient, in-network benefits" are benefits furnished on an inpatient basis and within a network of contracted providers under a health plan.

"Inpatient, out-of-network benefits" are benefits furnished on an inpatient basis by providers without a contract under a health plan or for a health plan that has no network of providers.

"Medical necessity" or "Medically necessary" means an item or service is from a provider who is exercising prudent clinical judgment, is safe and effective, is not experimental or investigational, and is appropriate. An appropriate item or service is appropriate in duration and frequency, is furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition, is furnished in a setting appropriate to the patient's medical needs and condition, is ordered and furnished by qualified personnel, meets, but does not exceed, the patient's medical need, and is at least as beneficial as an existing and available medically appropriate alternative.

"Medical/surgical (Med/Surg) benefits" has the meaning prescribed at 45 C.F.R. § 146.136(a) "Medical/surgical benefits."

"Mental (MH) health benefits" has the meaning prescribed at 45 C.F.R.§ 146.136(a) "Mental health benefits."

"MHPAEA" means the Mental Health Parity and Addiction Equity Act prescribed in A.R.S. § 20-3501(4).

"Nonquantitative treatment limitation (NQTL)" is a limitation that restricts the scope or duration of benefits for treatment under a health plan or coverage. Illustrations of NQTLs include: medical management standards limiting or excluding benefits based on medical necessity or appropriateness or based on whether the treatment is experimental or investigative as identified under 45 C.F.R. 146.136(c)(4)(ii)(A); formulary design for prescription drugs as identified under 45 C.F.R. 146.136(c)(4)(ii)(B); network tier design (for health plans with multiple network tiers such as preferred providers and participating providers) as identified under 45 C.F.R. 146.136(c)(4)(ii)(C); standards for provider admission to participate in a network, including reimbursement rates as identified under 45 C.F.R. 146.136(c)(4)(ii)(D); methods for determining usual, customary, and reasonable charges as identified under 45 C.F.R. 146.136(c)(4)(ii)(E); refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as "fail-first policies" or "step therapy protocols") as identified under 45 C.F.R. 146.136(c)(4)(ii)(F); exclusions based on failure to complete a course of treatment; and restrictions based on geographic location as identified under 45 C.F.R. 146.136(c)(4)(ii)(G), facility type, provider specialty, and other criteria than limit the scope or duration of benefits for services provided under the health plan or coverage as identified under 45 C.F.R. 146.136(c)(4)(ii)(H).

"Outpatient, in-network benefits" are benefits furnished on an outpatient basis and within a network of providers established or recognized under a health plan.

"Outpatient, out-of-network benefits" are benefits furnished on an outpatient basis and outside any network of providers established or recognized under a health plan or under a health plan that has no network of providers.

"Predominant test" means that if a type of FR or QTL applies to substantially all of the Med/Surg benefits in a classification, the predominant level of the FR or QTL is the level that applies to more than 1/2 of the Med/Surg benefits in that classification subject to the FR or QTL. If no single level can be determined, the health plan (or health insurance issuer) may combine levels until the combination of levels applies to more than 1/2 of Med/Surg benefits subject to the FR or QTL in the classification. The least restrictive level within the combination is considered the predominant level of that type of classification. For this purpose, a health plan may combine the most restrictive levels first with each less restrictive level added to the combination until the combination applies to more than 1/2 of the benefits subject to the FR or QTL.

"Quantitative treatment limitation (QTL)" is a limitation on the scope or duration of a benefit

that can be expressed numerically that includes day or visit limits such as "50 outpatient visits per year." QTLs include annual, episode, and lifetime day and visit limits such as number of treatments, number of visits, or days of coverage.

"Substance use disorder (SUD) benefits has the meaning prescribed at 45 C.F.R.§ 146.136(a) "Substance use disorder benefits."

"Substantially all test" means that a FR or QTL applies to at least 2/3 of all Med/Surg benefits in a classification of benefits for a coverage unit. (For this purpose, benefits expressed as subject to a zero level of a type of FR are treated as not subject to that type of FR. In addition, benefits expressed as subject to an unlimited QTL are treated as not subject to that type of QTL.) If a type of FR or QTL does not apply to at least 2/3 of all Med/Surg benefits in a classification, then that type of FR or QTL cannot be applied to MH or SUD benefits in that classification.

R20-6-1302. Medical Necessity Criteria and NQTL Reporting

A. Health care insurers subject to the reporting requirement. A health care insurer that issues health plans in Arizona is required to file the reports required by this Section with the Division.

B. Health plans subject to reporting. A health care insurer shall submit a separate report for all health plans it offers in this state (including grandfathered and non-grandfathered health plans) that meet all of the criteria listed in subsections (B)(1) through (B)(4) of this Section. If a health care insurer determines that the information to be reported varies by network plan, or varies in the individual, small group, or large group market, the health care insurer must submit a report for each variation.

1. The health plan offers either MH or SUD benefits in addition to Med/Surg benefits.
2. The health plan offers either MH or SUD benefits in any one of the following classifications:
   a. Inpatient, in-network;
   b. Inpatient, out-of-network;
   c. Outpatient, in-network;
   d. Outpatient, out-of-network;
   e. Emergency care; or
   f. Prescription drugs.
3. The health plan is offered on a group (large or small) or individual basis.
4. The health plan has not received and notified the Division of an increased cost exemption pursuant to 45 C.F.R. 146.136(g).

C. Health plans exempt from reporting. A health plan that meets the criteria of Subsection (B) above is exempt from reporting under this Article if it is one of the following types of health plans:

1. A small group grandfathered health plan; or
2. A health plan that meets the definition of excepted benefit provided in 45 C.F.R. 146.145(b) or 45 C.F.R. 148.220.

D. Required reports. A health care insurer shall file a separate report for each fully insured product network type the insurer issues in Arizona. If the information to be reported varies by network or health plan, or varies in the individual, small group or large group market, the

insurer must file a separate report for each variation.

E. Triennial Reports.

1. Existing health care insurers. Beginning on March 15, 2023 and every third year thereafter, a health care insurer issuing health plans and collecting premium in Arizona as of January 1, 2022 shall file a triennial report with the Division for each health plan subject to reporting.
2. Entering or re-entering health care insurers. On or before March 15 of the second year an entering or re-entering health care insurer issues health plans and collects premiums in Arizona, a health care insurer shall file an original triennial report with the Division for each health plan subject to reporting. Following the filing of the original triennial report, the health care insurer shall submit subsequent triennial reports on the schedule described in subsection (E)(1) of this Section.
3. Due date for triennial reports. Triennial reports are due on or before March 15 of each reporting year.
4. Content of the original triennial report. Health care insurers shall file an original triennial report with the Division under A.R.S. § 20-3502(B) that provides the required information in Exhibit A.
5. Subsequent triennial reports.
   a. A health care insurer must file an updated triennial report, including the information required in Exhibit A, unless the insurer can attest that it has made no changes since the previously filed triennial report.
   b. As required by A.R.S. § 20-3502(E), a health care insurer shall file the following with the Division for each health plan subject to reporting:
      i. An updated triennial report, including the information required in Exhibit A; or
      ii. The last triennial report filed with the Division and a written attestation that the health care insurer has made no changes since it filed the previous triennial report.

F. Annual Reports. Pursuant to A.R.S. § 20-3502(E), on or before March 15 of each intervening year between the filing of a triennial report, a health care insurer shall file:

1. A report that summarizes any changes made to its medical necessity criteria and NQTLs (Exhibit A, Parts I, II, and III);
2. A written attestation that the insurer is in compliance with MHPAEA; and
3. If requested, any additional data required by the Division including Exhibit A, Part IV.

G. Additional information. At any time after an insurer files a report under this Section, the Division may request additional information, including an updated triennial or annual report, by contacting the insurer and making the request in writing. The insurer shall provide contact information to the Division when it files any of the reports required by this Section. The Division may set a deadline for an insurer to respond to its request and specify the format for the response.

R20-6-1303. FR and QTL Reporting

A. Method of reporting. A health care insurer that issues health plans in Arizona and is not exempt from the form filing requirement shall demonstrate its compliance with the FR and QTL parity requirements of MHPAEA through its form and rate filings with the Division.

B. Division's authority to require additional data. In addition to the forms filed by a health insurer, the Division may require a health insurer to submit additional data relating to its methods for meeting, and complying with, the MHPAEA FR and QTL standards. The

Division may also utilize the HHS MHPAEA tool and request samples of a health insurer's internal testing to demonstrate compliance with the substantially all and predominant tests within each classification of benefits for a health plan.

C. Separate consolidated report for large group health plans. The Division may require a health insurer that issues large group health plans to file a report that demonstrates compliance with the substantially all and predominant tests within each classification of benefits for health plans with similar benefit structures.

D. Special rule for FRs - Prescription Drug Classification. The multi-tiered prescription drug benefits exception of A.R.S. § 20-3502(D)(1) applies to the FRs for the prescription drug classification. For example, a health plan applies 4 tiers as follows: Tier 1: Generic Drugs for which the health plan pays 90%; Tier 2: Preferred Brand-name Drugs for which the health plan pays 80%; Tier 3: Non-preferred Brand-name Drugs for which the health plan pays 60%; and Tier 4: Specialty Drugs for which the health plan pays 50%. These FRs are applied without regard to whether a drug is prescribed for Med/Surg or MH/SUD benefits. In addition, the process for certifying a particular drug within a tier complies with the rules for NQTLs. Therefore, the FRs applied to prescription drug benefits meet the parity requirements under MHPAEA.

E. Special rules for FRs and QTLs.

1. In-network Classifications. The multiple network tiers exception of A.R.S. § 20-3502(D)(2) applies to the FRs and QTLs for the in-network classifications. For example, a health plan has 2 tiers of in-network providers: Tier 1: Preferred provider; and Tier 2: Participating provider. Placement of a provider into a tier complies with the rules for NQTLs and is determined without regard to whether the provider specializes in the treatment of Med/Surg conditions or MH/SUD disorders. The in-network classifications are divided into 2 subclassifications: 1. In-network preferred; and 2. In-network participating. The health plan does not impose any FR or QTL on MH/SUD benefits in either subclassification that is more restrictive than the predominant FR or QTL that applies to all Med/Surg benefits in each subclassification. Therefore, the FRs or QTLs applied to the in-network subclassifications that reflect the provider tiers meet the parity requirements under MHPAEA.
2. Outpatient Classifications. The sub-classification permitted for the office visits exception of A.R.S. § 20-3502(D)(3) applies to the FRs and QTLs for the outpatient classifications. For example, a health plan divides the outpatient, in-network classification into 2 subclassifications: 1. In-network office visits; and 2. All other outpatient, in-network items and services. The health plan does not impose any FR or QTL on MH/SUD benefits in either subclassification that is more restrictive than the predominant FR or QTL that applies to Med/Surg benefits in each subclassification. Therefore, the FRs or QTLs applied to the outpatient subclassifications for office visits and all other outpatient items and services meet the parity requirements under MHPAEA.
   The health plan cannot use a subclassification for generalists and specialists. The only subclassifications permitted for the in-network classifications are: 1. Office visits (such as physician visits); and 2. All other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).

R20-6-1304. Additional Information or Data

Pursuant to A.R.S. § 20-3502(F), the Department is not prohibited from otherwise requesting information or data that is necessary to verify compliance with MHPAEA and the Arizona Mental Health Parity Act.

Exhibit A
Medical Necessity Criteria and NQTL Reports

Instructions for Exhibit A:
Submit an Exhibit A for each fully insured health plan subject to reporting under Section R20-6-1303(B). Please submit the information in a word-searchable PDF file which is organized and identified in accordance with the numbered sections that appear below.

Part I: Identify Plan and Reporting Year.
Instructions for Part I:
The reporting year is the year, from January 1 through December 31, immediately preceding the submission of this Exhibit A.

Reporting Year:		
Insurer Name:		
Insurer NAIC Company Code:		
Network Name(s):		
Service Area: (List all counties in the service area for these networks)		
Covered Lives: (List the number of covered lives enrolled in plans in these networks in the reporting year)		
Plan Types: (Check all that apply)	☐Individual ACA-Compliant	☐Small Group ACA-Compliant
	☐Individual Transitional, plans include MH/SUD benefits	☐Small Group Transitional, plans include MH/SUD benefits
	☐Individual Grandfathered, plans include MH/SUD benefits	☐Large Group Fully Insured, plans include MH/SUD benefits
Product Types: (Check all that apply)	☐PPO	☐HMO (HCSO)
	☐POS	☐Indemnity

Part II: Medical necessity criteria.
Instructions for Part II:
To comply with A.R.S. § 20-3502(B)(1), describe the process that is used to develop or select medical necessity criteria for the plan and reporting year identified in Part I. When the plan

describes the process used to develop or select criteria for MH/SUD benefits, then it must also describe the process used to develop or select criteria for Med/Surg benefits.

To comply with ARS § 20-3502(B)(1), report:

A. Describe the process used to develop or select medical necessity criteria for MH/SUD benefits.
B. Describe the process used to develop or select medical necessity criteria for Med/Surg benefits.

Part III: Identify all NQTLs.
Instructions for Part III:
To comply with A.R.S. § 20-3502(B)(2), identify all NQTLs that are applied to MH/SUD benefits and all NQTLs that are applied to Med/Surg benefits for the plan and reporting year identified in Part I. NQTLs shall be identified within each classification of benefits.

A. Identify and report all NQTLs applied to MH/SUD benefits

1. All NQTLs applied to In-Patient, In-Network Classification
2. All NQTLs applied to In-Patient, Out-of-Network Classification
3. All NQTLs applied to Out-Patient, In-Network Classification
4. All NQTLs applied to Out-Patient, Out-of-Network Classification
5. All NQTLs applied to Emergency Care
6. All NQTSs applied to Prescription Benefits

B. Identify and report all NQTLs applied to Med/Surg benefits

1. All NQTLs applied to In-Patient, In-Network Classification
2. All NQTLs applied to In-Patient, Out-of-Network Classification
3. All NQTLs applied to Out-Patient, In-Network Classification
4. All NQTLs applied to Out-Patient, Out-of-Network Classification
5. All NQTLs applied to Emergency Care
6. All NQTSs applied to Prescription Benefits

Part IV: Demonstrate parity through analysis.
Instructions for Part IV:
To comply with A.R.S. § 20-3502(B)(3), for **each** NQTL listed in Part III, demonstrate through analysis that the process, strategy, evidentiary standard, and other factor of applying the NQTL to MH/SUD benefits in a classification of benefits, as written and in operation, is comparable to, and applied not more stringently than, any process, strategy, evidentiary standard or other factor used in applying the NQTL to Med/Surg benefits in the same classification. The report should include qualitative and quantitative statistical data to support and explain the analysis.

Identify and report on the NQTLs reported in Part III as follows.

A. Classification - Inpatient, in-network

1. Process
   a. Process applying NQTL to MH/SUD benefit
   b. Process applying NQTL to Med/Surg benefit
   c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
2. Strategy
   a. Strategy applying NQTL to MH/SUD benefit
   b. Strategy applying NQTL to Med/Surg benefit
   c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
3. Evidentiary Standard
   a. Evidentiary standard applying NQTL to MH/SUD benefit
   b. Evidentiary standard applying NQTL to Med/Surg benefit
   c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
4. Other Factor
   a. Other factor applying NQTL to MH/SUD benefit
   b. Other factor applying NQTL to Med/Surg benefit
   c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.

B. Classification - Inpatient, out-of-network

1. Process
   a. Process applying NQTL to MH/SUD benefit
   b. Process applying NQTL to Med/Surg benefit

   c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
2. Strategy
   a. Strategy applying NQTL to MH/SUD benefit
   b. Strategy applying NQTL to Med/Surg benefit
   c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
3. Evidentiary Standard
   a. Evidentiary standard applying NQTL to MH/SUD benefit
   b. Evidentiary standard applying NQTL to Med/Surg benefit
   c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
4. Other Factor
   a. Other factor applying NQTL to MH/SUD benefit
   b. Other factor applying NQTL to Med/Surg benefit
   c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.

C. Classification - Outpatient, in-network

1. Process
   a. Process applying NQTL to MH/SUD benefit
   b. Process applying NQTL to Med/Surg benefit
   c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
2. Strategy
   a. Strategy applying NQTL to MH/SUD benefit
   b. Strategy applying NQTL to Med/Surg benefit
   c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.

   d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
3. Evidentiary Standard
   a. Evidentiary standard applying NQTL to MH/SUD benefit
   b. Evidentiary standard applying NQTL to Med/Surg benefit
   c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
4. Other Factor
   a. Other factor applying NQTL to MH/SUD benefit
   b. Other factor applying NQTL to Med/Surg benefit
   c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.

D. Classification - Outpatient, out-of-network

1. Process
   a. Process applying NQTL to MH/SUD benefit
   b. Process applying NQTL to Med/Surg benefit
   c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
2. Strategy
   a. Strategy applying NQTL to MH/SUD benefit
   b. Strategy applying NQTL to Med/Surg benefit
   c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
3. Evidentiary Standard
   a. Evidentiary standard applying NQTL to MH/SUD benefit
   b. Evidentiary standard applying NQTL to Med/Surg benefit
   c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.

   d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
4. Other Factor
   a. Other factor applying NQTL to MH/SUD benefit
   b. Other factor applying NQTL to Med/Surg benefit
   c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.

E. Classification – Emergency care

1. Process
   a. Process applying NQTL to MH/SUD benefit
   b. Process applying NQTL to Med/Surg benefit
   c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
2. Strategy
   a. Strategy applying NQTL to MH/SUD benefit
   b. Strategy applying NQTL to Med/Surg benefit
   c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
3. Evidentiary Standard
   a. Evidentiary standard applying NQTL to MH/SUD benefit
   b. Evidentiary standard applying NQTL to Med/Surg benefit
   c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
4. Other Factor
   a. Other factor applying NQTL to MH/SUD benefit
   b. Other factor applying NQTL to Med/Surg benefit
   c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.

d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.

F. Classification – Prescription benefits

1. Process
   a. Process applying NQTL to MH/SUD benefit
   b. Process applying NQTL to Med/Surg benefit
   c. Analysis showing that the process of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the process of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
2. Strategy
   a. Strategy applying NQTL to MH/SUD benefit
   b. Strategy applying NQTL to Med/Surg benefit
   c. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the strategy of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
3. Evidentiary Standard
   a. Evidentiary standard applying NQTL to MH/SUD benefit
   b. Evidentiary standard applying NQTL to Med/Surg benefit
   c. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, as written, is comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that the evidentiary standard of applying the NQTL to MH/SUD benefits, in operation, is comparable to and not applied more stringently than to Med/Surg benefits.
4. Other Factor
   a. Other factor applying NQTL to MH/SUD benefit
   b. Other factor applying NQTL to Med/Surg benefit
   c. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, as written, are comparable to and not applied more stringently than to Med/Surg benefits.
   d. Analysis showing that other factors used to apply the NQTL to MH/SUD benefits, in operation, are comparable to and not applied more stringently than to Med/Surg benefits.