

In the Matter of

EmblemHealth, Inc.

Assurance No.: 14-031

**ASSURANCE OF DISCONTINUANCE
UNDER EXECUTIVE LAW
SECTION 63, SUBDIVISION 15**

Pursuant to the provisions of Section 63(12) of the Executive Law and Article 22-A of the General Business Law, Eric T. Schneiderman, Attorney General of the State of New York, caused an inquiry to be made into certain business practices of EmblemHealth, Inc. (“Emblem”), relating to its administration of behavioral health benefits. Based upon that inquiry, the Office of the Attorney General (“the OAG”) has made the following findings, and Emblem has agreed to modify its practices and assure compliance with the following provisions of this Assurance of Discontinuance (“Assurance”).

I. BACKGROUND

1. Emblem, a not-for-profit corporation formed in 2006 by the merger of Group Health Incorporated (“GHI”) and the Health Insurance Plan of Greater New York (“HIP”), offers health plans to New York consumers. Emblem’s principal offices are located at 55 Water Street, New York, New York 10041.

2. In the regular course of business, Emblem enrolls consumers in health plans and contracts with health care providers for the delivery of health care services to those consumers. Offering hundreds of different health plans in New York State,

Emblem, through its GHI and HIP divisions, provides health care coverage for approximately 3.4 million New York consumers, most of whom live in the downstate region, and 1.18 million of whom are New York City employees and retirees. In 2012, Emblem had revenues of \$10 billion.

II. THE OAG'S INVESTIGATION AND FINDINGS

3. The Health Care Bureau of the OAG conducted an investigation into Emblem's administration of behavioral health benefits following the receipt of consumer complaints alleging that Emblem had improperly denied coverage for behavioral health services. In this Assurance, "behavioral health services" will refer to both mental health and substance use disorder services.

The Need for Adequate Coverage of Behavioral Health Treatment

4. Mental and emotional well-being is essential to overall health. Every year, almost one in four New Yorkers has symptoms of a mental disorder. Moreover, in any year, one in ten adults and children experience mental health challenges serious enough to affect functioning in work, family, and school life. Lack of access to treatment, which can be caused by health plans' coverage denials, can have serious consequences for consumers, resulting in interrupted treatment, more serious illness, and even death.

5. Mental illness is the leading illness-related cause of disability, a major cause of death (via suicide), and a driver of school failure, poor overall health, incarceration and homelessness.

6. For example, in any given year, one in ten individuals has a diagnosable mood disorder, such as major depression. Three to four percent of women will have an

eating disorder, such as anorexia nervosa or bulimia nervosa, at some point in their lives. Individuals with anorexia have a level of mortality up to 18 times greater than the average population without anorexia, the highest mortality rate of any mental illness.

7. The failure of health plans to adequately reimburse members for behavioral health costs, including those for substance abuse treatment, means that plan members who need treatment may not be getting the treatment recommended by their providers. In any given year, 11%, or 1.8 million, of New Yorkers have a substance use disorder, but only 11% of these individuals receive any treatment for their condition. In contrast, more than 70% of individuals with hypertension and diabetes receive treatment for those conditions.

Emblem's Behavioral Health Benefits

8. Emblem offers health plans that provide inpatient and outpatient benefits for medical/surgical and behavioral health conditions. Emblem subcontracts administration of its members' behavioral health benefits to ValueOptions, Inc. ("ValueOptions"), a managed behavioral health organization. Emblem pays ValueOptions a fixed fee per member, per month, for ValueOptions to provide behavioral health benefits for Emblem plans. Emblem delegates its administration of benefits in only a few other limited areas: acupuncture/massage therapy, radiology, transplants, oncology care, skilled nursing, dental services, occupational and physical therapy, and chiropractic. For a very small portion of its members, Emblem delegates a full range of benefits to a provider organization. Emblem's subcontracting of its members' behavioral health benefits has resulted in Emblem's placing all behavioral health claim coverage determinations with ValueOptions. Despite the passage of both federal and state laws

requiring that plans provide behavioral health coverage “on par” with medical/surgical coverage, neither Emblem nor ValueOptions, its contractor, has been comparing behavioral health claims approvals and denials with those in the medical/surgical realm.

9. Access to adequate behavioral health care appears to be an issue for Emblem members. Emblem does not track penetration rate, an important metric that shows the percentage of members accessing behavioral health benefits. Emblem’s data, however, do show that its overall spending on behavioral health care (not including prescription drugs) has declined precipitously from 2011 to 2013, from 3.6% of spending on health care claims to 2.6%. In contrast, behavioral health care, including prescription drugs, accounts for approximately 7.3% of all health spending in the U.S. These data suggest that Emblem may not be sufficiently covering behavioral health treatment.

Emblem’s Utilization Review of Behavioral Health Benefits

10. Utilization review is the process by which a health plan examines plan members’ requests or claims for health care services to determine whether the services are medically necessary, and thus eligible for coverage. For services for which preauthorization is required, such as inpatient services, typically a provider will file a request for authorization with the plan on behalf of the member, and the plan will review the request to determine whether the services are medically necessary under its medical necessity criteria. If the plan denies the request, in many cases, the member will not receive the requested service, and will not file a claim for benefits. On the other hand, where services have already been provided, a member or provider will typically submit a claim for benefits, and the plan will either pay the claim automatically or conduct

utilization review for the claim. In the latter situation, the plan will determine whether the services are medically necessary under its medical necessity criteria.

11. Medically necessary services are those that are reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of an individual. If Emblem deems the services to satisfy its criteria, Emblem will pay the claim.¹ If Emblem does not deem the services to satisfy its criteria, Emblem will send the member an adverse determination letter, which, under New York law, must contain a detailed explanation of the clinical rationale for the denial and information about the member's appeals rights.

12. A member whose request or claim for behavioral health services has been denied due to lack of medical necessity (and for certain other reasons) has the right, under New York law, to file an internal appeal, which is decided by ValueOptions without any involvement or oversight by Emblem, and, in some cases, a second-level, internal appeal, which is decided by ValueOptions without any involvement or oversight by Emblem, and then an external appeal, which is reviewed by an independent clinician who has no relationship with Emblem or ValueOptions. ValueOptions, on behalf of Emblem, typically performs utilization review for all inpatient, partial hospitalization and intensive outpatient behavioral health claims, and certain outpatient visits.

13. The OAG's review of consumer complaints, as well as Emblem's utilization review data, indicates that Emblem applies more rigorous – and frequent – utilization review for behavioral health benefits than for medical/surgical benefits.

¹ Where this Assurance describes the administration of Emblem's behavioral health benefits, it refers to actions taken by ValueOptions pursuant to contracts in which Emblem has delegated responsibility to ValueOptions to administer the behavioral health benefits of Emblem members.

Indeed, Emblem’s own Senior Director of Behavioral Health has described ValueOptions’ approach to utilization review for behavioral health benefits as “aggressive.” From January 2011 through mid-2013, 18% of the reviews Emblem conducted for behavioral health treatment coverage resulted in denials, encompassing more than 7,500 denied requests; after many of these denials, the member did not receive the requested care, and did not file a claim for benefits. In contrast, Emblem’s medical/surgical reviews resulted in denials only 11% of the time. Additionally, during the same period, Emblem denied 22% of behavioral health claims submitted, whereas Emblem denied only 13% of medical claims submitted during that period. Emblem also denied 38% of all substance abuse treatment claims during that time. From January 2011 through March 2014, Emblem denied at least 15,000 requests or claims of its members for behavioral health treatment due to the plan’s determination that the treatment was not medically necessary, with billed charges of more than \$31,000,000.

14. Emblem’s denial rates for more intensive levels of behavioral health care – such as inpatient treatment – are especially high. From January 2011 through mid-2013, 26% of Emblem’s reviews of its members’ requests for inpatient psychiatric treatment resulted in adverse decisions, totaling approximately 4,000 denied requests; after many of these denials, the member did not receive the requested care, and did not file a claim for benefits. Additionally, Emblem denied 36% of its members’ claims for inpatient psychiatric treatment, totaling more than 2,500 denied claims. In the same period, 39% of the reviews of Emblem members’ requests for inpatient substance abuse rehabilitation resulted in adverse decisions, totaling more than 2,300 denied requests, and

Emblem denied 41% of Emblem members' claims for that level of care, totaling almost 2,000 denied claims.

15. In contrast, Emblem's approach to utilization review for medical/surgical benefits is more lenient. A senior Emblem medical director stated that Emblem leaves decision planning for medical services to the provider's discretion. From 2011 through 2013, only 20% of Emblem's reviews for inpatient medical/surgical treatment resulted in denials, and only 29% of inpatient medical/surgical claims were denied by Emblem.

16. Not only does Emblem apply more stringent utilization review to behavioral health than to medical/surgical benefits, Emblem applies medical necessity criteria incorrectly when it reviews behavioral health-related requests and claims. For example, even though substance abuse rehabilitation is not an acute level of care, in denying requests for coverage of rehabilitation, Emblem classifies it as acute care, and in certain cases, Emblem has denied requests for coverage of substance abuse rehabilitation on the grounds that the member was not experiencing "life-threatening withdrawal," which is not a requirement for such treatment. In fact, Emblem members who are suffering from life-threatening withdrawal require a more intensive level of care than rehabilitation, such as medically managed inpatient detoxification.

17. Although Emblem's medical necessity criteria do not contain any "fail first" requirements, in some cases, Emblem has denied requests for coverage of substance abuse rehabilitation treatment through application of "fail first" requirements. For example, Emblem denied a request for coverage of substance abuse rehabilitation because the member had not recently failed an outpatient program. This requirement places yet another obstacle in front of members who, suffering from addiction, may have

a small window of opportunity to access treatment and embark on the path to recovery. Emblem's own doctors, however, state that a member's lack of an attempt at an outpatient mode of care is not a reason to deny an inpatient stay. Emblem does not apply such a "fail first" requirement to medical/surgical benefits.

18. Persons with mental health and substance use disorders comprise a vulnerable population, and may be reluctant to seek care. Frequent and time-consuming utilization review may pose obstacles preventing them from accessing or completing treatment. Moreover, when Emblem approves more intensive levels of care, such as inpatient or partial hospitalization treatment, it will often approve just a few days or visits at a time, requiring members and providers to focus on health coverage rather than treatment. The utilization review that Emblem conducts for behavioral health claims is so intensive and frequent that it often interferes with treatment, because providers and members must spend a great deal of time justifying each day or visit, or because the member cannot get treatment when a claim is denied. For example, although it is not possible to complete substance abuse rehabilitation treatment in one day, in some cases, Emblem authorizes one day of inpatient substance abuse rehabilitation treatment at a time.

19. Further, Emblem requires behavioral health providers – even at the outpatient level – to develop treatment and discharge plans, denying coverage if such plans are not filed. In contrast, Emblem does not typically require medical/surgical providers to develop treatment plans or to demonstrate discharge planning.

The Outpatient Outlier Model

20. Additionally, Emblem applies a utilization review tool for outpatient behavioral health benefits known as the Outpatient Outlier Model, under which a certain number of member outpatient psychotherapy visits triggers a special form of intensive utilization review whereby additional treatments are more deeply scrutinized, and are often denied. For example, after a member with major depression – a chronic, often life-long, biologically based illness – submits claims for a certain number of psychotherapy visits, Emblem places that member in the Outpatient Outlier Model, with the expectation that the member will soon terminate treatment. Emblem has never discussed basing the Outpatient Outlier Model on clinical evidence or research regarding length of treatment for particular mental health conditions.

21. Once Emblem places a member in the Outpatient Outlier Model, it may request extensive records from the member's provider, including progress notes, a treatment plan, a discharge plan, and other information, before it will authorize further coverage. Emblem will also recommend a lower frequency of visits as a strategy of working towards treatment termination, even though it cannot point to any literature or evidence supportive of session frequency as a treatment variable. Emblem does not implement a utilization review tool equivalent to the Outpatient Outlier Model in administering medical/surgical benefits.

22. The thresholds in Emblem's Outpatient Outlier Model are inconsistent across Emblem's plans. For example, for GHI members, Emblem requires prior approval for the first session of outpatient substance abuse treatment, and another approval prior to the eleventh session of such treatment. Additionally, Emblem has failed to perform

analyses supporting the Outpatient Outlier Model that are required by its own policies, which calls into question the integrity of the model. For example, the Outpatient Outlier Model policy requires Emblem to, on an annual basis: perform an evaluation of population-based utilization and clinical data to determine a set of specific types of potential outlier cases; provide the rationale for inclusion in the outlier program, reporting micromanagement strategies and specific interventions to be followed; and reevaluate the designated national outlier types and the results of the specialized interventions and clinical care management process to assure that the interventions initiated continue to be clinically appropriate. Emblem has never taken any of these actions. In fact, Emblem lacks a written policy and procedure stating exactly how the Outpatient Outlier Model is performed.

Inadequate Denial Letters

23. Emblem's adverse determination letters denying behavioral health claims are generic and lack specific detail explaining why coverage was denied for particular members. The letters also fail to explain adequately the medical necessity criteria used in making the determinations and why members failed to meet such criteria. For example, each of the denial letters contain boilerplate language such as:

- “[T]he information indicates the patient has made progress toward treatment goals and no longer requires the same frequency of treatment.”
- “[T]he review indicates that the treatment plan goals and objectives have been attained and that the signs and symptoms that brought the patient into the treatment have been stabilized.”
- “[T]he review does not indicate the presence of biomedical or psychological impairment, or the likelihood of relapse requiring treatment at the acute inpatient hospitalization with 24 hour medical supervision level of care. An appropriate level of care to the current needs of the patient is intensive outpatient services.”

Without details of the denial or the criteria used in making the determination, members are without the means to lodge a meaningful appeal of Emblem's denials.

24. Emblem has admitted that, in its denial letters, "[c]linical rationales primarily state in general rather than specific terms why the member's condition does not meet medical necessity criteria." Emblem has also admitted that the boilerplate denial reasons in the letters are not sufficient and that denial letters often mischaracterize the level of treatment requested. Such flawed letters call into question the accuracy of Emblem's adverse decisions. Emblem's letters denying coverage for medical/surgical conditions, however, are more detailed.

25. Additionally, until at least 2012, Emblem did not provide detailed language regarding the reason for its denial of substance abuse treatment requests and claims. Emblem neither cited the medical necessity criteria it used in its denial letters, nor provided the criteria upon request to members, as it is legally required to do.

26. Although substance abuse programs in New York State are required to use Guidelines for Level of Care Determinations approved by the New York Office of Alcoholism and Substance Abuse Services ("OASAS"), Emblem uses different criteria, created by ValueOptions, for determining medical necessity for substance abuse treatment, which results in denial of care since providers are required to use OASAS-approved criteria.

27. Although, for medical/surgical benefits, Emblem classifies denials due to lack of preauthorization or clinical information as medical necessity denials, in many cases involving behavioral health benefits, Emblem has classified such denials as

“administrative,” thereby depriving these members with behavioral health conditions of vital appeal rights.

Lack of Coverage for Residential Treatment for Behavioral Health Conditions

28. Most Emblem plans for HIP members do not cover residential treatment for behavioral health conditions. Residential treatment is a standard, recommended, evidence-based form of behavioral health treatment. Offering medication, counseling and structure, residential treatment facilities for behavioral health disorders provide a critical intermediate level of care between acute inpatient and outpatient treatment, enabling patients to transition back to living with their families. Residential treatment programs provide an intermediate level of care as compared to inpatient services, similar to skilled nursing treatment for medical/surgical conditions.

29. For example, residential treatment is deemed to be a potentially medically necessary option for treating persons with severe eating disorders, which can require round-the-clock supervision. According to the treatment guidelines of ValueOptions, Emblem’s behavioral health contractor, residential treatment is the standard form of treatment for eating disorders for persons who do not meet the criteria for inpatient hospitalization, but nevertheless are ill enough that they require 24-hour structure and supervision of all meals in order to achieve a healthier weight level, to decrease suicidality, and to develop sufficient motivation to successfully undertake outpatient treatment. Given the potentially lethal nature of eating disorders, denial of coverage for residential treatment can place members’ lives in jeopardy.

30. According to Section 3.301 of the medical necessity criteria of ValueOptions, Emblem’s behavioral health contractor:

Residential Treatment Services are provided to children/adolescents who require 24-hour treatment and supervision in a safe therapeutic environment. RTS is a 24 hour a day/7 day a week facility-based level of care. RTS provides individuals with severe and persistent psychiatric disorders therapeutic intervention and specialized programming in a controlled environment with a high degree of supervision and structure. RTS address the identified problems through a wide range of diagnostic and treatment services, as well as through training in basic skills such as social skills and activities of daily living that cannot be provided in a community setting.

31. Residential treatment is also a standard form of treatment for substance abuse disorders. According to Section 4.301 of the medical necessity criteria of ValueOptions, Emblem's behavioral health contractor:

Residential treatment is a 24 hour a day/7 day a week facility-based level of care which provides individuals with significant and persistent substance abuse disorders therapeutic intervention and specialized programming in a controlled environment with a high degree of supervision and structure. Residential rehabilitation addresses the identified problems through a wide range of diagnostic and treatment services by reliance on the treatment community setting.

32. Despite Emblem's exclusion of residential treatment coverage for HIP members, ValueOptions' medical director stated that there is evidence to support residential treatment for eating disorders. Moreover, ValueOptions has designated certain residential treatment facilities as diagnostic specialty units, because such units have demonstrated areas of clinical expertise and provide effective treatment. Nevertheless, Emblem has refused to cover such treatment for its HIP members. In one case, Emblem denied residential treatment for a 14-year old girl suffering from Anorexia Nervosa, even though her doctors in an inpatient facility (where she had been hospitalized with an irregular heartbeat) believed that she needed such care. Emblem covered day treatment, where the girl relapsed after a short period of time, necessitating further hospitalization.

Emblem's Cost-Sharing for Behavioral Health Services

33. Approximately 23% of HIP large-group plans charge a higher co-payment for outpatient mental health visits than for outpatient primary care visits. In some of these HIP large-group plans (containing approximately 5% of HIP large group members), the mental health co-payment is twice as high as the primary care co-payment. GHI plans charge the same co-payment for outpatient mental health visits and outpatient primary care visits.

Other Problems With Emblem's Behavioral Health Benefits

34. The OAG's investigation has revealed numerous other deficiencies in Emblem's administration of behavioral health benefits. For example, from 2011 through 2013, in 42% of behavioral health cases that went to external appeal, Emblem's denials were reversed, compared with only a 30% reversal rate in medical/surgical cases. Recognizing the problem in the behavioral health realm, after the OAG began its investigation of Emblem's administration of behavioral health benefits, Emblem directed its staff to review behavioral health cases before they went to external appeal, to determine whether the denials were correct. Emblem subsequently reversed the denials in almost 20% of the cases it reviewed.

35. Emblem failed to load the correct out-of-network reimbursement rates into its claims system in 2013, resulting in lowered and delayed reimbursement for many members' treatment. Additionally, in some instances, Emblem did not cover treatment pending completion of internal appeals.

36. A 2012 Department of Financial Services audit concluded that Emblem failed to meet the notification requirements of the New York Utilization Review Law for prospective and concurrent review in almost all cases sampled.

37. Despite receiving an estimated \$17.7 million in State funds to subsidize compliance with Timothy's Law – the New York mental health parity law, enacted in 2006 – Emblem violated the law by failing to provide policy holders with notice of their option to purchase enhanced mental health benefits.

38. Due to numerous deficiencies with Emblem's administration of its behavioral health benefits, including the issues described above, the director of the office where those benefits are administered was recently terminated.

III. RELEVANT LAWS

39. Timothy's Law, enacted in 2006, mandates that New York group health plans that provide coverage for inpatient hospital care or physician services must also provide "broad-based coverage for the diagnosis and treatment of mental, nervous or emotional disorders or ailments, . . . at least equal to the coverage provided for other health conditions." N.Y. Ins. Law §§ 3221(l)(5)(A); 4303(g)(1). Further, all group plans must cover, annually, a minimum of 30 days of inpatient care, 20 visits of outpatient care, and up to 60 visits of partial hospitalization treatment for the diagnosis and treatment of mental, nervous or emotional disorders or ailments. N.Y. Ins. Law §§ 3221(l)(5)(A)(i)&(ii); 4303(g)(1)(A)&(B).

40. Timothy's Law also requires that deductibles, co-payments and co-insurance for mental health treatment be consistent with those imposed on other benefits, N.Y. Ins. Law §§ 3221(l)(5)(A)(iii); 4303(g)(1)(C), and that utilization review for mental

health benefits be applied “in a consistent fashion to all services covered by [health insurance and health maintenance organization] contracts.” 2006 N.Y. Laws Ch. 748, § 1. From 2007 through 2010, Emblem received an estimated \$17.7 million in New York State funds to subsidize its compliance with Timothy’s Law.

41. The New York Insurance Law requires every group plan that provides coverage for inpatient hospital care to cover at least 60 outpatient visits in any calendar year for the diagnosis and treatment of chemical dependence, of which up to twenty may be for family members. N.Y. Ins. Law §§ 3221(1)(7); 4303(1).

42. In 2004, New York enacted legislation creating Comprehensive Care Centers for Eating Disorders (the “CCCED Law”). New York L. 2004, c.114. Pursuant to the CCCED Law, the New York State Department of Health designated three Centers, each of which must provide or arrange for a continuum of care tailored to the specialized needs of individuals with eating disorders, including residential treatment. N.Y. Public Health Law § 2799-g. The CCCED Law prohibits plans from excluding coverage provided by a Comprehensive Care Center for Eating Disorders. N.Y. Ins. Law §§ 3221(k)(14); 4303(dd).

43. The federal Mental Health Parity and Addiction Equity Act (“The Federal Parity Act”), enacted in 2008, prohibits large group, individual, and Medicaid health plans that provide both medical/surgical benefits, and mental health or substance use disorder benefits, from: (i) imposing financial requirements (such as deductibles, co-payments, co-insurance, and out-of-pocket expenses) on mental health or substance use disorder benefits that are more restrictive than the predominant level of financial requirements applied to substantially all medical/surgical benefits; (ii) imposing

treatment limitations (such as limits on the frequency of treatment, number of visits, and other limits on the scope or duration of treatment) on mental health or substance use disorder treatment that are more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits, or applicable only with respect to mental health or substance use disorder benefits; and (iii) conducting medical necessity review for mental health or substance use disorder benefits using processes, strategies or standards that are not comparable to, or are applied more stringently than, those applied to medical necessity review for medical/surgical benefits. 29 U.S.C. § 1185a; 42 U.S.C. § 300gg-26; 45 C.F.R. § 146.136(c)(4)(i). The essential health benefit regulations under the Affordable Care Act extend the federal parity requirements to small and individual plans. 45 C.F.R. § 156.115(a)(3).

44. The Affordable Care Act requires health plans to allow enrollees to receive coverage of treatment pending completion of internal appeals. 42 U.S.C. § 300gg-19(a)(1)(C).

45. The New York State Executive Law authorizes the Attorney General, where there are “repeated fraudulent or illegal acts” or “persistent fraud or illegality in the carrying on, conducting or transaction of business,” to seek relief, including enjoining the continuance of such business activity or of any fraudulent or illegal acts, as well as restitution and damages. N.Y. Exec. Law § 63(12).

46. Based on the findings of the Attorney General’s investigation, the Attorney General has determined that Emblem’s conduct has resulted in violations of N.Y. Executive Law Section 63(12), Timothy’s Law, the Federal Parity Act, and the

Affordable Care Act. Emblem's practices have had the effect of unlawfully limiting Emblem members' access to behavioral health services.

NOW, WHEREAS, Emblem neither admits nor denies the Attorney General's findings in Paragraphs 8 through 46 above; and

WHEREAS, access to adequate behavioral health treatment is essential for individual and public health; and

WHEREAS, Emblem has cooperated with the OAG's investigation; and

WHEREAS, the Attorney General is willing to accept the terms of this Assurance under Executive Law Section 63(15) and to discontinue his investigation; and

WHEREAS, the parties each believe that the obligations imposed by this Assurance are prudent and appropriate; and

WHEREAS, the Attorney General has determined that this Assurance is in the public interest.

IT IS HEREBY UNDERSTOOD AND AGREED, by and between the parties that:

IV. PROSPECTIVE RELIEF

47. Within ninety (90) days of the Effective Date, Emblem will implement the reforms set forth below in Paragraphs 48 through 61.

48. Cost-Sharing Requirements: For Emblem members' outpatient behavioral health visits, Emblem will apply the member's primary care cost-sharing schedule. If a member receives behavioral health services in a facility on an outpatient basis, facility cost-sharing requirements may apply in addition to the member's primary care cost-sharing schedule, but any such facility charges can be no greater than Emblem's facility charges for medical/surgical services. Self-funded health plans for which Emblem provides only administrative services may opt out of this requirement. As of July 1, 2014, the vast majority of Emblem's fully insured health plans will comply with the terms of this Paragraph 48. The reforms set forth in this Paragraph shall be implemented with respect to the remainder of Emblem's fully insured health plans, renewing on or after October 1, 2014, upon date of renewal.

49. Comparability of Utilization Review Processes: Emblem and/or any entity that administers benefits on behalf of Emblem will not use the Outpatient Outlier Model for utilization review purposes. If Emblem and/or any entity that administers benefits on behalf of Emblem uses a utilization review tool for behavioral health services that is based on quantity or frequency of outpatient visits, such tool will be developed and updated annually based on clinical evidence and will be approved by a physician who is board-certified in general psychiatry, or, in the case of substance abuse services, a physician who is certified in addiction medicine. Any utilization review performed by Emblem and/or any entity that administers benefits on behalf of Emblem under such tool

will be conducted only to the extent that the quantity or frequency of visits is inconsistent with clinical evidence. Where, after applying such tool to the requests or claims of a member, Emblem denies coverage for services, the member shall be afforded all internal and external appeal rights.

50. No visit limits:

- a. There will not be any day or visit limits for behavioral health services in any Emblem plan, except for family counseling services, which may be capped at 20 visits per year.
- b. Emblem will provide coverage for services provided by mental health practitioners licensed under Article 163 of the New York Education Law; provided, however, that this does not impact Emblem's right to establish more stringent criteria for purposes of determining eligibility for participation in provider networks.

51. Utilization Review Process Reforms:

- a. Integration of Utilization Review for Medical/Surgical and Behavioral Health Benefits: The OAG and Emblem will agree on measures to promote the integration of administration of medical/surgical and behavioral health benefits, which measures will include regularly scheduled meetings (at least every two weeks), with agendas and minutes, attended by individuals responsible for administering Emblem's medical/surgical and behavioral health benefits.
- b. Collection of Information During Utilization Review: Emblem and any entity that administers behavioral health benefits on behalf of Emblem

will follow a protocol for the collection of information during utilization review, which will include the elements set forth in Exhibit A.

- c. Substance Abuse Treatment: Emblem will not apply any “fail first” requirement for substance abuse rehabilitation treatment. Emblem will provide coverage of outpatient substance abuse treatment received in office settings, including, but not limited to, medication-assisted treatment for opioid addiction.
- d. Substance Abuse Treatment Criteria: On behalf of Emblem, ValueOptions has applied to OASAS for approval of its criteria for determining medical necessity for substance abuse treatment, and Emblem will continue to exercise best efforts to secure such approval.
- e. Continued Treatment: When an Emblem member transitions from one level of behavioral health treatment to another, for example from inpatient to outpatient care, the review for the second level will be conducted as a concurrent review, because it concerns continued treatment.
- f. Classification of Denials: any denials by Emblem of coverage for behavioral health services due to lack of clinical information and/or preauthorization will be processed as medical necessity denials.
- g. Duration of Approvals: The number of days or visits approved for behavioral health treatment will not be limited to one day or one visit

per approval and will be based on the treatment needs of the member, unless clinically appropriate.

52. Independent Parity Compliance Administrator: Within 30 days of the Effective Date, the OAG will appoint an independent party compliance administrator (the “Administrator”), with experience in reviewing and certifying health plan performance quality, to: (i) evaluate Emblem’s compliance with this Assurance; (ii) evaluate Emblem’s utilization review system for behavioral health benefits, including compliance with Paragraph 51 above; (iii) provide guidance to Emblem and entities administering behavioral health benefits on behalf of Emblem; and (iv) provide quarterly reports concerning items (i) through (iii) to Emblem’s Chief Medical Officer and the OAG. Emblem may suggest candidates for the Administrator, but the OAG shall have final discretion in the selection process.

- a. The Administrator will serve for a minimum of three (3) years from the date such Administrator commences service, subject to the provisions of subparagraph (g) below.
- b. Emblem will pay for the costs of the Administrator.
- c. Emblem will provide the Administrator with data sufficient for the Administrator to evaluate Emblem’s administration of behavioral health benefits. Data to be provided to the Administrator will be determined jointly by the OAG, Emblem and the Administrator, and specific data elements to be considered include: (i) claims review; (ii) metrics demonstrating adequate access to effective behavioral health services, including, at a minimum: adequacy of the provider network;

penetration rate; dollar spend on behavioral health services; utilization review results; internal appeals and results thereof; external appeals and results thereof; and member satisfaction with behavioral health coverage; and (iii) adverse determination letters. The data described in this subparagraph (c) may be provided in the form of utilization analyses, key indicator reports, population analyses, and/or other reports generated in the normal course of business by Emblem.

- d. The Administrator will analyze metrics for each level of behavioral health care: inpatient psychiatric, substance use disorder detoxification, substance use disorder rehabilitation, residential, partial hospitalization, intensive outpatient, and outpatient. The Administrator will also review a sample of Emblem's behavioral health medical necessity determinations, including cases eligible for external appeal, but for which no external appeal is filed.
- e. Based on the analyses described above, on a quarterly basis, the Administrator will provide a report to Emblem's Chief Medical Officer and to the OAG, which report will address the adequacy of behavioral health benefits offered by Emblem and Emblem's compliance with mental health parity laws, and include the data in support of the report's conclusions. The report will also evaluate the performance of the Behavioral Health Advocates (who are described below), reviewing, in particular, metrics regarding call volume and case load.

- f. If, in the quarterly reports described above, the Administrator or OAG concludes that Emblem is not compliant with mental health parity laws, or that Emblem's administration of behavioral health benefits is inadequate, Emblem will create a written plan of corrective action, which it will provide within 30 days to the OAG. If, after reviewing the quarterly reports, OAG determines that Emblem is not compliant with mental health parity laws, or that Emblem's administration of behavioral health benefits is inadequate, upon written notice from the OAG, Emblem will create a written plan of corrective action, which it will provide within 30 days to the OAG.
- g. If, after the Administrator has functioned in the position for two years, Emblem makes a showing to the OAG that it is compliant with the terms of this Assurance and with mental health parity laws, and that its administration of behavioral health benefits is adequate, the Administrator shall cease to function.
- h. If, after the expiration of a three (3)-year period after the Effective Date, the Administrator or OAG determine that Emblem does not provide adequate access to effective behavioral health services, the Administrator will continue to function, pursuant to the provisions of this Paragraph 52, until such time as the Administrator and OAG are satisfied that Emblem provides adequate access to effective behavioral health services.

53. Adverse Determination Notification: When making adverse benefit determinations, Emblem and entities administering behavioral health benefits on behalf of Emblem must provide to the member and provider:

- a. Telephonically, and in writing, a detailed explanation of the clinical reason for the denial, citing to specific medical necessity criteria and treatment records;
- b. Telephonically, and in writing, what, if any, additional necessary information must be provided to, or obtained by, Emblem to render a decision on the appeal;
- c. Telephonically, and in writing, information about contacting Behavioral Health Advocates (who are described below), with a notation that the provider and member can contact an Advocate to obtain information about facilities and providers able to provide alternative services to the member; and
- d. Telephonically, and in writing, clear, specific information about internal and external appeals (including information as described below in Paragraphs 55 and 56);
- e. In writing, the address of a website containing the medical necessity criteria used in making the adverse determination, and notice of the availability, free of charge upon request, of a copy of such criteria.

Adverse determination letters will be reviewed for accuracy by the individual who authorized the adverse determination, prior to distribution to members and providers.

54. Behavioral Health Advocates: Emblem will designate a minimum of five (5) full-time employees to serve as Behavioral Health Advocates, each of whom will spend all necessary time on services related to behavioral health advocacy, as set forth below:

- a. The Advocates, who may be employees of Emblem or an entity that administers behavioral health benefits on behalf of Emblem, will provide information and assistance to members with behavioral health complaints and appeals. Each member whose claim or request for coverage for behavioral health services is denied will be assigned an Advocate. Upon any denial of coverage for behavioral health services, upon request, Emblem will provide to the member and provider the name of the assigned Advocate, who will be accessible to both the member and the provider and will supply them with assistance and detailed, accurate and current information regarding utilization review determinations and processes, medical necessity criteria, and appeals, as well as alternative treatment options for the member in the member's area. Emblem will also provide the OAG with the names of all Advocates and the members for whom each is responsible, upon request.
- b. As set forth above in Paragraph 52(e), on a quarterly basis, Emblem will provide the OAG with data regarding the utilization of Behavioral Health Advocates, in particular, daily/weekly call volume and case load (for each Advocate). If, based on its review of such data, the

OAG determines that the number of Advocates or the time spent by Advocates on services related to behavioral health advocacy is insufficient, Emblem shall designate additional Advocates.

- c. Nothing in this Assurance shall be interpreted to prevent any Behavioral Health Advocate from engaging in other work activities so long as all members who have requested assistance from a Behavioral Health Advocate have been provided assistance within the scope of this Paragraph.

55. Internal Appeals: Emblem will offer members the assistance of Behavioral Health Advocates (described above) in internal appeals. Emblem will retain the ability to overrule internal appeal decisions of any entity that administers behavioral health benefits on behalf of Emblem, and will review a statistically significant sample of behavioral health cases for which external appeals have been filed. Emblem will continue coverage of treatment pending the completion of internal appeals.

56. External Appeals: To facilitate Emblem members' timely submission of external appeals, in particular expedited appeals:

- a. When Emblem or any entity acting on its behalf renders an adverse determination of a request for coverage of behavioral health services, such determination will be eligible for expedited external review, if it:
 - (i) meets the criteria of under New York Insurance Law Section 4914(b)(3) or New York Public Health Law Section 4914(b)(3), *i.e.*, if the member's provider states that a delay in providing the services would pose an imminent or serious threat to the health of the member;

- (ii) relates to continued or extended behavioral health services; or (iii) relates to inpatient, residential, partial hospital, intensive outpatient mental health or substance use disorder treatment.
- b. When a member is eligible for expedited external appeal, as set forth in subpart (a) of this Paragraph, Emblem will provide clear and conspicuous instructions, to the member and provider, orally and in writing, regarding external appeal options, including expedited appeals.
 - c. A provider may file an external appeal (whether standard or expedited) on behalf of a member for a prospective, concurrent, or retrospective denial of coverage for behavioral health services.
 - d. When an Emblem member or such member's provider files an expedited external appeal of a denial of coverage for behavioral health services, Emblem must provide coverage of the requested service until the external review agent renders a decision.
 - e. Emblem will not charge the member or provider any fees for external appeals beyond those external review fees permitted by law. Emblem will continue to exercise discretion to waive fees upon request and determination of hardship.

57. Residential Treatment: Emblem will cover medically necessary residential treatment for behavioral health conditions. As described in Emblem's medical necessity criteria, residential treatment facilities provide 24 hours a day/7 days a week treatment and supervision to individuals with severe and persistent psychiatric disorders. Such

facilities typically provide therapeutic intervention and specialized programming in a controlled environment with a high degree of supervision and structure, in the context of a comprehensive, multidisciplinary and individualized treatment plan, with regular physician visits.

58. Training: Emblem will provide training to all utilization review and customer relations staff regarding the requirements of Timothy's Law, New York Insurance Law provisions regarding substance use and eating disorder treatment, the Federal Parity Act, proper application of medical necessity criteria, and appeals processes. Emblem will provide a copy of such training materials to the Administrator and the OAG for approval before dissemination.

59. Complaints: For a three (3)-year period, Emblem will provide the OAG and the Administrator with a quarterly summary of complaints from Emblem members regarding behavioral health coverage, without patient-identifying information. If, pursuant to the provisions of Paragraph 52(g) above, the Administrator ceases to function prior to the expiration of a three (3)-year period after the Effective Date, Emblem's obligation to provide quarterly member complaint summaries to the OAG and the Administrator will cease at the same time.

60. Disclosures: Emblem will provide to members, in clear and conspicuous language, in its member handbook and in correspondence with members, disclosures regarding behavioral health coverage, as set forth in Exhibit B.

61. Annual Parity Compliance Report: For each of the three (3) years following the Effective Date, Emblem will file an annual report with the Administrator and the OAG, certifying compliance with the terms of this Assurance and outlining how

its plans comply with Timothy's Law, New York Insurance Law provisions regarding substance use and eating disorder treatment, and the Federal Parity Act. Such reports shall include the information set forth in Exhibit C. If, pursuant to the provisions of Paragraph 52(g) above, the Administrator ceases to function prior to the expiration of a three (3)-year period after the Effective Date, Emblem's obligation to provide Annual Parity Compliance Reports to the OAG will cease at the same time.

V. RETROSPECTIVE RELIEF

62. Within ninety (90) days of the Effective Date, Emblem will implement the following remedial measures:

63. Independent Review of Medical Necessity Denials: For GHI members, for the period from January 1, 2011, through the Effective Date, and for HIP members, for the period from January 1, 2012 through the Effective Date, where Emblem denied a member or provider's request or claim for behavioral health treatment on the grounds of lack of medical necessity (other than residential treatment denials covered under Paragraph 64 below), and the member subsequently incurred out-of-pocket costs for such treatment, but the member did not file an external appeal with respect to such request or claim:

- a. If the member received services from an in-network provider and received a concurrent or retrospective denial, or if the member received services from an out-of-network denial, Emblem will offer such members the opportunity to appeal the denial to an independent entity, designated by the OAG, which will decide whether the treatment was medically necessary.

- b. Emblem will provide a notice letter to such members informing them of their right to an independent appeal, in the form attached as Exhibit D. The OAG and Emblem will agree on the form of the appeal application, which will be provided to such members along with the notice letter. These members will have four (4) months from the date of receipt of the notice letter and application to complete and return the application.
- c. Emblem will provide notice to in-network behavioral health providers in its provider newsletter and on its website, informing providers that, where providers balance billed members or entered into self-pay arrangements with members and did not collect payment, Emblem will waive the applicable appeal deadline and providers may appeal medical necessity denials rendered during the relief period outlined in this Paragraph. This waiver does not apply to appeals otherwise submitted by a member to the independent entity pursuant to Paragraph 63(d), below.
- d. If, under the provisions of this Paragraph, a member or provider files an appeal under this Paragraph, and the independent entity determines that the treatment was medically necessary, Emblem will reimburse that member for any out-of-pocket costs for such treatment, subject to applicable cost sharing.

- e. “Lack of medical necessity,” as used in this Paragraph, shall mean a request or claim for treatment denied due to lack of medical necessity, lack of clinical information, or lack of preauthorization.
- f. Emblem Behavioral Health Advocates, described above in Paragraph 54, will be available to assist members with the appeal process described in this Paragraph, in addition to the Advocates’ other duties.
- g. Emblem will bear the costs of the notice and appeals process.

Based on information provided by Emblem, it is anticipated that Emblem members who will receive notice pursuant to this Paragraph will include, at a minimum, those Emblem members who received, from January 2011 through March 2014, a total of 15,000 denials of requests or claims for behavioral health treatment due to the plan’s determination that the treatment was not medically necessary, with billed charges of at least \$31,000,000.

64. Residential Treatment Reimbursement: For HIP members, for the period from January 1, 2011, through March 31, 2014 (the date on which Emblem began covering residential treatment for all HIP members), where Emblem denied a member or provider’s request or claim for residential treatment for behavioral health services on the grounds that residential treatment was not a covered service, and the member subsequently incurred out-of-pocket costs for such treatment, or where an Emblem member obtained residential treatment services for behavioral health treatment purposes, and the member incurred out-of-pocket costs for such treatment but did not submit a claim to Emblem for coverage of such services (“Residential Treatment Recipients”), Emblem will reimburse such members as follows:

- a. Emblem will provide a notice letter to certain members, including Residential Treatment Recipients, giving them the opportunity to submit information regarding any behavioral health treatment that resulted in out-of-pocket costs for residential treatment services during the period specified in this Paragraph, including those claims that were subsequently denied. The OAG and Emblem will agree on the types of members who will receive such notice, to include, at a minimum, members who filed requests or claims for residential treatment and/or partial hospitalization services. Residential Treatment Recipients will have four (4) months from the date of receipt of this letter to submit all relevant information.
- b. Emblem Behavioral Health Advocates, described above in Paragraph 54, will be available to assist Residential Treatment Recipients with the appeal process described in this Paragraph, in addition to the Advocates' other duties.
- c. Emblem will reimburse Residential Treatment Recipients for any out-of-pocket costs for residential treatment incurred during the period of time contemplated in this Paragraph, subject to applicable cost-sharing.
- d. Emblem will bear the costs of the notice and appeals process.

VI. PENALTIES

65. Within sixty (60) days of the Effective Date, Emblem shall pay \$1,200,000 to the OAG as a civil penalty, in lieu of any other action which could be taken

by the OAG in consequence of the foregoing. Such sum shall be payable by check to “State of New York Department of Law.”

VII. LIQUIDATED DAMAGES

66. If Emblem violates any provision of this Assurance, or does not provide information required under Sections IV and V of the Assurance and requested by the OAG pursuant to Paragraph 75 below, within 30 days of such request, the OAG may elect as its exclusive remedy in lieu of Paragraphs 78, 79, and 80 below, to demand that Emblem pay liquidated damages of \$1,000 per day for such non-compliance or failure to provide requested information. Before liquidated damages may be imposed, the OAG shall give Emblem written notice that Emblem may be subject to liquidated damages under this paragraph. In the event that Emblem does not cure the violation or provide the requested information within 10 days of receipt of the OAG’s written notice, the OAG may impose liquidated damages pursuant to this paragraph. The damages period shall commence on the date that Emblem receives the OAG’s written notice and end on the date that Emblem cures the violation or provides the requested information.

VIII. MISCELLANEOUS

Compliance

67. Emblem shall submit to the OAG, within ninety (90) days of the completion of the activities and restitution set forth in Paragraphs 47 through 64 above, a letter certifying and setting forth its compliance with this Assurance.

Emblem’s Representations

68. The OAG has agreed to the terms of this Assurance based on, among other

things, the representations made to the OAG by Emblem and its counsel and the OAG's own factual investigation as set forth in the above Findings. To the extent that any material representations are later found to be inaccurate or misleading, this Assurance is voidable by the OAG in its sole discretion.

Communications

69. All communications, reports, correspondence, and payments that Emblem submits to the OAG concerning this Assurance or any related issues is to be sent to the attention of the person identified below:

Michael D. Reisman, Esq.
Assistant Attorney General
Health Care Bureau
Office of the New York Attorney General
120 Broadway
New York, New York 10271
Michael.reisman@ag.ny.gov

70. Receipt by the OAG of materials referenced in this Assurance, with or without comment, shall not be deemed or construed as approval by the OAG of any of the materials, and Emblem shall not make any representations to the contrary.

71. All notices, correspondence, and requests to Emblem shall be directed as follows:

Nicholas P. Kambolis, Esq.
General Counsel
EmblemHealth, Inc.
55 Water Street
New York, NY 10041

Valid Grounds and Waiver

72. Emblem hereby accepts the terms and conditions of this Assurance and waives any rights to challenge it in a proceeding under Article 78 of the Civil Practice

Law and Rules or in any other action or proceeding.

No Deprivation of the Public's Rights

73. Nothing herein shall be construed to deprive any member or other person or entity of any private right under law or equity.

No Blanket Approval by the Attorney General of Emblem's Practices

74. Acceptance of this Assurance by the OAG shall not be deemed or construed as approval by the OAG of any of Emblem's acts or practices, or those of its agents or assigns, and none of them shall make any representation to the contrary.

Monitoring by the OAG

75. To the extent not already provided under this Assurance, Emblem shall, upon request by the OAG, provide all documentation and information necessary for the OAG to verify compliance with this Assurance. Emblem may request an extension of particular deadlines under this Assurance, but OAG need not grant any such request. This Assurance does not in any way limit the OAG's right to obtain, by subpoena or by any other means permitted by law, documents, testimony, or other information.

No Limitation on the Attorney General's Authority

76. Nothing in this Assurance in any way limits the OAG's ability to investigate or take other action with respect to any non-compliance at any time by Emblem with respect to this Assurance, or Emblem's non-compliance with any applicable law with respect to any matters.

No Undercutting of Assurance

77. Emblem shall not take any action or make any statement denying, directly or indirectly, the propriety of this Assurance or expressing the view that this Assurance is

without factual basis. Nothing in this paragraph affects Emblem's (a) testimonial obligations or (b) right to take legal or factual positions in defense of litigation or other legal proceedings to which the OAG is not a party.

Governing Law; Effect of Violation of Assurance of Discontinuance

78. Under Executive Law Section 63(15), evidence of a violation of this Assurance shall constitute prima facie proof of a violation of the applicable law in any action or proceeding thereafter commenced by the OAG.

79. This Assurance shall be governed by the laws of the State of New York without regard to any conflict of laws principles.

80. If a court of competent jurisdiction determines that Emblem has breached this Assurance, Emblem shall pay to the OAG the cost, if any, of such determination and of enforcing this Assurance, including, without limitation, legal fees, expenses, and court costs.

No Presumption Against Drafter; Effect of any Invalid Provision

81. None of the parties shall be considered to be the drafter of this Assurance or any provision for the purpose of any statute, case law, or rule of interpretation or construction that would or might cause any provision to be construed against the drafter hereof. This Assurance was drafted with substantial input by all parties and their counsel, and no reliance was placed on any representation other than those contained in this Assurance.

82. In the event that any one or more of the provisions contained in this Assurance shall for any reason be held to be invalid, illegal, or unenforceable in any respect, in the sole discretion of the OAG such invalidity, illegality, or unenforceability

shall not affect any other provision of this Assurance.

Entire Agreement; Amendment

83. No representation, inducement, promise, understanding, condition, or warranty not set forth in this Assurance has been made to or relied upon by Emblem in agreeing to this Assurance.

84. This Assurance contains an entire, complete, and integrated statement of each and every term and provision agreed to by and among the parties, and the Assurance is not subject to any condition not provided for herein. This Assurance supersedes any prior agreements or understandings, whether written or oral, between and among the OAG and Emblem regarding the subject matter of this Assurance.

85. This Assurance may not be amended or modified except in an instrument in writing signed on behalf of all the parties to this Assurance.

86. The division of this Assurance into sections and subsections and the use of captions and headings in connection herewith are solely for convenience and shall have no legal effect in construing the provisions of this Assurance.

Binding Effect

87. This Assurance is binding on and inures to the benefit of the parties to this Assurance and their respective successors and assigns, provided that no party, other than the OAG, may assign, delegate, or otherwise transfer any of its rights or obligations under this Assurance without prior written consent of the OAG.

Effective Date

88. This Assurance is effective on the date that it is signed by the Attorney General or his authorized representative (the "Effective Date"), and the document may be

executed in counterparts, which shall all be deemed an original for all purposes.

AGREED TO BY THE PARTIES:

Dated: New York, New York

July 1, 2014

EmblemHealth, Inc.

By: Nicholas P. Kambolis

Nicholas P. Kambolis, Esq.
General Counsel

Dated: New York, New York

July 3, 2014

ERIC T. SCHNEIDERMAN

Attorney General of the State of New York

LISA LANDAU
Health Care Bureau Chief

By: Michael D. Reisman

MICHAEL D. REISMAN
Assistant Attorney General
Health Care Bureau

Exhibit A

Protocol for Collecting Information for Medical Necessity Determinations

In making medical necessity determinations regarding requests for coverage of behavioral health treatment, Emblem will:

1. Attempt to obtain from members and providers all information necessary for determining whether a request for coverage of treatment meets the medical necessity for the particular level of care at issue. Such information will, at a minimum, include: diagnosis; symptoms; treatment goals; and, where appropriate, risks to the member from not continuing treatment.
2. Inform the provider and member (where practicable), orally and in writing, of the specific information needed for making the medical necessity determination, the time frame to provide the information, and acceptable methods of submission.
3. Offer to make available to the member and provider a copy of Emblem's medical necessity criteria for the level of care at issue, as well as any checklist or questionnaire used by Emblem in making medical necessity determinations for the level of care at issue.
4. In a case in which Emblem determines that it lacks sufficient information to make a medical necessity determination, Emblem will make reasonable efforts to obtain such information from the member and/or provider within the applicable statutory time frames for rendering decisions, including at least one attempt in writing and at least one attempt telephonically.

Exhibit B

Parity Disclosures

Emblem will make the following disclosures in member handbooks, effective January 1, 2014:

1. Emblem provides broad-based coverage for the diagnosis and treatment of behavioral health conditions, at least equal to the coverage provided for other health conditions. Behavioral health conditions include mental health and substance abuse disorders.

2. Emblem provides, subject to medical necessity, unlimited benefits for inpatient and outpatient behavioral health care, as well as for residential treatment for behavioral health conditions.

3. For Emblem members' outpatient behavioral health visits, Emblem applies the member's primary care cost-sharing schedule. If a member receives behavioral health services in a facility on an outpatient basis, facility cost-sharing requirements may apply in addition to the member's primary care cost-sharing schedule, but any such facility charges must be equal to Emblem's facility charges for medical/surgical services. Self-funded health plans for which Emblem provides administrative services only may opt out of this requirement.

4. The utilization review conducted by Emblem for behavioral health benefits is comparable to, and applied no more stringently than, the utilization review conducted by Emblem for medical/surgical benefits.

5. Any annual or lifetime limits on behavioral health benefits for Emblem plans are no stricter than such limits on medical/surgical benefits.

6. Emblem does not apply any cost-sharing requirements that are applicable only to behavioral health benefits.

7. Emblem does not apply any treatment limitations that are applicable only to behavioral health benefits, except for family counseling services, which may be capped at 20 visits per year.

8. The criteria for medical necessity determinations made by Emblem regarding behavioral health benefits are made available on a public website, and, upon request, to any current or potential participant, beneficiary, or contracting provider.

9. Where an Emblem plan covers medical/surgical benefits provided by out-of-network providers, the plan covers behavioral health benefits provided by out-of-network providers.

10. Emblem members are charged a single deductible for all benefits, whether services rendered are for medical/surgical or behavioral health conditions, with the exception that Emblem charges a separate deductible for prescription drugs.

11. Emblem offers its members the services of Behavioral Health Advocates, who are trained to assist Emblem members in accessing their behavioral health benefits, by supplying them detailed, accurate, and current information regarding: treatment options in the member's area; utilization review determinations and processes; medical necessity criteria; and appeals.

Exhibit C

Parity Compliance Report

Emblem will include in its annual Parity Compliance Reports evidence of the following:

1. Emblem provides broad-based coverage for the diagnosis and treatment of behavioral health conditions, at least equal to the coverage provided for other health conditions. Behavioral health conditions include mental health and substance abuse disorders.
2. Emblem provides, subject to medical necessity, unlimited benefits for inpatient and outpatient behavioral health care, as well as for residential treatment for behavioral health conditions.
3. For Emblem members' outpatient behavioral health visits, Emblem applies the member's primary care cost-sharing schedule. If a member receives behavioral health services in a facility on an outpatient basis, facility cost-sharing requirements may apply in addition to the member's primary care cost-sharing schedule, but any such facility charges must be equal to Emblem's facility charges for medical/surgical services. Self-funded health plans for which Emblem provides only administrative services may opt out of this requirement.
4. The utilization review conducted by Emblem for behavioral health benefits is comparable to, and applied no more stringently than, the utilization review conducted by Emblem for medical/surgical benefits.
5. Any annual or lifetime limits on behavioral health benefits for Emblem plans are no stricter than such limits on medical/surgical benefits.

6. Emblem does not apply any cost-sharing requirements that are applicable only to behavioral health benefits.

7. Emblem does not apply any treatment limitations that are applicable only to behavioral health benefits, except for family counseling services, which may be capped at 20 visits per year.

8. The criteria for medical necessity determinations made by Emblem regarding behavioral health benefits are made available to any current or potential participant, beneficiary, or contracting provider upon request.

9. Where an Emblem plan covers medical/surgical benefits provided by out-of-network providers, the plan covers behavioral health benefits provided by out-of-network providers.

10. Emblem members are charged a single deductible for all benefits, whether services rendered are for medical/surgical or behavioral health conditions, with the exception that Emblem charges a separate deductible for prescription drugs.

