Wisconsin Office of the COMMISSIONER OF INSURANCE

Ref: s. 632.89, Wis. Stat.

# CERTIFICATE OF COMPLIANCE WITH STATE AND FEDERAL MENTAL HEALTH PARITY LAWS

The submitted forms are subject to the federal Mental Health Parity and Addiction Equity Act (Electronic Code of Federal Regulations): ___Yes ___No

I _____, (name), an officer of_____ (company name), hereby certify that I have authority to bind and obligate the company by filing this (these) form(s). I further certify that to the best of my information, knowledge, and belief the company has completed the analysis necessary to ensure that the forms submitted comply with s. 632.89, Wis. Stat., and with the federal Mental Health Parity and Addiction Equity Act (MHPAEA), including the following:

1. The company has assigned mental health/substance use disorder (MH/SUD) benefits to each of the 6 classifications and permitted sub-classifications, applying the same standards to medical/surgical benefits and MH/SUD benefits;

2. The company's analysis has documented that any financial requirements and quantitative treatment limitations (FR/QTL) applied to any MH/SUD benefits are no more restrictive than the predominant FR/QTL that apply to substantially all medical/surgical benefits in the same classification or sub-classification;

3. For each non-quantitative treatment limitation imposed on MH/SUD benefits, in each classification where the limitation is imposed, the company has performed an analysis to document that the limitation is comparable to, and applied no more stringently than used to apply the limitation to medical/surgical benefits, both as written and in operation;

4. The company has implemented a procedure to comply with the disclosure requirement in MHPAEA, including a procedure to make available the criteria for medical necessity determinations to any current or potential participant, beneficiary, or contracting provider upon request;

5. The company has implemented oversight procedures to ensure compliance with MHPAEA for any sub-contractors including any managed behavioral health organizations (MBHO).

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I understand that the commissioner of insurance will rely on this certification regarding the forms filed, and should it be determined that the policy form(s) do not comply with the applicable laws, regulations, filing requirements, and product standards or that this certification is materially false or incorrect, appropriate corrective and disciplinary action, including retroactive disapproval, as authorized by law, may be taken by the commissioner against the company and the officer completing this certification.

_____ _____
(Signature) (Title)

_____
(Date)

Individual responsible for this filing:

_____ _____
(Name) (Title)

_____
(Address)

_____ _____
(Phone Number) (Email)

_____
(Date)



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