



## Division of Insurance Market Regulation

### Access to Providers for Treatment of Mental Health Conditions

Certification pursuant to 20 CSR 400-2.165

(MUST be submitted by October 15)

- (7)(A) Legal Plan name: \_\_\_\_\_  
National Association of Insurance Commissioners (NAIC) number: \_\_\_\_\_
- (7)(B) Number of Insureds covered by Health Benefit Plans: \_\_\_\_\_
- (7)(C) Reason for Exception:  
\_\_\_\_ (2)(C)(1): Health benefit plans issued by an HMO.  
\_\_\_\_ (2)(C)(2): Health benefit plans issued by insurers that provide for some degree of management of care under the plan for all health conditions.  
\_\_\_\_ (2)(C)(3): Individual health benefit plans, including those that cover dependents.  
\_\_\_\_ (2)(C)(4): Individually underwritten group health benefits plans.  
\_\_\_\_ (2)(C)(5): Supplemental insurance policies: Please indicate each type of policy  
\_\_\_\_ Life Care Contracts  
\_\_\_\_ Accident-Only policies  
\_\_\_\_ Specified Disease policies  
\_\_\_\_ Hospital policies providing a fixed daily benefits only  
\_\_\_\_ Medicare supplement policies  
\_\_\_\_ Long-term care policies  
\_\_\_\_ Hospitalization-surgical care policies  
\_\_\_\_ Short-term major medical policies of six (6) months or less duration  
\_\_\_\_ (2)(C)(6): Any other supplemental policy as determined by the director.  
Please describe: \_\_\_\_\_
- (7)(D) Certification of Compliance with 20 CSR 400-2.165:  
Officer's Name: \_\_\_\_\_  
Officer's Title: \_\_\_\_\_  
Date: \_\_\_\_\_
- (7)(E) Contact information for any questions pertaining to the information provided.  
Contact Name: \_\_\_\_\_  
Contact Title: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Company Name: \_\_\_\_\_  
Company Address: \_\_\_\_\_  
Company City, State, & Zip Code: \_\_\_\_\_  
Phone Number & Extension: \_\_\_\_\_