QUEST Integration Program

Mental Health/Substance Use Disorder Parity Report

Health Plan Submission Information

Health Plan Name: **AlohaCare** Report Date: **7/28/2022**

Reporting Period: **01/01/2021 – 12/31/2021**

If Resubmission,
Date Submitted: _____

Section I: Quantitative Treatment Limitations

Does the Health Plan impose any of the following quantitative treatment limitations on MH/SUD benefits in any classification that is more restrictive than the predominant quantitative treatment limitations that applies to substantially all Medical/Surgical benefits in the same classification?

Classification	Annual Visits	Annual Days	Episode Visits	Episode Days	Lifetime Visits	Lifetime Days	None
Inpatient, In-Network	☐	☐	☐	☐	☐	☐	☒
Inpatient, Out-of-Network	☐	☐	☐	☐	☐	☐	☒
Office Visits, In-Network	☐	☐	☐	☐	☐	☐	☒
Other Outpatient, In-Network	☐	☐	☐	☐	☐	☐	☒
Office Visits, Out-of-Network	☐	☐	☐	☐	☐	☐	☒
Other Outpatient, Out-of-Network	☐	☐	☐	☐	☐	☐	☒
Emergency	☐	☐	☐	☐	☐	☐	☒
Prescription Drugs	☐	☐	☐	☐	☐	☐	☒

If any other than "NONE" were selected for a classification, please elaborate in the embedded worksheet below:

MH_SUD_QTL Calculations.xlsx

Section II: Non-Quantitative Treatment Limitations

Does the Health Plan impose any of the following Non-Quantitative Treatment Limitations on MH/SUD services that is more restrictive than the non-quantitative treatment limitations that applies to substantially all Medical/Surgical benefits?

	YES	NO
Medical management standards limiting or excluding benefits based on medical necessity, or medical appropriateness, or based on whether the treatment is experimental or investigative	☐	☒
Prior Authorization and ongoing authorization requirements	YES	NO

Concurrent review standards	☐ YES	☒ NO
Formulary design for prescription drugs	☐ YES	☒ NO
For plans with multiple networks tiers (such as preferred providers and participating providers), network tier designs	YES ☐	NO ☒
Standards for provider admission to participate in a network, including reimbursement rates	YES ☐	NO ☒
Methods for determining usual, customary, and reasonable charges	YES ☐	NO ☒
Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (i.e., "fail-first" policies or "step therapy" protocols)	YES ☐	NO ☒
Restrictions on applicable provider billing codes	YES ☐	NO ☒
Standards for providing access to out-of-network providers	YES ☐	NO ☒
Exclusions based on failure to complete a course of treatment	YES ☐	NO ☒
Restrictions based on geographic location, facility type, and provider specialty	YES ☐	NO ☒

If "YES" to any of the above, please describe in more detail below which benefits classification(s) the NQTL(s) are imposed on including the processes, strategies, evidentiary standards, and other factors.

Section III: Financial Requirements

Does the Health Plan impose any of the following financial requirements on MH/SUD benefits in any classification?

Classification	Deductibles	Co-payments	Co-insurance	Annual Out-of-Pocket Maximums	Lifetime Out-of-Pocket Maximums	None
Inpatient, In-Network	☐	☐	☐	☐	☐	☒
Inpatient, Out-of-Network	☐	☐	☐	☐	☐	☒
Office Visits, In-Network	☐	☐	☐	☐	☐	☒
Other Outpatient, In-Network	☐	☐	☐	☐	☐	☒
Office Visits, Out-of-Network	☐	☐	☐	☐	☐	☒
Other Outpatient, Out-of-Network	☐	☐	☐	☐	☐	☒
Emergency	☐	☐	☐	☐	☐	☒
Prescription Drugs	☐	☐	☐	☐	☐	☒

If any more restrictive financial requirements were selected above, then the Health Plan shall complete the following embedded worksheet.

MH_SUD_Financial Calculations.xlsx

Attestation

I, acting as the Chief Executive Officer or Authorized Agent of AlohaCare (i.e., the Health Plan), **declare under penalty of perjury** that: (1) the information reported above is true and correct; (2) any attached documentation and materials referenced are true and correct; and (3) I understand and agree to the terms of the QI RFP/contract at Sections 6, Health Plan Reporting and Encounter Data Responsibilities and Section 14.21, Remedies of Non-Performance of Contract.

Signature	Title	Date
Janelle Saucedo J anelle Saucedo (Jul 28, 2022 14:47 HST)	Dir. Of BH	07/28/22

Table 1: Quantitative Treatment Limitations, including, but not limited to, limits on inpatient days per admission/episode or per year, outpatient visits per episode/year, outpatient services per episode/year.

MEDICAL/SURGICAL (M/S) BENEFITS			MENTAL HEALTH/SUBSTANCE USE DISORDER (MH/SUD) BENEFITS	
Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Sub classification Below			Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Sub classification Below	
A. Inpatient, In-Network	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**Predominant quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**A. Inpatient, In-Network**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
Hospital facility fee (e.g., hospital room)--acute inpatient			Hospital facility fee (e.g., hospital room)--acute MH inpatient	
Physician/surgeon fee--acute inpatient			Physician/surgeon fee--acute MH inpatient	
Hospital facility fee (e.g., hospital room)--female sterilization			Hospital facility fee (e.g., hospital room)--inpatient psychiatric observation for acute psychiatric crisis	
Physician/surgeon fee--female sterilization			Physician/surgeon fee--psychiatric observation for acute psychiatric crisis	
Hospital facility fee (e.g., hospital room)--maternity delivery			Hospital facility fee (e.g., hospital room)--SUD detoxification	
Professional fees--maternity delivery			Physician/surgeon fee--SUD detoxification	
Inpatient hospice facility fee (e.g., hospital room)			Short-term mental health crisis residential treatment	
Skilled nursing facility fee (e.g., hospital room)			SUD transitional residential recovery services	
			Residential treatment services for SMI and SED	
B. Inpatient, Out-of-Network	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**B. Inpatient, Out-of-Network**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
C. Outpatient, In-Network: Office Visits	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**C. Outpatient, In-Network: Office Visits**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
Primary care visit to treat an injury, illness, or condition			Individual and group mental health evaluation and treatment	
Other practitioner office visit			Outpatient services for monitoring drug therapy	
Specialist physician visit			Individual and group chemical dependency evaluation and counseling	
Preventive care/screening/immunization			Medical treatment for withdrawal symptoms	
Family planning			Behavioral health treatment Office Visit for autism or pervasive developmental disorder (PDD)	
Prenatal care and preconception visits				
Acupuncture				
Health education				
Child dental: diagnostic and preventive				
Child eye exam				
D. Outpatient, In-Network: Other Outpatient Items and Services	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**D. Outpatient, In-Network: Other Outpatient Items and Services**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)			Short-term partial hospitalization	
Outpatient surgery --physician/surgeon fee			Short-term intensive outpatient psychiatric treatment	
Outpatient surgery facility fee--female sterilization			Outpatient psychiatric observation for an acute psychiatric crisis	
Outpatient surgery--physician/surgeon fee--female sterilization			Psychological testing to evaluate a mental disorder	
Outpatient visit regarding outpatient surgery			Day treatment program for substance use disorder	
BRCA testing and related genetic counseling			Intensive outpatient treatment for substance use disorder	
Laboratory tests			Behavioral health therapy delivered in the home for autism and PDD	
X-rays and diagnostic imaging			Nonemergency psychiatric transportation	
Imaging (CT/PET Scans, MRIs)				
Nonemergency medical transportation				
Outpatient rehabilitation services				
Outpatient habilitation services				
Home health				
Hospice				
Durable medical equipment, including in-home DME				
Medical supplies				
Prosthetic and orthotic services and devices				

Diabetes equipment and supply services				
Contact lenses for aniridia or aphakia				
Infusion therapy				
Child eye glasses/contact lenses				
Child dental: basic services				
Child dental: major services				
Child medically necessary orthodontics				
E. Outpatient, Out-of-Network: Office Visits	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**E. Outpatient, Out-of-Network: Office Visits**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**F. Outpatient, Out-of-Network: Other Outpatient Items and Services**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
G. Emergency	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**G. Emergency**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
Emergency room facility fee (waived if admitted)			Emergency room facility fee (waived if admitted)	
Emergency room physician fee (waived if admitted)			Emergency room physician fee (waived if admitted)	
Emergency medical transportation			Emergency medical/psychiatric transportation	
Urgent care			Urgent care	
H. Prescription Drugs	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**If prescription drugs are covered in a tiered structure that does not distinguish between M/S and MH/SUD drugs, the "predominant" and "substantially all" analyses are not necessary.**	**H. Prescription Drugs**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
Tier One			Tier One	
Tier Two			Tier Two	
Tier Three			Tier Three	
Tier Four			Tier Four	

Classification "Substantially All" Test for Copays or Coinsurance, Predominant Level		Copayment ($) or Coinsurance (%) amount	FY 2022 Projected Expense	% of Total Plan Cost (Allowed)	Projected Expense for this Benefit as % of Projected Expense for All Benefits Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coinsurance %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)
A. Inpatient, In-Network								
Hospital facility fee (e.g., hospital room)--acute inpatient				#DIV/0!				
Physician/surgeon fee--acute inpatient				#DIV/0!				
Hospital facility fee (e.g., hospital room)--female sterilization				#DIV/0!				
Physician/surgeon fee--female sterilization				#DIV/0!				
Hospital facility fee (e.g., hospital room)--maternity delivery				#DIV/0!				
Professional fees--maternity delivery				#DIV/0!				
Inpatient hospice facility fee (e.g., hospital room)				#DIV/0!				
Skilled nursing facility fee (e.g., hospital room)				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				

"Substantially All" Test for Deductible		Deductible $	FY 2022 Projected Expense (Allowed) Subject to Deductible	CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)			Substantially All Deductible (2/3 test)	
	Total Subject to Deductible			#DIV/0!				

Classification		Copayment ($) or Coinsurance(%) amount	CY 2016 Projected Expense	% of Total Plan Cost (Allowed)	Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)
B. Inpatient, Out-of-Network								
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				

				#DIV/0!				
				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		**Copayment ($) or Coinsurance(%) amount**	**FY 2022 Projected Expense**	**% of Total Plan Cost (Allowed)**	**Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)**
C. Outpatient, In-Network: Office Visits								
Primary care visit to treat an injury, illness, or condition				#DIV/0!				
Other practitioner office visit				#DIV/0!				
Specialist physician visit				#DIV/0!				
Preventive care/screening/immunization				#DIV/0!				
Family planning				#DIV/0!				
Prenatal care and preconception visits				#DIV/0!				
Acupuncture				#DIV/0!				
Health education				#DIV/0!				
Child dental: diagnostic and preventive				#DIV/0!				
Child eye exam				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		Copayment ($) or Coinsurance(%) amount	FY 2022 Projected Expense	% of Total Plan Cost (Allowed)	Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)
D. Outpatient, In-Network: Other Outpatient Items and Services								
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)				#DIV/0!				
Outpatient surgery --physician/surgeon fee				#DIV/0!				
Outpatient surgery facility fee--female sterilization				#DIV/0!				
Outpatient surgery--physician/ surgeon fee--female sterilization				#DIV/0!				
Outpatient visit re: outpatient surgery				#DIV/0!				
BRCA testing and related genetic counseling				#DIV/0!				
Laboratory tests				#DIV/0!				
X-rays and diagnostic imaging				#DIV/0!				
Imaging (CT/PET Scans, MRIs)				#DIV/0!				
Nonemergency medical transportation				#DIV/0!				
Outpatient rehabilitation services				#DIV/0!				
Outpatient habilitation services				#DIV/0!				
Home health				#DIV/0!				
Hospice				#DIV/0!				
Durable medical equipment, including in-home DME				#DIV/0!				
Medical supplies				#DIV/0!				
Prosthetic and orthotic services and devices				#DIV/0!				
Diabetes equipment and supply services				#DIV/0!				
Contact lenses for aniridia or aphakia				#DIV/0!				
Infusion therapy				#DIV/0!				
Child eye glasses/contact lenses				#DIV/0!				
Child dental: basic services				#DIV/0!				
Child dental: major services				#DIV/0!				
Child medically necessary orthodontics				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		Copayment ($) or Coinsurance(%) amount	FY 2022 Projected Expense	% of Total Plan Cost (Allowed)	Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)
E. Outpatient, Out-of-Network: Office Visits								
				#DIV/0!				

				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		**Copayment ($) or Coinsurance(%) amount**	**FY 2022 Projected Expense**	**% of Total Plan Cost (Allowed)**	**Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
F. Outpatient, Out-of-Network: Other Outpatient Items and Services								
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		**Copayment ($) or Coinsurance(%) amount**	**FY 2022 Projected Expense**	**% of Total Plan Cost (Allowed)**	**Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Expense Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)**

G. Emergency								
Emergency room facility fee (waived if admitted)				#DIV/0!				
Emergency room physician fee (waived if admitted)				#DIV/0!				
Emergency medical transportation				#DIV/0!				
Urgent care				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Please include any comments:

QUEST Integration Program

Mental Health/Substance Use Disorder Parity Report

Health Plan Submission Information

Health Plan Name: **HMSA** Report Date: **07/01/2022**

Reporting Period: **01/01/2021 – 12/31/2021**

If Resubmission,
Date Submitted: _____

Section I: Quantitative Treatment Limitations

Does the Health Plan impose any of the following quantitative treatment limitations on MH/SUD benefits in any classification that is more restrictive than the predominant quantitative treatment limitations that applies to substantially all Medical/Surgical benefits in the same classification?

Classification	Annual Visits	Annual Days	Episode Visits	Episode Days	Lifetime Visits	Lifetime Days	None
Inpatient, In-Network	☐	☐	☐	☐	☐	☐	☒
Inpatient, Out-of-Network	☐	☐	☐	☐	☐	☐	☒
Office Visits, In-Network	☐	☐	☐	☐	☐	☐	☒
Other Outpatient, In-Network	☐	☐	☐	☐	☐	☐	☒
Office Visits, Out-of-Network	☐	☐	☐	☐	☐	☐	☒
Other Outpatient, Out-of-Network	☐	☐	☐	☐	☐	☐	☒
Emergency	☐	☐	☐	☐	☐	☐	☒
Prescription Drugs	☐	☐	☐	☐	☐	☐	☒

If any other than "NONE" were selected for a classification, please elaborate in the embedded worksheet below:

Section II: Non-Quantitative Treatment Limitations

Does the Health Plan impose any of the following Non-Quantitative Treatment Limitations on MH/SUD services that is more restrictive than the non-quantitative treatment limitations that applies to substantially all Medical/Surgical benefits?

	YES	NO
Medical management standards limiting or excluding benefits based on medical necessity, or medical appropriateness, or based on whether the treatment is experimental or investigative	☐	☒
Prior Authorization and ongoing authorization requirements	☐	☒
Concurrent review standards	☐	☒

Formulary design for prescription drugs	YES ☐	NO ☒
For plans with multiple networks tiers (such as preferred providers and participating providers), network tier designs	YES ☐	NO ☒
Standards for provider admission to participate in a network, including reimbursement rates	YES ☐	NO ☒
Methods for determining usual, customary, and reasonable charges	YES ☐	NO ☒
Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (i.e., "fail-first" policies or "step therapy" protocols)	YES ☐	NO ☒
Restrictions on applicable provider billing codes	YES ☐	NO ☒
Standards for providing access to out-of-network providers	YES ☐	NO ☒
Exclusions based on failure to complete a course of treatment	YES ☐	NO ☒
Restrictions based on geographic location, facility type, and provider specialty	YES ☐	NO ☒

If "YES" to any of the above, please describe in more detail below which benefits classification(s) the NQTL(s) are imposed on including the processes, strategies, evidentiary standards, and other factors.

N/A

Section III: Financial Requirements

Does the Health Plan impose any of the following financial requirements on MH/SUD benefits in any classification?

Classification	Deductibles	Co-payments	Co-insurance	Annual Out-of-Pocket Maximums	Lifetime Out-of-Pocket Maximums	None
Inpatient, In-Network	☐	☐	☐	☐	☐	☒
Inpatient, Out-of-Network	☐	☐	☐	☐	☐	☒
Office Visits, In-Network	☐	☐	☐	☐	☐	☒
Other Outpatient, In-Network	☐	☐	☐	☐	☐	☒
Office Visits, Out-of-Network	☐	☐	☐	☐	☐	☒
Other Outpatient, Out-of-Network	☐	☐	☐	☐	☐	☒
Emergency	☐	☐	☐	☐	☐	☒
Prescription Drugs	☐	☐	☐	☐	☐	☒

If any more restrictive financial requirements were selected above, then the Health Plan shall complete the following embedded worksheet.

Attestation

I, Kenny Fink, acting as the Chief Executive Officer or Authorized Agent of Hawai'i Medical Service Association (HMSA), **declare under penalty of perjury** that: (1) the information reported above is true and correct; (2) any attached documentation and materials referenced are true and correct; and (3) I understand and agree to the terms of the QI RFP/contract at Sections 6, Health Plan Reporting and Encounter Data Responsibilities and Section 14.21, Remedies of Non-Performance of Contract.

Signature	Title	Date
	Vice President, Government Programs	07/01/2022

QUEST Integration Program

Mental Health/Substance Use Disorder Parity Report

Health Plan Submission Information

Health Plan Name: **KAISER PERMANENTE** Report Date: **7/29/2022**

Reporting Period: **01/01/2021 – 12/31/2021**

If Resubmission,
Date Submitted: _____

Section I: Quantitative Treatment Limitations

Does the Health Plan impose any of the following quantitative treatment limitations on MH/SUD benefits in any classification that is more restrictive than the predominant quantitative treatment limitations that applies to substantially all Medical/Surgical benefits in the same classification?

Classification	Annual Visits	Annual Days	Episode Visits	Episode Days	Lifetime Visits	Lifetime Days	None
Inpatient, In-Network	☐	☐	☐	☐	☐	☐	☒
Inpatient, Out-of-Network	☐	☐	☐	☐	☐	☐	☒
Office Visits, In-Network	☐	☐	☐	☐	☐	☐	☒
Other Outpatient, In-Network	☐	☐	☐	☐	☐	☐	☒
Office Visits, Out-of-Network	☐	☐	☐	☐	☐	☐	☒
Other Outpatient, Out-of-Network	☐	☐	☐	☐	☐	☐	☒
Emergency	☐	☐	☐	☐	☐	☐	☒
Prescription Drugs	☐	☐	☐	☐	☐	☐	☒

If any other than "NONE" were selected for a classification, please elaborate in the embedded worksheet below:

MH_SUD_QTL Calculations.xlsx

Section II: Non-Quantitative Treatment Limitations

Does the Health Plan impose any of the following Non-Quantitative Treatment Limitations on MH/SUD services that is more restrictive than the non-quantitative treatment limitations that applies to substantially all Medical/Surgical benefits?

Medical management standards limiting or excluding benefits based on medical necessity, or medical appropriateness, or based on whether the treatment is experimental or investigative	YES ☐	NO ☒	
Prior Authorization and ongoing authorization requirements	YES ☐	NO ☒	
Concurrent review standards	YES	NO	

	☐	☒	
Formulary design for prescription drugs	YES ☐	NO ☒	
For plans with multiple networks tiers (such as preferred providers and participating providers), network tier designs	YES ☐	NO ☐	N/A ☒
Standards for provider admission to participate in a network, including reimbursement rates	YES ☐	NO ☒	
Methods for determining usual, customary, and reasonable charges	YES ☐	NO ☒	
Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (i.e., "fail-first" policies or "step therapy" protocols)	YES ☐	NO ☒	
Restrictions on applicable provider billing codes	YES ☐	NO ☒	
Standards for providing access to out-of-network providers	YES ☐	NO ☒	
Exclusions based on failure to complete a course of treatment	YES ☐	NO ☐	N/A ☒
Restrictions based on geographic location, facility type, and provider specialty	YES ☐	NO ☒	

If "YES" to any of the above, please describe in more detail below which benefits classification(s) the NQTL(s) are imposed on including the processes, strategies, evidentiary standards, and other factors.

Section III: Financial Requirements

Does the Health Plan impose any of the following financial requirements on MH/SUD benefits in any classification?

Classification	Deductibles	Co-payments	Co-insurance	Annual Out-of-Pocket Maximums	Lifetime Out-of-Pocket Maximums	None
Inpatient, In-Network	☐	☐	☐	☐	☐	☒
Inpatient, Out-of-Network	☐	☐	☐	☐	☐	☒
Office Visits, In-Network	☐	☐	☐	☐	☐	☒
Other Outpatient, In-Network	☐	☐	☐	☐	☐	☒
Office Visits, Out-of-Network	☐	☐	☐	☐	☐	☒
Other Outpatient, Out-of-Network	☐	☐	☐	☐	☐	☒
Emergency	☐	☐	☐	☐	☐	☒
Prescription Drugs	☐	☐	☐	☐	☐	☒

If any more restrictive financial requirements were selected above, then the Health Plan shall complete the following embedded worksheet.

MH_SUD_Financial Calculations.xlsx

Attestation

I, acting as the Chief Executive Officer or Authorized Agent of Kaiser Permanente (i.e., the Health Plan), **declare under penalty of perjury** that: (1) the information reported above is true and correct; (2) any attached documentation and materials referenced are true and correct; and (3) I understand and agree to the terms of the QI RFP/contract at Sections 6, Health Plan Reporting and Encounter Data Responsibilities and Section 14.21, Remedies of Non-Performance of Contract.

Signature	Director, QI Member Services Title	7/29/2022 Date

Table 1: Quantitative Treatment Limitations, including, but not limited to, limits on inpatient days per admission/episode or per year, outpatient visits per episode/year, outpatient services per episode/year.

MEDICAL/SURGICAL (M/S) BENEFITS			MENTAL HEALTH/SUBSTANCE USE DISORDER (MH/SUD) BENEFITS	
Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Sub classification Below			Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Sub classification Below	
A. Inpatient, In-Network	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**Predominant quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**A. Inpatient, In-Network**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
Hospital facility fee (e.g., hospital room)--acute inpatient			Hospital facility fee (e.g., hospital room)--acute MH inpatient	
Physician/surgeon fee--acute inpatient			Physician/surgeon fee--acute MH inpatient	
Hospital facility fee (e.g., hospital room)--female sterilization			Hospital facility fee (e.g., hospital room)--inpatient psychiatric observation for acute psychiatric crisis	
Physician/surgeon fee--female sterilization			Physician/surgeon fee--psychiatric observation for acute psychiatric crisis	
Hospital facility fee (e.g., hospital room)--maternity delivery			Hospital facility fee (e.g., hospital room)--SUD detoxification	
Professional fees--maternity delivery			Physician/surgeon fee--SUD detoxification	
Inpatient hospice facility fee (e.g., hospital room)			Short-term mental health crisis residential treatment	
Skilled nursing facility fee (e.g., hospital room)			SUD transitional residential recovery services	
			Residential treatment services for SMI and SED	
B. Inpatient, Out-of-Network	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**B. Inpatient, Out-of-Network**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
C. Outpatient, In-Network: Office Visits	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**C. Outpatient, In-Network: Office Visits**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
Primary care visit to treat an injury, illness, or condition			Individual and group mental health evaluation and treatment	
Other practitioner office visit			Outpatient services for monitoring drug therapy	
Specialist physician visit			Individual and group chemical dependency evaluation and counseling	
Preventive care/screening/immunization			Medical treatment for withdrawal symptoms	
Family planning			Behavioral health treatment Office Visit for autism or pervasive developmental disorder (PDD)	
Prenatal care and preconception visits				
Acupuncture				
Health education				
Child dental: diagnostic and preventive				
Child eye exam				
D. Outpatient, In-Network: Other Outpatient Items and Services	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**D. Outpatient, In-Network: Other Outpatient Items and Services**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)			Short-term partial hospitalization	
Outpatient surgery --physician/surgeon fee			Short-term intensive outpatient psychiatric treatment	
Outpatient surgery facility fee--female sterilization			Outpatient psychiatric observation for an acute psychiatric crisis	
Outpatient surgery--physician/surgeon fee--female sterilization			Psychological testing to evaluate a mental disorder	
Outpatient visit regarding outpatient surgery			Day treatment program for substance use disorder	
BRCA testing and related genetic counseling			Intensive outpatient treatment for substance use disorder	
Laboratory tests			Behavioral health therapy delivered in the home for autism and PDD	
X-rays and diagnostic imaging			Nonemergency psychiatric transportation	
Imaging (CT/PET Scans, MRIs)				
Nonemergency medical transportation				
Outpatient rehabilitation services				
Outpatient habilitation services				
Home health				
Hospice				
Durable medical equipment, including in-home DME				
Medical supplies				
Prosthetic and orthotic services and devices				

Diabetes equipment and supply services				
Contact lenses for aniridia or aphakia				
Infusion therapy				
Child eye glasses/contact lenses				
Child dental: basic services				
Child dental: major services				
Child medically necessary orthodontics				
E. Outpatient, Out-of-Network: Office Visits	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**E. Outpatient, Out-of-Network: Office Visits**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**F. Outpatient, Out-of-Network: Other Outpatient Items and Services**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
G. Emergency	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**G. Emergency**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
Emergency room facility fee (waived if admitted)			Emergency room facility fee (waived if admitted)	
Emergency room physician fee (waived if admitted)			Emergency room physician fee (waived if admitted)	
Emergency medical transportation			Emergency medical/psychiatric transportation	
Urgent care			Urgent care	
H. Prescription Drugs	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**If prescription drugs are covered in a tiered structure that does not distinguish between M/S and MH/SUD drugs, the "predominant" and "substantially all" analyses are not necessary.**	**H. Prescription Drugs**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
Tier One			Tier One	
Tier Two			Tier Two	
Tier Three			Tier Three	
Tier Four			Tier Four	

Classification "Substantially All" Test for Copays or Coinsurance, Predominant Level		Copayment ($) or Coinsurance (%) amount	FY 2022 Projected Expense	% of Total Plan Cost (Allowed)	Projected Expense for this Benefit as % of Projected Expense for All Benefits Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coinsurance %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)
A. Inpatient, In-Network								
Hospital facility fee (e.g., hospital room)--acute inpatient				#DIV/0!				
Physician/surgeon fee--acute inpatient				#DIV/0!				
Hospital facility fee (e.g., hospital room)--female sterilization				#DIV/0!				
Physician/surgeon fee--female sterilization				#DIV/0!				
Hospital facility fee (e.g., hospital room)--maternity delivery				#DIV/0!				
Professional fees--maternity delivery				#DIV/0!				
Inpatient hospice facility fee (e.g., hospital room)				#DIV/0!				
Skilled nursing facility fee (e.g., hospital room)				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				

"Substantially All" Test for Deductible		Deductible $	FY 2022 Projected Expense (Allowed) Subject to Deductible	CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)			Substantially All Deductible (2/3 test)	
	Total Subject to Deductible			#DIV/0!				

Classification		Copayment ($) or Coinsurance(%) amount	CY 2016 Projected Expense	% of Total Plan Cost (Allowed)	Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)
B. Inpatient, Out-of-Network								
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				

				#DIV/0!				
				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		**Copayment ($) or Coinsurance(%) amount**	**FY 2022 Projected Expense**	**% of Total Plan Cost (Allowed)**	**Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)**
C. Outpatient, In-Network: Office Visits								
Primary care visit to treat an injury, illness, or condition				#DIV/0!				
Other practitioner office visit				#DIV/0!				
Specialist physician visit				#DIV/0!				
Preventive care/screening/immunization				#DIV/0!				
Family planning				#DIV/0!				
Prenatal care and preconception visits				#DIV/0!				
Acupuncture				#DIV/0!				
Health education				#DIV/0!				
Child dental: diagnostic and preventive				#DIV/0!				
Child eye exam				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		Copayment ($) or Coinsurance(%) amount	FY 2022 Projected Expense	% of Total Plan Cost (Allowed)	Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)
D. Outpatient, In-Network: Other Outpatient Items and Services								
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)				#DIV/0!				
Outpatient surgery --physician/surgeon fee				#DIV/0!				
Outpatient surgery facility fee--female sterilization				#DIV/0!				
Outpatient surgery--physician/ surgeon fee--female sterilization				#DIV/0!				
Outpatient visit re: outpatient surgery				#DIV/0!				
BRCA testing and related genetic counseling				#DIV/0!				
Laboratory tests				#DIV/0!				
X-rays and diagnostic imaging				#DIV/0!				
Imaging (CT/PET Scans, MRIs)				#DIV/0!				
Nonemergency medical transportation				#DIV/0!				
Outpatient rehabilitation services				#DIV/0!				
Outpatient habilitation services				#DIV/0!				
Home health				#DIV/0!				
Hospice				#DIV/0!				
Durable medical equipment, including in-home DME				#DIV/0!				
Medical supplies				#DIV/0!				
Prosthetic and orthotic services and devices				#DIV/0!				
Diabetes equipment and supply services				#DIV/0!				
Contact lenses for aniridia or aphakia				#DIV/0!				
Infusion therapy				#DIV/0!				
Child eye glasses/contact lenses				#DIV/0!				
Child dental: basic services				#DIV/0!				
Child dental: major services				#DIV/0!				
Child medically necessary orthodontics				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		Copayment ($) or Coinsurance(%) amount	FY 2022 Projected Expense	% of Total Plan Cost (Allowed)	Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)
E. Outpatient, Out-of-Network: Office Visits								
				#DIV/0!				

				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		**Copayment ($) or Coinsurance(%) amount**	**FY 2022 Projected Expense**	**% of Total Plan Cost (Allowed)**	**Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
F. Outpatient, Out-of-Network: Other Outpatient Items and Services								
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		**Copayment ($) or Coinsurance(%) amount**	**FY 2022 Projected Expense**	**% of Total Plan Cost (Allowed)**	**Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Expense Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)**

G. Emergency								
Emergency room facility fee (waived if admitted)				#DIV/0!				
Emergency room physician fee (waived if admitted)				#DIV/0!				
Emergency medical transportation				#DIV/0!				
Urgent care				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Please include any comments:

QUEST Integration Program

Mental Health/Substance Use Disorder Parity Report

Health Plan Submission Information

Health Plan Name: **Ohana Health Plan** Report Date: **7/31/2022**

Reporting Period: **01/01/2021 – 12/31/2021**

If Resubmission,
Date Submitted: _____

Section I: Quantitative Treatment Limitations

Does the Health Plan impose any of the following quantitative treatment limitations on MH/SUD benefits in any classification that is more restrictive than the predominant quantitative treatment limitations that applies to substantially all Medical/Surgical benefits in the same classification?

Classification	Annual Visits	Annual Days	Episode Visits	Episode Days	Lifetime Visits	Lifetime Days	None
Inpatient, In-Network	☐	☐	☐	☐	☐	☐	☒
Inpatient, Out-of-Network	☐	☐	☐	☐	☐	☐	☒
Office Visits, In-Network	☐	☐	☐	☐	☐	☐	☒
Other Outpatient, In-Network	☐	☐	☐	☐	☐	☐	☒
Office Visits, Out-of-Network	☐	☐	☐	☐	☐	☐	☒
Other Outpatient, Out-of-Network	☐	☐	☐	☐	☐	☐	☒
Emergency	☐	☐	☐	☐	☐	☐	☒
Prescription Drugs	☐	☐	☐	☐	☐	☐	☒

If any other than "NONE" were selected for a classification, please elaborate in the embedded worksheet below:

MH_SUD_QTL Calculations.xlsx

Section II: Non-Quantitative Treatment Limitations

Does the Health Plan impose any of the following Non-Quantitative Treatment Limitations on MH/SUD services that is more restrictive than the non-quantitative treatment limitations that applies to substantially all Medical/Surgical benefits?

	YES	NO
Medical management standards limiting or excluding benefits based on medical necessity, or medical appropriateness, or based on whether the treatment is experimental or investigative	☐	☒
Prior Authorization and ongoing authorization requirements	☐	☒
Concurrent review standards	YES	NO

Formulary design for prescription drugs	☐ YES	☒ NO
For plans with multiple networks tiers (such as preferred providers and participating providers), network tier designs	☐ YES	☒ NO
Standards for provider admission to participate in a network, including reimbursement rates	☐ YES	☒ NO
Methods for determining usual, customary, and reasonable charges	☐ YES	☒ NO
Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (i.e., "fail-first" policies or "step therapy" protocols)	☐ YES	☒ NO
Restrictions on applicable provider billing codes	☐ YES	☒ NO
Standards for providing access to out-of-network providers	☐ YES	☒ NO
Exclusions based on failure to complete a course of treatment	☐ YES	☒ NO
Restrictions based on geographic location, facility type, and provider specialty	☐ YES	☒ NO

If "YES" to any of the above, please describe in more detail below which benefits classification(s) the NQTL(s) are imposed on including the processes, strategies, evidentiary standards, and other factors.

N/A

Section III: Financial Requirements

Does the Health Plan impose any of the following financial requirements on MH/SUD benefits in any classification?

Classification	Deductibles	Co-payments	Co-insurance	Annual Out-of-Pocket Maximums	Lifetime Out-of-Pocket Maximums	None
Inpatient, In-Network	☐	☐	☐	☐	☐	☒
Inpatient, Out-of-Network	☐	☐	☐	☐	☐	☒
Office Visits, In-Network	☐	☐	☐	☐	☐	☒
Other Outpatient, In-Network	☐	☐	☐	☐	☐	☒
Office Visits, Out-of-Network	☐	☐	☐	☐	☐	☒
Other Outpatient, Out-of-Network	☐	☐	☐	☐	☐	☒
Emergency	☐	☐	☐	☐	☐	☒
Prescription Drugs	☐	☐	☐	☐	☐	☒

If any more restrictive financial requirements were selected above, then the Health Plan shall complete the following embedded worksheet.

MH_SUD_Financial Calculations.xlsx

Attestation

I, acting as the Chief Executive Officer or Authorized Agent of 'Ohana Health Plan (i.e., the Health Plan), **declare under penalty of perjury** that: (1) the information reported above is true and correct; (2) any attached documentation and materials referenced are true and correct; and (3) I understand and agree to the terms of the QI RFP/contract at Sections 6, Health Plan Reporting and Encounter Data Responsibilities and Section 14.21, Remedies of Non-Performance of Contract.

_____	Plan President & CEO	7/31/2022
Signature	Title	Date

Classification "Substantially All" Test for Copays or Coinsurance, Predominant Level		Copayment ($) or Coinsurance (%) amount	FY 2022 Projected Expense	% of Total Plan Cost (Allowed)	Projected Expense for this Benefit as % of Projected Expense for All Benefits Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coinsurance %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)
A. Inpatient, In-Network								
Hospital facility fee (e.g., hospital room)--acute inpatient				#DIV/0!				
Physician/surgeon fee--acute inpatient				#DIV/0!				
Hospital facility fee (e.g., hospital room)--female sterilization				#DIV/0!				
Physician/surgeon fee--female sterilization				#DIV/0!				
Hospital facility fee (e.g., hospital room)--maternity delivery				#DIV/0!				
Professional fees--maternity delivery				#DIV/0!				
Inpatient hospice facility fee (e.g., hospital room)				#DIV/0!				
Skilled nursing facility fee (e.g., hospital room)				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				

"Substantially All" Test for Deductible		Deductible $	FY 2022 Projected Expense (Allowed) Subject to Deductible	CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)			Substantially All Deductible (2/3 test)	
	Total Subject to Deductible			#DIV/0!				

Classification		Copayment ($) or Coinsurance(%) amount	CY 2016 Projected Expense	% of Total Plan Cost (Allowed)	Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)
B. Inpatient, Out-of-Network								
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				

				#DIV/0!				
				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		**Copayment ($) or Coinsurance(%) amount**	**FY 2022 Projected Expense**	**% of Total Plan Cost (Allowed)**	**Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)**
C. Outpatient, In-Network: Office Visits								
Primary care visit to treat an injury, illness, or condition				#DIV/0!				
Other practitioner office visit				#DIV/0!				
Specialist physician visit				#DIV/0!				
Preventive care/screening/immunization				#DIV/0!				
Family planning				#DIV/0!				
Prenatal care and preconception visits				#DIV/0!				
Acupuncture				#DIV/0!				
Health education				#DIV/0!				
Child dental: diagnostic and preventive				#DIV/0!				
Child eye exam				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		Copayment ($) or Coinsurance(%) amount	FY 2022 Projected Expense	% of Total Plan Cost (Allowed)	Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)
D. Outpatient, In-Network: Other Outpatient Items and Services								
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)				#DIV/0!				
Outpatient surgery --physician/surgeon fee				#DIV/0!				
Outpatient surgery facility fee--female sterilization				#DIV/0!				
Outpatient surgery--physician/ surgeon fee--female sterilization				#DIV/0!				
Outpatient visit re: outpatient surgery				#DIV/0!				
BRCA testing and related genetic counseling				#DIV/0!				
Laboratory tests				#DIV/0!				
X-rays and diagnostic imaging				#DIV/0!				
Imaging (CT/PET Scans, MRIs)				#DIV/0!				
Nonemergency medical transportation				#DIV/0!				
Outpatient rehabilitation services				#DIV/0!				
Outpatient habilitation services				#DIV/0!				
Home health				#DIV/0!				
Hospice				#DIV/0!				
Durable medical equipment, including in-home DME				#DIV/0!				
Medical supplies				#DIV/0!				
Prosthetic and orthotic services and devices				#DIV/0!				
Diabetes equipment and supply services				#DIV/0!				
Contact lenses for aniridia or aphakia				#DIV/0!				
Infusion therapy				#DIV/0!				
Child eye glasses/contact lenses				#DIV/0!				
Child dental: basic services				#DIV/0!				
Child dental: major services				#DIV/0!				
Child medically necessary orthodontics				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		Copayment ($) or Coinsurance(%) amount	FY 2022 Projected Expense	% of Total Plan Cost (Allowed)	Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)
E. Outpatient, Out-of-Network: Office Visits								
				#DIV/0!				

				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		**Copayment ($) or Coinsurance(%) amount**	**FY 2022 Projected Expense**	**% of Total Plan Cost (Allowed)**	**Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
F. Outpatient, Out-of-Network: Other Outpatient Items and Services								
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		**Copayment ($) or Coinsurance(%) amount**	**FY 2022 Projected Expense**	**% of Total Plan Cost (Allowed)**	**Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Expense Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)**

G. Emergency								
Emergency room facility fee (waived if admitted)				#DIV/0!				
Emergency room physician fee (waived if admitted)				#DIV/0!				
Emergency medical transportation				#DIV/0!				
Urgent care				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Please include any comments:

Table 1: Quantitative Treatment Limitations, including, but not limited to, limits on inpatient days per admission/episode or per year, outpatient visits per episode/year, outpatient services per episode/year.

MEDICAL/SURGICAL (M/S) BENEFITS			MENTAL HEALTH/SUBSTANCE USE DISORDER (MH/SUD) BENEFITS	
Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Sub classification Below			Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Sub classification Below	
A. Inpatient, In-Network	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**Predominant quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**A. Inpatient, In-Network**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
Hospital facility fee (e.g., hospital room)--acute inpatient			Hospital facility fee (e.g., hospital room)--acute MH inpatient	
Physician/surgeon fee--acute inpatient			Physician/surgeon fee--acute MH inpatient	
Hospital facility fee (e.g., hospital room)--female sterilization			Hospital facility fee (e.g., hospital room)--inpatient psychiatric observation for acute psychiatric crisis	
Physician/surgeon fee--female sterilization			Physician/surgeon fee--psychiatric observation for acute psychiatric crisis	
Hospital facility fee (e.g., hospital room)--maternity delivery			Hospital facility fee (e.g., hospital room)--SUD detoxification	
Professional fees--maternity delivery			Physician/surgeon fee--SUD detoxification	
Inpatient hospice facility fee (e.g., hospital room)			Short-term mental health crisis residential treatment	
Skilled nursing facility fee (e.g., hospital room)			SUD transitional residential recovery services	
			Residential treatment services for SMI and SED	
B. Inpatient, Out-of-Network	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**B. Inpatient, Out-of-Network**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
C. Outpatient, In-Network: Office Visits	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**C. Outpatient, In-Network: Office Visits**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
Primary care visit to treat an injury, illness, or condition			Individual and group mental health evaluation and treatment	
Other practitioner office visit			Outpatient services for monitoring drug therapy	
Specialist physician visit			Individual and group chemical dependency evaluation and counseling	
Preventive care/screening/immunization			Medical treatment for withdrawal symptoms	
Family planning			Behavioral health treatment Office Visit for autism or pervasive developmental disorder (PDD)	
Prenatal care and preconception visits				
Acupuncture				
Health education				
Child dental: diagnostic and preventive				
Child eye exam				
D. Outpatient, In-Network: Other Outpatient Items and Services	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**D. Outpatient, In-Network: Other Outpatient Items and Services**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)			Short-term partial hospitalization	
Outpatient surgery --physician/surgeon fee			Short-term intensive outpatient psychiatric treatment	
Outpatient surgery facility fee--female sterilization			Outpatient psychiatric observation for an acute psychiatric crisis	
Outpatient surgery--physician/surgeon fee--female sterilization			Psychological testing to evaluate a mental disorder	
Outpatient visit regarding outpatient surgery			Day treatment program for substance use disorder	
BRCA testing and related genetic counseling			Intensive outpatient treatment for substance use disorder	
Laboratory tests			Behavioral health therapy delivered in the home for autism and PDD	
X-rays and diagnostic imaging			Nonemergency psychiatric transportation	
Imaging (CT/PET Scans, MRIs)				
Nonemergency medical transportation				
Outpatient rehabilitation services				
Outpatient habilitation services				
Home health				
Hospice				
Durable medical equipment, including in-home DME				
Medical supplies				
Prosthetic and orthotic services and devices				

Diabetes equipment and supply services				
Contact lenses for aniridia or aphakia				
Infusion therapy				
Child eye glasses/contact lenses				
Child dental: basic services				
Child dental: major services				
Child medically necessary orthodontics				
E. Outpatient, Out-of-Network: Office Visits	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**E. Outpatient, Out-of-Network: Office Visits**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**F. Outpatient, Out-of-Network: Other Outpatient Items and Services**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
G. Emergency	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**G. Emergency**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
Emergency room facility fee (waived if admitted)			Emergency room facility fee (waived if admitted)	
Emergency room physician fee (waived if admitted)			Emergency room physician fee (waived if admitted)	
Emergency medical transportation			Emergency medical/psychiatric transportation	
Urgent care			Urgent care	
H. Prescription Drugs	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**If prescription drugs are covered in a tiered structure that does not distinguish between M/S and MH/SUD drugs, the "predominant" and "substantially all" analyses are not necessary.**	**H. Prescription Drugs**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
Tier One			Tier One	
Tier Two			Tier Two	
Tier Three			Tier Three	
Tier Four			Tier Four	

QUEST Integration Program

Mental Health/Substance Use Disorder Parity Report

Health Plan Submission Information

Health Plan Name: **UnitedHealthcare Community Plan - Hawaii** Report Date: **07/26/2022**

Reporting Period: **01/01/2021-12/31/2021**

If Resubmission,
Date Submitted: _____

Section I: Quantitative Treatment Limitations

Does the Health Plan impose any of the following quantitative treatment limitations on MH/SUD benefits in any classification that is more restrictive than the predominant quantitative treatment limitations that applies to substantially all Medical/Surgical benefits in the same classification?

Classification	Annual Visits	Annual Days	Episode Visits	Episode Days	Lifetime Visits	Lifetime Days	None
Inpatient, In-Network	☐	☐	☐	☐	☐	☐	☒
Inpatient, Out-of-Network	☐	☐	☐	☐	☐	☐	☒
Office Visits, In-Network	☐	☐	☐	☐	☐	☐	☒
Other Outpatient, In-Network	☐	☐	☐	☐	☐	☐	☒
Office Visits, Out-of-Network	☐	☐	☐	☐	☐	☐	☒
Other Outpatient, Out-of-Network	☐	☐	☐	☐	☐	☐	☒
Emergency	☐	☐	☐	☐	☐	☐	☒
Prescription Drugs	☐	☐	☐	☐	☐	☐	☒

If any other than "NONE" were selected for a classification, please elaborate in the embedded worksheet below:

MH_SUD_QTL Calculations.xlsx

Section II: Non-Quantitative Treatment Limitations

Does the Health Plan impose any of the following Non-Quantitative Treatment Limitations on MH/SUD services that is more restrictive than the non-quantitative treatment limitations that applies to substantially all Medical/Surgical benefits?

	YES	NO
Medical management standards limiting or excluding benefits based on medical necessity, or medical appropriateness, or based on whether the treatment is experimental or investigative	☐	☒
Prior Authorization and ongoing authorization requirements	☐	☒

Concurrent review standards	YES ☐	NO ☒
Formulary design for prescription drugs	YES ☐	NO ☒
For plans with multiple networks tiers (such as preferred providers and participating providers), network tier designs	YES ☐	NO ☒
Standards for provider admission to participate in a network, including reimbursement rates	YES ☐	NO ☒
Methods for determining usual, customary, and reasonable charges	YES ☐	NO ☒
Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (i.e., "fail-first" policies or "step therapy" protocols)	YES ☐	NO ☒
Restrictions on applicable provider billing codes	YES ☐	NO ☒
Standards for providing access to out-of-network providers	YES ☐	NO ☒
Exclusions based on failure to complete a course of treatment	YES ☐	NO ☒
Restrictions based on geographic location, facility type, and provider specialty	YES ☐	NO ☒

If "YES" to any of the above, please describe in more detail below which benefits classification(s) the NQTL(s) are imposed on including the processes, strategies, evidentiary standards, and other factors.

Section III: Financial Requirements

Does the Health Plan impose any of the following financial requirements on MH/SUD benefits in any classification?

Classification	Deductibles	Co-payments	Co-insurance	Annual Out-of-Pocket Maximums	Lifetime Out-of-Pocket Maximums	None
Inpatient, In-Network	☐	☐	☐	☐	☐	☒
Inpatient, Out-of-Network	☐	☐	☐	☐	☐	☒
Office Visits, In-Network	☐	☐	☐	☐	☐	☒
Other Outpatient, In-Network	☐	☐	☐	☐	☐	☒
Office Visits, Out-of-Network	☐	☐	☐	☐	☐	☒
Other Outpatient, Out-of-Network	☐	☐	☐	☐	☐	☒
Emergency	☐	☐	☐	☐	☐	☒
Prescription Drugs	☐	☐	☐	☐	☐	☒

If any more restrictive financial requirements were selected above, then the Health Plan shall complete the following embedded worksheet.

MH_SUD_Financial Calculations.xlsx

Attestation

I, acting as the Chief Executive Officer or Authorized Agent of UnitedHealthcare Community Plan - Hawaii (i.e., the Health Plan), **declare under penalty of perjury** that: (1) the information reported above is true and correct; (2) any attached documentation and materials referenced are true and correct; and (3) I understand and agree to the terms of the QI RFP/contract at Sections 6, Health Plan Reporting and Encounter Data Responsibilities and Section 14.21, Remedies of Non-Performance of Contract.

_____	Health Plan CEO	07/26/2022
Signature	Title	Date

Table 1: Quantitative Treatment Limitations, including, but not limited to, limits on inpatient days per admission/episode or per year, outpatient visits per episode/year, outpatient services per episode/year.

MEDICAL/SURGICAL (M/S) BENEFITS			MENTAL HEALTH/SUBSTANCE USE DISORDER (MH/SUD) BENEFITS	
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Hospital facility fee (e.g., hospital room)--acute inpatient			Hospital facility fee (e.g., hospital room)--acute MH inpatient	
Physician/surgeon fee--acute inpatient			Physician/surgeon fee--acute MH inpatient	
Hospital facility fee (e.g., hospital room)--female sterilization			Hospital facility fee (e.g., hospital room)--inpatient psychiatric observation for acute psychiatric crisis	
Physician/surgeon fee--female sterilization			Physician/surgeon fee--psychiatric observation for acute psychiatric crisis	
Hospital facility fee (e.g., hospital room)--maternity delivery			Hospital facility fee (e.g., hospital room)--SUD detoxification	
Professional fees--maternity delivery			Physician/surgeon fee--SUD detoxification	
Inpatient hospice facility fee (e.g., hospital room)			Short-term mental health crisis residential treatment	
Skilled nursing facility fee (e.g., hospital room)			SUD transitional residential recovery services	
			Residential treatment services for SMI and SED	
B. Inpatient, Out-of-Network	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**B. Inpatient, Out-of-Network**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
C. Outpatient, In-Network: Office Visits	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**C. Outpatient, In-Network: Office Visits**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
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Other practitioner office visit			Outpatient services for monitoring drug therapy	
Specialist physician visit			Individual and group chemical dependency evaluation and counseling	
Preventive care/screening/immunization			Medical treatment for withdrawal symptoms	
Family planning			Behavioral health treatment Office Visit for autism or pervasive developmental disorder (PDD)	
Prenatal care and preconception visits				
Acupuncture				
Health education				
Child dental: diagnostic and preventive				
Child eye exam				
D. Outpatient, In-Network: Other Outpatient Items and Services	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**D. Outpatient, In-Network: Other Outpatient Items and Services**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)			Short-term partial hospitalization	
Outpatient surgery --physician/surgeon fee			Short-term intensive outpatient psychiatric treatment	
Outpatient surgery facility fee--female sterilization			Outpatient psychiatric observation for an acute psychiatric crisis	
Outpatient surgery--physician/surgeon fee--female sterilization			Psychological testing to evaluate a mental disorder	
Outpatient visit regarding outpatient surgery			Day treatment program for substance use disorder	
BRCA testing and related genetic counseling			Intensive outpatient treatment for substance use disorder	
Laboratory tests			Behavioral health therapy delivered in the home for autism and PDD	
X-rays and diagnostic imaging			Nonemergency psychiatric transportation	
Imaging (CT/PET Scans, MRIs)				
Nonemergency medical transportation				
Outpatient rehabilitation services				
Outpatient habilitation services				
Home health				
Hospice				
Durable medical equipment, including in-home DME				
Medical supplies				
Prosthetic and orthotic services and devices				

Diabetes equipment and supply services				
Contact lenses for aniridia or aphakia				
Infusion therapy				
Child eye glasses/contact lenses				
Child dental: basic services				
Child dental: major services				
Child medically necessary orthodontics				
E. Outpatient, Out-of-Network: Office Visits	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**E. Outpatient, Out-of-Network: Office Visits**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**F. Outpatient, Out-of-Network: Other Outpatient Items and Services**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
G. Emergency	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**"Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification**	**G. Emergency**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
Emergency room facility fee (waived if admitted)			Emergency room facility fee (waived if admitted)	
Emergency room physician fee (waived if admitted)			Emergency room physician fee (waived if admitted)	
Emergency medical transportation			Emergency medical/psychiatric transportation	
Urgent care			Urgent care	
H. Prescription Drugs	**List all Quantitative Treatment Limits that Apply to Each Benefit**	**If prescription drugs are covered in a tiered structure that does not distinguish between M/S and MH/SUD drugs, the "predominant" and "substantially all" analyses are not necessary.**	**H. Prescription Drugs**	**List all Quantitative Treatment Limits that Apply to Each Benefit**
Tier One			Tier One	
Tier Two			Tier Two	
Tier Three			Tier Three	
Tier Four			Tier Four	

Classification "Substantially All" Test for Copays or Coinsurance, Predominant Level		Copayment ($) or Coinsurance (%) amount	FY 2022 Projected Expense	% of Total Plan Cost (Allowed)	Projected Expense for this Benefit as % of Projected Expense for All Benefits Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coinsurance %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)
A. Inpatient, In-Network								
Hospital facility fee (e.g., hospital room)--acute inpatient				#DIV/0!				
Physician/surgeon fee--acute inpatient				#DIV/0!				
Hospital facility fee (e.g., hospital room)--female sterilization				#DIV/0!				
Physician/surgeon fee--female sterilization				#DIV/0!				
Hospital facility fee (e.g., hospital room)--maternity delivery				#DIV/0!				
Professional fees--maternity delivery				#DIV/0!				
Inpatient hospice facility fee (e.g., hospital room)				#DIV/0!				
Skilled nursing facility fee (e.g., hospital room)				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				

"Substantially All" Test for Deductible		Deductible $	FY 2022 Projected Expense (Allowed) Subject to Deductible	CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)			Substantially All Deductible (2/3 test)	
	Total Subject to Deductible			#DIV/0!				

Classification		Copayment ($) or Coinsurance(%) amount	CY 2016 Projected Expense	% of Total Plan Cost (Allowed)	Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)
B. Inpatient, Out-of-Network								
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				

				#DIV/0!				
				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		**Copayment ($) or Coinsurance(%) amount**	**FY 2022 Projected Expense**	**% of Total Plan Cost (Allowed)**	**Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)**
C. Outpatient, In-Network: Office Visits								
Primary care visit to treat an injury, illness, or condition				#DIV/0!				
Other practitioner office visit				#DIV/0!				
Specialist physician visit				#DIV/0!				
Preventive care/screening/immunization				#DIV/0!				
Family planning				#DIV/0!				
Prenatal care and preconception visits				#DIV/0!				
Acupuncture				#DIV/0!				
Health education				#DIV/0!				
Child dental: diagnostic and preventive				#DIV/0!				
Child eye exam				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		Copayment ($) or Coinsurance(%) amount	FY 2022 Projected Expense	% of Total Plan Cost (Allowed)	Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)
D. Outpatient, In-Network: Other Outpatient Items and Services								
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)				#DIV/0!				
Outpatient surgery --physician/surgeon fee				#DIV/0!				
Outpatient surgery facility fee--female sterilization				#DIV/0!				
Outpatient surgery--physician/ surgeon fee--female sterilization				#DIV/0!				
Outpatient visit re: outpatient surgery				#DIV/0!				
BRCA testing and related genetic counseling				#DIV/0!				
Laboratory tests				#DIV/0!				
X-rays and diagnostic imaging				#DIV/0!				
Imaging (CT/PET Scans, MRIs)				#DIV/0!				
Nonemergency medical transportation				#DIV/0!				
Outpatient rehabilitation services				#DIV/0!				
Outpatient habilitation services				#DIV/0!				
Home health				#DIV/0!				
Hospice				#DIV/0!				
Durable medical equipment, including in-home DME				#DIV/0!				
Medical supplies				#DIV/0!				
Prosthetic and orthotic services and devices				#DIV/0!				
Diabetes equipment and supply services				#DIV/0!				
Contact lenses for aniridia or aphakia				#DIV/0!				
Infusion therapy				#DIV/0!				
Child eye glasses/contact lenses				#DIV/0!				
Child dental: basic services				#DIV/0!				
Child dental: major services				#DIV/0!				
Child medically necessary orthodontics				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		Copayment ($) or Coinsurance(%) amount	FY 2022 Projected Expense	% of Total Plan Cost (Allowed)	Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)
E. Outpatient, Out-of-Network: Office Visits								
				#DIV/0!				

				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		**Copayment ($) or Coinsurance(%) amount**	**FY 2022 Projected Expense**	**% of Total Plan Cost (Allowed)**	**Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
F. Outpatient, Out-of-Network: Other Outpatient Items and Services								
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Classification		**Copayment ($) or Coinsurance(%) amount**	**FY 2022 Projected Expense**	**% of Total Plan Cost (Allowed)**	**Projected Expense for this Benefit as % of Projected Expense for all Benefits Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Expense Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)**

G. Emergency								
Emergency room facility fee (waived if admitted)				#DIV/0!				
Emergency room physician fee (waived if admitted)				#DIV/0!				
Emergency medical transportation				#DIV/0!				
Urgent care				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay $			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost Sharing			#DIV/0!				
		Deductible $	**FY 2022 Projected Expense (Allowed) Subject to Deductible**	**CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)**	
	Total Subject to Deductible			#DIV/0!				

Please include any comments: