# Mental Health/Substance Use Disorder Parity Report

	Health	Plan Sub	mission I	nformatio	on		
Health Plan Name: AlohaCare					Repor	t Date: <b>7/28</b>	3/2022
Reporting Period: 01/01/202	<u> 12/3</u>	1/2021					
If Resubmission, Date Submitted:							
So	ction I. O	)uantitati	ivo Troats	nent Limit	ations		
Does the Health Plan impose a in any classification that is mo applies to substantially all Med	any of the re restrict	following ive than t	quantitativ he predom	e treatme inant quar	nt limitatio ntitative tre		
Classification Inpatient, In-Network Inpatient, Out-of-Network Office Visits, In-Network Other Outpatient, In- Network	Annual Visits	Annual Days	Episode Visits	Episode Days	Lifetime Visits  □ □ □ □	Lifetime  Days	None ⊠ ⊠ ⊠
Office Visits, Out-of-Network Other Outpatient, Out-of- Network Emergency Prescription Drugs							<b>X X X X X</b>
If any other than "NONE" were below:  MH_SUD_QTL Calculations.xlsx							
Does the Health Plan impose a services that is more restrictive substantially all Medical/Surgion	any of the e than the	following e non-qua	Non-Quant	itative Tre			
Medical management standar based on medical necessity, based on whether the treatm Prior Authorization and ongoi	or medical ent is exp	l appropri erimental	ateness, or or investig			NO ⊠ 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 NQTL(s) are imposed on including the processes, strategies, eviden		

# Section III: Financial Requirements

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

<u>Classification</u>	Deductibles	Co- payments	Co- insurance	Annual Out- of-Pocket Maximums	Lifetime Out- of-Pocket Maximums	None
Inpatient, In-Network						$\boxtimes$
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						$\boxtimes$

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



#### Attestation

I, acting as the Chief Executive Officer or Authorized Agent of <u>AlohaCare</u> (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.

Janelle Saucedo	Dir. Of BH	07/28/22
Janelle Saucedo (Jul 28, 2022 14:47 HST)		
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 Copy Benefits Listed in Each Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Sub classification Below Classification /Subclassification Above and Paste into the same Classification/Sub classification Below Predominant quantitative treatment List all Quantitative Treatment limitation applicable to "substantially all" List all Quantitative Treatment A. Inpatient, In-Network A. Inpatient, In-Network Limits that Apply to Each Benefit M/S benefits in the classification/sub Limits that Apply to Each Benefit classification 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)--inpatient psychiatric observation for acute Hospital facility fee (e.g., hospital room)--female sterilization psychiatric crisis Physician/surgeon fee--psychiatric observation for acute psychiatric crisis Physician/surgeon fee--female sterilization Hospital facility fee (e.g., hospital room)--maternity delivery Hospital facility fee (e.g., hospital room)--SUD detoxification Physician/surgeon fee--SUD detoxification Professional fees--maternity delivery npatient 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 "Predominant" quantitative treatment List all Quantitative Treatment limitation applicable to "substantially all" List all Quantitative Treatment B. Innatient Out-of-Network B. Inpatient, Out-of-Network Limits that Apply to Each Benefit M/S benefits in the classification/sub Limits that Apply to Each Benefit classification "Predominant" quantitative treatment List all Quantitative Treatment limitation applicable to "substantially all" **List all Quantitative Treatment** C. Outpatient, In-Network: Office Visits C. Outpatient, In-Network: Office Visits Limits that Apply to Each Benefit M/S benefits in the classification/sub Limits that Apply to Each Benefit classification 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 Behavioral health treatment Office Visit for autism or pervasive developmental disorder Family planning Prenatal care and preconception visits Acupuncture Health education Child dental: diagnostic and preventive Child eye exam "Predominant" quantitative treatment List all Quantitative Treatment limitation applicable to "substantially all" List all Quantitative Treatment D. Outpatient, In-Network: Other Outpatient Items and Services D. Outpatient, In-Network: Other Outpatient Items and Services Limits that Apply to Each Benefit M/S benefits in the classification/sub Limits that Apply to Each Benefit classification 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 Infusion therapy Child expert in a similar or aphabia Infusion therapy Child denderal basic services Child denderal b
Infusion therapy Child gertal basic services Child dental: basic services  E. Outpatient, Out-of-Network: Office Visits  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit Classification  Predominant" quantitative treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  Predominant" quantitative treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quanti
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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
List all Quantitative Treatment Limits that Apply to Each Benefit and "substantially all" analyses are not necessary.  List all Quantitative Treatment Limits that Apply to Each Benefit and "substantially all" analyses are not necessary.  List all Quantitative Treatment Limits that Apply to Each Benefit and "substantially all" analyses are not necessary.  List all Quantitative Treatment Limits that Apply to Each Benefit
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Tier Two Tier Two
Tier Three Tier Three

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					Projected Expense			
					for this Benefit as	Projected Expense		
					% of Projected	for this Benefit as		
		Copayment (\$) or			Expense for All	% of Projected	Substantially All	
Classification "Substantially All" Test for Copays or Coinsurance, Predominant		Coinsurance (%)	FV 2022 Projected	% of Total Plan Cost		Claims Subject to	Cost Share Type	Predominant Level
Level		amount		(Allowed)		Coinsurance %		(50% test)
		amount	Expense	(Allowed)	Copay \$	Comsurance %	(2/3 test)	(50% test)
A. Inpatient, In-Network								
Hospital facility fee (e.g., hospital room)acute inpatient				#DIV/0!				
Physician/surgeon feeacute inpatient				#DIV/0!				
Hospital facility fee (e.g., hospital room)female sterilization				#DIV/0!				
Physician/surgeon feefemale sterilization				#DIV/0!				
Hospital facility fee (e.g., hospital room)maternity delivery	1			#DIV/0!				
Professional feesmaternity delivery	+	1	<del> </del>	#DIV/0!				
	<del> </del>	1	1					
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 S	Sharing		#DIV/0!				
				CY 2022				
				Projected Expense				
			FY 2022 Projected	(Allowed) Subject				
			Expense (Allowed)	to Deductible as %			Substantially All	
			Subject to	of Total Plan Cost			Deductible (2/3	
"Substantially All" Test for Deductible		Deductible \$	Deductible	(Allowed)			test)	
	Total Subject to Deductible			#DIV/0!				
	•							
					Projected Expense			
		1		1	for this Benefit as	Projected Expense		
				1	% of Projected	for this Benefit as		
		Copayment (\$) or		1	Expense for all	% of Projected	Substantially All	
		Coinsurance( %)	CY 2016 Projected	% of Total Plan Cost	Benefits Subject to	Claims Subject to	Cost Share Type	Predominant Level
Classification		amount	Expense	(Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)
B. Inpatient, Out-of-Network								
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Total				#DIV/0!				
	Total Subject to Copay \$			#DIV/0!				
	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost S	Sharing		#DIV/0!				
				CY 2022				
				Projected Expense				
			FY 2022 Projected	(Allowed) Subject				
			Expense (Allowed)	to Deductible as %			Substantially All	
			Subject to	of Total Plan Cost			Deductible (2/3	
		Deductible \$	Deductible	(Allowed)			test)	
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	Total Subject to Deductible			#DIV/0:				
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	1		<u> </u>		<u> </u>			<u> </u>
					Projected Expense			
					for this Benefit as	Projected Expense		
					% of Projected	for this Benefit as		
		Copayment (\$) or			Expense for all	% of Projected	Substantially All	
			EV 2022 Dunington	% of Total Plan Cost			Cost Share Type	Predominant Leve
Classification		Coinsurance( %)		(Allowed)				(50% test)
C. Outpatient, In-Network: Office Visits		amount	Expense	(Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)
				#DIV/01				
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!				
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Outpatient surgeryphysician/surgeon fee				#DIV/0!				
Outpatient surgery facility feefemale sterilization				#DIV/0!				
Outpatient surgeryphysician/ surgeon feefemale 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!				+
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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!				
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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!			
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Please include any comments:

# Mental Health/Substance Use Disorder Parity Report

	Health	Plan Sub	mission 1	Informatio	on		
Health Plan Name: <b>HMSA</b>					Report	t Date: <b>07/</b>	01/2022
Reporting Period: <b>01/01/202</b>	1 - 12/3	1/2021					
If Resubmission, Date Submitted:							
Se	ction I: Q	uantitati	ive Treatr	nent Limi	tations		
Does the Health Plan impose a in any classification that is mo applies to substantially all Med	re restrict	ive than t	he predom	inant quar	ititative tre		
Classification	Annual Visits	Annual	Episode Visits	Episode	Lifetime Visits	Lifetime	None
Inpatient, In-Network		Days	VISILS	Days		Days	⊠
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 below:	e selected	for a clas	sification,	please elat	orate in th	e embedded	d workshee
Section	n II: Nor	n-Quanti	tative Tre	atment Li	mitations		
Does the Health Plan impose a services that is more restrictiv substantially all Medical/Surgio	e than the	e non-qua					
Medical management standar based on medical necessity,						NO ⊠	
based on whether the treatm	·			ΥF	S	NO	
Prior Authorization and ongoi	ng authori	ization red	quirements	YE		NO ⊠ NO	
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 v NQTL(s) are imposed on including the processes, strategies, evider		
N/A		
Section III, Einancial Bequiren	aonto	

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						$\boxtimes$

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

Vice President, Government Programs
Title

O7/01/2022
Date

# Mental Health/Substance Use Disorder Parity Report

Кероге										
	Health Plan Submission Information									
Health Plan Name: KAISER PI	ERMANEN	ITE			Report Date: <b>7/29/2022</b>					
Reporting Period: <b>01/01/2021 – 12/31/2021</b>										
If Resubmission,										
Date Submitted:										
Se	ction I: Q	uantitati	ive Treatr	ment Limi	tations					
Does the Health Plan impose a in any classification that is mo										
applies to substantially all Med						activation than				
	Annual	Annual	Episode	Episode	Lifetime	Lifetime	None			
Classification	Visits	Days	Visits	Days	Visits	Days				
Inpatient, In-Network										
Inpatient, Out-of-Network							⊠ ⊠			
Office Visits, In-Network Other Outpatient, In-							⊠ ⊠			
Network	Ц	ш		ш	Ш					
Office Visits, Out-of-Network							⊠			
Other Outpatient, Out-of-							$\boxtimes$			
Network										
Emergency										
Prescription Drugs							$\boxtimes$			
If any other than "NONE" were	e selected	for a clas	sification,	please elab	oorate in the	e embedded	d worksheet			
below:										
X≡										
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	
Prior Authorization and originity authorization requirements		$\boxtimes$	
Concurrent review standards	YES	NO	

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

## Section III: Financial Requirements

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

<u>Classification</u>	Deductibles	Co- payments	Co- insurance	Annual Out- of-Pocket Maximums	Lifetime Out- of-Pocket Maximums	None
Inpatient, In-Network						$\boxtimes$
Inpatient, Out-of-Network						⊠
Office Visits, In-Network						⊠
Other Outpatient, In- Network						⊠
Office Visits, Out-of- Network						⊠
Other Outpatient, Out-of- Network						
Emergency						$\boxtimes$
Prescription Drugs						$\boxtimes$

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



#### 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.

Director, QI Member Services

7/29/2022

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 Copy Benefits Listed in Each Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Sub classification Below Classification /Subclassification Above and Paste into the same Classification/Sub classification Below Predominant quantitative treatment List all Quantitative Treatment limitation applicable to "substantially all" List all Quantitative Treatment A. Inpatient, In-Network A. Inpatient, In-Network Limits that Apply to Each Benefit M/S benefits in the classification/sub Limits that Apply to Each Benefit classification 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)--inpatient psychiatric observation for acute Hospital facility fee (e.g., hospital room)--female sterilization psychiatric crisis Physician/surgeon fee--psychiatric observation for acute psychiatric crisis Physician/surgeon fee--female sterilization Hospital facility fee (e.g., hospital room)--maternity delivery Hospital facility fee (e.g., hospital room)--SUD detoxification Physician/surgeon fee--SUD detoxification Professional fees--maternity delivery npatient 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 "Predominant" quantitative treatment List all Quantitative Treatment limitation applicable to "substantially all" List all Quantitative Treatment B. Innatient Out-of-Network B. Inpatient, Out-of-Network Limits that Apply to Each Benefit M/S benefits in the classification/sub Limits that Apply to Each Benefit classification "Predominant" quantitative treatment List all Quantitative Treatment limitation applicable to "substantially all" **List all Quantitative Treatment** C. Outpatient, In-Network: Office Visits C. Outpatient, In-Network: Office Visits Limits that Apply to Each Benefit M/S benefits in the classification/sub Limits that Apply to Each Benefit classification 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 Behavioral health treatment Office Visit for autism or pervasive developmental disorder Family planning Prenatal care and preconception visits Acupuncture Health education Child dental: diagnostic and preventive Child eye exam "Predominant" quantitative treatment List all Quantitative Treatment limitation applicable to "substantially all" List all Quantitative Treatment D. Outpatient, In-Network: Other Outpatient Items and Services D. Outpatient, In-Network: Other Outpatient Items and Services Limits that Apply to Each Benefit M/S benefits in the classification/sub Limits that Apply to Each Benefit classification 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 Infusion therapy Child expert in a similar or aphabia Infusion therapy Child denderal basic services Child denderal b
Infusion therapy Child gertal basic services Child dental: basic services  E. Outpatient, Out-of-Network: Office Visits  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit Classification  Predominant" quantitative treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  Predominant" quantitative treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quantitative Treatment Limits that Apply to Each Benefit  List all Quanti
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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  F. Outpatient, Out-of-Network: Other Outpatient Items and Services  List all Quantitative Treatment Limits that Apply to Each Benefit  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  Predominant" quantitative treatment limitation applicable to "substantially all" M/S benefits in the classification/sub classification applicable to "substantially all" M/S benefits in the classification/sub classification applicable to "substantially all" M/S benefits in the classification applicable to "substantially all" M/S benefits in the classification applicable to "substantially all" M/S benefits in the classification applicable to "substantially all" M/S benefits in the classification applicable to "substantially all" M/S benefits in the classification applicable to "substantially all" M/S benefits in the classification applicable to "substantially all" M/S benefits in the classification applicable to "substantially all" M/S benefits in the classification applicable to "substantially all" M/S benefits in the classification applicable to "substantially all" M/S benefits in the classification applicable to "substantially all" M/S benefits in the classification applicable to "substantially all" M/S benefits in the classification applicable to "substantially all" M/S benefits in the classification applicable to "substantially all" M/S benefits in the classification applicable to "substantially all" M/S benefits in the classification applicable to "substantially all" M/S benefits in the classification applicable to "substantially all" M/S benefits in the classification applicable to "substantially all" M/S benefits in the classification applicable to "substantially all" M/S benefits in the classif
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F. Outpatient, Out-of-Network: Other Outpatient Items and Services  List all Quantitative Treatment Limits that Apply to Each Benefit  M/S benefits in the classification/sub classification  Classification  G. Emergency  Emergency room facility fee (waived if admitted)  List all Quantitative Treatment Limits that Apply to Each Benefit  I imitation 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  List all Quantitative Treatment Limitative Treatment Limitation applicable to "substantially all" M/S benefits in the classification/sub classification  C. Emergency room facility fee (waived if admitted)  List all Quantitative Treatment Limits that Apply to Each Benefit  Emergency room facility fee (waived if admitted)  Emergency room facility fee (waived if admitted)
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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
List all Quantitative Treatment Limits that Apply to Each Benefit and "substantially all" analyses are not necessary.  List all Quantitative Treatment Limits that Apply to Each Benefit and "substantially all" analyses are not necessary.  List all Quantitative Treatment Limits that Apply to Each Benefit and "substantially all" analyses are not necessary.  List all Quantitative Treatment Limits that Apply to Each Benefit
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Tier Three Tier Three

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					for this Benefit as	Projected Expense		
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		Copayment (\$) or			Expense for All	% of Projected	Substantially All	
Classification "Substantially All" Test for Copays or Coinsurance, Predominant		Coinsurance (%)	FV 2022 Projected	% of Total Plan Cost		Claims Subject to	Cost Share Type	Predominant Level
Level		amount		(Allowed)		Coinsurance %		(50% test)
		amount	Expense	(Allowed)	Copay \$	Comsurance %	(2/3 test)	(50% test)
A. Inpatient, In-Network								
Hospital facility fee (e.g., hospital room)acute inpatient				#DIV/0!				
Physician/surgeon feeacute inpatient				#DIV/0!				
Hospital facility fee (e.g., hospital room)female sterilization				#DIV/0!				
Physician/surgeon feefemale sterilization				#DIV/0!				
Hospital facility fee (e.g., hospital room)maternity delivery	1			#DIV/0!				
Professional feesmaternity delivery	+	1	<del> </del>	#DIV/0!				
	<del> </del>	1	1					
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 S	Sharing		#DIV/0!				
				CY 2022				
				Projected Expense				
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			Expense (Allowed)	to Deductible as %			Substantially All	
			Subject to	of Total Plan Cost			Deductible (2/3	
"Substantially All" Test for Deductible		Deductible \$	Deductible	(Allowed)			test)	
	Total Subject to Deductible			#DIV/0!				
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					Projected Expense			
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				1	% of Projected	for this Benefit as		
		Copayment (\$) or		1	Expense for all	% of Projected	Substantially All	
		Coinsurance( %)	CY 2016 Projected	% of Total Plan Cost	Benefits Subject to	Claims Subject to	Cost Share Type	Predominant Level
Classification		amount	Expense	(Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)
B. Inpatient, Out-of-Network								
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Total				#DIV/0!				
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				CY 2022				
				Projected Expense				
			FY 2022 Projected	(Allowed) Subject				
			Expense (Allowed)	to Deductible as %			Substantially All	
			Subject to	of Total Plan Cost			Deductible (2/3	
		Deductible \$	Deductible	(Allowed)			test)	
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	Total Subject to Deductible			#DIV/0:				
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					Projected Expense			
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					% of Projected	for this Benefit as		
		Copayment (\$) or			Expense for all	% of Projected	Substantially All	
			EV 2022 Dunington	% of Total Plan Cost			Cost Share Type	Predominant Leve
Classification		Coinsurance( %)		(Allowed)				(50% test)
C. Outpatient, In-Network: Office Visits		amount	Expense	(Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)
				#DIV/01				
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 %	<u> </u>		#DIV/0!				
	Total Subject to No Member Cost S	Sharing		#DIV/0!				
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				Projected Expense			•	1
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			FY 2022 Projected Expense (Allowed)	(Allowed) Subject			Substantially All	
			Expense (Allowed)	(Allowed) Subject to Deductible as %			Substantially All Deductible (2/3	
		Deductible \$	Expense (Allowed) Subject to	(Allowed) Subject to Deductible as % of Total Plan Cost			Deductible (2/3	
	Total Subject to Deductible	Deductible \$	Expense (Allowed)	(Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)				
	Total Subject to Deductible	Deductible \$	Expense (Allowed) Subject to	(Allowed) Subject to Deductible as % of Total Plan Cost			Deductible (2/3	
	Total Subject to Deductible	Deductible \$	Expense (Allowed) Subject to	(Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)			Deductible (2/3	
	Total Subject to Deductible	Deductible \$	Expense (Allowed) Subject to	(Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)			Deductible (2/3	

					Projected Expense			
					for this Benefit as	Projected Expense		
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		Copayment (\$) or			Expense for all	% of Projected	Substantially All	
		Coinsurance( %)	FY 2022 Projected	% of Total Plan Cost	Benefits Subject to	Claims Subject to	Cost Share Type	Predominant Level
Classification		amount	Expense	(Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)
D. Outpatient, In-Network: Other Outpatient Items and Services			·					
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)				#DIV/0!				
Outpatient surgeryphysician/surgeon fee				#DIV/0!				
Outpatient surgery facility feefemale sterilization				#DIV/0!				
Outpatient surgeryphysician/ surgeon feefemale 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!				+
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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 S	haring		#DIV/0!				
	Total Subject to No Member Cost							
				CY 2022				
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			Expense (Allowed)	to Deductible as %			Substantially All	
			Subject to	of Total Plan Cost			Deductible (2/3	
		Deductible \$	Deductible	(Allowed)			test)	
	Total Subject to Deductible			#DIV/0!				
					Projected Expense			
					for this Benefit as	Projected Expense		
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		Copayment (\$) or			Expense for all	% of Projected	Substantially All	
		Coinsurance( %)	FY 2022 Projected	% of Total Plan Cost	•	Claims Subject to	Cost Share Type	Predominant Level
Classification		amount	Expense	(Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)
E. Outpatient, Out-of-Network: Office Visits			,	,,	1.7.			(
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	Total Subject to Coinsurance %			#DIV/0!				
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				CY 2022				
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		Deductible \$	Deductible	(Allowed)		-	test)	<del> </del>
	Total Subject to Deductible			#DIV/0!				<u> </u>
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					Projected Expense			
					for this Benefit as	Projected Expense		
					% of Projected	for this Benefit as		
		Copayment (\$) or			Expense for all	% of Projected	Substantially All	
		Coinsurance( %)	FY 2022 Projected	% of Total Plan Cost	Benefits Subject to	Claims Subject to	Cost Share Type	<b>Predominant Level</b>
Classification		amount	Expense	(Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)*
Contractions Out of Naturally Other Outrestient Items and Comition								
F. Outpatient, Out-of-Network: Other Outpatient Items and Services								
r. Outpatient, Out-or-Network: Other Outpatient Items and Services				#DIV/0!				
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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!			
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Please include any comments:

# Mental Health/Substance Use Disorder Parity Report

	Health	Plan Sub	mission 1	Informati	ion		
Health Plan Name: Ohana Hea	ith Plan				Repor	t Date: <b>7/3</b> :	1/2022
Reporting Period: 01/01/202	1 – 12/3	1/2021					
11001 017 017 202							
If Docubmission							
If Resubmission, Date Submitted:							
Sec	ction I: Q	uantitati	ive Treatr	ment Lim	itations		
Door the Health Diam immedia		fallanda			ant linaitatia	MII/CI	ID hanafita
Does the Health Plan impose a in any classification that is mo							
applies to substantially all Med						acmene mm	cacions chac
	Annual	Annual	Enicodo	Enicodo	Lifatima	Lifetime	None
Classification	Visits	Annual Days	Episode Visits	Episode Days	Lifetime Visits	Days	None
Inpatient, In-Network							$\boxtimes$
Inpatient, Out-of-Network							⊠
Office Visits, In-Network							$\boxtimes$
Other Outpatient, In-							⊠
Network	_						$\boxtimes$
Office Visits, Out-of-Network Other Outpatient, Out-of-							⊠
Network	Ц		ы		Ц		
Emergency							$\boxtimes$
Prescription Drugs							$\boxtimes$
If any other than "NONE" were	selected	for a clas	sification,	please ela	borate in th	e embedded	d worksheet
below:							
X≡							
MH_SUD_QTL							
Calculations.xlsx							
Socie	n II. No	n Ouanti	tativo Tro	atmont l	imitations	_	_
Section	III III. NO	ıı-Qualiti	tative He	atillelit L	.IIIIItations		
Does the Health Plan impose a	ny of the	following	Non-Quan	titative Tr	eatment Lin	nitations on	MH/SUD
services that is more restrictiv			ntitative tr	eatment l	imitations th	nat applies t	:0
substantially all Medical/Surgion	al benefit	s?					
Medical management standar	ds limitin	n or exclu	dina henef	its YF	ΞS	NO	
based on medical necessity, o					_	×	
based on whether the treatm							
						NO	
Prior Authorization and ongoi	ng author	ization red	quirements	Y	ES 1	NO ⊠	

Concurrent review standards

YES

NO

Formulary design for prescription drugs  For plans with multiple networks tiers (such as preferred	YES YES	⊠ NO ⊠ NO	
providers and participating providers), network tier designs  Standards for provider admission to participate in a network,	YES	⊠ NO	
including reimbursement rates		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 NQTL(s) are imposed on including the processes, strategies, evide			
N/A			
Section III: Financial Requirer	nents		

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						$\boxtimes$
Inpatient, Out-of-Network						$\boxtimes$
Office Visits, In-Network						⊠
Other Outpatient, In- Network						⊠
Office Visits, Out-of- Network						×
Other Outpatient, Out-of- Network						⊠
Emergency						$\boxtimes$
Prescription Drugs						$\boxtimes$

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



#### Attestation

I, acting as the Chief Executive Officer or Authorized Ager <b>declare under penalty of perjury</b> that: (1) the informal any attached documentation and materials referenced are agree to the terms of the QI RFP/contract at Sections 6, Responsibilities and Section 14.21, Remedies of Non-Performance of the Contract at Sections 14.21, Remedies of Non-Performance of Non-Performan	ition reported above is true and e true and correct; and (3) I und Health Plan Reporting and Encou	correct; (2) derstand and
Signature	<u>Plan President &amp; CEO</u> Title	<u>7/31/2022</u> Date

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Integrated Transport (reg., p., loogs)and room) - cute inspatiated	A. Inpatient, In-Network								
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Physician four-fermate sterilization									
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Hospital facility fee (e.g., hospital room)maternity delivery	Physician/surgeon feefemale sterilization				#DIV/0!				
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Primary care visit to treat an injury, illness, or condition  Other practitioner office visit  Specialist physician visit  Preventive care/screening/immunization  Family planning  Prenatal care and preconception visits  Acupuncture  HDIV/OI  Frenatal care and preconception visits  HDIV/OI  Total definate diagnostic and preventive  HDIV/OI  Total Subject to Copay \$  HDIV/OI  Total Subject to Copay \$  HDIV/OI  Total Subject to Coinsurance %  Total Subject to No Member Cost Sharing  HDIV/OI  Total Subject to Coinsurance %  FY 2022 Projected Expense  (Allowed) Subject  Golductible as %  of Total Plan Cost  Of Deductible (2/3  Deductible (2/3  Test)	Classification		amount	Expense	(Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)
Other practitioner office visit         #DIV/O!         #DIV/O! <td< td=""><td>C. Outpatient, In-Network: Office Visits</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>	C. Outpatient, In-Network: Office Visits								
#DIV/0!   #DIV	Primary care visit to treat an injury, illness, or condition				#DIV/0!				
Preventive care/screening/immunization #DIV/0!	Other practitioner office visit				#DIV/0!				
Family planning Prenatal care and preconception visits Accupancture Health education Health education Holly/OI Health education Holly/OI Health education Holly/OI Health education Holly/OI Holl dental: diagnostic and preventive Holly/OI Holl dental: diagnostic and preventive Holly/OI Total Total Subject to Copay \$ Holly/OI Total Subject to Copay \$ Holly/OI Total Subject to Coinsurance % Total Subject to Coinsurance % Total Subject to No Member Cost Sharing FY 2022 Projected Expense FY 2022 Projected Expense (Allowed) Subject Subject to Deductible \$ Holly/OI  Total Substantially All Deductible (2/3 Lest) Deductible \$ Holly/OI	Specialist physician visit				#DIV/0!				
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Acupuncture Health education    #DIV/O!	Family planning				#DIV/0!				
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Classification		amount	Expense	(Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)
D. Outpatient, In-Network: Other Outpatient Items and Services								
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)				#DIV/0!				
Outpatient surgeryphysician/surgeon fee				#DIV/0!				
Outpatient surgery facility feefemale sterilization				#DIV/0!				
Outpatient surgeryphysician/ surgeon feefemale 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!				
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		Coinsurance( %)	-		Benefits Subject to	Claims Subject to	Cost Share Type	Predominant Level
Classification		amount	Expense	(Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)
E. Outpatient, Out-of-Network: Office Visits								

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

Table 1: Quantitative Treatment Limitations, including but not	· limited to limits on innation	at days nor admission (onicodo or n	or year, authorized vicits nor enicode (year, authorized convices nor	nicada (vaar
MEDICAL/SURGICAL (M/S) BENEFIT		it days per admission/episode or p	er year, outpatient visits per episode/year, outpatient services per e MENTAL HEALTH/SUBSTANCE USE DISORDER (MH/S	
	•			02,02
Copy Benefits Listed in Each			Copy Benefits Listed in Each	
Classification /Subclassification Above and Paste into the same Classifica	tion/Sub classification Below		Classification /Subclassification Above and Paste into the same Classification	n/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 feeacute inpatient			Physician/surgeon feeacute 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 feefemale sterilization			Physician/surgeon feepsychiatric observation for acute psychiatric crisis	
Hospital facility fee (e.g., hospital room)maternity delivery			Hospital facility fee (e.g., hospital room)SUD detoxification	
Professional feesmaternity delivery			Physician/surgeon feeSUD 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	
			Residential deathers services for Sivil 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 alamina			Behavioral health treatment Office Visit for autism or pervasive developmental disorder	
Family planning Prenatal care and preconception visits			(PDD)	
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 surgeryphysician/surgeon fee			Short-term intensive outpatient psychiatric treatment	
Outpatient surgery facility feefemale sterilization			Outpatient psychiatric observation for an acute psychiatric crisis	
Outpatient surgeryphysician/surgeon feefemale 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  Behavioral health therapy delivered in the home for autism and PDD	
Laboratory tests X-rays and diagnostic imaging	+		Nonemergency psychiatric transportation	
Imaging (CT/PET Scans, MRIs)			reconcined by payoritation transportation	
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	<u> </u>			

		•		
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	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.		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	
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# Mental Health/Substance Use Disorder Parity Report

	Health	Plan Sul	mission 1	Informatio	on			
<b>UnitedHea</b> Health Plan Name: <b>Communit</b>	lthcare					t Date: <b>07/2</b>	26/2022	
Reporting Period: 01/01/202	<u>!1-12/31,</u>	/2021						
If Resubmission, Date Submitted:								
Se	ction I: Q	uantitat	ive Treatr	nent Limit	tations			
Does the Health Plan impose a in any classification that is mo applies to substantially all Med	re restricti	ive than t	he predom	inant quan	titative tre			
	Annual	Annual	Episode	Episode	Lifetime	Lifetime	None	
<u>Classification</u>	Visits	Days	Visits	Days	Visits	Days		
Inpatient, In-Network							$\boxtimes$	
Inpatient, Out-of-Network							$\boxtimes$	
Office Visits, In-Network							$\boxtimes$	
Other Outpatient, In- Network								
Office Visits, Out-of-Network							$\boxtimes$	
Other Outpatient, Out-of- Network								
Emergency							$\boxtimes$	
Prescription Drugs							$\boxtimes$	
If any other than "NONE" were below:  MH_SUD_QTL Calculations.xlsx	e selected	for a clas	sification,	please elab	orate in th	e embedded	worksheet	
Section	on II: Nor	n-Quanti	tative Tre	atment Li	mitations			
Does the Health Plan impose a services that is more restrictive substantially all Medical/Surgion	e than the	non-qua						

YES

YES

NO

 $\boxtimes$ 

NO

 $\boxtimes$ 

Medical management standards limiting or excluding benefits

based on whether the treatment is experimental or investigative

based on medical necessity, or medical appropriateness, or

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 NQTL(s) are imposed on including the processes, strategies, evider		

## 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						$\boxtimes$
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						$\boxtimes$

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



#### Attestation

I, acting as the Chief Executive Officer or Authorized Agent of <u>UnitedHealthcare Community Plan - Hawaii</u> (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.

David W. Heywood		
	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 Copy Benefits Listed in Each Copy Benefits Listed in Each Classification /Subclassification Above and Paste into the same Classification/Sub classification Below Classification /Subclassification Above and Paste into the same Classification/Sub classification Below Predominant quantitative treatment List all Quantitative Treatment limitation applicable to "substantially all" List all Quantitative Treatment A. Inpatient, In-Network A. Inpatient, In-Network Limits that Apply to Each Benefit M/S benefits in the classification/sub Limits that Apply to Each Benefit classification 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)--inpatient psychiatric observation for acute Hospital facility fee (e.g., hospital room)--female sterilization psychiatric crisis Physician/surgeon fee--psychiatric observation for acute psychiatric crisis Physician/surgeon fee--female sterilization Hospital facility fee (e.g., hospital room)--maternity delivery Hospital facility fee (e.g., hospital room)--SUD detoxification Physician/surgeon fee--SUD detoxification Professional fees--maternity delivery npatient 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 "Predominant" quantitative treatment List all Quantitative Treatment limitation applicable to "substantially all" List all Quantitative Treatment B. Innatient Out-of-Network B. Inpatient, Out-of-Network Limits that Apply to Each Benefit M/S benefits in the classification/sub Limits that Apply to Each Benefit classification "Predominant" quantitative treatment List all Quantitative Treatment limitation applicable to "substantially all" **List all Quantitative Treatment** C. Outpatient, In-Network: Office Visits C. Outpatient, In-Network: Office Visits Limits that Apply to Each Benefit M/S benefits in the classification/sub Limits that Apply to Each Benefit classification 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 Behavioral health treatment Office Visit for autism or pervasive developmental disorder Family planning Prenatal care and preconception visits Acupuncture Health education Child dental: diagnostic and preventive Child eye exam "Predominant" quantitative treatment List all Quantitative Treatment limitation applicable to "substantially all" List all Quantitative Treatment D. Outpatient, In-Network: Other Outpatient Items and Services D. Outpatient, In-Network: Other Outpatient Items and Services Limits that Apply to Each Benefit M/S benefits in the classification/sub Limits that Apply to Each Benefit classification 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		1		
Child dental: basic services		1		
Child dental: major services		1		
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
		"Predominant" quantitative treatment		
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	List all Quantitative Treatment Limits that Apply to Each Benefit	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	
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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		1	Tier Two	
Tier Three		1	Tier Three	
Tier Four		1	Tier Four	
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		Copayment (\$) or			Expense for All	% of Projected	Substantially All	
Classification "Substantially All" Test for Copays or Coinsurance, Predominant		Coinsurance (%)	FY 2022 Projected	% of Total Plan Cost	Benefits Subject to	Claims Subject to	Cost Share Type	Predominant Level
Level		amount	Expense	(Allowed)	Copay \$	Coinsurance %	(2/3 test)	(50% test)
A. Inpatient, In-Network			<b>1</b>		,,		( )	(CEE CEE)
Hospital facility fee (e.g., hospital room)acute inpatient				#DIV/0!				
				#DIV/0!				
Physician/surgeon feeacute inpatient				#DIV/U!				
Hospital facility fee (e.g., hospital room)female sterilization				#DIV/0!				
Physician/surgeon feefemale sterilization				#DIV/0!				
Hospital facility fee (e.g., hospital room)maternity delivery				#DIV/0!				
Professional feesmaternity 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 S	Sharing		#DIV/0!				
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				Projected Expense				
			FY 2022 Projected	(Allowed) Subject				
			Expense (Allowed)	to Deductible as %			Substantially All	
			Subject to	of Total Plan Cost			Deductible (2/3	
"Substantially All" Test for Deductible		Deductible \$	Deductible	(Allowed)			test)	
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					for this Benefit as	Projected Expense		
					% of Projected	for this Benefit as		
		Copayment (\$) or		1	Expense for all	% of Projected	Substantially All	
		Coinsurance(%)	CV 2016 Projected	% of Total Plan Cost			Cost Share Type	Predominant Level
Classification			-			Claims Subject to		
Classification		amount	Expense	(Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)
B. Inpatient, Out-of-Network								
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Total				#DIV/0!				
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	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost S	Sharing		#DIV/0!				
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				Projected Expense				
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			Expense (Allowed)	to Deductible as %			Substantially All	
			Subject to	of Total Plan Cost			Deductible (2/3	
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			EV 2022 Dunington	% of Total Plan Cost			Cost Share Type	Predominant Leve
Classification		Coinsurance( %)		(Allowed)				(50% test)
C. Outpatient, In-Network: Office Visits		amount	Expense	(Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)
				#DIV/01				
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 %	<u> </u>		#DIV/0!				
	Total Subject to No Member Cost S	Sharing		#DIV/0!				
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			Expense (Allowed)	(Allowed) Subject to Deductible as %			Substantially All	
		Deductible \$	Expense (Allowed) Subject to	(Allowed) Subject to Deductible as % of Total Plan Cost			Deductible (2/3	
	Total Subject to Deductible	Deductible \$	Expense (Allowed)	(Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)				
	Total Subject to Deductible	Deductible \$	Expense (Allowed) Subject to	(Allowed) Subject to Deductible as % of Total Plan Cost			Deductible (2/3	
	Total Subject to Deductible	Deductible \$	Expense (Allowed) Subject to	(Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)			Deductible (2/3	
	Total Subject to Deductible	Deductible \$	Expense (Allowed) Subject to	(Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)			Deductible (2/3	

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					Projected Expense			
					for this Benefit as	Projected Expense		
					% of Projected	for this Benefit as		
		Copayment (\$) or			Expense for all	% of Projected	Substantially All	
		Coinsurance( %)	FY 2022 Projected	% of Total Plan Cost	Benefits Subject to	Claims Subject to	Cost Share Type	Predominant Level
Classification		amount	Expense	(Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)
D. Outpatient, In-Network: Other Outpatient Items and Services			·					
Outpatient surgery facility fee (e.g. Ambulatory Surgery Center)				#DIV/0!				
Outpatient surgeryphysician/surgeon fee				#DIV/0!				
Outpatient surgery facility feefemale sterilization				#DIV/0!				
Outpatient surgeryphysician/ surgeon feefemale 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!				+
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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!				
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	Total Subject to Coinsurance %			#DIV/0!				
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		Coinsurance( %)	FY 2022 Projected	% of Total Plan Cost	•	Claims Subject to	Cost Share Type	Predominant Level
Classification		amount	Expense	(Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)
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		Copayment (\$) or			Expense for all	% of Projected	Substantially All	
		Coinsurance( %)	FY 2022 Projected	% of Total Plan Cost	Benefits Subject to	Claims Subject to	Cost Share Type	<b>Predominant Level</b>
Classification		amount	Expense	(Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)*
Contractions Out of Naturally Other Outrestient Items and Comities								
F. Outpatient, Out-of-Network: Other Outpatient Items and Services								
r. Outpatient, Out-or-Network: Other Outpatient Items and Services				#DIV/0!				
r. Outpatient, Out-of-Network: Other Outpatient items and Services				#DIV/0! #DIV/0!				
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Total				#DIV/0! #DIV/0! #DIV/0!				
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	Total Subject to Coinsurance %	haring	Expense (Allowed)	#DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0!  #DIV/0!  #DIV/0!  CY 2022 Projected Expense (Allowed) Subject to Deductible as %			Substantially All	
	Total Subject to Coinsurance %		Expense (Allowed) Subject to	#DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0!  #DIV/0!  #DIV/0!  #DIV/0!  #DIV/0!  TY 2022  Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost			Deductible (2/3	
	Total Subject to Coinsurance % Total Subject to No Member Cost S	haring  Deductible \$	Expense (Allowed)	#DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0!  #DIV/0!  #DIV/0!  #DIV/0!  TY 2022  Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)				
	Total Subject to Coinsurance %		Expense (Allowed) Subject to	#DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0!  #DIV/0!  #DIV/0!  #DIV/0!  #DIV/0!  TY 2022  Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost			Deductible (2/3	
	Total Subject to Coinsurance % Total Subject to No Member Cost S		Expense (Allowed) Subject to	#DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0!  #DIV/0!  #DIV/0!  #DIV/0!  TY 2022  Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)			Deductible (2/3	
	Total Subject to Coinsurance % Total Subject to No Member Cost S		Expense (Allowed) Subject to	#DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0!  #DIV/0!  #DIV/0!  #DIV/0!  TY 2022  Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)			Deductible (2/3	
	Total Subject to Coinsurance % Total Subject to No Member Cost S		Expense (Allowed) Subject to	#DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0!  #DIV/0!  #DIV/0!  #DIV/0!  TY 2022  Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)			Deductible (2/3	
	Total Subject to Coinsurance % Total Subject to No Member Cost S		Expense (Allowed) Subject to	#DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0!  #DIV/0!  #DIV/0!  #DIV/0!  TY 2022  Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)			Deductible (2/3	
	Total Subject to Coinsurance % Total Subject to No Member Cost S		Expense (Allowed) Subject to	#DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0!  #DIV/0!  #DIV/0!  #DIV/0!  TY 2022  Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)	Projected Expense		Deductible (2/3	
	Total Subject to Coinsurance % Total Subject to No Member Cost S		Expense (Allowed) Subject to	#DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0!  #DIV/0!  #DIV/0!  CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed) #DIV/0!	Projected Expense for this Benefit as	Projected Expense	Deductible (2/3	
	Total Subject to Coinsurance % Total Subject to No Member Cost S		Expense (Allowed) Subject to	#DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0!  #DIV/0!  #DIV/0!  CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed) #DIV/0!		Projected Expense for this Benefit as	Deductible (2/3	
	Total Subject to Coinsurance % Total Subject to No Member Cost S		Expense (Allowed) Subject to	#DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0!  #DIV/0!  #DIV/0!  CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed) #DIV/0!	for this Benefit as		Deductible (2/3	
	Total Subject to Coinsurance % Total Subject to No Member Cost S	Deductible \$  Copayment (\$) or	Expense (Allowed) Subject to Deductible	#DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0!  #DIV/0!  #DIV/0!  #DIV/0!  #DIV/0!  #DIV/0!  #DIV/0!  #DIV/0!  #DIV/0!	for this Benefit as % of Projected Expense for all	for this Benefit as % of Projected	Deductible (2/3 test)  Substantially All	Predominant Level
	Total Subject to Coinsurance % Total Subject to No Member Cost S	Deductible \$	Expense (Allowed) Subject to Deductible	#DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0!  #DIV/0!  #DIV/0!  CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed) #DIV/0!	for this Benefit as % of Projected Expense for all	for this Benefit as	Deductible (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 S	haring		#DIV/0!			
				CY 2022			
				Projected Expense			
			FY 2022 Projected				
			Expense (Allowed)			Substantially All	
			Subject to	of Total Plan Cost		Deductible (2/3	
		Deductible \$	Deductible	(Allowed)		test)	
	Total Subject to Deductible			#DIV/0!		,	
	20000000						
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Please include any comments: