### Mental Health/Substance Use Disorder Parity Report

	Health	Plan Sub	omission 1	Informatio	on		
Health Plan Name: Aloha Car						Date: <b>5/1</b>	6/23
rieditii i idii Name. Alona Car	<u> </u>				_ Keport	. Date. <u>371</u>	0/23
Reporting Period: 01/22/202	2 - 12/3	31/22					
If Resubmission, Date Submitted:							
Se	ction I: Q	uantitati	ive Treatn	nent Limit	tations		
Does the Health Plan impose a in any classification that is mo applies to substantially all Med	re restrict	ive than t	the predon	ninant qua	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							
If any other than "NONE" were below:	e selected	for a class	sification, p	olease elab	orate in the	e embedded	worksheet
MH_SUD_QTL Calculations.xlsx							
Section	n II: Noi	า-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-quai					
Medical management standar based on medical necessity, of based on whether the treatme	or medical	appropria	ateness, or		S	NO ⊠	

YES

NO

Prior Authorization and ongoing authorization requirements

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		⊠ 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 ⊠
f "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 Requirer		
Section III: Financial Requirer	ntehirs	

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						$\boxtimes$
Other Outpatient, In- Network						$\boxtimes$
Office Visits, Out-of- Network						$\boxtimes$

Other Outpatient, Out-of- Network			$\boxtimes$
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 Author under penalty of perjury that: (1) the informattached documentation and materials reference to the terms of the QI RFP/contract at Sections Responsibilities and Section 14.21, Remedies of	nation reported above sed are true and corre 6, Health Plan Repor	e is true and correct; (2) any ect; and (3) I understand and agree ting and Encounter Data
Signature		 Date

### Mental Health/Substance Use Disorder Parity Report

	Health	Plan Sub	omission 1	Informat	ion		
Health Plan Name: Ohana He	alth Plan				Repor	t Date: <b>05/</b> 3	31/2023
Reporting Period: 01/01/202	2 - 12/31	/2022					
Reporting Ferrous Off Off 202	2 12/51	. / 2022					
If Doguhmicaion							
If Resubmission, Date Submitted:							
Se	ction I: Q	uantitati	ive Treatr	ment Lim	itations		
Does the Health Plan impose	any of the	following	quantitativ	ve treatm	ent limitatio	ns on MH/S	IID henefits
in any classification that is mo							
applies to substantially all Me	dical/Surgi	ical benefi	its in the s	ame class	sification?		
	Annual	Annual	Episode	Episode	Lifetime	Lifetime	None
<u>Classification</u>	Visits	Days	Visits	Days	Visits	Days	
Inpatient, In-Network							
Inpatient, Out-of-Network							⊠ ⊠
Office Visits, In-Network Other Outpatient, In-							⊠
Network	Ц			Ш	Ш		Δ
Office Visits, Out-of-Network							$\boxtimes$
Other Outpatient, Out-of-							$\boxtimes$
Network	_						=
Emergency							$\boxtimes$
Prescription Drugs							<b>N</b>
If any other than "NONE" wer	e selected	for a clas	sification,	please ela	aborate in th	e embedded	d worksheet
below:							
X ≡							
MH_SUD_QTL							
Calculations.xlsx							
Secti	on II: No	n-Ouanti	tative Tre	atment	Limitations		
Section		ii Quaiiti	tative ire	acment			
Does the Health Plan impose a							
services that is more restrictive			ntitative tr	reatment	limitations tl	nat applies t	to
substantially all Medical/Surgi	cal benefit	:s?					
Medical management standa	rds limitin	a or exclu	dina benef	its Y	ES	NO	
based on medical necessity,						$\boxtimes$	
based on whether the treatm							
				.,	EC	NO	
Prior Authorization and ongo	ing author	ization red	quirements	3	ES ¬	NO ⊠	

Concurrent review standards

YES

NO

Formulary design for prescription drugs  For plans with multiple networks tiers (such as preferred providers and participating providers), network tier designs	□ YES □ YES	⊠ NO ⊠ 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			
N/A			
Section III: Financial Requirer	nents		
Does the Health Plan impose any of the following financial requirer	nents on MH,	/SUD benefits in any	

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						$\boxtimes$
Prescription Drugs						$\boxtimes$

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



#### Attestation

I, Scott Sivik, acting as the Chief Executive Officer or Aut	horized Agent of 'Ohana Health	Plan (i.e., the
Health Plan), declare under penalty of perjury that: (3	1) the information reported abo	ve is true and
correct; (2) any attached documentation and materials re		
understand and agree to the terms of the QI RFP/contrac		
Encounter Data Responsibilities and Section 14.21, Reme	dies of Non-Performance of Cor	ntract.
	Plan President & CEO	05/31/2023
Signature	Title	Date

Table 1: Quantitative Treatment Limitations, including but not	· limited to limits on innation	at days nor admission/onicodo or n	or year, authorized visits nor enisode (year, authorized convises 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 payerinative 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>			

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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	
<u> </u>	l .			1

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Copyment (5) or Colorariance (75) Pr 2022 Projected Superior (5) or Colorariance (75) Pr 2022 Projected Superior (75) Deductible Superior (75) Ded									
Copayment (5) or Coloranace (9) P7 2022 Projected Substantially All* Test for Copay or Coloranace, Predominant Cost Starting All* Test for Copay or Coloranace, Predominant Cost Starting All* Test for Copay or Coloranace, Predominant Cost Starting All* Test for Copay or Coloranace, Predominant Cost Starting All* Test for Deductible Subject to Coloranace Substantially All* Subject to Coloranace Substantially All* Test for Deductible Subject to Coloranace Substantially All* Deductible (2/3 test)  **Coloranace Subject to Coloranace Substantially All* Deductible (2/3 test)  **Coloranace Subject to Coloranace Substantially All* Deductible (2/3 test)  **Coloranace Subject to Deductible Subject to Coloranace Substantially All* Deductible (2/3 test)  **Coloranace Subject to Coloranace Substantially All* Deductible (2/3 test)  **Coloranace Subject to Coloranace Substantially All* Deductible (2/3 test)  **Coloranace Subject to Coloranace Substantially All* Deductible (2/3 test)  **Coloranace Subject to Coloranace Substantially All* Deductible (2/3 test)  **Coloranace Subject to Coloranace Substantial Subject to Coloranace Substan									
Copayment (5) or Coloranace (9) P7 2022 Projected Substantially All* Test for Copay or Coloranace, Predominant Cost Starting All* Test for Copay or Coloranace, Predominant Cost Starting All* Test for Copay or Coloranace, Predominant Cost Starting All* Test for Copay or Coloranace, Predominant Cost Starting All* Test for Deductible Subject to Coloranace Substantially All* Subject to Coloranace Substantially All* Test for Deductible Subject to Coloranace Substantially All* Deductible (2/3 test)  **Coloranace Subject to Coloranace Substantially All* Deductible (2/3 test)  **Coloranace Subject to Coloranace Substantially All* Deductible (2/3 test)  **Coloranace Subject to Deductible Subject to Coloranace Substantially All* Deductible (2/3 test)  **Coloranace Subject to Coloranace Substantially All* Deductible (2/3 test)  **Coloranace Subject to Coloranace Substantially All* Deductible (2/3 test)  **Coloranace Subject to Coloranace Substantially All* Deductible (2/3 test)  **Coloranace Subject to Coloranace Substantially All* Deductible (2/3 test)  **Coloranace Subject to Coloranace Substantial Subject to Coloranace Substan						for this Benefit as	Projected Expense		
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Coinstrance			Consument (\$) or			-		Substantially All	
Level						•	-		
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Integrated Transport (reg., p., loogs)and room) - cute inspatiated	Level		amount	Expense	(Allowed)	Copay \$	Coinsurance %	(2/3 test)	(50% test)
Integrated Transport (reg., p., loogs)and room) - cute inspatiated	A. Inpatient, In-Network								
Physician/Jurgeon fee—acute inputient					#DIV/0I				
Hospital facility fee (e.g., hospital aromi)—female sterilization Physician facility fee (e.g., hospital aromi)—female sterilization Physician facility fee (e.g., hospital aromi)—female sterilization Physician facility fee (e.g., hospital aromi) Physic		+							
Physician four-fermate sterilization	Physician/surgeon reeacute inpatient	-			#DIV/0:				
Physician four-fermate sterilization									
Hospital facility fee (e.g., hospital room)maternity delivery	Hospital facility fee (e.g., hospital room)female sterilization				#DIV/0!				
Hospital facility fee (e.g., hospital room)maternity delivery	Physician/surgeon feefemale sterilization				#DIV/0!				
Professional fees—maternaty delivery		†			#DIV/01				
Impatient hospite facility fee (e.g., hospital room)  Total Subject to Copay 5 Total Subject to No Member Cost Sharing  Deductible S  Substantially All" Test for Deductible  Total Subject to Deductible  Total Subject to Deductible  Deductible S  Deductib		+	<del> </del>						
Salied nursing facility fee (e.g., hospital room)  Total Subject to Copay \$   #DIV/0		+	<b>_</b>						
Total Subject to Copay S Total Subject to Romerance % Total Subject to No Member Cost Sharing Total Subject to No Member Cost Sharing FY 2022 Projected Expense (Allowed) FY 2022 Projected Expense FY 2		<u> </u>							
Total Subject to Colonsurance % Total Subject to No Member Cost Sharing  Total Subject to No Member Cost Sharing  FY 2022 Projected Expense (Allowed) Subject to Deductible S Subject to Deductible as % Subject to Deductible as % Total Subject to Deductible \$ Deducti	Skilled nursing facility fee (e.g., hospital room)		L		#DIV/0!	<u> </u>			
Total Subject to Coinsurance % Total Subject to No Member Cost Sharing  FY 2022 Projected Expense FY 2022 Projected Expense (Allowed) Subject to Deductible a % Subject to Deductible S  Deductible S  Copayment (\$) or Coinsurance( %) amount  Classification  B, inpatient, Out-of-Network  FY 2022 Projected Expense FY 2022 Projected	Total				#DIV/0!				
Total Subject to Coinsurance % Total Subject to No Member Cost Sharing  FY 2022 Projected Expense FY 2022 Projected Expense (Allowed) Subject to Deductible a % Subject to Deductible S  Deductible S  Copayment (\$) or Coinsurance( %) amount  Classification  B, inpatient, Out-of-Network  FY 2022 Projected Expense FY 2022 Projected		Total Subject to Copay \$			#DIV/0!				
Total Subject to No Member Cost Sharing #DIV/O!  FY 2022 Projected Expense (Allowed) Substantially All* Test for Deductible  Total Subject to Deductible 2/3  Test of Total Plan Cost  Total Plan									
"Substantially All" Test for Deductible  Total Subject to Total Fine Cost  Total		-	\		•				
Projected Expense (Allowed) Subject Expense (Allowed) Subject to Deductible (2/3 to Total Plan Cost (Allowed) Subject to Deductible (2/3 to Total Plan Cost (Allowed) Subject to Deductible (2/3 test)		Total Subject to No Member Cost S	naring		#DIV/0!				
Projected Expense (Allowed) Subject Expense (Allowed) Subject to Deductible (2/3 to Total Plan Cost (Allowed) Subject to Deductible (2/3 to Total Plan Cost (Allowed) Subject to Deductible (2/3 test)									
Projected Expense (Allowed) Subject Expense (Allowed) Subject to Deductible (2/3 to Total Plan Cost (Allowed) Subject to Deductible (2/3 to Total Plan Cost (Allowed) Subject to Deductible (2/3 test)									
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Substantially All" Test for Deductible  Total Subject to Deductible  #DIV/OI  Projected Expense for this Benefit as Expense for this Benefit as Expense for all Expense for this Subject to Cost Share Type  Classification  Classification  Total Plan Cost (Allowed)  Projected Expense for this Benefit as Expense for all Expense for all Expense (Allowed)  Expense  (Allowed)  Copay \$  Copa								Substantially All	
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Classification   Expense   (Allowed)   Copay \$   Coins %   (2/3 test)   (50% test)		1		04.004.5	0, 5=				<b>.</b>
B. Inpatient, Out-of-Network  #DIV/0!			Coinsurance( %)	-					
#DIV/0!	Classification	<u> </u>	amount	Expense	(Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)
#DIV/0!	B. Inpatient, Out-of-Network								
#DIV/0!					#DIV/0!				
#DIV/0!		†							
#DIV/0!			1	1		1	-	-	
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Total Subject to Copay \$					#DIV/0!				
Total Subject to Copary S Total Subject to No Member Cost Sharing  Total Subject to Deductible S  Deductible S  Deductible S  Total Subject to Deductible S  Deductible S  Deductible S  Total Subject to Deductible S  Deductible S  Total Subject to No Member Cost Sharing  Total Subject to Deductible S  Total Subject to No Member Cost Sharing  Total Subject to No Member Cost Sharing  Total Subject to Deductible S  Total Subject to No Member Cost Sharing  Total Subject to No Member Cost Sha					#DIV/0!				
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Total Subject to No Member Cost Sharing    Projected Expense (Allowed)   Deductible   S   D		Total Subject to Copay \$			#DIV/0!				
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Total Subject to Deductible   POIV/OI   Projected Expense for this Benefit as Substantially All Construction of Fire Value Careful Car									
Copayment (5) or Coinsurance( %) amount  Coupation, in-Network: Office Visits  Coupay file of the Coupay of Coinsurance ( %) amount  Coupay file of the Coinsurance ( %) amount  Coins			Deductible \$	Deductible				test)	
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Coinsurance (%) Expense (Allowed) Copay S coins Subject to Coins Subject t						-			
Classification   Expense   (Allowed)   Copay \$ Coins % (2/3 test)   (50% test)							-		
C. Outpatient, in-Network: Office Visits Primary care visit to treat an injury, liness, or condition  Divider practitioner office visit  Divider office visit to treat an injury, liness, or condition  Divider office visit to read an injury, liness, or condition  Divider office visit to read an injury, liness, or condition  Divider office visit to read an injury, liness, or condition  Divider office visit to read an injury, liness, or condition  Divider office visit to read an injury, liness, or condition  Divider office visit to read an injury, liness, or condition  Divider office visit to read an injury, liness, or condition  Divider office visit to read an injury, liness, or condition  Divider office visit to read an injury, liness, or condition  Divider office visit to read an injury, liness, or condition  Divider office visit to read an injury, liness, or condition  Divider office visit to read an injury, liness, or condition  Divider office visit to read an injury, liness, or condition  Divider office visit to read an injury, liness, or condition  Divider office visit to read an injury, lines, or condition  Divider office visit to read an injury, lines, or condition  Divider of read an injury, lines, or condition  Divider o			Coinsurance( %)	FY 2022 Projected	% of Total Plan Cost		Claims Subject to		Predominant Level
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!				
Prenatal care and preconception visits  Acupuncture  Health education  Child dental: diagnostic and preventive  Child eye exam  Total Subject to Copay \$  Total Subject to Coinsurance %  Total Subject to No Member Cost Sharing  Total Subject to No Member Cost Sharing  Deductible \$	Preventive care/screening/immunization				#DIV/0!				
Acupuncture Health education    #DIV/O!	Family planning				#DIV/0!				
Health education Child dental: diagnostic and preventive Child depta exam Child eye exam Total  Total  Total Subject to Copay \$ Total Subject to Coinsurance % Total Subject to No Member Cost Sharing  Total Subject to No Member Cost Sharing  Total Subject to No Member Cost Sharing  FY 2022 Projected Expense (Allowed) Subject to Deductible \$ Deductible \$ Deductible \$ Deductible (Allowed) Label Subject to Subject to Subject to Subject to Subject to Subject to Deductible (Allowed) Label Subject to Subject to Subject to Deductible (Allowed) Label Subject (Allowed) Label Subj	Prenatal care and preconception visits				#DIV/0!				
Child dental: diagnostic and preventive  Child eye exam  Total  Total Subject to Copay \$  Total Subject to Coinsurance %  Total Subject to No Member Cost Sharing  Total Subject to No Member Cost Sharin	Acupuncture				#DIV/0!				
Child eye exam  Total  Total Subject to Copay \$  Total Subject to Coinsurance %  Total Subject to No Member Cost Sharing  Total Subject to No Member Cost Sharing  FY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)  Deductible \$ Deductible (Allowed)  Total Subject to (Allowed)  Total Subject to Deductible (2/3 test)	Health education				#DIV/0!				
Total Subject to Copay \$ #DIV/0!	Child dental: diagnostic and preventive				#DIV/0!				
Total Subject to Copay \$ #DIV/0!	Child eye exam				#DIV/0!				
Total Subject to Copay \$ #DIV/0!	Total								
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		Copayment (\$) or			Expense for all	% of Projected	Substantially All	
		Coinsurance( %)	-		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!				
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!				
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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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				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
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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	haring		#DIV/0!				
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				Projected Expense				
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			FY 2022 Projected	(Allowed) Subject			C la a de a a de la	
			Expense (Allowed)	to Deductible as %			Substantially All	
			Subject to	of Total Plan Cost			Deductible (2/3	
		Deductible \$	Deductible	(Allowed)			test)	
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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		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!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
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Total				#DIV/0!				
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	Total Subject to Coinsurance %	haring		#DIV/0!				
	Total Subject to Coinsurance %	haring		#DIV/0! #DIV/0!				
	Total Subject to Coinsurance %	haring	FY 2022 Projected	#DIV/0! #DIV/0! CY 2022				
	Total Subject to Coinsurance %	haring	FY 2022 Projected Expense (Allowed)	#DIV/0! #DIV/0! CY 2022 Projected Expense			Substantially All	
	Total Subject to Coinsurance %	haring	Expense (Allowed)	#DIV/0! #DIV/0! CY 2022 Projected Expense (Allowed) Subject				
	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	haring  Deductible \$	Expense (Allowed)	#DIV/0! #DIV/0!  CY 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! 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	
	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)			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		Expense (Allowed) Subject to	#DIV/0! #DIV/0! CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed) #DIV/0!	for this Benefit as	Projected Expense	Deductible (2/3	
	Total Subject to Coinsurance % Total Subject to No Member Cost S	Deductible \$	Expense (Allowed) Subject to	#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	for this Benefit as	Deductible (2/3 test)	
	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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Please include any comments:

# Mental Health/Substance Use Disorder Parity Report

	11111.				•		
	Health	Plan Sub	mission 1	Informa	tion		
Health Plan Name: <b>HMSA</b>					Repor	t Date: <b>05/</b>	08/2023
Reporting Period: 01/01/202	22 - 12/2	21 /2022					
Reporting Feriod. O1/01/202	<u> </u>	31/2022					
If Resubmission, Date Submitted:							
Date Submitted.							
50	stion I. O	wantitati	vo Troatr	nont Lin	aitations		
Sec	ction 1: Q	uantitati	ive Treatr	nent Lin	nitations		
Does the Health Plan impose a							
in any classification that is mo						atment limi	tations that
applies to substantially all Med	ııcaı/Surgı Annual	cai benefi Annual	ts in the sa Episode	ame cias: Episode		Lifetime	None
Classification	Visits	Days	Visits	Days	Visits	Days	None
Inpatient, In-Network		Ĺ		Ĺ		Ĺ	$\boxtimes$
Inpatient, Out-of-Network							$\boxtimes$
Office Visits, In-Network							⊠
Other Outpatient, In-							$\boxtimes$
Network	_						_
Office Visits, Out-of-Network							
Other Outpatient, Out-of- Network							
Emergency					П		lacktriangle
Prescription Drugs							
•							•
If any other than "NONE" were	selected	for a clas	sification,	please el	aborate in th	e embedde	d worksheet
below:							
Section	n II: Noi	n-Quanti	tative Tre	atment	Limitations		
Does the Health Plan impose a							
services that is more restrictiv			ntitative tr	eatment	limitations th	nat applies t	to
substantially all Medical/Surgion	cal benefit	s?					
Medical management standar	de limitina	a or evolu	dina henef	itc \	'ES	NO	
based on medical necessity,						×	
based on whether the treatm					_		
	0.110 10 0/kp			J			
Prior Authorization and ongoi	ng authori	ization red	quirements	5 Y	'ES	NO	
	-		-			$\boxtimes$	
Concurrent review standards				Υ	′ES	NO	
						$\boxtimes$	
Formulary design for prescrip	tion drugs	5			'ES	NO	
						$\boxtimes$	

For plans with multiple net providers and participating				YES □	NO ⊠	
Standards for provider adnincluding reimbursement ra		cipate in a n	etwork,	YES	NO ⊠	
Methods for determining us charges	sual, customar	y, and reaso	nable	YES	NO ⊠	
Refusal to pay for higher-ce that a lower-cost therapy is or "step therapy" protocols	s not effective			YES	NO ⊠	
Restrictions on applicable p	provider billing	codes		YES □	NO ⊠	
Standards for providing acc	cess to out-of-	network pro	viders	YES	NO ⊠	
Exclusions based on failure	to complete a	course of tr	reatment	YES □	NO ⊠	
Restrictions based on geog provider specialty	raphic locatior	ı, facility typ	e, and	YES □	NO ⊠	
NQTL(s) are imposed on inc	luding the pro	cesses, strat	egies, evider	ntiary standard	ls, and other fac	ctors.
	6		-1.0			
Does the Health Plan impose classification?		III: Financi llowing finan			UD benefits in a	any
<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						⊠

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

 $\boxtimes$ 

Prescription Drugs

#### Attestation

I, Jennifer Awakuni, 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.

Jenniku Awalund		
	Assistant Vice President, Medicaid Programs	05/10/2023
Signature	Title	Date

### Mental Health/Substance Use Disorder Parity Report

	Health	Plan Sub	omission 1	[nformat	ion		
Health Plan Name: KAISER PE	RMANEN	ITE			Rep	ort Date: <b>5</b> /	/30/2023
Reporting Period: 01/01/202	2 - 12/3	31/2022					
If Resubmission, Date Submitted:							
Se	ction I: Q	<u>)</u> uantitat	ive Treatr	nent Lim	itations	_	
Does the Health Plan impose a in any classification that is mo applies to substantially all Med	re restrict	ive than t	he predom	ninant qua	antitative t		
Classification Inpatient, In-Network Inpatient, Out-of-Network Office Visits, In-Network Other Outpatient, In-	Annual Visits	Annual Days	Episode Visits	Episode Days	Lifetime Visits	e Lifetime Days	None  M M M M
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 ela	aborate in	the embedd	ed worksheet
MH_SUD_QTL Calculations.xlsx							
Section	on II: No	n-Quanti	tative Tre	atment l	Limitatio	าร	
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, of based on whether the treatm	or medica	l appropri	ateness, o	r	YES 🗆	NO ⊠	

Prior Authorization and ongoing authorization requirements

Concurrent review standards

YES

□ YES NO

 $\boxtimes$ 

NO

		$\boxtimes$	
Formulary design for prescription drugs	YES	NO	
Formularly design for prescription drugs		$\boxtimes$	
For plans with multiple networks tiers (such as preferred	YES	NO	N/A
providers and participating providers), network tier designs			$\boxtimes$
Standards for provider admission to participate in a network,	YES	NO	
including reimbursement rates		$\boxtimes$	
Methods for determining usual, customary, and reasonable	YES	NO	
charges		$\boxtimes$	
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		$\boxtimes$	
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		$\boxtimes$	
promise opening	<u> </u>		
If "YES" to any of the above, please describe in more detail below	which benefi	ts classificat	ion(s) the
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						$\boxtimes$
Office Visits, In-Network						$\boxtimes$
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.



Signature

#### Attestation

I, Christina K. Hause 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.

VP, Marketing, Sales, Business Development & Community Health

5/30/2023 Title Date

3

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 expert in a similar or aphabia Infusion therapy Child dendaria hasis services  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 Limits that Apply to Each Benefit M/S benefits in the classification/sub classification  "Predominant" quantitative treatment Limits that Apply to Each Benefit M/S benefits in the classification/sub classification  "Predominant" quantitative treatment Limits that Apply to Each Benefit Limits that Apply to Eac
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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
Tier One Tier One
Tier Two Tier Two
Tier Three Tier Three

	1						T	
					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!				
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C. Outpatient, In-Network: Office Visits		amount	Expense	(Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)
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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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		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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		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)*
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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!			
	Total Subject to Copay \$			#DIV/0!			
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Please include any comments:

## Mental Health/Substance Use Disorder Parity Report

	Haalib	Dlan Cuk	mission 1	Informati			
Health Plan Name: Ohana Hea		Plan Sut	omission 1	Intormati		t Date: <b>5/3</b> :	1 /2023
rieditii Fidii Nailie. Olidiid Hea	aitii Piaii				_ Kepon	. Date. <b>5/ 5</b> .	1/2023
Reporting Period: 01/01/202	2 - 12/31	/2022					
If Resubmission, Date Submitted:							
Se	ction I: Q	uantitat	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	ntitative tre		
Classification Inpatient, In-Network Inpatient, Out-of-Network Office Visits, In-Network Other Outpatient, In-	Annual Visits	Annual Days	Episode Visits	Episode Days	Lifetime Visits  □ □ □ □	Lifetime  Days	None ⊠ ⊠ ⊠
Network Office Visits, Out-of-Network Other Outpatient, Out-of- Network	_ _						× ×
Emergency Prescription Drugs							$\boxtimes$
If any other than "NONE" were below:  MH_SUD_QTL Calculations.xlsx	e selected	for a clas	sification,	please elal	oorate in th	e embedded	d worksheet
Cooki	on II. No.	- Ous-sti	tativa Tua	atus aut l			
Does the Health Plan impose a services that is more restrictive substantially all Medical/Surgin	any of the e than the	following e non-qua	Non-Quan	titative Tre			
Medical management standar based on medical necessity, based on whether the treatm	or medical	appropri	ateness, o			NO ⊠	
Prior Authorization and ongo	ing author	ization red	auirements	s YE	S	NO	

Concurrent review standards  Formulary design for prescription drugs  For plans with multiple networks tiers (such as preferred providers and participating providers), network tier designs	U YES U YES U YES U YES	⊠ NO ⊠ NO ⊠ 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			
N/A			

### 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.



MH\_SUD\_Financial Calculations.xlsx

#### Attestation

I, Scott Sivik, acting as the Chief Executive Officer or Authorized Agent of 'Ohana Health Plan (i.e., t	he
Health Plan), declare under penalty of perjury that: (1) the information reported above is true as	nd
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.	

4X	Plan President & CEO	5/31/2023
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 expert in a similar or aphabia Infusion therapy Child dendaria hasis services  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 Limits that Apply to Each Benefit M/S benefits in the classification/sub classification  "Predominant" quantitative treatment Limits that Apply to Each Benefit M/S benefits in the classification/sub classification  "Predominant" quantitative treatment Limits that Apply to Each Benefit Limits that Apply to Eac
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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		
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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				
			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!				
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					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!				
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	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!				
	Total Subject to Copay \$			#DIV/0!				
	Total Subject to Coinsurance %	<u> </u>		#DIV/0!				
	Total Subject to No Member Cost S	Sharing		#DIV/0!				
				CY 2022				
			1	1				
				Projected Expense			•	1
			FY 2022 Proiected					
			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		
					% 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!				
	Total Subject to Copay \$			#DIV/0!				
	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)
E. Outpatient, Out-of-Network: Office Visits			,	,,	1.7.			(
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		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)*
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	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	
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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!			
	Total Subject to Copay \$			#DIV/0!			
	Total Subject to Coinsurance %			#DIV/0!			
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Please include any comments:

### **Mental Health/Substance Use Disorder Parity** Report

<b>United Ho</b> Health Plan Name: <b>Communi</b>	ealthcare		omission 1	informati		Date: <b>5/2</b> 3	3/2023
Reporting Period: 01/01/202	22 – 12/3	1/2022					
If Resubmission, Date Submitted:							
Se	ction I: Q	uantitati	ive Treatr	nent Limi	tations	_	_
Does the Health Plan impose in any classification that is monapplies to substantially all Me	any of the ore restrict	following ive than t	quantitativ	ve treatme inant quar	nt limitatior ntitative tre		
Classification Inpatient, In-Network Inpatient, Out-of-Network Office Visits, In-Network Other Outpatient, In-	Annual Visits	Annual Days	Episode Visits  □ □ □ □	Episode Days	Lifetime Visits  □ □ □ □	Lifetime Days  □ □ □ □	None  M M M M M M
Network Office Visits, Out-of-Network Other Outpatient, Out-of- Network							⊠ ⊠
Emergency Prescription Drugs							$\boxtimes$
If any other than "NONE" wer below:	e selected	for a clas	sification,	please elal	oorate in the	e embedded	d worksheet
MH_SUD_QTL Calculations.xlsx							
Secti	on II: No	n-Quanti	tative Tre	atment L	imitations		
Does the Health Plan impose services that is more restrictive substantially all Medical/Surgi	e than the	e non-qua					
Medical management standa based on medical necessity, based on whether the treatm	or medica	l appropri	ateness, or	. 🗆		NO ⊠	
Prior Authorization and ongo	ing author	ization red	quirements	YE	S	NO ⊠	

 $\boxtimes$ 

Concurrent review standards  Formulary design for prescription drugs  For plans with multiple networks tiers (such as preferred providers and participating providers), network tier designs	YES  YES  YES  C	NO MO MO MO MO
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 ⊠
f "YES" to any of the above, please describe in more detail below 'NQTL(s) are imposed on including the processes, strategies, eviden		
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?

<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 Author Hawaii (i.e., the Health Plan), declare use reported above is true and correct; (2) any attended and correct; and (3) I understand and agree to Plan Reporting and Encounter Data Responsibility Contract.	<b>Inder penalty of perjury</b> that: (1) ached documentation and materials the terms of the QI RFP/contract a	the information referenced are true it Sections 6, Health
$\mathcal{O}$	Health Plan CEO	05/23/2023
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

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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	1
Urgent care			Urgent care	+
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		If prescription drugs are covered in a tiered		
H. Prescription Drugs	List all Quantitative Treatment Limits that Apply to Each Benefit	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	1
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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	Benefits Subject to		Cost Share Type	Predominant Level
Level		amount	Expense	Cost (Allowed)	Copay \$	Coinsurance %	(2/3 test)	(50% test)
		amount	LAPETISE	Cost (Allowed)	сорау э	Consulance /6	(2/3 test)	(30% 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!		1	1	
Hospital facility fee (e.g., hospital room)maternity delivery				#DIV/0!				
Professional feesmaternity delivery								
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Inpatient hospice facility fee (e.g., hospital room)				#DIV/0!				
Skilled nursing facility fee (e.g., hospital room)				#DIV/0!				
Total				#DIV/0!				
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	Total Subject to Coinsurance %			#DIV/0!				
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					for this Benefit as	Projected Expense		
					% of Projected	for this Benefit as		
		Copayment (\$) or			Expense for all	% of Projected	Substantially All	
		Coinsurance( %)	CY 2016 Projected	% of Total Plan	Benefits Subject to	Claims Subject to	Cost Share Type	Predominant Level
Classification		amount	Expense	Cost (Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)
B. Inpatient, Out-of-Network								(
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	Total Subject to Coinsurance %			#DIV/0!				
	Total Subject to No Member Cost S	haring		#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)	
	Total Subject to Deductible			#DIV/0!				
					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	Benefits Subject to	Claims Subject to	Cost Share Type	Predominant Level
Classification		amount	Expense		Copay \$	Coins %	(2/3 test)	(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 S	haring		#DIV/0!				
				CY 2022				
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			FY 2022 Projected	(Allowed) Subject				
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		Coinsurance( %)	FY 2022 Projected	% of Total Plan	Benefits Subject to	Claims Subject to	Cost Share Type	Predominant Level
Classification		amount	Expense	Cost (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!				
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				
			EV 2022 Dunington	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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		Copayment (\$) or			Expense for all	% of Projected	Substantially All	<u>_</u>
		Coinsurance( %)	FY 2022 Projected	% of Total Plan		Claims Subject to	Cost Share Type	Predominant Level
Classification		amount	Expense	Cost (Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)
E. Outpatient, Out-of-Network: Office Visits								
				#DIV/0!				

Total Subject to Consument (5) or Cons		T			#DIV/0!				
Solution of the second of the		+							
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Classification  Consurance(%) amount  Classification  Consurance(%) amount  Expense  Cost (Allowed)  Classification  Consurance(%) amount  Expense  Cost (Allowed)  Cost (Allo		Total Subject to Deductible			#DIV/0!				
Classification  Consurance(%) amount  Classification  Consurance(%) amount  Expense  Cost (Allowed)  Classification  Consurance(%) amount  Expense  Cost (Allowed)  Cost (Allo									
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Consument (5) or Cons		1							
Coissification  Coissification  Expense  F. Outpatient, Out-of-Network: Other Outpatient Items and Services  F. Outpatient, Out-of-Network: Other Outpatient, Out-of-Network: Out-of-Network: Out-of-Network: Out-of-Network: Out-of-Network: Outpatient, Out-of-Network: Out-		1							
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F. Outpatient, Out-of-Network: Other Outpatient Items and Services    BDIV/OI		1	Coinsurance( %)	FY 2022 Projected	% of Total Plan	Benefits Subject to	Claims Subject to	Cost Share Type	Predominant Level
### ### ##############################	Classification		amount	Expense	Cost (Allowed)	Copay \$	Coins %	(2/3 test)	(50% test)*
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BDIV/OI									
Total Subject to Copay \$   #DIV/OI					#DIV/0!				
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Deductible   Subject to Deductible   Deduc		Total Subject to Coinsurance %	haring	FY 2022 Projected	#DIV/0! #DIV/0! #DIV/0! CY 2022 Projected Expense				
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Liassification   amount Expense   Cost (Allowed)   Copay \$   Coins %   (2/3 test)   (50% test)		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!  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	
		Total Subject to Coinsurance % Total Subject to No Member Cost S	Deductible \$  Copayment (\$) or Coinsurance( %)	Expense (Allowed) Subject to Deductible  FY 2022 Projected	#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 Benefits Subject to	for this Benefit as % of Projected Expense Subject to	Deductible (2/3 test)  Substantially All Cost Share Type	Predominant Level

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!			
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			Expense (Allowed)	to Deductible as % of Total Plan Cost		Substantially All Deductible (2/3	
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	T . 16 1:	Deductible \$	Deductible	(Allowed)		test)	
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						1	

Please include any comments: