	Health	Plan Sub	mission 1	Informa	tion		
Health Plan Name: AlohaCare)				Repor	t Date: 5/ :	15/2024
Reporting Period: 01/01/202	3-12/31 _,	/2023					
If Resubmission, Date Submitted:							
Sec	ction I: Q	uantitati	ive Treatr	nent Lir	nitations		
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 qu	iantitative tre		
O. 16	Annual	Annual	Episode	Episode		Lifetime	None
<u>Classification</u> Inpatient, In-Network	Visits □	Days	Visits □	Days	Visits □	Days	\boxtimes
Inpatient, In-Network Inpatient, Out-of-Network							
Office Visits, In-Network							\boxtimes
Other Outpatient, In-							⊠
Network							
Office Visits, Out-of-Network Other Outpatient, Out-of-							
Network	Ц				Ш	ш	
Emergency							\bowtie
Prescription Drugs							\boxtimes
If any other than "NONE" were below:	selected	for a clas	sification,	please e	laborate in th	e embedde	d worksheet
X							
MH_SUD_QTL Calculations_Rel04.24.							
Section	n II: No	า-Quanti	tative Tre	atment	Limitations		
Does the Health Plan impose a							
services that is more restrictiv substantially all Medical/Surgion			nillative tr	eaumem	. וווווונמנוטווא נו	пас аррпеѕ і	.0
Medical management standar based on medical necessity, of based on whether the treatme	or medical	appropri	ateness, or	r	YES	NO ⊠	
Prior Authorization and ongoi	ng authori	ization red	quirements	5	YES	NO ⊠	
Concurrent review standards					YES	NO ⊠	

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

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 MH inpatient Hospital facility fee (e.g., hospital room)--acute 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 limitation applicable to "substantially all' List all Quantitative Treatment List all Quantitative Treatment B. Inpatient, Out-of-Network B. Innatient 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 (PDD) 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				
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
		"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"	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	
_				
U. Saraniakira Danas	List all Quantitative Treatment	If prescription drugs are covered in a tiered structure that does not distinguish between		List all Quantitative Treatment
H. Prescription Drugs	Limits that Apply to Each Benefit	M/S and MH/SUD drugs, the "predominant" and "substantially all" analyses are not necessary.	H. Prescription Drugs	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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Classification "Substantially All" Test for Copays or Coinsurance, Predominant		Coinsurance (%)	FY 2022 Projected	% of Total Plan Cost	Benefits Subject to	Subject to	Cost Share Type	Predominant Level
Level		amount	Expense	(Allowed)	Copay \$	Coinsurance %	(2/3 test)	(50% test)
A. Inpatient, In-Network		amount	Expense	(Allowed)	copay 5	Comparance 70	(2/3 test)	(50% test)
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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				#DIV/0!				
		 						
Professional feesmaternity delivery		1		#DIV/0!	1			
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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		Copayment (\$) or			Expense for all	for this Benefit as %	Substantially All	
			CV 2016 Duniant - 1	0/ of Total Diam Co	•			Predominant Level
at 17: 11		Coinsurance(%)	-	% of Total Plan Cost	-	of Projected Claims		
Classification		amount	Expense	(Allowed)	Copay \$	Subject to Coins %	(2/3 test)	(50% test)
B. Inpatient, Out-of-Network								
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			Expense (Allowed)					
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		Copayment (\$) or			Expense for all	for this Benefit as %	Substantially All	
		Coinsurance(%)	FY 2022 Projected	% of Total Plan Cost	Benefits Subject to	of Projected Claims		Predominant Level
Classification		amount	Expense	(Allowed)	Copay \$	Subject to Coins %	(2/3 test)	(50% test)
C. Outpatient, In-Network: Office Visits			·	, ,	1,7,		, ,	,
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!				
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Child dental: diagnostic and preventive				#DIV/0!				
Child eye exam				#DIV/0!				
Total				#DIV/0!				
	Total Subject to Copay \$			#DIV/0!				
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		Coinsurance(%)	FY 2022 Projected	% of Total Plan Cost	Benefits Subject to	of Projected Claims	Cost Share Type	Predominant Level
Classification		amount	Expense	(Allowed)	Copay \$	Subject to 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!				
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Classification		amount	Expense	(Allowed)	Copay \$	Subject to Coins %	(2/3 test)	(50% test)
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Classification		amount	Expense	(Allowed)	Copay \$	Subject to Coins %	(2/3 test)	(50% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services								
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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!			
	Total Subject to No Member Cost S	haring		#DIV/0!			
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			FY 2022 Projected				
				to Deductible as %		Substantially All	
			Subject to	of Total Plan Cost		Deductible (2/3	
		Deductible \$	Deductible	(Allowed)		test)	
	Total Subject to Deductible			#DIV/0!			
	-			,			

Please include any comments:

Mental Health/Substance Use Disorder Parity Report

	Health	Plan Sub	mission 1	Informat	ion		
Health Plan Name: Ohana He	alth Plan				Repor	t Date: 5/3	1/24
Danastina Daviado es (es (es)							
Reporting Period: 01/01/202	3 - 12/31	1/2023					
If Resubmission,							
Date Submitted:							
So	ction I. C)uantitati	ivo Troatr	mont Lim	itations		
Se	Ction 1: Q	<u>z</u> uaninai	ive Treatr	nent Liii	itations		
Does the Health Plan impose a							
in any classification that is mo applies to substantially all Med						atment limi	tations that
applies to substantially all Med	aicai/ Sui gi	icai belleli	ts iii tile s	airie Ciass	ilications		
	Annual	Annual	Episode	Episode	Lifetime	Lifetime	None
<u>Classification</u> Inpatient, In-Network	Visits □	Days	Visits □	Days	Visits □	Days	\boxtimes
Inpatient, Out-of-Network							×
Office Visits, In-Network							\boxtimes
Other Outpatient, In-							lacktriangle
Network Office Visits, Out-of-Network							\boxtimes
Other Outpatient, Out-of-							
Network		_	_	_	_	_	_
Emergency							\boxtimes
Prescription Drugs							
If any other than "NONE" wer	e selected	for a clas	sification,	please ela	borate in th	e embedde	d worksheet
below:							
X							
MH_SUD_QTL							
Calculations.xlsx							
Section	on II: No	n-Ouanti	tative Tre	atment l	Limitations		
333		· · · · · · · · · · · · · · · · · · ·					
Does the Health Plan impose a							
services that is more restrictive substantially all Medical/Surgi		-	ntitative tr	eatment	iimitations ti	nat applies	.0
substantially an incarcal, surgi	car benen	.5.					
Medical management standa					ES	NO	
based on medical necessity, based on whether the treatm						\boxtimes	
based on whether the treath	iciic is exp	CHIHEHLAI	טו ווועכטנונ	gative			
Prior Authorization and ongo	ing author	ization re	nuiremente	2	ES	NO	
	_		quii ciriciită	L]	NO.	
Concurrent review standards				Y I	ES	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 Health Plan), declare under penalty of perjury the correct; (2) any attached documentation and materia understand and agree to the terms of the QI RFP/cor Encounter Data Responsibilities and Section 14.21, R	at: (1) the information reported a als referenced are true and corre- ntract at Sections 6, Health Plan	above is true and ct; and (3) I Reporting and
Signature	<u>Plan President & CEO</u> Title	<u>05/31/24</u> 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

<u></u>		<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	1
Urgent care			Urgent care	+
. 6			- 0	
				
				+
		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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Physician four-fermate sterilization									
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#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) Holly OI Holly OI Holly OI Ho	Specialist physician visit				#DIV/0!				
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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 as % Subject to to Deductible \$ Deductible \$ Deductible \$ Deductible (Allowed) Line (Allowed) Deductible (Prenatal care and preconception visits				#DIV/0!				
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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!				
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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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	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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			Expense (Allowed)	to Deductible as %			Substantially All	
			Subject to	of Total Plan Cost			Deductible (2/3	
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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)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services				, ,			,	,
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
				#DIV/0!				
Total				#DIV/0!				
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	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	
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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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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	
		Deductible \$	Deductible	(Allowed)		test)	
	Total Subject to Deductible			#DIV/0!			

Please include any comments:

	Health	Plan Sub	omission 1	Inform	ation		
Health Plan Name: HMSA						t Date: 05/	03/2024
Reporting Period: 01/01/202	23 - 12/3	31/2023					
If Resubmission, Date Submitted:							
Sec	ction I: Q	uantitat	ive Treatr	nent Li	mitations		
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 q	uantitative tre		
<u>Classification</u> Inpatient, In-Network Inpatient, Out-of-Network Office Visits, In-Network Other Outpatient, In- Network	Annual Visits	Annual Days	Episode Visits	Episod Days 		Lifetime Days	None ⊠ ⊠ ⊠ ⊠
Office Visits, Out-of-Network Other Outpatient, Out-of- Network Emergency Prescription Drugs	<u> </u>						X X X X
If any other than "NONE" were below: Section					elaborate in th		d worksheet
Does the Health Plan impose a services that is more restrictiv substantially all Medical/Surgion	e than the cal benefit	e non-qua s?	ntitative tr	eatmen			
based on whether the treatme	or medical	appropri	ateness, o	r		×	
Prior Authorization and ongoi	•				YES	NO	
Concurrent review standards					□ YES □ YES	⊠ NO ⊠ NO	
Formulary design for prescrip	cion arugs	•				\boxtimes	

For plans with multiple networks tiers (such as preferred providers and participating providers), network tier designs Standards for provider admission to participate in a network, including reimbursement rates Methods for determining usual, customary, and reasonable charges 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 PES PES PES PES PES	NO ⊠ NO ⊠ NO ⊠ NO	
Restrictions on applicable provider billing codes	YES	NO	
restrictions on applicable provider bining codes	П	\boxtimes	
Standards for providing access to out-of-network providers	YES	NO	
The state of the s			
Fundaminana hannad on Grillian to consulate a second of two two and	YES	NO	
Exclusions based on failure to complete a course of treatment		\boxtimes	
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 Require	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						⊠
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, 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

Jenniku Awaluni		
	Assistant Vice President, Medicaid Programs	05/08/2024
Signature	Title	Date

(3) I understand and agree to the terms of the QI RFP/contract at Sections 6, Health Plan Reporting and Encounter Data Responsibilities and Section 14.21, Remedies of Non-Performance of Contract.

	Health	Plan Sub	omission 1	Informatio	on	_		
Health Plan Name: KAISER P l						t Date: 05/ 2	28/2024	
Reporting Period: 01/01/2023 – 12/31/2023								
If Resubmission, Date Submitted:								
Se	ction I: O	uantitat	ive Treatr	ment Limi	tations			
Does the Health Plan impose a in any classification that is mo applies to substantially all Med	any of the ore restrict	following ive than t	quantitativ	ve treatme ninant quar	nt limitatioi 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	<u> </u>						⊠ ⊠	
Prescription Drugs If any other than "NONE" wer below:	□ e selected	□ for a clas	□ sification,	□ please elab	□ porate in th	□ e embedded	⊠ d worksheet	
MH_SUD_QTL Calculations.xlsx								
Section	on II: Noi	n-Quanti	tative Tre	atment L	imitations			
Does the Health Plan impose a 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 medical	appropri	ateness, o	r 🗖	S	NO ⊠		
Prior Authorization and ongo	ing author	ization re	auiremente	y YF	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	□ YES □ YES □ 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 which benefits classification(s) the NQTL(s) are imposed on including the processes, strategies, evidentiary standards, and other factors.							

Section III: Financial Requirements

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

Classification	Deductibles	Co- payments	Co- insurance	Annual Out- of-Pocket Maximums	Lifetime Out- of-Pocket Maximums	None
Inpatient, In-Network						\boxtimes
Inpatient, Out-of-Network						⋈
Office Visits, In-Network						\boxtimes
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, **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.

Signature

Vice President, Marketing, Sales, Business Development & Community Health
Title

5/28/2024
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 Inflation applicable to "substantially all" M/S benefits in the classification/sub 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 Cassification 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 Cassification Predominant" quantitative treatment Limits that Apply to Each Benefit Cassification
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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	 	#DIV/0!				
	 	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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				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								
				#DIV/0!				
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				#DIV/0!				
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Total				#DIV/0!				
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	Total Subject to No Member Cost S	Sharing		#DIV/0!				
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				Projected Expense				
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			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			
					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!				+
•								
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				
				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 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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		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)*
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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!				
r. Outpatient, Out-of-Network: Other Outpatient items and Services								
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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:

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Health Plan Name: Ohana Hea		Plan Sut	omission 1	Intormatio		t Data: E / 3 :	1 /2024
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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	<u> </u>						⊠ ⊠
Emergency Prescription Drugs							\boxtimes
If any other than "NONE" were below: MH_SUD_QTL Calculations.xlsx	e selected	for a clas	sification,	please elab	oorate in th	e embedded	d worksheet
Section	on II: Noi	n-Ouanti	tative Tre	atment L	imitations		
Does the Health Plan impose a services that is more restrictive substantially all Medical/Surgi	any of the e than the	following e non-qua	Non-Quan	titative Tre	eatment Lim		
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 ⊠						
NQTL(s) are imposed on including the processes, strategies, eviden	If "YES" to any of the above, please describe in more detail below which benefits classification(s) the NQTL(s) are imposed on including the processes, strategies, evidentiary standards, and other factors.							
N/A								

Section III: Financial Requirements

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

<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						\boxtimes
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., 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.

4	Plan President & CEO	5/31/2024
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 Limits that Ea
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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 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 Cassification Emergency room facility fee (waived if admitted) Emergency room facility fee (waived if admitted) 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)
Emergency room facility fee (waived if admitted) List all Quantitative Treatment Limits that Apply to Each Benefit Pack Benefit Limits that Apply to Each Benefit Limits that A
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 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 Cassification Emergency room facility fee (waived if admitted) Emergency room facility fee (waived if admitted) 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 Two Tier Two
Tier Three Tier Three

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					Projected Expense			
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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	1	#DIV/0!				
	 	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 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	
		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	
			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				
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			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!				
	Total Subject to No Member Cost S	haring		#DIV/0!				
	Total Subject to No Member Cost							
				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			
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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				#DIV/0!				
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			Expense (Allowed)				Substantially All	
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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)*
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!				
r. Outpatient, Out-of-Network: Other Outpatient items and Services								
r. Outpatient, Out-of-Network: Other Outpatient items and Services				#DIV/0!				
r. Outpatient, Out-of-Network: Other Outpatient items and Services				#DIV/0! #DIV/0!				
Total				#DIV/0! #DIV/0! #DIV/0!				
	Total Subject to Copay \$			#DIV/0! #DIV/0! #DIV/0! #DIV/0!				
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	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! CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost			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! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #DIV/0! #OV 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! #OV 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! #OV 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)	Projected Expense		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! #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! Allowed) #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	Deductible 9	Deddelible	#DIV/0!		1000	
	Total Subject to Deductible			#DIV/0:			
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Please include any comments:

QUEST Integration Program

Mental Health/Substance Use Disorder Parity Report

Health Plan Submission Information							
Health Plan Name: UnitedHea	Ithcare C	Communi	ty Plan - I	Hawaii	Repor	t Date: 05/ 3	31/2024
Reporting Period: 01/01/202	23 - 12/3	1/2023					
If Resubmission,							
Date Submitted:							
Se	ction I: Q	uantitat	ive Treatr	nent Lin	nitations		
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 qu	antitative tre		
	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-							\boxtimes
Network	Ш	Ш					
Office Visits, Out-of-Network							\boxtimes
Other Outpatient, Out-of-							\boxtimes
Network	_					_	_
Emergency							\boxtimes
Prescription Drugs							
If any other than "NONE" were below: MH_SUD_QTL Calculations.xlsx	e selected	for a clas	sification,	please el	aborate in th	e embedded	d worksheet
Section	on II: No	n-Quanti	tative Tre	atment	Limitations		
Does the Health Plan impose a services that is more restrictive substantially all Medical/Surgion	e than the	e non-qua					
Medical management standar based on medical necessity, based on whether the treatm	or medical	appropri	ateness, o	-	′ES □	NO ⊠	
Prior Authorization and ongoi				Y	′ES □	NO ⊠	
					ŒS	NO	

 \boxtimes

Concurrent review standards

Formulary design for prescription drugs	YES □	NO ⊠	
For plans with multiple networks tiers (such as preferred	YES	NO	
providers and participating providers), network tier designs		\boxtimes	
Standards for provider admission to participate in a network,	YES	NO	
including reimbursement rates			
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 or "step therapy" protocols)			
Restrictions on applicable provider billing codes	YES	NO	
Restrictions on applicable provider billing codes		\boxtimes	
Standards for providing access to out-of-network providers	YES	NO	
Standards for providing access to out-of-network providers		\boxtimes	
Exclusions based on failure to complete a course of treatment	YES	NO	
		\boxtimes	
Restrictions based on geographic location, facility type, and	YES	NO	
provider specialty			
if "YES" to any of the above, please describe in more detail below NQTL(s) are imposed on including the processes, strategies, evide			

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						\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 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.

Kalari Rednagna	Health Plan CEO	05/31/2024
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 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 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
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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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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!				
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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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F. Outpatient, Out-of-Network: Other Outpatient Items and Services		amount	Expense		Copay \$	Coins %	(2/3 test)	(50% test)*
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F. Outpatient, Out-of-Network: Other Outpatient Items and Services	Total Subject to Coinsurance %		FY 2022 Projected	#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/O! CY 2022 Projected Expense (Allowed) Subject	Copay \$	Coins %		(SU% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	Total Subject to Coinsurance %		FY 2022 Projected 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! CY 2022 Projected Expense (Allowed) Subject to Deductible as %	Copay \$	Coins %	Substantially All	(50% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	Total Subject to Coinsurance %	haring	FY 2022 Projected 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! CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost	Copay \$	Coins %	Substantially All Deductible (2/3	(SU% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	Total Subject to Coinsurance % Total Subject to No Member Cost S		FY 2022 Projected 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)	Copay \$	Coins %	Substantially All	(SU% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	Total Subject to Coinsurance %	haring	FY 2022 Projected 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! CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost	Copay \$	Coins %	Substantially All Deductible (2/3	(SU% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	Total Subject to Coinsurance % Total Subject to No Member Cost S	haring	FY 2022 Projected 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)	Copay \$	Coins %	Substantially All Deductible (2/3	(SU% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	Total Subject to Coinsurance % Total Subject to No Member Cost S	haring	FY 2022 Projected 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)	Copay \$	Coins %	Substantially All Deductible (2/3	(SU% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	Total Subject to Coinsurance % Total Subject to No Member Cost S	haring	FY 2022 Projected 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)	Copay \$	Coins %	Substantially All Deductible (2/3	(SU% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	Total Subject to Coinsurance % Total Subject to No Member Cost S	haring	FY 2022 Projected 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)		Coins %	Substantially All Deductible (2/3	(SU% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	Total Subject to Coinsurance % Total Subject to No Member Cost S	haring	FY 2022 Projected 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		Substantially All Deductible (2/3	(SU% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	Total Subject to Coinsurance % Total Subject to No Member Cost S	haring	FY 2022 Projected 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	Substantially All Deductible (2/3	(SU% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	Total Subject to Coinsurance % Total Subject to No Member Cost S	haring Deductible \$	FY 2022 Projected 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 % of Projected	Projected Expense for this Benefit as	Substantially All Deductible (2/3 test)	(SU% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	Total Subject to Coinsurance % Total Subject to No Member Cost S	haring	FY 2022 Projected 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	Substantially All Deductible (2/3	
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	Total Subject to Coinsurance % Total Subject to No Member Cost S	haring Deductible \$	FY 2022 Projected 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!	Projected Expense for this Benefit as % of Projected Expense for all	Projected Expense for this Benefit as	Substantially All Deductible (2/3 test) Substantially All Cost Share Type	Predominant Level
F. Outpatient, Out-of-Network: Other Outpatient Items and Services	Total Subject to Coinsurance % Total Subject to No Member Cost S	haring Deductible \$ Copayment (\$) or	FY 2022 Projected 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! **CY 2022 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed) #DIV/0!	Projected Expense for this Benefit as % of Projected Expense for all	Projected Expense for this Benefit as % of Projected	Substantially All Deductible (2/3 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!			
				CV 2022			
				CY 2022			
			EV 2022 D	Projected Expense			
			FY 2022 Projected	(Allowed) Subject			
			Expense (Allowed)			Substantially All	
			Subject to	of Total Plan Cost		Deductible (2/3	
		Deductible \$	Deductible	(Allowed)		test)	
	Total Subject to Deductible			#DIV/0!			

Please include any comments: