MHPAEA QTL
Spreadsheet Instructions

1. Start in the "Covered Services" worksheet/tab.

2. In cells C2, C3, and C4, enter the Company, Plan Name/ID, and Plan Year.

3. In cell E4, complete the drop-down box based on whether the plan is for Small Group, Large Group, or Individual Market.

	C	D	E	F
Company:			*Small, Large or Individual Market?*	**Coverage type?** (HMO, PPO, EPO, POS, etc)
Plan Name/ID:				
Plan Year:			**Select**	
			Select	
			Individual	
			Small Group	
			Large Group	
Are outpatient services sub-classified into "office visit" and "other"?			Select	
Is this a tiered network?			Select	
				Please provide the page numbers and sec
If "yes", please select the number of tiers:			**Select (If Applicable)**	*found within both o*
	Medical/Surgical or MH/SUD	**List the Expected Claim Dollar Amount for Each Medical/Surgical Benefit**		**COC Cites:**
			Classification	

4. In cell F4, enter the coverage type (HMO, PPO, EPO, etc.).

E	F
Small, Large or Individual Market?	**Coverage type?** (HMO, PPO, EPO, POS, etc)
Select	
Select Option From Drop Down Boxes Below	
Select	
Select	
Select (If Applicable)	*Please provide the page numbers and sec* *found within both o*

5. Complete the drop-down boxes in cells E6, E7, and E8 based on whether the plan involves outpatient sub-classifications for "office visit" and "other" and whether the plan involves a tiered network:

    See *45 CFR 146.136 (c)(3)(iii)(C) and 45 CFR 146.136 (c)(3)(iii)(B)*.

6. List all Medical/Surgical and MH/SUD covered services in column B.

7. FOR MULTI-TIERED NETWORKS ONLY:

Please include a separate service line for services separated by tier, e.g. preferred specialist on one-line, non-preferred specialist on a separate line.

	Covered Services	Medical/Surgical or MH/SUD	List the Expected Claim Dollar Amount for Each Medical/Surgical Benefit	Classification
	Company:			*Small, Large or Individual Market?*
	Plan Name/ID:			Select
	Plan Year:			*Select Option From Drop Down Boxes Below*
	Are outpatient services sub-classified into "office visit" and "other"?	No		
	Is this a tiered network?	Yes		
	If "yes", please select the number of tiers:			2
10	Covered Service A - Tier 1	Med/Surg	$10,000	InPt, IN
11	Covered Service A - Tier 2	Med/Surg	$10,000	InPt, IN
12	Covered Service B - Tier 1	MH/SUD		InPt, IN
13	Covered Service B - Tier 2	MH/SUD		InPt, IN
14	Covered Service C - Tier 1	Med/Surg	$20,000	InPt, IN
15	Covered Service C - Tier 2	Med/Surg	$20,000	InPt, IN
16	Covered Service D - Tier 1	Med/Surg	$30,000	InPt, IN
17	Covered Service D - Tier 2	Med/Surg	$30,000	InPt, IN

Sheet tabs: **Covered Services** | INPATIENT, IN-NETWORK | INPATIENT, OUT-OF-NETWORK | OUTPATIENT, OUT-OF-NETWORK | OUTPATIENT, IN-NETWORK

8. Select the drop down in column C to indicate if the covered service was for a Medical/Surgical or MH/SUD diagnosis/condition.

	Covered Services	Medical/Surgical or MH/SUD	List the Expected Claim Dollar Amount for Each Medical/Surgical Benefit	Classification
	Company:			*Small, Large or Individual Market?*
	Plan Name/ID:			
	Plan Year:			Select
				Select Option From Drop Down Boxes Below
	Are outpatient services sub-classified into "office visit" and "other"?	No		
	Is this a tiered network?	No		
	If "yes", please select the number of tiers:			Select (If Applicable)
Covered Service A		Med/Surg	$10,000	InPt, IN
Covered Service B		MH/SUD		InPt, IN
Covered Service C		Med/Surg	$20,000	InPt, IN
Covered Service D		Med/Surg	$30,000	InPt, IN
		Med/Surg		
		MH/SUD		

Covered Services | INPATIENT, IN-NETWORK | INPATIENT, OUT-OF-NETWORK | OUTPATIENT, OUT-OF-NETWORK | OUTPATIENT, IN-NETWORK

9. List the expected claim dollar amount in column D. This is for benefits related to Medical/Surgical diagnoses/conditions only.

	Covered Services	Medical/Surgical or MH/SUD	List the Expected Claim Dollar Amount for Each Medical/Surgical Benefit	Classification
	Company:			Small, Large or Individual Market?
	Plan Name/ID:			
	Plan Year:			Select
				Select Option From Drop Down Boxes Below
	Are outpatient services sub-classified into "office visit" and "other"?		No	
	Is this a tiered network?		Yes	
	If "yes", please select the number of tiers:			2
10	Covered Service A - Tier 1	Med/Surg	$10,000	InPt, IN
11	Covered Service A - Tier 2	Med/Surg	$10,000	InPt, IN
12	Covered Service B - Tier 1	MH/SUD		InPt, IN
13	Covered Service B - Tier 2	MH/SUD		InPt, IN
14	Covered Service C - Tier 1	Med/Surg	$20,000	InPt, IN
15	Covered Service C - Tier 2	Med/Surg	$20,000	InPt, IN
16	Covered Service D - Tier 1	Med/Surg	$30,000	InPt, IN
17	Covered Service D - Tier 2	Med/Surg	$30,000	InPt, IN

Covered Services | INPATIENT, IN-NETWORK | INPATIENT, OUT-OF-NETWORK | OUTPATIENT, OUT-OF-NETWORK | OUTPATIENT, IN-NETWORK

10. Select the classification from the drop-down box in column E.

	Covered Services	Medical/Surgical or MH/SUD	List the Expected Claim Dollar Amount for Each Medical/Surgical Benefit	Classification
	Company:			Small, Large or Individual Market?
	Plan Name/ID:			
	Plan Year:			Select
				Select Option From Drop Down Boxes Below
	Are outpatient services sub-classified into "office visit" and "other"?		No	
	Is this a tiered network?		No	
	If "yes", please select the number of tiers:			Select (If applicable)
10	Covered Service A	Med/Surg	$10,000	InPt, IN
11	Covered Service B	MH/SUD		InPt, IN
12	Covered Service C	Med/Surg	$20,000	InPt, IN
13	Covered Service D	Med/Surg	$30,000	InPt, IN

11. Reference COC and SOB page numbers and sections where the corresponding covered services are found in columns F and G.

12. Once the information has been entered in the "Covered Services" worksheet/tab, the other worksheets/tabs for each classification will auto-populate with the covered services and expected claim dollar amounts.

13. Complete Column 1 through Column 6 in each of the applicable classification worksheets/tabs.

14. In the worksheet/tab for each classification, Cell C66 provides instructions to interpret the results of the substantially all test. Cells D67 through H67 will tell you if the substantially all threshold has been met.

	A	B	C	D
		Plan:		
2				
3		Service Categories within the Classification of:	COLUMN 1	COLUMN 2
4		INPATIENT, IN-NETWORK	EXPECTED CLAIM DOLLAR AMOUNT	COPAY APPLICATION
5		INSTRUCTIONS: All MEDICAL/SURGICAL service categories provided within this classification are listed below.	INSTRUCTIONS: List Claim Expected Allowed Dollar Amounts (Annual) for each service category listed.	INSTRUCTIONS: Is a copay applied to this service category? If yes, list the copay dollar amount applied to the Service Category. If no, put a "N" for every Service Category where there is no copay application.
6		Covered Service A	$10,000.00	$20.00
7		Covered Service C	$20,000.00	$30.00
8		Covered Service D	$30,000.00	$20.00
62				
63		AGGREGATE TOTAL OF MEDICAL AND SURGICAL BENEFITS EXPECTED CLAIM DOLLAR AMOUNT WITHIN THIS CLASSIFICATION	$60,000.00	For every row in COLUMN 2 with an amount listed, ADD the expected claim dollar amounts (COLUMN 1) for the service category listed within that row.
64			AGGREGATE TOTALS	$60,000.00
65				DIVIDE the AGGREGATE TOTAL of all rows with COPAY listed (COLUMN 2), indicating copay is applied, by the AGGREGATE TOTAL of COLUMN 1.
66			If the amount listed within this row is not greater than or equal to 2/3, or 66.67%, the QTL cannot be applied for this plan design.	100.00%
67				Threshold Met
68		PREDOMINANT TEST- 45 CFR 146.136 (c)(3)(i)(B): Predominant - If a type of financial requirement or quantitative treatment limitation applies to at (c)(3)(i)(A) of this section, the level of the financial requirement or quantitative treatment limitation that is considered the predominant level of that type in a cl in that classification subject to the financial requirement or quantitative treatment limitation.		
				PERCENT (%) OF CLASSIFICATION

| Covered Services | INPATIENT, IN-NETWORK | INPATIENT, OUT-OF-NETWORK | OUTPATIENT, OUT-OF-NETWORK |

15. Starting in row 68, columns E and F provide instructions to interpret the results of the predominant test for the level of financial requirement/QTL. A cell in column F will auto-populate with "Predominant Level Met" at the level which passes the predominant test. For example, the image below shows the predominant level being met at the $20.00 copay level.

68	**PREDOMINANT TEST-** 45 CFR 146.136 (c)(3)(i)(B): Predominant - If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification as determined under paragraph (c)(3)(i)(A) of this section, the level of the financial requirement or quantitative treatment limitation that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.				
69	**LEVELS OF COPAYS, LOWEST TO HIGHEST**	**TOTAL EXPECTED CLAIM DOLLARS APPLIED AT THIS COPAY LEVEL**	**PERCENT (%) OF CLASSIFICATION APPLIED AT THIS LEVEL [LEVEL $ AMOUNT DIVIDED BY TOTAL A $]**	**START HERE, MOVE DOWNWARD ONE LEVEL UNTIL AGGREGATE TOTAL OF LEVELS REACH OVER 50.01%; STOP. THAT IS THE PREDOMINANT LEVEL, AND THE HIGHEST LEVEL THAT CAN BE APPLIED TO MH/SUD BENEFITS.**	*NOTE: If any of the levels individually reach over 50.01%, that level may be applied to MH/SUD benefits. Otherwise, use chart to determine appropriate level.*
70	$20.00	$50,000.00	83.33%	83.33%	**Predominant Level Met**
71	$30.00	$10,000.00	16.67%	100.00%	
72				0.00%	
73				0.00%	
74				0.00%	
75				0.00%	
76	*TOTAL A:*	$ 60,000.00			
77					
78	**LEVELS OF COINSURANCE, LOWEST TO HIGHEST**	**TOTAL EXPECTED CLAIM DOLLARS APPLIED AT THIS COINSURANCE LEVEL**	**PERCENT (%) OF CLASSIFICATION APPLIED AT THIS LEVEL [LEVEL $ AMOUNT DIVIDED BY TOTAL B $]**	**START HERE, MOVE DOWNWARD ONE LEVEL UNTIL AGGREGATE TOTAL OF LEVELS REACH OVER 50.01%; STOP. THAT IS THE PREDOMINANT LEVEL, AND THE HIGHEST LEVEL THAT CAN BE APPLIED TO MH/SUD BENEFITS.**	*NOTE: If any of the levels individually reach over 50.01%, that level may be applied to MH/SUD benefits. Otherwise, use chart to determine appropriate level.*

Covered Services | **INPATIENT, IN-NETWORK** | INPATIENT, OUT-OF-NETWORK | OUTPATIENT, OUT-OF-NETWORK | OUTPATIENT, IN-NETWORK