Figure: 28 TAC §21.2408(c)(4)

Example 1

Facts. For inpatient, out-of-network medical/surgical benefits, a health benefit plan imposes five levels of coinsurance. Using a reasonable method, the plan projects its payments for the upcoming year as follows:

Coinsurance rate	0%	10%	15%	20%	30%	Total
Projected payments	$200x	$100x	$450x	$100x	$150x	$1,000x
Percent of total plan costs	20%	10%	45%	10%	15%	
Percent subject to coinsurance level	N/A	12.5% (100x/800x)	56.25% (450x/800x)	12.5% (100x/800x)	18.75% (150x/800x)	

The plan projects plan costs of $800x to be subject to coinsurance ($100x + $450x + $100x + $150x = $800x). Thus, 80% ($800x/$1,000x) of the benefits are projected to be subject to coinsurance, and 56.25% of the benefits subject to coinsurance are projected to be subject to the 15% coinsurance level.

Conclusion. In this example, the two-thirds threshold of the substantially all standard is met for coinsurance because 80% of all inpatient, out-of-network medical/surgical benefits are subject to coinsurance. Moreover, the 15% coinsurance is the predominant level because it is applicable to more than one-half of inpatient, out-of-network medical/surgical benefits subject to the coinsurance requirement. The plan may not impose any level of coinsurance with respect to inpatient, out-of-network mental health or substance use disorder benefits that is more restrictive than the 15% level of coinsurance.

Example 2

Facts. For outpatient, in-network medical/surgical benefits, a plan imposes five different copayment levels. Using a reasonable method, the plan projects payments for the upcoming year as follows:

Copayment amount	$0	$10	$15	$20	$50	Total
Projected payments	$200x	$200x	$200x	$300x	$100x	$1,000x
Percent of total plan costs	20%	20%	20%	30%	10%	
Percent subject to copayments	N/A	25% (200x/800x)	25% (200x/800x)	37.5% (300x/800x)	12.5% (100x/800x)	

The plan projects plan costs of $800x to be subject to copayments ($200x + $200x + $300x + $100x = $800x). Thus, 80% ($800x/$1,000x) of the benefits are projected to be subject to a copayment.

Conclusion. In this example, the two-thirds threshold of the substantially all standard is met for copayments because 80% of all outpatient, in-network medical/surgical benefits are subject to a copayment. Moreover, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to a copayment (for the $10 copayment, 25%; for the $15 copayment, 25%; for the $20 copayment, 37.5%; and for the $50 copayment, 12.5%). The plan can combine any levels of copayment, including the highest levels, to determine the predominant level that can be applied to mental health or substance use disorder benefits. If the plan combines the highest levels of copayment, the combined projected payments for the two highest copayment levels, the $50 copayment and the $20 copayment, are not more than one-half of the outpatient, in-network medical/surgical benefits subject to a copayment because they are exactly one-half ($300x + $100x = $400x; $400x/$800x = 50%). The combined projected payments for the three highest copayment levels--the $50 copayment, the $20 copayment, and the $15 copayment--are more than one-half of the outpatient, in-network medical/surgical benefits subject to the copayments ($100x + $300x + $200x = $600x; $600x/$800x = 75%). Thus, the plan may not impose any copayment on outpatient, in-network mental health or substance use disorder benefits that is more restrictive than the least restrictive copayment in the combination, the $15 copayment.

Example 3

Facts. A plan imposes a $250 deductible on all medical/surgical benefits for self-only coverage and a $500 deductible on all medical/surgical benefits for family coverage. The plan has no network of providers. For all medical/surgical benefits, the plan imposes a coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

Conclusion. In this example, because the plan has no network of providers, all benefits are provided out-of-network. Because self-only and family coverage are subject to different deductibles, whether the deductible applies to substantially all medical/surgical benefits is determined separately for self-only medical/surgical benefits and family medical/surgical benefits. Because the coinsurance is applied without regard to coverage units, the predominant coinsurance that applies to substantially all medical/surgical benefits is determined without regard to coverage units.

Example 4

Facts. A plan applies the following financial requirements for prescription drug benefits. The requirements are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits. Moreover, the process for certifying a particular drug as "generic," "preferred brand name," "non-preferred brand name," or "specialty" complies with the requirements of §21.2409(a) of this title (relating to Requirements for Nonquantitative Treatment Limitations).

Tier level	Tier 1	Tier 2	Tier 3	Tier 4

Tier description	Generic drugs	Preferred brand name drugs	Non-preferred brand name drugs (which may have Tier 1 or Tier 2 alternatives)	Specialty drugs
Percent paid by plan	90%	80%	60%	50%

Conclusion. In this example, the financial requirements that apply to prescription drug benefits are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits; the process for certifying drugs in different tiers complies with §21.2409(a) of this title; and the bases for establishing different levels or types of financial requirements are reasonable. The financial requirements applied to prescription drug benefits do not violate the parity requirements of this subsection.

Example 5

Facts. A plan has two tiers of network of providers: A preferred provider tier and a participating provider tier. Providers are placed in either the preferred tier or participating tier based on reasonable factors determined in accordance with the requirements in §21.2409(a) of this title, such as accreditation, quality and performance measures (including customer feedback), and relative reimbursement rates. Furthermore, provider tier placement is determined without regard to whether a provider specializes in the treatment of mental health conditions or substance use disorders, or medical/surgical conditions. The plan divides the in-network classifications into two subclassifications (in-network/preferred and in-network/participating). The plan does not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in either of these subclassifications that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in each subclassification.

Conclusion. In this example, the division of in-network benefits into subclassifications that reflect the preferred and participating provider tiers does not violate the parity requirements of this subsection.

Example 6

Facts. With respect to outpatient, in-network benefits, a plan imposes a $25 copayment for office visits and a 20% coinsurance requirement for outpatient surgery. The plan divides the outpatient, in-network classification into two subclassifications (in-network office visits and all other outpatient, in-network items and services). The plan does not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in either of these subclassifications that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in each subclassification.

Conclusion. In this example, the division of outpatient, in-network benefits into subclassifications for office visits and all other outpatient, in-network items and services does not violate the parity requirements of this subsection.

Example 7

Facts. Same facts as Example 6, but for purposes of determining parity, the plan divides the outpatient, in-network classification into outpatient, in-network generalists and outpatient, in-network specialists.

Conclusion. In this example, the division of outpatient, in-network benefits into any subclassifications other than office visits and all other outpatient items and services violates the requirements of paragraph (3)(C) of this subsection.