

Plan Name: \_\_\_\_\_

**SCHEDULE F  
UTILIZATION AND UNIT COST JUSTIFICATION**

Rate Period: \_\_\_\_\_

**Please provide utilization and unit cost justification on attached sheets for the major categories of service that may include all or most of the listed services below. The justification should include the data sources used and the basis for any actuarial adjustments, such as the impact of managed care, case mix assumptions, inflation factors, etc.**

- |                                    |  |
|------------------------------------|--|
| 1. Hospital Inpatient Care:        | 8. Outpatient Drug & Alcohol Treatment |
| a. Medical Surgical                | 9. Dental                              |
| b. Mental Health & Substance Abuse | 10. Home Health Care                   |
| c. Newborn Births                  | 11. Transportation                     |
| 2. Primary Care                    | 12. Diagnostic Tests, Lab & X-Ray      |
| 3. Physician Specialty Services    | 13. Family Planning                    |
| 4. Ambulatory Surgery              | 14. Vision Care Inc. Eyeglasses        |
| 5. Other Professional Services     |  |
| 6. Emergency Room                  |  |
| 7. Outpatient Mental Health        |  |