UnitedHealthcare
Golden Rule Insurance Co.

Mental Health Parity and Addiction Equity Act Disclosure
Out-of-Network Provider Reimbursement Frequently Asked Questions

This document includes standard responses to questions related to Mental Health Parity (MHP) and Non-Quantitative Treatment Limitations (NQTL). This communication is not intended, nor should it be construed, as legal advice. Federal and state laws and regulations are subject to change. The content provided is for informational purposes only and does not constitute medical advice. Decisions about medical care should be made by the doctor and patient. Please note, your plan documents govern all benefit determinations and in the case of conflict with this document your plan controls. Always refer to the plan documents for specific benefit coverage and limitations or call the toll-free member phone number on the ID card.

The following explanations apply to both Medical/Surgical benefits and Mental Health/Substance Use Disorder benefits unless stated otherwise.

What does it mean if something is Out-of-Network?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
Out-of-Network care is health care received from a provider that does not have a contract with the health insurance plan or provider network.	

How does my health plan decide how to pay Out-of-Network Provider claims?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
Your health plan applies one or more of the following approaches to pay Out-of-Network claims: 1. A Usual, Customary, and Reasonable (UCR) standard; 2. A Maximum Non-Network Reimbursement Program (MNRP) methodology; 3. The health plan may attempt to negotiate a discount to the Out-of-Network Provider's billed charges. Review your plan documents for the approach that applies to your Out-of-Network claims.	

How does my health plan decide which standard applies?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
Your health plan may consider one or more of the following factors in determining which standard to apply: • Regional market dynamics • The nature of the service • CMS (Medicare and Medicaid) standards and fee schedules • The median rate paid to In-Network Providers in that market	

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How does my health plan analyze whether the payments to Out-of-Network Providers meet parity requirements?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
Your health plan completes claim quality reviews on a regular basis. The review is for financial and procedural accuracy across a large number of claims. If the health plan finds any errors, it takes steps to correct them.	

How does my health plan decide what to pay when I visit an Out-of-Network Provider in an emergency?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
The health plan may try to negotiate a discount to the Out-of-Network Provider's billed charges.	

Are there any restrictions on what types of claims an Out-of-Network Provider can submit?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
Out-of-Network Providers can only bill for services within their scope of licensure. Also, providers have to follow national coding and billing guidelines.	