UnitedHealthcare
Golden Rule Insurance Co.

Mental Health Parity and Addiction Equity Act Disclosure
In-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 In-Network?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
In-Network care is health care received from a provider that has a contract with the health insurance plan or provider network. In-Network care usually comes with a discount – a reduction in the provider's actual charge for the service.	

How does my health plan decide what to pay In-Network Providers?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
The following factors and sources are used to determine In-Network reimbursements:	

Individual or Group Provider:

Factor
Provider type and/or specialty including provider licensure, board certification, education, and training

Source
- Provider application

Factor
Services and/or procedures provided

Source
- Most current version of industry standard code sets, e.g., CPT, HCPCS, etc.
- CMS RBRVS
- CMS RVU for a given service or procedure
- FairHealth Medicare Gap Fill Database
- CMS Clinical Lab Fee Schedule
- CMS Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule
- CMS Average Sales Pricing (ASP) and RJ Health ASP (for drug pricing)
- CMS Ambulance Fee Schedule
- Optum RBRVS (for codes not priced by CMS)
- CMS Carrier Priced Fees (for codes referred to the local carrier for pricing)

Factor
Market dynamics

Source
- Market research
- Provider directory; network adequacy reports, member reported access data
- Provider claims data
- State and internal claims data

Does the Plan treat Mental Health/Substance Use Disorder In-Network Provider Reimbursement differently than Medical/Surgical In-Network Provider Reimbursement "as written" in policy?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
No. A comparison was conducted, and the results found that the process is equal. The same factors, standards, and sources of information are used to decide the mental health/substance use disorder in-network provider reimbursements and are used no more strict than the medical/surgical in-network provider reimbursement "as written" in policy.	

Are Mental Health/Substance Use Disorder decisions about In-Network Provider Reimbursement made any differently than Medical/Surgical decisions in practice ("in-operation")?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
No. Comparisons are conducted to make sure that the process is equal as used to determine mental health/substance use disorder facility-based and individual provider In-Network reimbursement "in operation" as is used to determine medical/surgical facility- based and individual provider in-network reimbursement "in operation." The Plan uses a standard process outlined by UHC, to make sure that the rules of the Mental Health Parity and Addiction Equity Act (MHPAEA) are followed, and if there are any errors we have steps to fix it.	