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 treated as legal advice. Federal and state laws and regulations are subject to change. The content provided is for informational purposes only and i is not 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 your 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 facility or provider who does not have a contract with your Plan or provider network.	

How does your Plan decide how to pay out-of-network provider claims?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
Your Plan uses one or more of the following methods to pay out-of-network claims: • Federal and state regulations • A Maximum Non-Network Reimbursement Program (MNRP) methodology • Extended Non-Network Reimbursement Program (ENRP) methodology, as applicable under state or federal law • Shared savings - Your plan may attempt to negotiate a discount to the out-of-network provider's billed charges.	

How does your Plan decide which standard applies?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
Your Plan considers one or more of the following sources in determining which standard to apply: • Federal and state regulations • Regional market dynamics • Procedure or Service Type • Data iSight tool • The type of service • Centers for Medicare and Medicaid Services (CMS) reimbursement guidelines • The average rate paid to in-network providers in your area.	

Developed: February 2022 Last Review: 08/23, 11/23, 11/24 Next Review: November 2025

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

How does your 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
Your Plan uses applicable state and federal law to pay out-of-network emergency claims.	

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 charge for services they are licensed to do. They must follow national coding and billing guidelines.	

When your Plan determines out-of-network reimbursement, does your Plan treat mental health/substance use disorder benefits differently than medical/surgical benefits "as written?" Are decisions about out-of-network reimbursement for mental health/substance use disorder benefits made any differently than decisions about out-of-network reimbursement for medical/surgical benefits in practice ("in operation")?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
No. Your Plan found that the rules and processes for paying out-of-network claims are the same for both mental health/substance use disorder benefits and medical/surgical benefits. This means the rules are not stricter for mental health/substance use disorder benefits "as written" and "in operation."	

Developed: February 2022 Last Review: 08/23, 11/23, 11/24 Next Review: November 2025