CONSUMER GUIDE TO DISCLOSURE RIGHTS: MAKING THE MOST OF YOUR MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

ACKNOWLEDGMENTS
This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS), in consultation with the Employee Benefits Security Administration (EBSA), U.S. Department of Labor (DOL), by Truven Health Analytics, an IBM Company, under SAMHSA IDIQ Prime Contract #HHSS283200700029I, Task Order #HHSS28342002T with SAMHSA, HHS. Mariel Lifshitz served as the Government Project Officer.

DISCLAIMER
This document is not meant to be considered legal advice and is not representative of the official position of the U.S. Departments of Labor, Health and Human Services, and the Treasury. This document is intended to give a basic understanding of certain requirements related to MHPAEA and claims and appeals under the Public Health Service Act (PHSA), the Employee Retirement Income Security Act (ERISA), and the Internal Revenue Code (the Code). The statute, recent regulations, and other guidance issued by the Departments should be consulted.

SAMHSA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SAMHSA cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ELECTRONIC ACCESS AND COPIES OF PUBLICATION
This publication may be downloaded on the Substance Abuse and Mental Health Services Administration website at http://store.samhsa.gov or the U.S. Department of Labor, Employee Benefits Security Administration website at www.dol.gov/agencies/ebsa.

RECOMMENDED CITATION
Substance Abuse and Mental Health Services Administration. Consumer Guide to Disclosure Rights: Making the Most of your Mental Health and Substance Use Disorder Benefits. HHS Publication No. (SMA)16-4992, Rockville, MD: Substance Abuse and Mental Health Services Administration; 2016.

ORIGINATING OFFICES
Office of Policy, Planning, and Innovation, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, 18E85C, Rockville, MD 20852. U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Washington, DC 20210.

HHS Publication: No. (SMA)16-4992

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration
U.S. Department of Labor, Employee Benefits Security Administration

CONSUMER GUIDE TO DISCLOSURE RIGHTS: MAKING THE MOST OF YOUR MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

One of the many important components of both the Affordable Care Act and the Mental Health Parity and Addiction Equity Act is to ensure that health plans treat mental health and substance use disorders the same way that they treat other health issues. The Mental Health Parity and Addiction Equity Act requires group health plans and insurers that offer mental health and substance use disorder benefits to provide coverage that is comparable to their coverage for general medical and surgical (medical/surgical) care. Limitations on mental health and substance use disorder benefits (such as copayments, visit limits, and preauthorization requirements) must generally be comparable with those for medical/surgical benefits.[i]

The parity law, also known as the Mental Health Parity and Addiction Equity Act, and other laws require transparency and disclosure of information. This publication provides a general explanation of the various federal disclosure laws[ii] affecting private-sector, employer-sponsored group health plans and health insurers. The following table provides information about important documents that may be available to you under various federal laws. This resource can help you better understand what information to request to help determine which mental health or substance use disorder benefits will be paid for by your health plan, what information your plan relies on to approve or deny benefits, and what information is available to help you determine if your plan's mental health and substance use disorder benefits are offered at parity. In general, employees and former employees who are eligible to enroll in the plan or who may become eligible to enroll in the plan (referred to as "participants"), their covered family members (referred to as "beneficiaries"), and an authorized representative (such as an appropriately authorized family member or medical provider acting on behalf of a participant or beneficiary) are entitled to receive this information.

Under the Mental Health Parity and Addiction Equity Act and other Federal laws, you are entitled to many different documents related to your mental health and substance use disorder and medical/surgical benefits. These scenarios offer suggestions of certain documents you may want to request, but you have a legal right under the Mental Health Parity and Addiction Equity Act and other federal laws to request additional information, if you believe it will be helpful. While this document will assist you in understanding your rights to information that may be helpful, it is not a comprehensive description of these laws and should not be considered legal advice. For other types of coverage, such as individual market coverage, you should check with your state department of insurance for the most accurate information regarding your disclosure rights. Also, your state may have other laws that affect your behavioral health coverage. The National Association of Insurance Commissioners at http://naic.org/state_web_map.htm provides access to state websites with information on particular state health insurance laws.

A glossary defining common health plan and legal terms is included at the end of this publication. These terms and definitions are intended to help you understand this document and may be different from the terms and definitions used by your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in that case, the policy or plan governs.

Common scenarios that may affect your mental health and substance use disorder benefits

**Important note: You may fit into more than one scenario at a time. Review all the scenarios to see all the information that is relevant for you.

SCENARIO	WHERE TO START? SUGGESTIONS FOR INFORMATION YOU HAVE A RIGHT TO THAT CAN HELP	WHEN CAN I GET THESE DOCUMENTS?
1. I am thinking about changing health coverage and would like to understand the benefits available under my coverage options (known as a benefits overview).	***A Summary of Benefits and Coverage*** The Summary of Benefits and Coverage provides a brief description of benefits and coverage under a plan, including coverage of mental health and substance use disorder benefits. The Summary of Benefits and Coverage includes: 1. A description of the health coverage (including cost sharing, such as deductibles, co-insurance, and copays); 2. The exceptions or changes to the benefit plan, and limitations on coverage; and 3. Coverage examples. If you have more questions after reviewing your Summary of Benefits and Coverage, request a Summary Plan Description, described below.	Summaries of Benefits and Coverage are distributed with initial enrollment materials and annually. They also must be provided upon request, generally within seven business days. If a plan makes a significant mid-year coverage change that would affect the contents of the Summary of Benefits and Coverage, it must send out a notice at least 60 days before the change takes effect.

SCENARIO	WHERE TO START? SUGGESTIONS FOR INFORMATION YOU HAVE A RIGHT TO THAT CAN HELP	WHEN CAN I GET THESE DOCUMENTS?
2. I am not sure what mental health and substance use disorder treatments my plan will pay for, or if there are limits or exclusions on these benefits.	***Summary Plan Description and any Summaries of Material Modifications***. Summary Plan Descriptions are important disclosure documents prepared by the plan that describe, in understandable terms, the rights, benefits, and responsibilities of participants and beneficiaries. The Summary Plan Description must include important information regarding the plan, such as information on how the plan works, eligibility requirements, what benefits the plan provides, and how those benefits may be obtained, including how the plan covers mental health and substance use disorder benefits. The plan's claims procedure, including applicable time frames, must also be included in the Summary Plan Description, or in a separate document distributed with the Summary Plan Description. Summaries of Material Modifications describe important changes made to the plan and the Summary Plan Description.	Summary Plan Descriptions are generally distributed within 90 days after the date a participant first becomes covered by the plan. They also must be provided upon written request, generally within 30 days. Summaries of Material Modifications that describe an important reduction in covered services or benefits must generally be provided automatically within 60 days of the change taking effect.

SCENARIO	WHERE TO START? SUGGESTIONS FOR INFORMATION YOU HAVE A RIGHT TO THAT CAN HELP	WHEN CAN I GET THESE DOCUMENTS?
3. My plan says it will cover medically necessary treatment. How do I know what the plan considers to be medically necessary?	***Medical necessity criteria for the treatment.*** These documents provide rules for determining medical necessity for specific mental health and substance use disorder treatment, including criteria that determine whether a person qualifies for a specific mental health and substance use disorder benefit and how the plan developed these medical necessity criteria. A person can request medical necessity criteria for medical/surgical benefits, and information to verify the plan applies the criteria in a comparable way to the medical necessity criteria for mental health and substance use disorder benefits. For example, you could request the medical necessity criteria for inpatient treatment of eating disorders. In addition to the medical necessity criteria, the plan must identify what information or processes were used to develop the medical necessity criteria for both medical/surgical and mental health and substance use disorder benefits. For instance, if a plan claims that its medical necessity criteria is based primarily on a specific established treatment guideline, such as the American Psychiatric Association's latest Practice Guideline for the Treatment of Patients with Eating Disorders and Guideline Watch, the plan must disclose these guidelines. Similarly, if a plan claims that its medical necessity criteria for treatment of opioid use disorder is based primarily on a specific established treatment guideline, such as the criteria put forth by the American Society of Addiction Medicine for Treatment of Substance Use Disorders, the plan must disclose these guidelines.	Promptly, but generally not later than 30 days after your request. Shorter time limits apply in the case of urgent care claims.

SCENARIO	WHERE TO START? SUGGESTIONS FOR INFORMATION THAT YOU HAVE A RIGHT TO THAT CAN HELP	WHEN CAN I GET THESE DOCUMENTS?
3. (Continued)	The plan also must disclose: 1. Whether the plan departed from the guidelines used to develop the medical necessity criteria; 2. The standards it uses to decide when to depart from these guidelines; 3. Whether the plan uses similar information and processes to develop medical necessity criteria for medical/surgical benefits (including information on whether treatment guidelines generally are used to determine medical necessity for medical/surgical care and which guidelines it uses); and 4. The criteria it uses to decide when to depart from the medical/surgical guidelines. This information also may include criteria related to medical appropriateness, or whether the treatment is experimental or investigative. This may be the basis for various medical management standards, including standards related to when your health care services have to be reviewed in order for an ongoing course of treatment to continue to be covered (concurrent review). Note: Medical providers who contract with the plan to provide services will still be able to request the plan's medical necessity criteria under the Mental Health Parity and Addiction Equity Act, regardless of whether they are acting as an authorized representative.	Promptly, but generally not later than 30 days after your request. Shorter time limits apply in the case of urgent care claims.

SCENARIO	WHERE TO START? SUGGESTIONS FOR INFORMATION THAT YOU HAVE A RIGHT TO THAT CAN HELP	WHEN CAN I GET THESE DOCUMENTS?
4. I have a question about the amount my plan pays to an out-of-network provider for mental health and substance use disorder benefits. My plan appears to pay less than what they pay for my out-of-network medical/surgical benefits. I am concerned I will receive a large bill.	***Plan methods for determining what are called "usual, customary, and reasonable charges" or other methods for determining payments to out-of-network providers.*** You can request information on what a plan pays to out-of-network providers and whether these amounts are based on sources such as Medicare rates; a schedule of "usual, customary and reasonable rates" developed by a third party or the plan's own, proprietary fee schedule. You can request information about: 1. What percentage of these rates or fees the plan pays; 2. Whether the plan relies on the same rate or fee schedule and percentage for out-of-network medical/surgical benefits; 3. Any modifications to the rate or fees when it comes to specific types of mental health and substance use disorder providers (such as psychologists or social workers); and 4. Whether any similar modifications are imposed on specific types of medical/surgical benefits for specific providers and how they are determined. If the plan relies on its own fee schedule, you may request the studies, schedules or similar documents that provide the basis for the payments to providers. A plan or insurer cannot refuse to provide this information by claiming it is proprietary.	Promptly, but generally not later than 30 days after your request. Shorter time limits apply in the case of urgent care claims

SCENARIO	WHERE TO START? SUGGESTIONS FOR INFORMATION THAT YOU HAVE A RIGHT TO THAT CAN HELP	WHEN CAN I GET THESE DOCUMENTS?
5. I would like to know what mental health and substance use disorder benefits **and** what medical/surgical benefits are subject to preauthorization. My plan says they are all based on clinical utilization review guidelines.	***Utilization review criteria related to both mental health and substance use disorder and medical/surgical benefits provided under the plan or coverage.*** You can request the plan's specific utilization review criteria, and other materials, which could include: 1. Standards developed by an outside organization. Many health plans use third-party standards to determine the level of care required by an individual plan participant; 2. Criteria which may be developed by the issuer or third-party administrator, for both mental health and substance use disorder benefits and medical/surgical benefits; 3. Information on how the plan determines when it is appropriate to depart from the criteria developed by an outside organization for both medical/surgical and mental health and substance use disorder benefits (if the plan departs from these criteria). You can also request any analyses the plan has performed to verify whether the plan complies with the Mental Health Parity and Addiction Equity Act.	Promptly, but generally not later than 30 days after your request. Shorter time limits apply in the case of urgent care claims.

SCENARIO	WHERE TO START? SUGGESTIONS FOR INFORMATION THAT YOU HAVE A RIGHT TO THAT CAN HELP	WHEN CAN I GET THESE DOCUMENTS?
6. My plan will not authorize a treatment recommended by my health provider (in this case, a specific medication that was prescribed). If treatment is not authorized, my plan will not pay or will reduce payment.	***The plan's requirement for preauthorization, including utilization review standards, and its medical criteria or "other evidentiary standards, procedures, or strategies" used to develop its utilization review standards.*** To determine whether mental health and substance use disorder and medical/surgical benefits are being provided comparably, you may request information regarding the basis for determining what mental health and substance use disorder and medical/surgical benefits are subject to utilization review. This includes information about the medical guidelines, costs, or other factors supporting the basis for the application of the utilization review standard. This may include the following: 1. Medical necessity criteria (see scenario 3); 2. Utilization review standards (see scenario 5); and 3. Other factors related to imposing a utilization review requirement on a particular mental health and substance use disorder benefit being sought, such as cost or whether it is considered clinically effective. For example, plans and insurers often use reports of pharmacy and therapeutics committees to decide how to cover prescription drug benefits. These reports should be requested in order to determine parity in prescription drug benefits. You also can request any analyses the plan has performed to verify whether the plan complies with the Mental Health Parity and Addiction Equity Act.	Promptly, but generally not later than 30 days after your request. Shorter time limits apply in the case of urgent care claims.

SCENARIO	WHERE TO START? SUGGESTIONS FOR INFORMATION THAT YOU HAVE A RIGHT TO THAT CAN HELP	WHEN CAN I GET THESE DOCUMENTS?
7. I am seeking coverage for services performed by a mental health or substance use disorder provider. My primary care doctor recommends a therapist with certain licensure and training, but my plan says that such therapists are not part of its network.	***Standards for provider admission to participate in a network, including reimbursement rates.*** You can request information about the plan's standards for admitting providers to the network, such as the following: 1. The specific requirements for mental health and substance use disorder providers to participate in the plan's network (which could include requirements based on degree, licensing, and/or supervised clinical experience); 2. What these requirements are for providers of medical/surgical treatment; and 3. The underlying reasons for certain requirements (such as supervised clinical experience after a degree has been earned).	Promptly, but generally not later than 30 days after your request. Shorter time limits apply in the case of urgent care claims.

SCENARIO	WHERE TO START? SUGGESTIONS FOR INFORMATION THAT YOU HAVE A RIGHT TO THAT CAN HELP	WHEN CAN I GET THESE DOCUMENTS?
8. My mental health or substance use disorder claim is being denied.	***The reason for any denial of payment for services for mental health or substance use disorder benefits***. The health plan or issuer must provide an adverse benefit determination containing: 1. A specific reason for the denial; 2. Reference to the specific plan rules used to make the determination; and 3. A description of the plan's appeal procedures.	The time for providing the notice will vary based on the type of claim. • For urgent care claims, the plan must provide notice within 72 hours of when it received a claim. • For pre-service claims (i.e., when a service is denied before you receive it), the plan must provide notice within 15 days, with a one-time extension of 15 days allowed. • For post-service claims (i.e., when a payment for a service is denied after you receive it), the plan must provide notice within 30 days, with a one-time extension of 15 days allowed. • For concurrent care claims, which involve a determination to continue, reduce or terminate your current course of treatment previously approved by the plan, the plan must provide notice sufficiently in advance of the coverage termination date to allow you to appeal. Additional rules apply to decisions on requests you make to extend an already approved course of treatment.

SCENARIO	WHERE TO START? SUGGESTIONS FOR INFORMATION THAT YOU HAVE A RIGHT TO THAT CAN HELP	WHEN CAN I GET THESE DOCUMENTS?
9. I am appealing my plan's denial of a mental health or substance use disorder claim.	***Copies of all documents, records, and other information relevant to your claim for mental health or substance use disorder benefits.*** The plan or issuer must provide all information relevant to the claim, including information relevant to compliance with the Mental Health Parity and Addiction Equity Act. If the denial is because you did not give the plan enough information, a description will be provided of any additional material necessary for the claimant to perfect the claim (i.e., provide the complete information) with an explanation of why the information is necessary. In addition, relevant information may include medical necessity criteria for mental health and substance use disorder benefits and medical benefits (see scenario 3) and rules about how treatment is limited and under what conditions. This includes information on how non-quantitative treatment limitations (e.g., preauthorization, medical management) are used for benefits under the plan, and if a specific non-quantitative treatment limitation was utilized in denying a claim. This information could include: 1. Information about the underlying factors considered by the plan in determining the application of a non-quantitative treatment limitation to a benefit; 2. Comparable information related to application of the non-quantitative treatment limitation to medical/surgical benefits; 3. The plan's analysis in applying the plan requirement or limitation and all documents used to develop the analysis for this requirement or limitation; and 4. Any analyses the plan has performed, to verify whether the plan complies with the Mental Health Parity and Addiction Equity Act.	Upon request and free of charge, the plan must give you reasonable access to and copies of relevant documents, records, and other information. The plan must respond to your request promptly but generally not later than 30 days after you make a request. Shorter time limits apply in the case of urgent care claims. • If your plan considers, relies upon, or generates new or additional evidence or reasons for denying your benefit during your appeal, this information should be provided to you automatically with sufficient time for you to respond. **NOTE:** While you are entitled to copies of all documents relevant to your mental health or substance use disorder claim, in some instances, this request can result in more information than you may want. Talk to your plan about what documents you wish to request, and, if you prefer, how you can receive the documents electronically.

SCENARIO	WHERE TO START? SUGGESTIONS FOR INFORMATION THAT YOU HAVE A RIGHT TO THAT CAN HELP	WHEN CAN I GET THESE DOCUMENTS?
10. My doctor ordered a certain treatment, but my plan denied my claim. My plan said I must try another, less expensive treatment first. My plan will only consider my claim for the treatment my doctor ordered if the less expensive treatment does not work.	***Information on the plan's "fail-first" policies or step therapy protocols.*** To determine whether the plan's mental health and substance use disorder benefits and medical/surgical benefits are being provided comparably, you can request information regarding the basis for determining which mental health and substance use disorder benefits and medical/surgical benefits are subject to "fail-first policies" or "step-therapy protocols." "Fail-first" policies or "step-therapy protocols" are plan medical management tools. The basis may, for example, be the cost of treatment, medical guidelines, or a combination of factors, but they need to be applied comparably across mental health and substance use disorder benefits and medical/surgical benefits.	Promptly, but generally not later than 30 days after your request. Shorter time limits apply in the case of urgent care claims.
11. I am being denied payment by my plan for a mental health or substance use disorder treatment (such as intensive outpatient therapy) because I have not already completed previously prescribed treatment which I stopped against the medical advice of my provider.	***Exclusions based on failure to complete a course of treatment.*** To determine whether the mental health and substance use disorder benefits and medical/surgical benefits are being provided comparably, you may request information regarding the basis for determining which mental health and substance use disorder benefits and medical/surgical benefits are subject to exclusions based on failure to complete a course of treatment. The basis may be cost of treatment, medical guidelines, or a combination of factors, but they need to be applied comparably across mental health and substance use disorder benefits and medical/surgical benefits.	Promptly but generally not later than 30 days after your request. Shorter time limits apply in the case of urgent care claims.

Resources

If you would like more information about the Mental Health Parity and Addiction Equity Act, there are a number of resources available to help you understand where to go to get further assistance:

1) To learn more about MHPAEA and your health plan's compliance with parity, call or go to the following:

   - U.S. Department of Labor Employee Benefits Security Administration (EBSA) web page has consumer information on health plans. Or contact EBSA toll-free at: 1-866-444-3272 or through EBSA's website at www.dol.gov/ebsa.
   - U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information & Insurance Oversight: 1-877-267-2323 ext. 61565
   - Your state's department of insurance website and contact information, which can be found on the National Association of Insurance Commissioners website.
   - The Substance Abuse and Mental Health Services Administration (SAMHSA) Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA) web page.
     - See in particular: Know Your Rights: Parity for Mental Health and Substance Use Disorder Benefits and Parity of Mental Health and Substance Use Benefits with Other Benefits: Using Your Employer-Sponsored Health Plan to Cover Services

2) To learn more about benefits and the appeals process, go to:

   - The HealthCare.gov web page on health insurance rights and protections.
   - EBSA's web page Filing a Claim for Your Health or Disability Benefits

Glossary of Terms

Term	Acronym	Description
Affordable Care Act	ACA	Creates the Health Insurance Marketplaces, tax credits and Medicaid expansion to increase access to affordable coverage and provides protections for individual market health insurance and employment-based health coverage. Extends coverage of dependent children to age 26, prohibits preexisting condition exclusions, and prohibits lifetime and annual dollar limits on essential health benefits, among other consumer protections.
Allowed Amount		Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance," or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference.
Claim		This term refers to your request for payment for mental health and substance use disorder or medical/surgical services to your health plan. This can also include your request for preauthorization.
Co-insurance		Your share of the costs of a covered health care service, calculated as a percent (for example, 20 percent) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your co-insurance payment of 20 percent would be $20. The health insurance or plan pays the rest of the allowed amount.
Concurrent Care claims		Claims involving the continuation or extension of approved benefits or services to be provided over time or over a number of treatments (“concurrent care decisions”). A concurrent claim also includes a request for continued treatment beyond a course of treatment previously approved by the plan.

Term	Acronym	Description
Co-payment		A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.
Deductible		The amount you owe for health care services that your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan generally won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.
Employee Retirement Income Security Act of 1974	ERISA	A federal law that offers protection for individuals enrolled in retirement, health, and other benefit plans sponsored by private-sector employers, employee organizations or both and provides rights to information and a required claims and appeals process for participants to get benefits from their plans.
Financial Requirement (also referred to as "Cost Sharing")	FR	Deductibles, copayments, coinsurance, or other out-of-pocket expenses.
Medically Necessary		Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease, or its symptoms, and that meet accepted standards of medicine.
Mental Health Parity and Addiction Equity Act of 2008	MHPAEA	A federal law that requires group health plans and insurers to treat limitations on mental health and substance use disorder benefits (such as copayments, visit limits, and preauthorization requirements) comparably to their coverage for general medical and surgical (medical/surgical) care.
Non-quantitative Treatment Limitation	NQTL	Treatment limitations, including, but not limited to, geographic restrictions, restrictions on the types of facilities where services are covered, medical management, preauthorization, fail-first protocols, and prescription drug formularies.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration
U.S. Department of Labor, Employee Benefits Security Administration

Term	Acronym	Description
Out-of-network Provider		A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred (in-network) provider. Your plan or policy will explain what those costs may be. May also be called a "non-preferred provider" or "non-participating provider" instead of "out-of-network provider."
Plan Document or Instrument		These documents specify how the health plan is established or operated. The documents include the Summary Plan Description, trust agreement, and other written materials under which the plan is established or operated.
Post-service Claims		Claims for benefits that are not pre-service (meaning not approved prior to a service being delivered) or urgent care claims under your group health plan, including claims after medical services have been provided, such as requests for reimbursement or payment of the costs of the services provided. Most claims for group health benefits are post-service claims.
Preauthorization		A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan might require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise that your health insurance or plan will cover the cost.
Pre-service Claims		Requests for approval that the plan requires you to obtain before you get medical care, such as preauthorization or a decision on whether a treatment or procedure is medically necessary.
Summary of Benefits and Coverage	SBC	An easy-to-read summary of costs and coverage of health plans.

Term	Acronym	Description
Summary of Material Modifications	SMMs	Summarizes significant plan changes and corresponding changes in the information required to be in the Summary Plan Description.
Summary Plan Description	SPD	Disclosure documents prepared by the plan that describe, in understandable terms, the rights, benefits, and responsibilities of participants and beneficiaries in ERISA-covered health benefit plans. The Summary Plan Description must include important information regarding the plan, such as information on how the plan works, eligibility requirements, what benefits the plan provides, and how those benefits may be obtained.
Treatment Limitation		Limits on benefits, including limits based on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Examples include: outpatient visit limitations and inpatient day limits, as well as non-quantitative treatment limitations such as geographic restrictions, restrictions on the types of facilities where services are covered, utilization management, preauthorization, fail-first protocol, and prescription drug formularies.
Urgent Care Claims		A special kind of pre-service claim that requires a quicker decision because your health would be threatened if the plan took the normal time permitted to decide a pre-service claim. If a physician with knowledge of your medical condition tells the plan that a pre-service claim is urgent, the plan must treat it as an urgent care claim.
Usual, Customary & Reasonable	UCR	The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The usual, customary and reasonable amount sometimes is used to determine the allowed amount.
Utilization Review		Utilization review requires that the plan, insurer, or an external panel of providers assess a course of treatment or services to determine if it is medically necessary and merits coverage, typically after or during the episode of care.

[i] MHPAEA applies to group plans with 51 or more employees of private companies or governmental employers and individual insurance coverage. Smaller plans are generally subject to the parity provisions through the Affordable Care Act. For more information, see 78 FR 12834 (Feb. 25, 2013) (effective for plans years beginning in 2014); 45 CFR 156.115, available at 78 FR 12834 (Feb. 25, 2013) (effective for plans years beginning in 2014).

[ii] See Employee Retirement Income Security Act (ERISA) sections 102, 104, 502, 503, and 712, as well as Public Health Service Act sections 2715 and 2719, as incorporated in ERISA section 715 and implementing regulations at 29 CFR 2520.102-2, 2520.102-3, 2520.102-4, 2520.104b-1, 2520.104b-2, 2520.104b-3, 29 CFR 2560.503-1, 2590.712 (for mental health and substance use disorder benefits) 2590.715-2715 and 2590.715-2719. See also 78 FR 68240, 68247 (Nov. 13, 2013); Advisory Opinion 96-14A; Affordable Care Implementation FAQs, Part V, Q&A-10; Affordable Care Act Implementation FAQs, Part XVII, Q&A-8; Affordable Care Act Implementation FAQs, part XXIX, Q12 & Q13; & Affordable Care Implementation FAQs, Part 31, Q&A-9, available at https://www.dol.gov/ebsa/mentalhealthparity/ or https://www.cms.gov/cciio/resources/Fact-Sheets-and-FAQs/index.html.