IN-NETWORK REIMBURSEMENT RATES

For In-Network provider office visits only, for the CPT codes provided in Tables A, B (1) and B (2) provide, the weighted average allowed amounts for the following four (4) groups of providers:

• Primary Care Physicians, "PCPs", defined as general practice, family practice, internal medicine, and pediatric medicine physicians.

• Non-psychiatrist Medical/Surgical Specialist Physicians, defined to include nonpsychiatrist specialty physicians, such as orthopedic surgeons, dermatologists, neurologists, etc. This category excludes PCPs.

• Psychiatrists, including child psychiatrists.

• Non-psychiatrist Behavioral Health ("BH") Professionals, defined as psychologists and clinical social workers.

Please complete Tables A, B (1) and B (2) for claims data for Calendar Year 2021, or *for the period January 1, 2021, through the latest month in 2020 for which reasonably complete claims data is available.*

Instructions for completing Table A follow:

• In Rows 1– 4, insert the weighted average in-network allowed amounts (weighted by the proportion of claims allowed at each allowed amount level) for Column A (CPT 99213) and Column B (99214). This calculation will provide the same result as calculating the sum of the allowed amounts for every in-network 99213 and 99214 claim, separately, that was allowed for these providers, and dividing each sum by the total number of such claims allowed for such providers.

• In Row 5, insert the percentage amount (if any) by which the in-network reimbursement for PCPs and other non-psychiatrist M/S specialist physicians (combined) was greater than for psychiatrists.

Instructions for completing Tables B (1) and B (2) follow:

• In Rows 1– 3, Column A of Tables B (1) and B (2), insert the weighted average allowed amounts (weighted by the proportion of claims allowed at each allowed amount level) for Column A CPT Codes listed. This calculation will provide the same result as calculating the sum of the allowed amounts for every in-network 99213, 99214, 90834, and 90837 claim, separately, that was allowed for these providers, and dividing each sum by the total number of such claims allowed for such providers.

• Rows 1 - 3, Column C of Tables B (1) and B (2), insert weighted average allowed amount as a percentage of the Medicare Fee schedule amount.