Companion guide

ASC X12N 270/271 (005010X279A1)

Health Care Eligibility/Benefit Inquiry and Response

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cigna healthcare

Preface

The Cigna Healthcare® Companion Guide supplements the Health Insurance Portability and Accountability Act (HIPAA) ASC X12N 270/271 (005010X279A1) Implementation Guide for Eligibility Benefits Inquiry and Response. This document is intended to clarify the specific requirements for electronically exchanging eligibility and benefit data with Cigna Healthcare and complies with the Committee on Operating Rules for Information Exchange (CORE) standard format.

Disclosure statement

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1. Introduction

1.1 Scope

This companion guide has been designed to describe to Cigna Healthcare trading partners the format and data content of the 270/271 Eligibility and Benefit transaction set in the electronic data interchange (EDI) environment. The 270 transaction is used to request eligibility and benefit information for medical, behavioral, and dental lines of business. The 271 transaction is used to respond with eligibility and benefit information for the specified customer.

1.2 Overview

This companion guide will replace, in total, the previous Cigna Healthcare Companion Guides for the 270 Health Care Eligibility Benefit Inquiry and 271 Health Care Eligibility Benefit Response. This companion guide has been written to assist you in designing and implementing 270/271 transactions to meet Cigna Healthcare processing standards. The Cigna Healthcare Companion Guide identifies key data elements from the transaction set that we request you provide to us, as well as key data elements from the transaction set that Cigna Healthcare will provide to you. The recommendations made are to enable you to more effectively submit 270 requests and receive 271 responses.

The Council for Affordable and Quality Healthcare® (CAQH®) created the Committee on Operating Rules for Information Exchange (CORE). This committee established a common set of operating rules for health care systems that allow providers and other health entities the ability to receive consistent data across health care systems. Cigna Healthcare has implemented the operating rules for CORE.

1.3 References

This document is a companion to the ASC X12N Implementation Guide (005010X279A1) Health Eligibility Benefit Inquiry and Response 270/271.

2. Getting started

2.1 Working with Cigna Healthcare

Cigna Healthcare trading partners must have an active trading partner agreement. If a third party has been elected to perform electronic transactions, additional trading partner information may be required for setup. Health care providers can exchange EDI transactions by directly connecting to Cigna Healthcare systems using software from PNT Data or through a clearinghouse.

Direct connection:

Direct connection to Cigna Healthcare for the purpose of 270/271 005010X279A1 Eligibility Benefit Inquiry and Response transaction submissions may be available. This connection type will support real-time submissions and responses. Please contact your Cigna Healthcare Trading Partner Relationship Manager for setup opportunities.

Clearinghouse:

Health care providers should contact their clearinghouse vendor to discuss the clearinghouse's ability to support the 270/271 005010X279A1 Health Care Eligibility Benefit Inquiry and Response transaction set, as well as the associated time frame, costs, etc. Health care providers that do not already have a clearinghouse vendor can contact one of the Cigna Healthcare-connected clearinghouses. For a list of available clearinghouses, visit www.Cigna.com/EDIvendors > How to Submit Claims: Learn more about EDI vendors.

If you have additional questions, please contact your Cigna Healthcare Trading Partner Relationship Manager.

2.2 Trading partner registration

All trading partners that wish to submit eligibility transactions to Cigna Healthcare via the ASC X12 270 (Version 005010X279A1) and receive corresponding 271 responses must complete the Cigna Healthcare technical assessments and provide Cigna Healthcare with their contact information, desired connectivity method, and transaction-specific information. After completing the assessments, Cigna Healthcare will work with each trading partner to establish connectivity. Upon successful connectivity testing, each trading partner can then begin system testing.

2.3 Certification and testing overview

Cigna Healthcare became CAQH CORE v.1.1.0 recertified on July 7, 2023.

2.4 Testing with Cigna Healthcare

Physicians and health care providers should contact their current EDI vendor to discuss testing. For a list of available EDI vendors, visit www.Cigna.com/EDIvendors > How to Submit Claims: Learn more about EDI vendors.

3. Testing with the payer

3.1 EDI controls

Cigna Healthcare will utilize, when necessary and appropriate, both the TA1 – Interchange Acknowledgement and 999 – Functional Acknowledgement responses.

X12 transaction processing

- X12 270 requests will be verified as originating from a Cigna Healthcare-recognized clearinghouse (authentication) and checked for access to submit the eligibility inquiry transaction (authorization). Failure of authorization test will generate a TA1 or 999 response back to the clearinghouse.
- X12 270 requests will be checked for proper X12 270 structure via "envelope test validation." This ensures the transaction request is a complete and formatted real-time transaction. Failures of envelope tests can generate TA1 or 999 responses back to the clearinghouse.
- X12 270 data elements that are mapped to the Cigna Healthcare copybook will be checked for validity through a defined set of "exception processing tests." If an exception occurs, the appropriate 999 response is sent back to the clearinghouse.

Special test processing

If the ISA15 (usage indicator) is set to T (test data), then the X12 request ISA10, ISA11, GS04, and GS05 date and time elements are returned in the X12 response. This allows for regression test tools to validate expected date/time responses in those fields. If the ISA15 (usage indicator) is set to P (production data), then the date and time fields are populated with the current date and time.

3.2 X12 transaction authorization tests

The following table defines the "authorization tests" to be processed on receipt of each X12 270 request.

The authorization tests are run in the order shown. Upon detection of an error, the appropriate TA1 or 999 response is sent. Multiple errors are not processed in the TA1 response since this can lead to faulty error reporting. In the 999 error response, multiple errors may be sent with the exception of GS01 and GS08 errors. If both GS01 and GS08 errors are present, only the GS01 error will be sent since only one AK905 segment is allowed.

HIPAA element	Authorization tests	TA1 response		999 response							
		TA105		IK401	IK402	IK403	AK901	AK902	AK903	AK904	AK905
N/A	Clearinghouse source cannot be identified.	013		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
ISA05/ ISA06	Unknown clearinghouse (unknown ISA05/ISA06 combination).	006		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
ISA07/ ISA08	Unknown payer (unknown ISA07/ISA08 combination).	008		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
GS01	Unsupported transaction set in group.	N/A		N/A	N/A	N/A	R	1	1	0	1
GS02	Unknown originator ID value.	N/A		2	142	7	R	1	1	0	N/A
	Missing originator ID value.	N/A		2	142	1	R	1	1	0	N/A
GS03	Unknown recipient LOB value.	N/A		3	124	7	R	1	1	0	N/A
	Missing recipient LOB value.	N/A		3	124	1	R	1	1	0	N/A
GS08	Unsupported version of implementation guide.	N/A		N/A	N/A	N/A	R	1	1	0	2

3.3 X12 transaction envelope test validation

The following table defines the "envelope tests" to be processed on receipt of each X12 270 submission. The envelope tests are run in the order shown. Upon detection of an error, the appropriate TA1 or 999 response is sent. Multiple errors are not processed since this can lead to faulty error reporting.

HIPAA element	Envelope tests	TA1 response		999 response						
		TA105		IK501	IK502	AK901	AK902	AK903	AK904	AK905
IEA segment	Control number in IES02 does not match control number in ISA13.	001		N/A	N/A	N/A	N/A	N/A	N/A	N/A
IEA segment	Functional group count in IES01 does not match actual functional groups counted.	021		N/A	N/A	N/A	N/A	N/A	N/A	N/A
GE segment	Group control number in GE02 does not match group control number in GS06.	N/A		N/A	N/A	R	1	1	0	4
GS segments	IEA02 value not = 1 indicating that multiple or no GS segments received.	024		N/A	N/A	N/A	N/A	N/A	N/A	N/A

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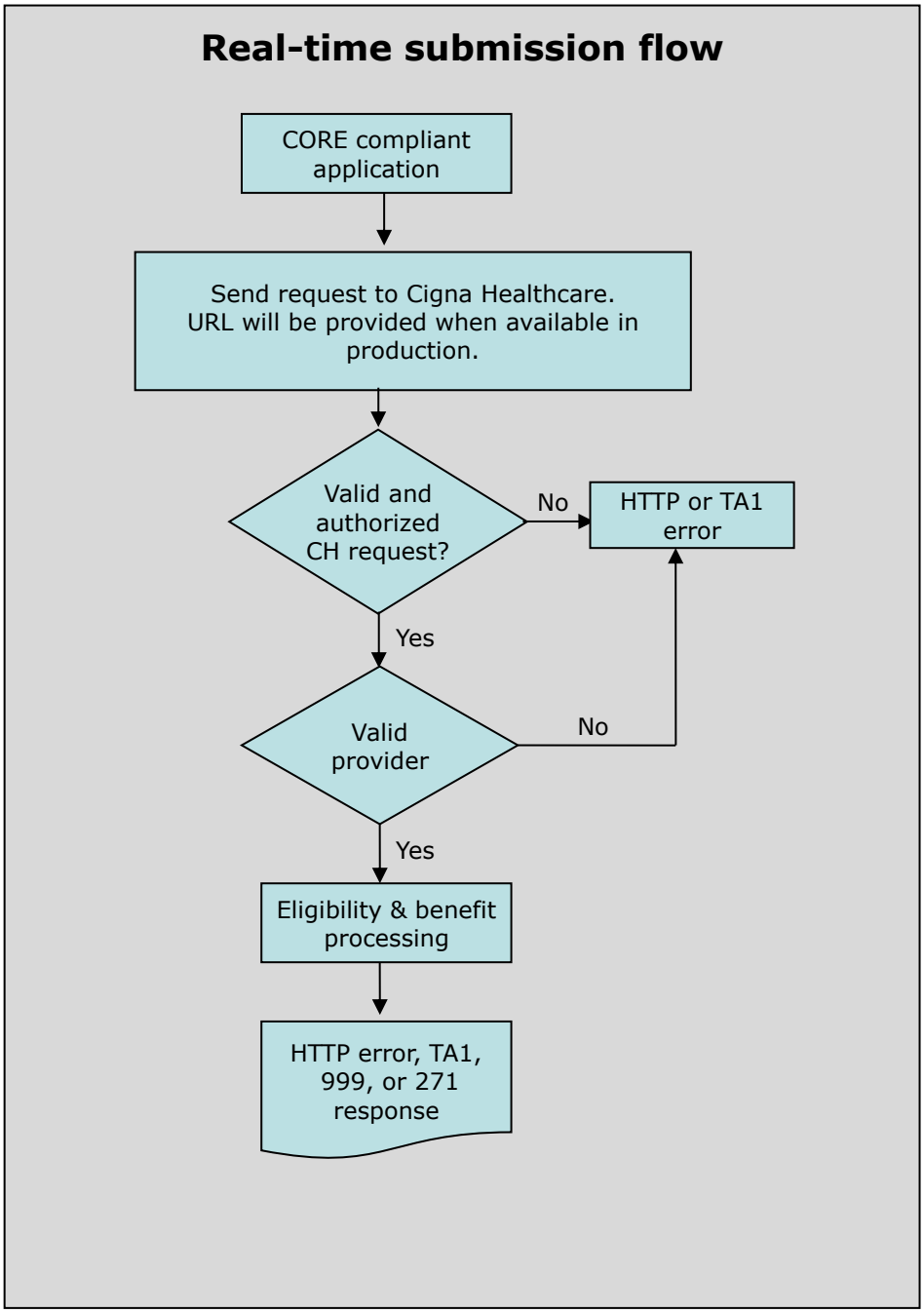
HIPAA element	Envelope tests	TA1 response		999 response						
		TA105		IK501	IK502	AK901	AK902	AK903	AK904	AK905
TS segments	Transaction sets included count in GE01 does not match actual transaction sets counted.	N/A		N/A	N/A	R	1	1	0	5
TS segments	Transaction set control number in ST02 does not match transaction set control number in SE02.	N/A		R	3	N/A	N/A	N/A	N/A	N/A
TS segments	GE01 value not = 1 indicating that multiple or no TS segments received.	024		N/A	N/A	N/A	N/A	N/A	N/A	N/A
HL segment (HL03=20) information source loop	Number of information source loops not = 1.	024		N/A	N/A	N/A	N/A	N/A	N/A	N/A
HL segment (HL03=21) information receiver loop	Number of information receiver loops not = 1.	024		N/A	N/A	N/A	N/A	N/A	N/A	N/A
HL segment (HL03=22) subscriber loop	Number of subscriber loops not = 1.	024		N/A	N/A	N/A	N/A	N/A	N/A	N/A
HL segment (HL03=23) dependent loop	Number of dependent loops > 1.	024		N/A	N/A	N/A	N/A	N/A	N/A	N/A
SE segment	Number of included segments count in SE01 does not match actual segment count.	N/A		R	4	N/A	N/A	N/A	N/A	N/A

4. Connectivity with the payer/communications

4.1 System availability

The 270/271 transaction set is available 24 hours a day, 7 days a week. However, to allow for maintenance, 270/271 transactions may be unavailable on some weekends. Communication will be sent at least a week in advance. Batch files are queued for processing after the release window completes.

4.2 Process flows



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4.3 Transmission administrative procedures

Real-time 270 requests contain only one inquiry per customer per transaction.

4.3.1 Retransmission procedure

A duplicate transaction may be sent by the user's CORE-compliant system if the HTTP post-reply message is not received within the 20-second response period.

4.4 Communication protocol specifications

In conformance with the CORE 270 Connect Rule, Cigna Healthcare now supports SOAP + WSDL and REST API with JSON connections. Trading partners that plan to use these new connectivity options must obtain a username and password from Cigna Healthcare.

Trading partners that plan to use REST API with JSON will use OAuth 2.0 Client Authorization over TLS 1.2 or higher as the authorization method. Cigna Healthcare will also offer the OAuth 2.0 Client Authorization for trading partners using SOAP + WSDL.

Detailed specifications for these connections are published by CAQH in the CAQH Core Rules.

SOAP + WSDL Connectivity

Protocol	Specifications
Protocol family:	TCP/IP
Application protocol:	http (secure)
Messaging protocol:	SOAP
HTTP method:	POST
Transaction payload format:	XML
SOAP XML input element name:	Payload
Content-type:	"application/soap+xml"

REST API (JSON) Connectivity

Protocol	Specifications
Protocol family:	TCP/IP
Application protocol:	http (secure)
Architectural style:	REST
HTTP method:	POST
Payload format:	JSON
Request payload element:	Payload
Content-type:	"application/JSON"

4.5 Passwords

When using SOAP + WSDL, a password must be obtained from Cigna Healthcare.

5. Contact information

5.1 EDI customer service

Most questions can be answered by referencing this companion guide. If you have additional questions related to the Cigna Healthcare eligibility and benefits transaction, contact your Cigna Healthcare Trading Partner Relationship Manager.

5.2 EDI technical assistance

If you have technical questions related to the Cigna Healthcare eligibility and benefits transaction, call the Customer Support Center at **800.810.3388**.

5.3 Provider service phone numbers

Listed below are phone numbers to call if you have contracting, provider service, or credentialing questions.

- Medical and behavioral preferred provider organization (PPO) and Open Access Plus (OAP) claims – 800.88Cigna (**800.882.4462**)
- All other behavioral claims – **800.926.2273**
- Dental claims – 800.Cigna24 (**800.244.6224**)

5.4 Applicable websites/email

For information about Cigna Healthcare policies, coverage positions, and claim edits, access the Cigna Healthcare website at Cigna.com > For Providers.

6. Control segments/envelopes

6.1 ISA – IEA (270)

This section describes the use of the interchange control segments ISA and IEA. These segments mark the beginning and ending of an interchange. The ISA segment has a fixed length and all the elements within this segment must be populated. This segment includes a description of the expected sender and receiver codes and delimiters. The first element delimiter in the ISA segment is an asterisk (*), which will be used as the delimiter throughout the transaction. The final character in the ISA segment is a tilde (~), which will be used as the delimiter for each segment in the transaction.

Segment ID	Element ID	Name	Code	Definition of code / notes
ISA		Interchange control header segment		
	ISA01	Authorization information qualifier	'00'	No authorization information present.
	ISA02	Authorization information	10 'spaces'	Authorization information.
	ISA03	Security information qualifier	'00'	No security information present.

Segment ID	Element ID	Name	Code	Definition of code / notes
	ISA04	Security information	10 'spaces'	No security information present. **Note:** Value should always be 'spaces'.
	ISA07	Interchange ID qualifier of receiver	'30'	U.S. federal Taxpayer Identification Number (TIN).
	ISA08	Interchange receiver ID	'06-1059331'	Interchange receiver ID for Cigna Healthcare.
	ISA11	Repetition separator	'^'	Repetition separator is a delimiter and not a data element. The recommended value is the implementation guide value of '^,' but any character can be used as a delimiter. This character cannot be used by any of the data elements. Whatever value is sent in is used and returned on the response.
	ISA15	Usage indicator; code to indicate whether data enclosed by this interchange envelope is test or production information	'P' 'T'	'P': Production data **Note**: Date and time fields are populated with current date and time. 'T': Test data **Note:** Date and time fields in ISA09, ISA10, G'0', GS05, BHT04, and BHT05 are returned in the X12 response.
	ISA16	Component element separator	:	Component element separator is a delimiter and not a data element. The recommended value is the implementation guide value of ':', but any character can be used as a delimiter. This character cannot be used by any of the data elements. Whatever value is sent in is used and returned on the response.

Segment ID	Element ID	Name	Code	Definition of code / notes
IEA		Interchange control trailer segment	~	Interchange control trailer is a delimiter and not a data element. The recommended value is the implementation guide value of '~', but any character can be used as a delimiter. This character cannot be used by any of the data elements. Whatever value is sent in is used and returned on the response.

6.2 GS – GE (270)

This section describes the functional group control segments GS and GE. These segments identify the application sender and receiver codes. The GS control segment indicates the beginning of a functional group and the GE control segment indicates the ending of a functional group. These control segments describe how Cigna Healthcare expects a trading partner to send functional groups and how Cigna Healthcare will send functional groups back to the clearinghouse.

Segment ID	Element ID	Name	Code	Definition of code / notes
GS		Functional group header		
	GS03	Application receiver's code	'CIGNA'	Code identifying party receiving transmission; value should always be Cigna.

6.3 ISA – IEA (271)

Segment ID	Element ID	Name	Code	Definition of code / notes
ISA		Interchange control header segment		
	ISA01	Authorization information qualifier	'00'	No authorization information present.
	ISA02	Authorization information	10 'spaces'	No authorization information present.
	ISA03	Security information qualifier	'00'	No security information present.
	ISA04	Security information	10 'spaces'	No security information present. **Note:** Value should always be 'spaces.'
	ISA05	Interchange ID qualifier of sender	'30'	U.S. federal identification number.
	ISA06	Interchange sender ID	'06-1059331'	Interchange sender ID for Cigna Healthcare.

6.4 GS – GE (271)

Segment ID	Element ID	Name	Code	Definition of code / notes
GS		Functional group header		
	GS02	Application sender's code	'CIGNA'	Code identifying party sending transmission; value should always be 'Cigna'.

7. Payer-specific business rules and limitations

Cigna Healthcare became CAQH CORE v.1.1.0 recertified on July 7, 2023.

7.1 270 request

7.1.1. Provider information

Cigna Healthcare will use provider-specific information supplied in the 270 request to identify the most accurate benefits possible to return in the 271 response.

- National Provider Identifier (NPI) NM108 – Using a type 1 NPI will provide the most accurate patient attribution for Cigna Collaborative Accountable Care (see section 7.2.5).
- Taxonomy code PRV03 – The submitted taxonomy code will be used to return benefits for an explicit Service Type Code (STC) that is valid for different products. When the taxonomy code is used to determine benefits, it will also be returned in the 271 response.

  Examples for use of taxonomy code:
  - If the provider participates in both the medical and behavioral health networks and a taxonomy code for behavioral health is submitted, the mental health benefits will be returned.
  - If diagnostic X-ray benefits exist for medical and dental products and a taxonomy code for a dental provider is submitted, only the dental diagnostic X-ray benefits will be returned.

7.1.2. Supported patient searches

Cigna Healthcare will identify the patient for whom benefit data is requested if the patient's identification number and their first name, last name, and date of birth are supplied. If any of these elements are missing, patient identification will be attempted in the following order, depending on the data supplied:

- Patient ID number, patient last name, patient date of birth
- Patient ID number, patient last name, patient first name
- Patient first name, patient last name, patient date of birth
- Patient ID number, patient date of birth

7.1.3. Supported Service Type Codes (STCs)

Eligibility requests for an explicit STC (EB03) or generic STC "30" will generate a 271 response. The following table displays the STCs that are generally supported by Cigna Healthcare. Due to differences between benefit plans, not all STCs are supported for all plans.

STC	Description
1	Medical care
2	Surgical
3	Consultation
4	Diagnostic X-ray
5	Diagnostic lab
6	Radiation therapy
7	Anesthesia
8	Surgical assistance
9	Other medical (used for specialty drugs as of June 2015)
10	Blood charges
11	Used durable medical equipment
12	Durable medical equipment purchase
13	Ambulatory service center facility
14	Renal supplies in the home
15	Alternate method dialysis
16	Chronic renal disease (CRD) equipment
17	Preadmission testing
18	Durable medical equipment rental
19	Pneumonia vaccine
20	Second surgical opinion
22	Social work
23	Diagnostic dental
24	Periodontics
25	Restorative
26	Endodontics
27	Maxillofacial prosthetics
28	Adjunctive dental services
30	Health benefit plan coverage
32	Plan waiting period
33	Chiropractic
34	Chiropractic office visits
35	Dental care
36	Dental crowns
37	Dental accident

STC	Description
38	Orthodontics
39	Prosthodontics
40	Oral surgery
41	Routine (preventive) dental
42	Home health care
43	Home health prescriptions
44	Home health visits
45	Hospice
46	Respite care
47	Hospital
48	Hospital – inpatient
49	Hospital – room and board
50	Hospital – outpatient
51	Hospital – emergency accident
52	Hospital – emergency medical
53	Hospital – ambulatory surgical
54	Long-term care
55	Major medical
56	Medically related transportation
57	Air transportation
58	Cabulance
59	Licensed ambulance
60	General benefits
61	In-vitro fertilization
62	MRI/CAT scan
63	Donor procedures
4	Acupuncture
65	Newborn care
66	Pathology
67	Smoking cessation
68	Well-baby care
69	Maternity
70	Transplants
71	Audiology exam
72	Inhalation therapy
73	Diagnostic medical
74	Private duty nursing
75	Prosthetic device
76	Dialysis
77	Ophthalmological exam

STC	Description
78	Chemotherapy
79	Allergy testing
80	Immunizations
81	Routine physical
82	Family planning
83	Infertility
84	Abortion
86	Emergency services
87	Cancer
88	Pharmacy
89	Free-standing prescription drug
90	Mail order prescription drug
91	Brand name prescription drug
92	Generic prescription drug
93	Podiatry
94	Podiatry office visits
95	Podiatry nursing home visits
96	Professional (physician)
97	Anesthesiologist
98	Professional (physician) visit – office
99	Professional (physician) visit – inpatient
A0	Professional (physician) visit – outpatient
A1	Professional (physician) visit – nursing home
A2	Professional (physician) visit – skilled nursing facility
A3	Professional (physician) visit – home
A4	Psychiatric
A5	Psychiatric – room and board
A6	Psychotherapy
A7	Psychiatric – inpatient
A8	Psychiatric – outpatient
A9	Rehabilitation
AA	Rehabilitation – room and board
AB	Rehabilitation – inpatient
AC	Rehabilitation – outpatient
AD	Occupational therapy
AE	Physical medicine
AF	Speech therapy
AG	Skilled nursing care
AH	Skilled nursing care – room and board
AI	Substance abuse

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STC	Description
AJ	Alcoholism
AK	Drug addiction
AL	Vision (optometry)
AM	Frames
AN	Routine exam (use for routine vision exam only)
AO	Lenses
AQ	Nonmedically necessary physical
AR	Experimental drug therapy
B1	Burn care
B2	Brand name prescription drug formulary
B3	Brand name prescription drug non-formulary
BB	Partial hospitalization (psychiatric)
BC	Day care (psychiatric)
BD	Cognitive therapy
BE	Massage therapy
BF	Pulmonary rehabilitation
BG	Cardiac rehabilitation
BH	Pediatric
BI	Nursery
BK	Orthopedic
BL	Cardiac
BN	Gastrointestinal
BQ	Neurology
BR	Eye
BS	Invasive procedures
BT	Gynecological
BU	Obstetrical
BV	Obstetrical gynecological
BW	Mail order prescription drug brand name
BX	Mail order prescription drug generic
BY	Physician visit office sick
BZ	Physician visit office well
C1	Coronary care
CA	Private duty nursing inpatient
CB	Private duty nursing home
CC	Surgical benefits professional physicians
CD	Surgical benefits facility
CE	Mental health provider inpatient
CF	Mental health provider outpatient
CG	Mental health facility inpatient

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STC	Description
CH	Mental health facility outpatient
CI	Substance abuse facility inpatient
CJ	Substance abuse facility outpatient
CK	Screening X-ray
CL	Screening laboratory
CM	Mammogram high-risk patient
CN	Mammogram low-risk patient
CO	Flu vaccination
CP	Eyewear and eyewear accessories
CQ	Case management
DG	Dermatology
DM	Durable medical equipment
DS	Diabetic supplies
GF	Generic prescription drug formulary
GN	Generic prescription drug non-formulary
GY	Allergy
IC	Intensive care
MH	Mental health
NI	Neonatal intensive care
ON	Oncology
PT	Physical therapy
PU	Pulmonary
RN	Renal
RT	Residential psychiatric treatment
TC	Transitional care
TN	Transitional nursery care
UC	Urgent care

7.1.4. Procedure codes

Cigna Healthcare supports the use of Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and American Dental Association® procedure codes in EQ02 on the 270 Eligibility Benefit Inquiry submission. When a procedure code is submitted, an STC must not be included on the same inquiry.

The provider NPI submitted on the request is used to determine whether primary care provider (PCP) or specialist benefits apply.

When requesting benefits using a procedure code, inclusion of the diagnosis code in the HI segment is strongly recommended to ensure the most accurate benefit response. If a diagnosis code is not provided, Cigna Healthcare will return benefits based on the most commonly billed diagnosis associated with the submitted procedure code.

7.1.5. Diagnosis codes

Cigna Healthcare supports the use of diagnosis codes in the HI segment and relates to the information provided in the EQ segment. When returning benefits, the diagnosis code pointer – as it relates to the position submitted in the HI segment – is reported in EB14.

7.1.6. Place of Service codes

Cigna Healthcare supports Place of Service codes (III segment) in a request when returning benefits.

7.2 271 response

7.2.1 Unable to identify customer

Cigna Healthcare will return the following AAA codes when a customer cannot be identified.

Result	Submitted identifiers				Subscriber/dependent AAA returned in response	
	ID	DOB	LN	FN		
Customer not found.	x	x	x	x	72/64	
	x	x	x		75/67	73/65
	x	x			75/67	73/65
	x	x		x	75/67	73/65
	x		x	x	75/67	58/58
		x	x	x	75/67	72/64
Multiple records found. Tie cannot be broken.	x	x	x	x	76/68	72/64
	x	x	x		76/68	73/65
	x	x			76/68	73/65
	x	x		x	76/68	73/65
	x		x	x	76/68	58/58
		x	x	x	76/68	72/64

7.2.2 General "30" response

The 271 response for a STC "30" (health benefit plan coverage) will include the following STCs when they are a covered benefit:

STC	Description
1	Medical care
30	Health benefit plan coverage
33	Chiropractic
35	Dental care
47	Hospital
48	Hospital – inpatient
50	Hospital – outpatient
86	Emergency services
88	Pharmacy

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98	Professional (physician) visit – office
AL	Vision (optometry)
MH	Mental health
UC	Urgent care

STC response details

- STC 30 represents the customer's plan-level benefits – deductible, out of pocket, and coinsurance. In most cases, the annual deductible, out-of-pocket, and limit amounts will be provided. When applicable, lifetime limits and the remaining amounts will be provided. Note that when the plan is for behavioral health, pharmacy, or vision, remaining amounts will not be reported.
- Some STCs may also return benefit rows containing EB01=CB to indicate the necessity for precertification.
- The Cigna Healthcare response to most covered STCs will contain:
  - Customer's status (active, inactive, or not covered).
  - When available, plan-level medical, dental, or behavioral benefits will be returned (STCs 1 and 30, 35, or MH), as applicable.
  - Appropriate benefit information – deductible (if different from the plan-level deductible), copayment, and/or coinsurance (if different from the plan-level coinsurance).
  - Any limits or remaining amounts (dollars, visits, days, etc.) for medical or dental STCs.
  - Limits for behavioral health, pharmacy, and vision STCs, but not remaining amounts.
- Requests for prior dates of service will not be returned with remaining amounts, nor will requests for future dates that are outside the customer's plan year, unless the customer's plan has plan year carryover provisions.
- STCs 88, AL, and MH represent a benefit that may be embedded in a medical product or be available as a stand-alone benefit. Therefore, an 88, AL, or MH response may be available in absence of standard medical coverage. Likewise, it may not be covered.
- When submitted as part of a standard 30 request, STC 35 will be responded to at a high level. A specific 35 request will return detailed dental benefit information.
- Some STCs have benefits for more than one plan type (e.g., diagnostic X-ray benefits could exist in a customer's medical, dental, and/or behavioral plans). If one of these STCs is requested and the customer has more than one plan, the relevant benefits for each plan will be returned with a message noting the plan type. However, if a health care provider taxonomy code is submitted in loop 2000B, 2100C, or 2100D, and that code can be aligned to a plan type (e.g., dentist taxonomy code is aligned to dental plans), then only the benefits for that plan type will be returned. The taxonomy code will also be returned since it was used to determine benefits.
- An EB*V response to a request for an explicit STC does not imply that the benefit is not covered and should not be construed as such.

7.2.3 Supported group responses

For most benefit plans, Cigna Healthcare supports the following groups and will return the following STCs when the group STC (bold) is requested and it is a covered benefit:

Group	STC	Description
Behavioral	**MH**	**Mental health**
Behavioral	4	Diagnostic X-ray
Behavioral	7	Anesthesia
Behavioral	22	Social work
Behavioral	97	Anesthesiologist
Behavioral	A4	Psychiatric
Behavioral	A5	Psychiatric – room and board
Behavioral	A6	Psychotherapy
Behavioral	A7	Psychiatric – inpatient
Behavioral	A8	Psychiatric – outpatient
Behavioral	BB	Partial hospitalization (psychiatric)
Behavioral	BC	Day care (psychiatric)
Cardiac	**BL**	**Cardiac**
Cardiac	5	Diagnostic lab
Cardiac	73	Diagnostic medical
Cardiac	BG	Cardiac rehabilitation
Cardiac	C1	Coronary care
Chiro	**33**	**Chiropractic**
Chiro	4	Diagnostic X-ray
Chiro	34	Chiropractic office visits
Dental	**35**	**Dental care**
Dental	4	Diagnostic X-ray
Dental	7	Anesthesia
Dental	23	Diagnostic dental
Dental	24	Periodontics
Dental	25	Restorative
Dental	26	Endodontics
Dental	27	Maxillofacial prosthetics
Dental	28	Adjunctive dental services
Dental	32	Plan waiting period
Dental	36	Dental crowns
Dental	38	Orthodontics
Dental	39	Prosthodontics
Dental	41	Routine (preventive) dental
Gastrointestinal	**BN**	**Gastrointestinal**
Gastrointestinal	4	Diagnostic X-ray

Group	STC	Description
Gastrointestinal	5	Diagnostic lab
Gastrointestinal	73	Diagnostic medical
Gastrointestinal	98	Professional (physician) visit – office
Gastrointestinal	BS	Invasive procedures
Neurology	**BQ**	**Neurology**
Neurology	4	Diagnostic X-ray
Neurology	5	Diagnostic lab
Neurology	73	Diagnostic medical
Neurology	98	Professional (physician) visit – office
Orthopedic	**BK**	**Orthopedic**
Orthopedic	4	Diagnostic X-ray
Orthopedic	12	Durable medical equipment purchase
Pharmacy	**88**	**Pharmacy**
Pharmacy	89	Free-standing prescription drug
Pharmacy	90	Mail order prescription drug
Pharmacy	91	Brand name prescription drug
Pharmacy	92	Generic prescription drug
Pharmacy	B2	Brand name prescription drug formulary
Pharmacy	B3	Brand name prescription drug non-formulary
Pharmacy	BW	Mail order prescription drug brand name
Pharmacy	BX	Mail order prescription drug generic
Pharmacy	GF	Generic prescription drug formulary
Pharmacy	GN	Generic prescription drug non-formulary
Rehabilitation	**A9**	**Rehabilitation**
Rehabilitation	AA	Rehabilitation – room and board
Rehabilitation	AB	Rehabilitation – inpatient
Rehabilitation	AC	Rehabilitation – outpatient
Rehabilitation	AD	Occupational therapy
Rehabilitation	AF	Speech therapy
Rehabilitation	BF	Pulmonary rehabilitation
Rehabilitation	BG	Cardiac rehabilitation
Rehabilitation	PT	Physical therapy
Surgical	**2**	**Surgical**
Surgical	7	Anesthesia
Surgical	8	Surgical assistance
Surgical	20	Second surgical opinion
Surgical	97	Anesthesiologist
Surgical	BS	Invasive procedures
Surgical	CC	Private duty nursing inpatient
Surgical	CD	Surgical benefits facility

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Group	STC	Description
Surgical	97	Anesthesiologist
Vision	**AL**	**Vision (optometry)**
Vision	AM	Frames
Vision	AN	Routine exam (use for routine vision exam only)
Vision	AO	Lenses
Vision	CP	Eyewear and eyewear accessories
Renal	**RN**	**Renal**
Renal	4	Diagnostic X-ray
Renal	5	Diagnostic lab
Renal	14	Renal supplies in the home
Renal	15	Alternate method dialysis
Renal	16	Chronic renal disease (CRD) equipment
Renal	73	Diagnostic medical
Renal	76	Dialysis
Renal	DS	Diabetic supplies
Cancer	**87**	**Cancer**
Cancer	6	Radiation therapy
Cancer	66	Pathology
Cancer	73	Diagnostic medical
Cancer	78	Chemotherapy
Cancer	ON	Oncology
Pediatric	**BH**	**Pediatric**
Pediatric	65	Newborn care
Pediatric	68	Well baby care
Pediatric	80	Immunizations
Pediatric	BI	Nursery

7.2.4 Tiered benefits

Some benefit plans include tiered in-network benefits, where customer cost sharing varies based on a provider's contractual participation. For plans with tiered benefits, Cigna Healthcare determines the applicable benefit tier using the NPI submitted on the 270 eligibility inquiry. The 271 response returns only the benefit information applicable to the appropriate tier, with messaging to identify the relevant network or tier (such as Cigna Care Network® or client-specific network).

7.2.5 Single patient attribution

Cigna Healthcare supports single patient attribution in the 271 response. Attribution means the health plan assigns a patient to a provider under a specific contract, making the provider responsible for care delivery and potentially cost of care (e.g., Cigna Collaborative Accountable Care, value-based care). The attribution (alignment) status returned in the 271 response is based on the NPI and the patient information submitted on the 270 eligibility inquiry.

When a 270 eligibility inquiry is sent, the 271 response will include the patient's attribution status (Yes, No, or Not Applicable) and the effective dates.

- EB segments that are reporting patient attribution will contain a 25 in the EB06.
- The effective dates of the attribution will be reported with DTP*356 and DTP*357.
- When the attribution status is Yes, the EB01 (eligibility or benefit information code) will contain a CB and the MSG segment will contain "Attribution Status – Yes."
- When the attribution status is No, the EB01 will contain a D and the MSG segment will contain "Attribution Status – No."
- When the attribution status is Not Applicable, the EB01 will contain an E and the MSG segment will contain "Attribution Status – Not Applicable."

Example:

EB*CB**30***25~
DTP*356*D8*20250701~
DTP*357*D8*20250731~
MSG*Attribution Status – Yes~

7.2.6 Health reimbursement account (HRA) information

HRA starting and remaining amounts will be reported as follows:

EB*F*IND*30***29*3300~
MSG*HRA Balance~
EB*F*IND*30***23*5000~
MSG*HRA remaining Balance~

7.2.7 Cigna Healthcare messages

Cigna Healthcare will often provide additional messages including:

- Network Participation:
  - When the requestor's network-participation status can be determined, Cigna Healthcare will send a message on the EB1*30 row that indicates whether the health care provider (or facility) is in network or out of network for the customer's medical plan.
  - For tiered benefit plans that use client-specific networks (CSNs), Cigna Healthcare may also send a message indicating whether the provider is participating in the applicable CSN based on the NPI submitted in the request.

    For example:

    EB*1**30**Choice Fund HSA Open Access Plus~
    MSG*Healthcare professional is in network based on NPI ID provided in request~

    EB*1**30**Choice Fund HSA Open Access Plus~
    MSG*Provider is in the ABC CSN based on NPI ID provided in request~

- When a customer's deductibles or maximums cross accumulate between plans (medical, dental, behavioral, pharmacy, or vision) or between different STCs, messages will be added to the appropriate EB* segment.

  For example:

  EB*C*FAM*30***23*4000.00~
  MSG*IG*Accumulators are shared between medical and mental health coverage~

- When a customer's dental benefits are determined by a patient charge schedule, messages will be added to the appropriate EB segments.

  For example:

  EB*B**35****20*****Y~
  MSG*Patient charge schedule K1-V7~

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7.2.8 Cigna Healthcare CareLink network

Customers that participate in the Cigna Healthcare CareLink® network will have an additional EB*1 30 row that will display CareLink in the EB05.

7.2.9 Restricted shared-risk networks

Customers that participate in one of the Cigna Healthcare restricted shared-risk networks will have an additional EB*N 30 row. The name and contact information for the provider organization that manages the network will be provided on the associated 2120 loop.

For example:

EB*N~
LS*2120I*13*2*SUPERCLINIC~
N3*PO BOX 99999~
N4*HOUSTON*TX*77230~

7.2.10 Patients with external partner arrangements

Eligibility for patients with a third-party administrator (TPA) or externally administered arrangements – such as Shared Administration Repricing (SAR), strategic alliances, and Payer Solutions – should be verified with the applicable partner entity. If eligibility is confirmed using both Cigna Healthcare and partner data, the 271 response will return both EB*U and EB*I segments. The partner name and telephone number will be provided in the MSG segment for the requestor to obtain additional eligibility or benefit information.

8. Acknowledgements and/or reports

Cigna Healthcare will generate the TA1/999 acknowledgement for a 270 X12 real-time request to indicate HIPAA/translation errors. Otherwise, the associated 271 response is returned.

9. Trading partner agreements

To initiate the evaluation process for potentially becoming a trading partner with Cigna Healthcare, please contact your Cigna Healthcare Trading Partner Relationship Manager.

In your request, please include the following information:

- Company name and address.
- Primary and alternate contact information (email address and phone numbers).
- Supported transactions (current environment).
- Proposed transactions.
- Provider pricing model.
- High-level workflow of proposed business model.
- Current compliances (HIPAA/ANSI, etc.).
- File submission size and frequency (current environment).

Cigna Healthcare requires all trading partners meet the minimum requirements:

- CAQH CORE certification.
- DirectTrust® accreditation (https://DirectTrust.org).
- HIPAA compliance.
- ANSI compliance.

Note: Cigna Healthcare reviews each trading partner request against the needs of its existing trading partner arrangements.

10. Transaction-specific information (loops)

This section describes how TR3s adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that Cigna Healthcare has something additional, over and above the information in the TR3s. That information can:

- Limit the repeat of loops or segments with the length of a simple data element.
- Specify a subset of the TR3s internal code listings.
- Clarify the use of loops, segments, composite, and simple data elements.
- Display any other information tied directly to a loop, segment, and composite or simple data element pertinent to trading electronically.

In addition to the row for each segment, one or more additional rows are used to describe Cigna Healthcare usage for composite and simple data elements and other information.

Notes and comments are placed at the deepest level of detail. For example, a note about a code value is placed on a row specifically for that code value, not in a general note about the segment. Further elaboration of these Cigna Healthcare-specific usage rules can be found in Section 9.

10.1 270 – Health Care Eligibility Benefit Inquiry (05010X279A1)

The table below represents only those fields that Cigna Healthcare requires a specific value in or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction. The TR3 should be reviewed for that information.

Pg#	Loop ID	Reference	Name	Value	Notes/comments
69	**2100A**	**NM1**	**NM1 – information source name**		Information source.
69	2100A	NM101	Entity identifier code	'PR'	Payer identifier code.
70	2100A	NM102	Information source name	'2'	Non-person entity.
70	2100A	NM103	Organization name	'Cigna HealthCare'	Organization name for Cigna Healthcare.
71	2100A	NM108	Identification code qualifier	'FI'	FI: Federal TIN.
71	2100A	NM109	Identification code	'06-1059331'	Identification code for Cigna Healthcare.
75		**NM1**	**NM1 – Information receiver name**		
77	2100B	NM108	Identification code qualifier		Cigna Healthcare requires that the NPI value be 'XX'. The only exception is when a provider is atypical; then 'FI' is required. Atypical providers must notify Cigna Healthcare in advance to be considered atypical.

Pg#	Loop ID	Reference	Name	Value	Notes/comments
78	2100B	NM109	Identification code		Cigna Healthcare may use the submitted identifier to determine the provider's network participation status, and attribution status for the customer.
84	**2100B**	**PRV**	**PRV – Information receiver provider information**		
85	2100B	PRV03	Reference identification		Submitted taxonomy code will be used to return benefits for an explicit STC that is valid for different plan types. For example: If diagnostic X-ray benefits exist for medical and dental products and a taxonomy code for a dental provider is submitted, only the dental diagnostic X-ray benefits will be returned. If a taxonomy code is submitted in loop 2100C/D–PRV, this taxonomy code is ignored.
103	**2100C**	**PRV**	**PRV – Provider information**		
106	2100C	PRV03	Reference identification		Submitted taxonomy code will be used to return benefits for an explicit STC that is valid for different products. For example, if diagnostic X-ray benefits exist for medical and dental plans and a taxonomy code for a dental provider is submitted, only the dental diagnostic X-ray benefits will be returned.
113	**2100C**	**HI**	**HI – Subscriber health care diagnosis**		
113	2100C	HI01-1 – HI08-1	Code qualifier		Supported by Cigna Healthcare and will be considered in the request for procedure codes.
113	2100C	HI02-1 – HI02-8	Industry diagnosis code		Supported by Cigna Healthcare and will be considered in the request for procedure codes.
124	**2110C**	**EQ**	**Subscriber eligibility or benefit inquiry**		Subscriber eligibility and benefit information. Cigna Healthcare supports up to and including 99 occurrences of the EQ segment per transaction.
125	2110C	EQ01	Service type code		Refer to section 7 for additional details.

Pg#	Loop ID	Reference	Name	Value	Notes/comments
130	2110C	EQ02-01	Composite medical procedure identifier		Supported by Cigna Healthcare and will be considered in the request; not used if EQ01 is submitted.
131	2110C	EQ02-2	Procedure code		Supported by Cigna Healthcare and will be considered in the request.
134	2110C	EQ03	Coverage level code	'FAM'	Not supported on Cigna Healthcare inquiry. Cigna Healthcare will return benefits only for the individual submitted on the 270 request.
134	2110C	EQ05	Composite diagnosis code pointer		Supported by Cigna Healthcare and will be considered in the request.
136	**2110C**	**AMT**	**AMT – Subscriber spend down amount**		Not used by Cigna Healthcare.
137	**2110C**	**AMT**	**AMT – Subscriber spend down total billed amount**		Not used by Cigna Healthcare.
138	**2110C**	**III**	**III – Subscriber eligibility or benefit additional inquiry information**		
140	2110C	III02	Industry code		Supported by Cigna Healthcare and will be considered in the request.
160	**2100D**	**PRV**	**PRV – Provider information**		
163	2110D	PRV03	Reference identification		Submitted taxonomy code will be used to return benefits for an explicit STC that is valid for different plan types. For example: If diagnostic X-ray benefits exist for medical and dental products and a taxonomy code for a dental provider is submitted, only dental diagnostic X-ray benefits will be returned.
170	**2100D**	**HI**	**HI – Dependent health care diagnosis code**		
171	2100D	HI01-1– HI08-1	Code qualifier		Supported by Cigna Healthcare and will be considered in the request for procedure codes.
171	2100D	HI02-2 – HI08-2	Industry diagnosis code		Supported by Cigna Healthcare and will be considered in the request for procedure codes.
181	**2110D**	**EQ**	**EQ – Subscriber eligibility or benefit inquiry**		Cigna Healthcare supports up to and including 99 occurrences of the EQ segment per transaction.

Pg#	Loop ID	Reference	Name	Value	Notes/comments
182	2100D	EQ01	Service type code		Refer to section 7 for additional details.
186	2110C	EQ02-01	Composite medical procedure identifier		Supported by Cigna Healthcare and will be considered in the request; not used if EQ01 is submitted.
186	2110C	EQ02-2	Procedure code		Supported by Cigna Healthcare and will be considered in the request.
190	2100D	EQ03	Coverage level code	'FAM'	Not supported on Cigna Healthcare inquiry. Cigna Healthcare will return benefits only for the individual submitted on the 270 request.
190	2100D	EQ05	Diagnosis code pointer		Supported by Cigna Healthcare and will be considered in the request.
192	**2100D**	**III**	**III – Dependent eligibility or benefit additional inquiry information**		
192	2100D	III02	Industry code		Supported by Cigna Healthcare and will be considered in the request.

10.2 271 – Health Care Eligibility Benefit Response (005010X279A1)

The table below represents only those fields that Cigna Healthcare requires a specific value in or has additional guidance on what the value in the response means. The table does not represent all of the fields that will be returned in a successful transaction. The TR3 should be reviewed for that information.

Pg#	Loop ID	Reference	Name	Value	Notes/comments
218	**2100A**	**NM1**	**NM1 - Information source name**		Information source.
219	2100A	NM103	Organization name	'CGLIC' 'CHLIC' 'Cigna Behavioral Health' 'Cigna Dental Health'	Legal entity administering customer's benefits.
220	2100A	NM109	Identification code	'06-1059331' '59-1031071' '41-1648670' '59-2308055'	TINS, respectively, for: • CGLIC • CHLIC • Cigna Healthcare Behavioral Health • Cigna Healthcare Dental

Pg#	Loop ID	Reference	Name	Value	Notes/comments
221	**2100A**	**PER**	**PER – Information source contact information**		Source contact for strategic alliance. When Cigna Healthcare has a Shared Administration Repricing (SAR) role or is a supporting party, the plan coverage description (EB05) will have the alliance partner's name. The alliance partner's contact information will be provided in the PER segment of loop 2120C.
222	2100A	PER02	Name		'Customer Support' or blank.
222	2100A	PER03	Communication number qualifier	'TE'	Telephone identification code.
223	2100A	PER04	Communication number	Format: AAABBBCCCC	Cigna Healthcare Customer Support telephone number.
224	2100A	PER05	Communication number qualifier	'UR'	Uniform Resource Locator (URL).
225	2100A	PER06	Communication number	Format: hostname/URL	Cigna Healthcare URL.
249	**2100C**	**NM1**	**NM1 – Subscriber name**		Subscriber information.
251	2100C	NM108	Identification code qualifier	'MI'	Member identification (MI) identifies a Cigna Healthcare-specific unique patient identifier rather than the Social Security number (SSN). If a unique patient identifier exists, it will be used as the primary identification code on all 271 responses in place of the customer's SSN. Once this unique patient identifier is provided to the information receiver, this identifier should be used for all future inquiries, communications, and claim submissions.
253	**2100C**	**REF**	**REF – Subscriber additional identification**		
254	2100C	REF01	Reference identification number	'N6'	Code for plan network identification number.
256	2100C	REF02	Reference identification	Network name MPO/NPO ID	Network name example: 'LocalFlex~' MPO/NPO example: '030 NY806 FLEX*HMO CODE, NETWORK ID, LOB.~'
256	2100C	REF03	Description	Definition of values in 'HMO Code, Network ID, LOB'	Description of values passed in REF02.

Pg#	Loop ID	Reference	Name	Value	Notes/comments
283	**2100C**	**DTP**	**DTP – Subscriber date**		
284	2100C	DTP03	Date time period		Eligibility and plan dates in loop 2100C are for the customer's primary plan relevant to this request. The primary plan selection is dependent on the submitted STCs and the customer's coverage. If the customer has a Cigna Healthcare medical plan and the request is for a generic 30 or an STC that is related to medical, the medical plan will be considered primary. The same logic will be applied for dental, behavioral, pharmacy, and vision plans and STCs. If the requested STC is not appropriate for the customer's coverage (e.g., medical STC but the customer only has a dental plan), the primary plan is selected using the following hierarchy: 1) medical, 2) behavioral, 3) dental, 4) pharmacy, and 5) vision. If a customer has multiple plans and those dates differ from the primary plan, the dates will be passed in loop 2110 and contain qualifiers of 348 and/or 349, as applicable. When all coverage dates are equal, only loop 2100 will be created. Benefits with dates that may vary from medical are: Dental, vision, and pharmacy.
289	**2110C**	**EB**	**EB – Subscriber eligibility or benefit information**		
291	2110C	EB01	Eligibility or benefit information code		Refer to section 7 for additional details.
293	2110C	EB03	Service type code		Refer to section 7 for additional details.
303	2110C	EB13	Composite medical procedure		If a procedure code is passed on the request, benefits will be returned on the response for the procedure code.
303	2110C	EB14	Diagnosis code pointer		

Pg#	Loop ID	Reference	Name	Value	Notes/comments
314	**2110C**	**REF**	**REF – Subscriber additional identification**		
316	2110C	REF02	Reference identification	1L	Reference ID. 1L: Policy/account number.
316	2110C	REF03	Description		Policy/account name in REF02.
317	**2110C**	**DTP**	**DTP – Subscriber eligibility/benefit date**		
317	2110C	DTP01	Date/time qualifier	'193', '194', '348', '349', '636'	Qualifiers 356 and, when applicable, 357 will be passed in the DTP segment of loop 2100 to indicate the customer's eligibility begin- and end-date qualifiers. Qualifiers 348 and/or 349 will be used in loop 2110 when the dates for the subordinate benefit differ from the priority benefit dates passed in loop 2100C. Qualifier 290 is used to indicate the effective date for coordination of benefits (COB). Qualifier 636 is used to indicate the last COB verification date. Qualifiers 193 and 194 may be returned to indicate deductible date variances from other benefit dates.
318	2110C	DTP03	Date time period		When EB01 = 'R' (COB), the field is populated with the other carrier's policy effective/cancel dates as reported to Cigna Healthcare. Otherwise, if a customer has secondary plan(s) and a benefit with a date that differs from the date reported in loop 2100C, the dates for the subordinate benefits will be passed in loop 2110 and contain a qualifier of 307. When all coverage dates are equal, no dates will be reported in loop 2110C. Only loop 2100 will be created.
322	**2110C**	**MSG**	**MSG – Message text**		
323	2110C	MSG01	Free-form message text	'PHS+' 'PHS'	The message 'PHS' or 'PHS+' indicates the customer's medical management service level e.g., EB*1**1~MSG*PHS+~

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Pg#	Loop ID	Reference	Name	Value	Notes/comments
328	**2115C**	**LS**	**Subscriber eligibility or benefit additional information**		
328	2115C	LS01	Loop identifier		
329	**2120C**	**NM1**	**Subscriber benefit related entity name**		
330	2120C	NM101	Entity identifier code	'PR'	Payer identifier code.
331	2120C	NM102	Information source name	'2'	Non-person entity.
331	2120C	NM103	Organization name		Alliance partner's name.
339	**2120C**	**PER**	**Subscriber benefit related entity contact information**		
340	2120C	PER01	Contact function code		'IC'.
340	2120C	PER02	Name		Alliance partner's name.
341	2120C	PER03	Communication number qualifier	'TE'	Telephone identification code.
341	2120C	PER04	Communication number	Format: AAABBBCCCC	Alliance telephone number.
342	2120C	PER05	Communication number qualifier	'EX' or 'TE'	(Optional) telephone or telephone extension identification code.
342	2120C	PER06	Communication number	Format: AAABBBCCCC	(Optional) alliance phone extension or second phone number.
343	2120C	PER07	Communication number qualifier	'UR'	URL.
343	2120C	PER08	Communication number	Format: hostname/URL	Alliance–website.
346	**2120C**	**LE**	**Loop trailer**		
346	2120C	LE01	Loop identifier		
354	**2100D**	**NM1**	**NM1 – Dependent name**		Dependent information.
357	**2100D**	**REF**	**REF – Subscriber additional identification**		Subscriber additional ID for customers with managed care plans.
358	2100D	REF01	Reference identification qualifier	'N6' '18'	Code for plan network identification number. Plan number.
360	2100D	REF02	Reference identification	Network name MPO/NPO ID	Network name example: 'LocalFlex ~' MPO/NPO example: '030 NY806 FLEX*HMO CODE, NETWORK ID, LOB.~'

Pg#	Loop ID	Reference	Name	Value	Notes/comments
360	2100D	REF03	Description	Definition of values in 'HMO Code, Network ID, LOB~'	Description of values passed in REF02.
387	**2100D**	**DTP**	**DTP – Subscriber date**		
388	2100D	DTP03	Date time period		Eligibility and plan dates in loop 2100D are for the customer's primary plan relevant to this request. The primary plan selection is dependent on the submitted STCs and the customer's coverage. If the customer has a Cigna Healthcare medical plan and the request is for a generic 30 or an STC that is related to medical, the medical plan will be considered primary. The same logic will be applied for dental, behavioral, pharmacy, and vision plans and STCs. If the requested STC is not appropriate for the customer's coverage, the primary plan is selected using the following hierarchy: 1) medical, 2) behavioral, 3) dental, 4) pharmacy, and 5) vision. If a customer has multiple plans and those dates differ from the primary plan, the dates will be passed in loop 2110 and contain qualifiers of 348 and/or 349, as applicable. When all coverage dates are equal, only loop 2100 will be created. Benefits with dates that may vary from medical are: Dental, vision, and pharmacy.
393	**2110D**	**EB**	**EB – Dependent eligibility or benefit information**		
395	2110D	EB01	Eligibility or benefit information code		Refer to section 7 for additional details.
397	2110D	EB03	Service type code		Refer to section 7 for additional details.
407	2110D	EB13	Composite medical procedure		If procedure code passed on the request, benefits will be returned on the response for the procedure code.
410	2110D	EB14	Diagnosis code pointer		

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Pg#	Loop ID	Reference	Name	Value	Notes/comments
420	**2110D**	**DTP**	**DTP – Dependent eligibility/benefit date**		
420	2110D	DTP01	Date/time qualifier	'193', '194', '348', '349', '636'	Qualifiers 356 and, when applicable, 357 will be passed in the DTP segment of loop 2100 to indicate the customers' eligibility begin date and end date. Qualifiers 348 and/or 349 will be used in loop 2110 when the dates for the subordinate benefit differ from the priority benefit dates passed in loop 2100C. Qualifier 290 is used to indicate the effective date for the COB. Qualifier 636 is used to indicate the last COB verification date. Qualifiers 193 and 194 may be returned to indicate deductible date variances from other benefit dates.
421	2110D	DTP03	Date time period		When EB01 = 'R' (COB), the field is populated with the other carrier's policy effective/cancel dates as reported to Cigna Healthcare. Otherwise, if a customer has secondary plan(s) and a benefit with a date that differs from the date reported in loop 2100C, the dates for the subordinate benefits will be passed in loop 2110 and contain a qualifier of 307. When all coverage dates are equal, no dates will be reported in loop 2110C. Only loop 2100 will be created.
425	**2110D**	**MSG**	**MSG – Message text**		
426	2110D	MSG01	Free-form message text	'PHS+' 'PHS'	The message 'PHS' or 'PHS+' indicates the customer's medical management service level. e.g., EB*1**1~MSG*PHS+~

11. Appendices

11.1 Implementation checklist

This implementation checklist can be used for implementing interactive transactions with a new trading partner. The main steps include:

- Register with trading partner.
- Create and sign contract with trading partner.
- Establish network connectivity.
- Create a website.
- Create an application to add the new trading partner and test application.
- Send test transactions.
- If testing succeeds, proceed to go-live and send production transactions.

Additional details for each of the steps above are provided below.

Network connectivity:

The work for setting up a network will vary based on requirements. However, it is likely the requirements will dictate a dedicated and redundant circuit.

Website creation:

In order to implement a new trading partner, a website needs to be developed internally. The requirements for volumes, certificate hardware, security, URLs, and firewall URLs should be considered.

Testing for transactions:

This testing involves conducting 270/271 and 276/277 transactions with the trading partner.

Go-live:

For go-live, some shake-out transactions will be run for 270/271 transactions. It is recommended that the shake-out transactions include subscriber and/or dependent scenarios. It's possible that shake-out activities can be conducted prior to the actual go-live, depending on the environmental constraints of the trading partner.

11.2 Business scenarios

- Scenario A: Eligibility and benefit request for a customer when a 30 STC is submitted.
- Scenario B: Eligibility and benefit request for a customer whose claims are adjudicated by a strategic alliance partner.
- Scenario C: Eligibility and benefit request for a customer, who is aligned to a PCP, when procedure code 92014 is submitted.

See the corresponding transmission examples in section 11.3 of this appendix for the 271 response for these scenarios.

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11.3 Transmission examples

Scenario A: 30 STC is submitted

271 response:

ISA*00* *00* *30*06-1059331 *ZZ*WEBMD
*260410*1636*^*00501*000000001*0*T*:~
GS*HB*CIGNA*WEBMD*20260410*163603*2*X*005010X279A1~
ST*271*TSC1*005010X279A1~
BHT*0022*11*EOT-715b62ae-f344-4ac2-988b-cca2e02ea014*20260410*163603~
HL*1**20*1~
NM1*PR*2*CHLIC*****FI*591056496~
PER*IC**TE*8664942111*UR*cignaforhcp.cigna.com~
HL*2*1*21*1~
NM1*1P*1*DARI*MANOHAR****XX*1295487239~
HL*3*2*22*0~
TRN*2*CAQH_GWFC_Grouping_SC21*9222222222~
NM1*IL*1*EVIA CYBKUEB*SOEDCRATES B****MI*10105115600~
REF*6P*00649396*CAA - Continuity of Care Plan~
N3*3873 INSPIRATION CIRCLE~
N4*ARVADA*CO*80007~
DMG*D8*19730503*M~
INS*Y*18*001*25~
DTP*346*D8*20260101~
DTP*347*D8*20261231~
DTP*356*D8*20250101~
EB*1**30**Open Access Plus~
MSG*Provider is in network based on NPI ID provided in request~
MSG*Complete Care Management~
EB*E**30***25~
DTP*356*D8*20260410~
DTP*357*D8*20260410~
MSG*Attribution Status - Not applicable~
EB*A*IND*30*****.2****Y~
EB*G*IND*30***23*12700*****N~
MSG*Deductible does apply to member's out-of-pocket maximum AND Copay does apply to member's out-of-pocket maximum AND Coinsurance does apply to member's out-of-pocket maximum~
EB*C*IND*30***23*3000*****N~
EB*G*FAM*30***23*12700*****Y~
MSG*Coinsurance does apply to member's out-of-pocket maximum AND Deductible does apply to member's out-of-pocket maximum AND Copay does apply to member's out-of-pocket maximum~
EB*C*FAM*30***23*4500*****Y~
EB*G*FAM*30***23*25400*****N~
MSG*Coinsurance does apply to member's out-of-pocket maximum AND Copay does apply to member's out-of-pocket maximum AND Deductible does apply to member's out-of-pocket maximum~
EB*C*FAM*30***23*9000*****N~
EB*A*IND*30*****.4****N~
EB*C*IND*30***23*1500*****Y~
EB*G*IND*30***23*6350*****Y~
MSG*Deductible does apply to member's out-of-pocket maximum AND Copay does apply to member's out-of-pocket maximum AND Coinsurance does apply to member's out-of-pocket maximum~
EB*1**98^UC^47^48^50^86^33^1*********W~
EB*B*IND*98***27*50****N*Y~
MSG*Specialist~
III*ZZ*11~
EB*B*IND*98***27*50****N*Y~
MSG*Specialist AND TMJ Specialist~

III*ZZ*02~
EB*A*IND*98*****0***N*Y~
MSG*Specialist AND PCP~
III*ZZ*11~
EB*A*IND*98*****0***N*Y~
MSG*Specialist AND TMJ Specialist AND PCP AND TMJ PCP~
III*ZZ*02~
EB*C*IND*98****0****N*Y~
MSG*Specialist AND PCP~
III*ZZ*11~
EB*C*IND*98****0****N*Y~
MSG*Specialist AND TMJ Specialist AND PCP AND TMJ PCP~
III*ZZ*02~
EB*C*IND*98^UC****0****N*Y~
III*ZZ*17~
EB*A*IND*98^UC*****0***N*Y~
III*ZZ*17~
EB*B*IND*98^UC***27*25****N*Y~
III*ZZ*17~
EB*A*IND*98*****0***N*Y~
MSG*Preventive AND Preventive - Included For Specific Services~
EB*C*IND*98****0****N*Y~
MSG*Preventive AND Preventive - Included For Specific Services AND Telehealth through contracted vendor~
EB*B*IND*98***27*25****N*Y~
MSG*PCP AND TMJ PCP~
III*ZZ*02~
EB*B*IND*98***27*25****N*Y~
MSG*PCP~
III*ZZ*11~
EB*A*IND*98*****0***N*Y~
MSG*Telehealth through contracted vendor~
III*ZZ*99~
EB*B*IND*98***27*25****N*Y~
MSG*Telehealth through contracted vendor~
III*ZZ*99~
EB*A*IND*UC*****0***N*W~
MSG*Facility AND Professional Services~
EB*C*IND*UC****0****N*W~
MSG*Facility AND Professional Services~
EB*B*IND*UC***27*75****N*Y~
MSG*Facility AND Professional Services~
EB*B*IND*UC***27*150****N*N~
MSG*Facility AND Professional Services~
EB*C*IND*86****0****N*W~
EB*A*IND*86*****0***N*W~
MSG*General~
III*ZZ*23~
EB*B*IND*86***27*250****N*W~
MSG*General~
III*ZZ*23~
EB*A*IND*33*****0***N*Y~
MSG*Virtual Care Included For Specific Services~
III*ZZ*11~
EB*F*IND*33***23***VS*20*N*W~
MSG*Virtual Care Included For Specific Services~
EB*C*IND*33****0****N*Y~
MSG*Virtual Care Included For Specific Services~
III*ZZ*11~
EB*B*IND*33***27*50****N*Y~

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MSG*Virtual Care Included For Specific Services~
III*ZZ*11~
EB*1**88**Advantage Pharmacy~
EB*F*IND*30***29*1992.00~
EB*G*IND*88***23*3850****N*N~
MSG*Coinsurance does apply to member's out-of-pocket maximum~
EB*G*FAM*88***23*7700****N*Y~
MSG*Copay does apply to member's out-of-pocket maximum AND Accumulators are shared between In Network Medical AND Mental Health~
EB*G*FAM*88***23*7700****N*N~
MSG*Coinsurance does apply to member's out-of-pocket maximum~
EB*G*IND*88***23*3850****N*Y~
MSG*Copay does apply to member's out-of-pocket maximum AND Accumulators are shared between In Network Medical AND Mental Health~
EB*1**MH~
EB*G*IND*30***29*12700*****N~
MSG*Deductible does apply to member's out-of-pocket maximum AND Copay does apply to member's out-of-pocket maximum AND Coinsurance does apply to member's out-of-pocket maximum~
EB*C*IND*30***29*3000*****N~
EB*G*FAM*30***29*12700*****Y~
MSG*Coinsurance does apply to member's out-of-pocket maximum AND Deductible does apply to member's out-of-pocket maximum AND Copay does apply to member's out-of-pocket maximum~
EB*C*FAM*30***29*4500*****Y~
EB*G*FAM*30***29*25400*****N~
MSG*Coinsurance does apply to member's out-of-pocket maximum AND Copay does apply to member's out-of-pocket maximum AND Deductible does apply to member's out-of-pocket maximum~
EB*C*FAM*30***29*9000*****N~
EB*C*IND*30***29*1500*****Y~
EB*G*IND*30***29*6350*****Y~
MSG*Deductible does apply to member's out-of-pocket maximum AND Copay does apply to member's out-of-pocket maximum AND Coinsurance does apply to member's out-of-pocket maximum~
EB*F*IND*33***29***VS*20**W~
MSG*Virtual Care Included For Specific Services~
SE*132*TSC1~
GE*1*2~
IEA*1*000000001~

Scenario B: Strategic alliance partner

271 response:

ISA*00* *00* *30*06-1059331
*ZZ*SENDERIDENTIFIC*150604*0936*^*00501*000000001*0*T*:~
GS*HB*CIGNA*SENDERIDENTIFIC*20150604*0936*002*X*005010X2I
ST*271*TSC1*005010X279A1~
BHT*0022*11*2015-06-04-10-35-56-IHG-I20150604*093606~
HL*1**20*1~
NM1*PR*2*CGLIC*****FI*06-0303370~
HL*2*1*21*1~
NM1*1P*1*Smith*John****XX*1111111112~
HL*3*2*22*0~
TRN*2*2015-06-04-10-35-56-IHG-TEST*9222222222~
NM1*IL*1* PEITERSEN*KEVIN****MI*912184054~
REF*6P*1234567*ALLIANCE HEALTH BENEFIT PLAN~
N3*PO BOX 123~
N4*BOSTON*MA*021080292~
DMG*D8*20070213*M~

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INS*N*01*001*25~
DTP*356*D8*20260101~
EB*1**30~
DTP*291*D8*20260616~
MSG*Patient has active coverage based on data available as of date of request. Contact other entity to validate~
EB*U**30~
LS*2120~
NM1*PR*2*SELF INSURED SERVICE COMPANY~
PER*IC*SELF INSURED SERVICE COMPANY*TE*8004574726~
LE*2120~
SE*21*1001~
GE*1*1~
IEA*1*282733395~

Scenario C: Customer is aligned to a PCP when procedure code 92014 is submitted.

271 response:

ISA*00* *00* *30*06-1059331
*ZZ*SENDERIDENTIFIC*260507*1616*^*00501*000000001*0*P*:~
GS*HB*CIGNA*SENDERIDENTIFIC*20260507*161636*2*X*005010X279A1~
ST*271*TSC1*005010X279A1~
BHT*0022*11*EOT-82f9c442-83fc-4b71-9c22-18083e11a771*20260507*161636~
HL*1**20*1~
NM1*PR*2*CHLIC*****FI*591056496~
PER*IC**TE*8664942111*UR*cignaforhcp.cigna.com~
HL*2*1*21*1~
NM1*1P*1*Smith*John****XX*1111111112~
HL*3*2*22*0~
TRN*2*06638_USR-426_Cigna_CPT_INDV_H_Plan_ISM_02*9222222222~
NM1*IL*1* PETER*JOHN****MI*U12121212101~
REF*6P*00649396*CAA - Continuity of Care Plan~
N3*3873 THIS ST~
N4*CITY*CO*80007~ 53216~
DMG*D8*19681216*M~
INS*Y*18*001*25~
HI*ABK:H04123~
DTP*346*D8*20260101~
DTP*347*D8*20261231~
DTP*356*D8*20210201~
EB*1**30**Open Access Plus~
MSG*Complete Care Management~
EB*C*IND****29*1500****N*N*CJ:92014*1~
EB*A*IND******50***N*N*CJ:92014*1~
III*ZZ*11~
EB*B*IND*****0****N*N*CJ:92014*1~
III*ZZ*11~
EB*L**1~
LS*2120~
NM1*P3*1*SMITH*JANE*E~
N3*118 E SOMEWHERE ST~
N4*SOMECITY*NV*89445~
PER*IC**TE*5556235222~
LE*2120~
SE*34*TSC1~
GE*1*2~
IEA*1*000000001~

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11.4 Frequently asked questions

1. **Does the companion guide apply to all Cigna Healthcare customers?**
   Yes. It applies to all Cigna Healthcare customers.

2. **How does Cigna Healthcare support, monitor, and communicate expected and unexpected connectivity outages?**
   Our systems have planned outages. The planned maintenance windows are identified in section 4.1 of this document.

   Non-routine downtime will be communicated to our trading partners at least week ahead of time.

   Unexpected outages will be communicated to the trading partners typically within one hour.

3. **If a 270 request is successfully transmitted to Cigna Healthcare, are there any situations that would result in no response being sent back?**
   No. Cigna Healthcare will always send a response. Even if Cigna Healthcare systems are down and the transaction cannot be processed at the time of receipt, a response detailing the situation will be returned.

11.5 Change summary

This section describes the differences between the current companion guide and previous guide(s).

Date	Version	Description	Author
10/01/2009	1.0	Initial version with CORE requirements.	
10/09/2009	1.1	Added trading partner information.	B. Fielder
12/30/2009	1.2	Updated section on Working with Cigna.	B. Fielder
10/31/2011	1.3	Updated for 5010.	S. Liebert
11/08/2011	1.4	Final draft for 5010.	S. Liebert
11/28/2011	1.4.1	Incorporated feedback.	J. Hoyt
11/30/2011	1.4.2	Updates to reference notes and comments; updated 271 example A.	P. Pac
11/30/2011	1.4.3	Replaced business scenario A; removed https:// from scenarios; changed link in sections 2.2 and 5.2.	S. Liebert
12/01/2011	1.4.4	Replaced business scenario B.	S. Liebert
12/02/2011	1.4.5	Updated I-gate http address.	S. Liebert
12/29/2011	1.4.6	Updated 2110C medical management service level mapping.	S. Liebert
01/04/2012	1.4.7	Updated: 2110D medical management service level mapping.	S. Liebert
08/23/2012	1.5	Updated section 10 tables and content.	P. Russell
08/28/2012	1.6	Updated with CAQH changes.	S. Liebert/ P. Russell/ M. Anand
02/2014	1.7	Removed endpoint URLs.	----
06/4/2014	1.8	Updated alliance partner contact information, new supported STC.	M. Langston/ H.W. Daley, Jr. / M. Karuppannan
03/10/2016	1.9	Removed reference of 'HP'.	S. Swyers
04/12/2016	2.0	Corrected email address in section 5.1.	K. Roberg

Date	Version	Description	Author
08/01/2018	2.1	Updated the contact number in section 5.2.	K. Roberg
04/05/2021	2.2	Addressed formatting issues in the document and updated the copyright date in the footer.	Taylor Morelli-Zwiebel
04/19/2024	2.3	Updated: • With CAQH certified date. • Working with Cigna Healthcare section. • System availability section. • Process flow. • Passwords section. • EDI customer service. Removed communication protocol; Cigna Healthcare no longer offers HTTP+Form connectivity.	M. Neeley

04/25/2026	2.4	Updated:
		• Section 4.4: Communication protocols specifications and section 4.6: Security authentication requirements –
		  ○ Support REST service using JSON connectivity.
		  ○ Support OAuth2.0 client authorization for SOAP + WSDL and REST connectivity.
		• Section 7.2.2: General 30 response table.
		• Section 7.2.3: Supported group responses.
		• Section 10.1: NPI requirement.
		• Section 11.2: Business scenarios.
		• Section 11.3: Transmission examples.
			T. Bakalas

08/01/2026	3.0	Updated: • Section 7.1.4: Procedure codes. • Section 7.1.5: Diagnosis codes. • Section 7.1.6: Place of Service codes. • Section 7.2.4: Tiered benefits. • Section 7.2.10: Patients with external partner arrangements. • Section 10.1: 270 – Health Care Eligibility Benefits Inquiry (05010X279A1) – HI and EQ rows in chart. • Section 10.2: 271 – Health Care Eligibility Benefit Response (005010X279A1) – NM103 and NM109 rows. • Section 11.2: Business scenarios. • Section 11.3: Transmission examples. Removed Section 4.6: Security and authentication requirements. Made editorial updates.	T. Bakalas