

2026 Nonquantitative Treatment Limitation (NQTL) Submission Template

Instructions: This NQTL reporting submission form includes the required six information elements or Required Steps as specified by the Mental Health Parity and Addiction Equity Act (MHPAEA) and its regulations, including 42 USC Section 300gg-26(a)(8)(A) and 45 CFR 146.137. The comparative analyses to be performed must be reported using this submission form and should comply with MHPAEA, its regulations, federal guidance, and the instructions, both separately provided and set forth herein.

A separate reporting form should be prepared and completed for each NQTL requested by the BOI in each benefits classification/sub-classification. For example, the comparative analysis for prior authorization for the Inpatient, In-Network benefits classification should be provided on its own reporting submission form, and the comparative analysis for prior authorization for the Inpatient, Out-of-Network classification should be provided in a separate reporting submission form. Similarly, the comparative analyses for prior authorization for Outpatient benefits should be reported separately, with a form used for In-Network and a form to be used for Out-of-Network. If there are questions about how to properly report using this form, please contact the BOI.

Out-of-Network Out-Patient Provider Reimbursement

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See [**45 CFR 146.137\(c\)\(1\)**](#). Step 1 must include the following:

- (i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;
- (ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and
- (iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also [FAQ 45](#) (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

This document represents an NQTL comparative analysis for the Out-of-Network (OON) Outpatient Provider Reimbursement parameters applied to mental health/substance use disorder (“MH/SUD”) and/or medical/surgical (“M/S”) services for the outpatient benefit classifications and is incorporated in plans insured by Cigna Health and Life Insurance Company (“CHLIC”) In the review and analysis of the Out-of-Network (OON) Outpatient Provider Reimbursement NQTL, Cigna reviewed policies applicable to Cigna and Evernorth Behavioral Health (EBH) and the M.C. Dean, Inc. plan certificate.

Evernorth Behavioral Health (“Evernorth,” “EBH”) an affiliate of CHLIC, administers the network for MH/SUD benefits, while CHLIC administers the network for M/S benefits not otherwise delegated to a separate entity. All entities collectively referred to as “Cigna” and references to “Cigna” or “Cigna Network” contained herein include Evernorth Behavioral Health Network unless otherwise noted separately.

No third parties or separate related entities played a role in developing the NQTL, its comparative analysis, or the policies and procedures contained in this response. Cigna maintains corporate-wide policies applicable to its multiple business segments including Cigna Healthcare (applicable to M/S services) and Evernorth Behavioral Health (applicable to MH/SUD services), and policies applicable to specific business segments only (either M/S or MH/SUD services).

Cigna has assessed several components of its standards for a provider and/or facility reimbursement (collectively “Provider Reimbursement”) NQTL applicable to the OON outpatient benefit classification for M/S and MH/SUD services.

Unless otherwise expressly stated, all information provided in Step 1 applies equally to the Base Rates, Final Rates, and Adjusted Rates described in this comparative analysis.

The plan language or coverage terms governing Out-of-Network (OON) Outpatient Provider Reimbursement NQTL is excerpted from the M.C. Dean, Inc. plan certificate and states as follows:

M.C. Dean, Inc. Plan Language	
Allowable Expense	The amount of charges considered for payment under the Plan for a Covered Service prior to any reductions due to coinsurance, copayment or deductible amounts. If Cigna contracts with an entity to arrange for the provision of Covered Services through that entity’s contracted network of health care providers, the amount that Cigna has agreed to pay that entity is the allowable amount used to determine your coinsurance or deductible payments. If

the Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.¹

Charges

The term charges means the actual billed charges; except when Cigna has contracted directly or indirectly for a different amount including where Cigna has directly or indirectly contracted with an entity to arrange for the provision of services and/or supplies through contracts with providers of such services and/or supplies.²

Maximum Reimbursable Charge - Medical 04-10 V1 The Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the provider's normal charge for a similar service or supply; or • a policyholder-selected percentage of a schedule that Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market. The percentage used to determine the Maximum Reimbursable Charge is listed in The Schedule. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the provider's normal charge for a similar service or supply; or • the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.³

Non-Participating Provider The term Non-Participating Provider means a Hospital, a Physician or any other health care practitioner or entity that does not have a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which you are covered. When you obtain services from a Non-Participating Provider, you may be responsible for the cost of services above the Maximum Reimbursable Charge in addition to any copayments, coinsurance and deductible. Certain Non Participating Providers have discount arrangements with vendors that Cigna is able to access. If Cigna is able to access those discounts, you will receive the benefit of such discounts and will also be protected from balance billing by those Non Participating Providers.⁴

Description of the NQTL:

The Out-of-Network Outpatient Provider Reimbursement NQTL consists of the standards, processes, and methodologies used to determine the allowable amount for covered outpatient services furnished by out-of-network practitioners and facilities. Subject to applicable federal and state law and the terms of the plan, Cigna determines the allowable amount through one or more of the following: an applicable out-of-network protection arrangement or negotiated rate; the lesser of the provider's covered billed charge or the plan sponsor's elected Maximum Reimbursable Charge methodology, including MRC1 or MRC2; or, when an applicable Medicare fee-schedule amount is unavailable, the Medicare Gap Fill process. These reimbursement methodologies may affect the amount payable by the plan and the members' potential financial responsibility for covered out-of-network services. The NQTL applies to MH/SUD and M/S benefits within the Outpatient Office Visit and Outpatient All Other sub-classifications, and the comparative analysis evaluates whether the processes, strategies, evidentiary standards, factors, and sources used to design and apply these methodologies are comparable and no more stringently applied to MH/SUD benefits than to M/S benefits, both as written and in operation.

Glossary:

¹ M.C. Dean, Inc. Plan Booklet pg. 56 of 90

² M.C. Dean, Inc. Plan Booklet pg. 76 of 90

³ M.C. Dean, Inc. Plan Booklet pg. 81 of 90

⁴ M.C. Dean, Inc. Plan Booklet pg. 82 of 90

1. Geographic Practice Cost Index (GPCI): Is a measure used by Medicare to adjust physician payments based on the geographic location where services are provided. It accounts for differences in the costs of providing care across various areas by applying GPICs to the three components of a procedure's relative value unit (RVU): work, practice expense, and malpractice. The Centers for Medicare & Medicaid Services (CMS) utilizes these indices to ensure that payments reflect the local cost of living and practice expenses.
2. Mental Health or Substance Use Disorder (MH/SUD): Means benefits with respect to items or services for mental health conditions or substance use disorders that are included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), as defined under the term of the plan and in accordance with applicable federal and state law. Any condition defined by the plan as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the International Classification of Diseases (ICD), or state guidelines).
3. Medical/Surgical: Means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan and in accordance with applicable federal and state law but does not include mental health or substance use disorder benefits. Any condition defined by the plan being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the ICD or state guidelines).
4. Medicare Gap Fill Plus: Internally developed maximum reimbursable charge, option 2 (MRC2), based on methodologies used by CMS to pay Medicare claims in the absence of a Medicare Fee Schedule rate.
5. Provider/Practitioner: A licensed physician, non-physician health care practitioner, hospital or other facility, supplier, or other individual or entity involved in the delivery of health care services or benefits.
6. Prospective Payment Systems (PPS): A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services). CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.
7. Qualifying Payment Amount (QPA): The median contracted rate recognized by the plan (determined by all plans/coverage offered by the plan/issuer in the same market, e.g. individual, small group, large group, self-insured group plans) as the total maximum payment provided on January 31, 2019 (or the previous year, for 2023+ plan years), for the same or similar item or service, by a similar provider, in the same geographic region.
8. Relative Value Unit (RVU): Is a system used in the United States to determine physician reimbursement rates for the services they provide. RVUs are a component of the Resource-Based Relative Value Scale (RBRVS), which is utilized by Medicare and private payers to establish payment amounts based on the resources and effort required for medical services.
9. Resource-Based Relative Value Scale (RBRVS): a CMS-created reimbursement methodology to reimburse providers for members covered under the Medicare program and as a baseline for commercial reimbursement rates.
10. MRC Policy Review Board: Where Medicare may not have a published rate for certain codes, we have an MRC policy review board that reviews clinical guidelines and procedure codes. The review board consists of clinicians and SME's who review comparable services and determine the appropriate rate and code, if available.

11. Usual and Customary (U&C): Average allowed amount for a M/S or MH/SUD service based on the provider of services geographical area.

Supporting Documents:

Document/Policy Name	Description
M.C. Dean, Inc. Plan Booklet	Plan specific document that outlines the details of a health insurance plan, including plan and benefit information, claim review procedures, and participation rights. The plan booklet provides comprehensive information about what the plan covers, how it is administered, and the procedures for reviewing claims. It is intended to help members understand their rights and responsibilities under the plan.
Benefit Enhancement Policy	The operational guidelines for enhancing services to the in-network benefit level when performed by a non-participating provider.
Comparative Analysis Network Services 2023-06-08 Final: Multiplan Reimbursement Comparative Analysis	Claritev formerly Multiplan Reimbursement Comparative Analysis in regard to network services.
Comparative Analysis Template Negotiation Services 2023-03-01 Final: Multiplan Reimbursement Comparative Analysis	Claritev formerly Multiplan Reimbursement Comparative Analysis in regard to rate negotiation.
ECPP (Cost Containment) Control Document	Document describing Cigna's cost containment programs in relation to out-of-network reimbursement.
Maximum Reimbursable Charge Policy Article number 000017315	Establishes guidelines for maximum reimbursable charge application when claims are submitted by non-participating providers.
MH/SUD Single Case Agreement (SCA) Standard Operating Procedure	This document establishes a consistent process for single case agreement negotiation and pricing methodologies.
M/S Single Case Agreement (SCA) Standard Operating Procedure	This document establishes a consistent process for single case agreement negotiation and pricing methodologies.
Out-of-Network Cost Containment (Power Point)	External facing document that outlines Cigna's Out-of-Network Protection Programs
Out-of-Network Reimbursement Rate Methodology	Describes the program provided by a partner entity that utilizes one of three methods to establish appropriate reimbursement levels for covered charges with non-contracted providers.
UM 20: Network Adequacy Provision Policy	Establishes a consistent process for evaluating and responding to network adequacy authorization requests when it is perceived that a qualified, participating health care professional or provider is not available to provide medically necessary services within a reasonable distance, as described in the applicable attachments, from the customer's home or within reasonable appointment availability timeframes.
Z24_ClaimPassSB_ERS_VF: Zelis Reimbursement Comparative Analysis	Zelis Reimbursement Comparative Analysis
OPS 18: Policy and Procedure Maintenance, Review and	The purpose of this policy is to ensure review and dissemination of policies and process within the scope of oversight by the Policy Committee in a timely

Approval Process	manner.
------------------	---------

For purposes of compliance with MHPAEA's parity requirements Cigna classifies Mental Health/Substance Use Disorder (MH/SUD) and Medical/Surgical (M/S) benefits in accordance with generally recognized independent standards of current medical practice. The applicable benefit classifications are Inpatient, Outpatient, Prescription Drugs, and emergency care. Cigna uses the permitted subclassification of Office Visit and Outpatient - All Other. All Outpatient services (Office Visit and Outpatient - All Other) are provided in an outpatient setting such as a physician's office, free standing surgical or behavioral health outpatient facility.

- **Outpatient Office Visits** include routine evaluation and management, consultation, preventive, examination, and treatment services provided by a health care provider in an office setting. Cigna classifies these benefits as Outpatient Office Visits, as they are an evaluation, visit or consultation during which other services can be provided. Routine care is provided by a practitioner that offers a wide array of evaluation, assessment, and treatment services, as compared to specialized providers who offer a narrow scope of services, as confined by their licensure or the conditions under which they provide services.
- **Outpatient - All Other** include non-routine or specialized programs, items, services, and procedures provided in an office or outpatient setting. Non-routine care is specialized treatment and/or services provided by a practitioner within a narrow scope allowed by licensure or the conditions under which services may be provided in an office or facility setting. Services assigned to the "Outpatient -All other" sub-classification include:
 - M/S Outpatient - All Other Services include lab, radiology, Outpatient surgery, Speech Therapy/Physical Therapy/Occupational Therapy, home health, Durable Medical Equipment, free standing surgical outpatient facility etc.
 - MH/SUD Outpatient - All Other Services include Partial Hospitalization (PHP), Applied Behavior Analysis (ABA), Transcranial Magnetic Stimulation (TMS), free standing behavioral outpatient facility etc.

List of Services Subject to the NQTL:

The Out-of-Network (OON) Outpatient Provider Reimbursement NQTL applies to the M/S and MH/SUD benefits listed below when furnished by non-participating facilities or practitioners and classified by the plan within the Out-of-Network Outpatient office and Outpatient All-Other benefit classifications. The table identifies all benefits and services within the benefit classification to which the NQTL applies: The listed benefits are classified as M/S or MH/SUD in accordance with the plan terms and generally recognized independent standards of current medical practice. The reimbursement NQTL applies to the processes used to establish, negotiate, approve, and apply non-participating-provider reimbursement for each listed benefit or service.

	<i>Medical/Surgical</i>	<i>Mental Health & Substance Use</i>
Is NQTL applied to Out-of-Network Outpatient-Office sub-classification?	Yes Primary Care Physician (PCP) Services/Office visit Specialty Care Physician Services/Office Visit Telehealth	Yes Office Visits, including Individual, Family and Group Psychotherapy and Medication Management Telehealth
Is NQTL applied to Out-of-Network	Yes	Yes

Outpatient-All Other sub-classification?	Advanced Radiology Consumable Medical Supplies Convenience Care (Lab, Radiology, Surgery) Dialysis not performed in a dialysis center Durable Medical Equipment (DME) Home Health Care Hospice - OP Lab Services Outpatient Short Term Rehab Outpatient Chiro Outpatient Facility Services (surgical and non-surgical) Outpatient Non-Office Preventive (Facility) Outpatient Non-Office Preventive (Professional) Outpatient Professional Services (surgical and non-surgical) Radiology Services - OP Facility (surgical and non-surgical) Radiology - Physician's Services/Office Visit (PCP/SCP) Surgery Performed in the Physician's Office (PCP/SCP) Urgent Care Facility	Partial Hospitalization Program Intensive Outpatient Services Applied Behavior Analysis Transcranial Magnetic Stimulation
---	--	--

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See [45 CFR 146.137\(c\)\(2\)](#). Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

- (i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and
- (ii) A definition of each factor, including:
 - (A) A detailed description of the factor;
 - (B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and
 - (C) A description of any steps the plan or issuer has taken to correct, cure, or

supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also [FAQ 45](#) guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Cigna utilizes **the factors outlined below** to determine services that are subject to Out-of-Network (OON) Outpatient Provider Reimbursement NQTL. In making and determination of the Out-of-Network Outpatient Provider Reimbursement NQTL there were no additional factors considered and rejected. The same reimbursement hierarchy and categories of decision factors apply to MH/SUD and M/S claims. The controlling methodology varies based on applicable law, plan terms, provider and service type, outpatient subclassification, availability of a vendor arrangement or negotiated rate, and availability of the applicable benchmark. Cigna does not apply a factor, threshold, or routing criterion more restrictively to MH/SUD claims than to M/S claims.

Base Rates:

Benefit Classification/ Sub-classification	Factors	Sources for Each Factor
Out of Network Outpatient-All Other	1. Maximum Reimbursable Charge (MRC) applied to both M/S or MH/SUD	1. Maximum Reimbursable Charge (MRC): • (MRC1) - For plans that elect MRC1, Cigna uses a rate developed from the external pricing partner claims database. • (MRC2) - For plans that elect MRC2, Cigna uses a client-elected percentage of the CMS Medicare Resources Based Relative Value Scale ("RBRVS") system for professional

Benefit Classification/ Sub-classification	Factors	Sources for Each Factor
		services. For facility services, Cigna leverages the Optum Medicare database.
Out of Network Outpatient- Office	1. Maximum Reimbursable Charge (MRC) applied to both M/S or MH/SUD	1. Maximum Reimbursable Charge (MRC) • (MRC1) - For plans that elect MRC1, rate developed from the external pricing partner claims database. • (MRC2)-For plans that elect MRC2, Cigna uses a client-elected percentage of the CMS Medicare Resources Based Relative Value Scale ("RBRVS") system.

In establishing the factors used to determine Out-of-Network Reimbursement, Cigna considers the following **sources and evidentiary standards**:

Benefit Classification/ Sub-classification	Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
Out of Network Outpatient- All Other	1. Maximum Reimbursable Charge (MRC) applied to both M/S or MH/SUD	1. Provider Reimbursement will be based on the lesser of the covered billed charges or the client-elected Maximum Reimbursable Charge (MRC). • MRC1: Based on a percentile of charges made by physicians and outpatient facilities in a given geographical area where the service is received. These charges are compiled in a national charges database selected by Cigna, and subject to change. Clients select an MRC1 percentile between 50 and 95. • MRC2: Based on a percentage of a fee schedule developed by Cigna based on methodology similar to that used by Medicare to determine the allowable fee for services within a geographical area. Clients	1. Maximum Reimbursable Charge (MRC) • (MRC1) – For plans that elect MRC1, Cigna uses FAIR Health data for professional services. • (MRC2) – For plans that elect MRC2, Cigna uses a client-elected percentage of the CMS Medicare Resources Based Relative Value Scale ("RBRVS") system for professional services. Cigna leverages the Optum Medicare database for facility services

		may select an MRC2 percentage between 100 and 300	
Out of Network Outpatient-Office	1. Maximum Reimbursable Charge (MRC) applied to both M/S or MH/SUD	1. Provider Reimbursement will be based on the lesser of the covered billed charges or the client-elected Maximum Reimbursable Charge (MRC). - MRC1: Based on a percentile of charges made by physicians and outpatient facilities in a given geographical area where the service is received. These charges are compiled in a national charges database selected by Cigna, and subject to change. Clients select an MRC1 percentile between 50 and 95. - MRC2: Based on a percentage of a fee schedule developed by Cigna based on methodology similar to that used by Medicare to determine the allowable fee for services within a geographical area. Clients may select an MRC2 percentage between 100 and 300.	1. Maximum Reimbursable Charge (MRC) (MRC1) - Cigna uses FAIR Health data for professional services. (MRC2)-For plans that elect MRC2, Cigna uses a client-elected percentage of the CMS Medicare Resources Based Relative Value Scale ("RBRVS") system for professional services. Cigna leverages the Optum Medicare database for facility services.

Adjusted Rates:

Benefit Classification/ Sub-classification	Factors	Sources for Each Factor
Out of Network Outpatient-All Other	1. Federal and State Law, as applicable. 2. Out of Network Protection Program 3. Medicare Gap Fill for procedures that are not covered by Medicare or do not have a CMS Medicare Resources Based Relative Value Scale ("RBRVS")	For the following, more details are available in the attachments titled Out-of-Network Reimbursement Methodology and Out-of-Network Cost Containment (sales collateral) 1. Consolidated Appropriations Act: No Surprises Act (NSA) qualifying services will be subject to NSA (e.g., emergency, non-participating providers rendering in a participating facility). Reimbursement is based on an amount negotiated with the provider or if an amount cannot be negotiated,

Benefit Classification/ Sub-classification	Factors	Sources for Each Factor
		the service is reimbursed on the Qualifying Payment Amount (QPA). 2. Out of Network Protection Programs Savings through Claritev (formerly Multiplan) and Zelis • External pricing partner network rate • External pricing partner direct negotiation • Cigna-initiated direct negotiation. 3. Fair Health Medicare Gap Fill Plus, and Internal MRC Policy Review Board
Out of Network Outpatient- Office	1. Federal and State Law, as applicable 2. Out of Network Protection Program 3. Medicare Gap Fill for procedures that are not covered by Medicare or do not have a CMS Medicare Resources Based Relative Value Scale ("RBRVS")	1. Federal and State Law, as applicable For the following, more details are available in the attachments titled Out-of-Network Reimbursement Methodology and Out-of-network Cost Containment (sales collateral) 2. Out-of-Network Protection Program • External pricing partner network rate • External pricing partner direct negotiation • External pricing partner 'offer' based on market rate; or • Cigna-initiated direct negotiation 3. Fair Health Medicare Gap Fill Plus, and Internal MRC Policy Review Board

In establishing the factors used to determine Out-of-Network Reimbursement, Cigna considers the following **sources and evidentiary standards**:

Benefit Classification/ Sub-classification	Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
Out of Network Outpatient- All Other	1. Federal and state Law, as applicable 2. Out of Network Protection	1. No Surprises Act (NSA) (45 CFR 149.420; Section 104 of the No Surprises Act; PHSA 2799B-2) 2. Out of Network Protection Program provided by an external	1. No Surprises Act (NSA) Reimbursement is based on an amount negotiated with the provider or if an

	Program 3. Medicare Gap Fill for procedures that are not covered by Medicare or do not have a CMS Medicare Resources Based Relative Value Scale ("RBRVS")	pricing partner that utilizes one of three methods to establish reimbursement levels for covered charges with out-of-network providers. These include the following: • Pricing partner has standing agreements with providers that establish discounted rates which Cigna can access through its pricing partner agreement. The provider remains out-of-network but agrees not to balance bill the member. • Pricing partner reviews out-of-network claims and pricing partner negotiates with the provider on the Cigna's behalf for a claim-specific discount. The provider remains out-of-network but agrees not to balance bill the member. • Cigna initiates a direct negotiated amount with the provider. 3. In the absence of a Medicare Fee Schedule rate for a service, provider reimbursement will be based on the Medicare Gap Fill process: • FairHealth - The external vendor pricing we currently use is the FAIR Health product called Medicare GapFill PLUS™. FAIR Health pulls values from all Medicare non-facility fee schedules, zip codes are mapped to the geographic areas and values are updated twice a year. Where Medicare and FairHealth do not have a published rate the following is utilized: • Internal MRC Policy Review Board Where Medicare may not have a published rate for certain codes, we have an MRC policy review board that reviews clinical guidelines and procedure codes. The review board consists of clinicians	amount cannot be negotiated, the service is reimbursed on the Qualifying Payment Amount (QPA). 2. Out of Network Protection Programs • Savings through Claritev (formerly Multiplan) and Zelis. This service provides discounted rates accompanied by a signed agreement with the health care professional or facility. • Savings through Claritev (formerly Multiplan) and Zelis. This service negotiates charge reductions accompanied by a signed agreement with the health care professional or facility. • Cigna uses in-network rates as a basis for negotiation. 3. Fair Health Medicare Gap Fill Plus, and Internal MRC Policy Review Board
--	---	---	--

		and SME's who review comparable services and determine the appropriate rate and code, if available.	
Out of Network Outpatient-Office	1. Federal and State Law, as applicable 2. Out of Network Protection Program 3. Medicare Gap Fill for procedures that are not covered by Medicare or do not have a CMS Medicare Resources Based Relative Value Scale ("RBRVS")	1. Federal and State Law, as applicable 2. Out of Network Protection Program provided by an external pricing partner that utilizes one of three methods to establish reimbursement levels for covered charges with out-of-network providers. These include the following: • Pricing partner has standing agreements with providers that establish discounted rates which Cigna can access through its pricing partner agreement. The provider remains out-of-network but agrees not to balance bill the member. • Pricing partner reviews out-of-network claims and pricing partner negotiates with the provider on Cigna's behalf for a claim-specific discount. The provider remains out-of-network but agrees not to balance bill the member. • Pricing partner offers a market rate reimbursement, as determined by the pricing partner company. • Cigna: Cigna attempts negotiation with the provider at a claim-specific rate. The provider remains out-of-network but agrees not to balance bill the member. 3. In the absence of a Medicare Fee Schedule rate for a service, provider reimbursement will be based on the Medicare Gap Fill process: • FairHealth - The external vendor pricing we currently use is the FAIR Health product called Medicare GapFill PLUS™. FAIR Health pulls values from all Medicare	1. Federal and State Law, as applicable 2. Out of Network Protection Programs • Savings through Claritev (formerly Multiplan) and Zelis. This service provides discounted rates accompanied by a signed agreement with the health care professional or facility. • Savings through Claritev (formerly Multiplan) and Zelis. This service negotiates charge reductions accompanied by a signed agreement with the health care professional or facility. • Savings through Claritev (formerly Multiplan) and Zelis. • Commercial benchmarks, CMS data, Contractual allowables, Historical claims, Provider insights, Geographic adjustments. Offer, not accompanied by a signed agreement. If the provider agrees to the rate, they agree not to balance bill the member. 3. Fair Health Medicare Gap Fill Plus, and Internal MRC Policy Review Board

		non-facility fee schedules, zip codes are mapped to the geographic areas and values are updated twice a year. Where Medicare and FairHealth do not have a published rate the following is utilized: Internal MRC Policy Review Board Where Medicare may not have a published rate for certain codes, we have an MRC policy review board that reviews clinical guidelines and procedure codes. The review board consists of clinicians and SME's who review comparable services and determine the appropriate rate and code, if available.	
--	--	---	--

Final Rates:

Benefit Classification/ Sub-classification	Factors	Sources for Each Factor
Out of Network Outpatient-All Other	1. Federal and State Law, as applicable. 2. Out of Network Protection Program 3. Maximum Reimbursable Charge (MRC) applied to both M/S or MH/SUD 4. Medicare Gap Fill for procedures that are not covered by Medicare or do not have a CMS Medicare Resources Based Relative Value Scale ("RBRVS")	For the following, more details are available in the attachments titled Out-of-Network Reimbursement Methodology and Out-of-Network Cost Containment (sales collateral) 1. Consolidated Appropriations Act: No Surprises Act (NSA) qualifying services will be subject to NSA (e.g., emergency, non-participating providers rendering in a participating facility). Reimbursement is based on an amount negotiated with the provider or if an amount cannot be negotiated, the service is reimbursed on the Qualifying Payment Amount (QPA). 2. Out of Network Protection Programs Savings through Claritev (formerly Multiplan) and Zelis • External pricing partner network rate • External pricing partner direct negotiation • Cigna-initiated direct

Benefit Classification/ Sub-classification	Factors	Sources for Each Factor
		negotiation. 3. Maximum Reimbursable Charge (MRC): • (MRC1) - For plans that elect MRC1, Cigna uses a rate developed from the external pricing partner claims database. • (MRC2) - For plans that elect MRC2, Cigna uses a client-elected percentage of the CMS Medicare Resources Based Relative Value Scale ("RBRVS") system for professional services. For facility services, Cigna leverages the Optum Medicare database. 4. Fair Health Medicare Gap Fill Plus, and Internal MRC Policy Review Board
Out of Network Outpatient- Office	1. Federal and State Law, as applicable 2. Out of Network Protection Program 3. Maximum Reimbursable Charge (MRC) applied to both M/S or MH/SUD 4. Medicare Gap Fill for procedures that are not covered by Medicare or do not have a CMS Medicare Resources Based Relative Value Scale ("RBRVS")	1. Federal and State Law, as applicable For the following, more details are available in the attachments titled Out-of-Network Reimbursement Methodology and Out-of-network Cost Containment (sales collateral) 2. Out-of-Network Protection Program • External pricing partner network rate • External pricing partner direct negotiation • External pricing partner 'offer' based on market rate; or • Cigna-initiated direct negotiation 3. Maximum Reimbursable Charge (MRC) • (MRC1) - For plans that elect MRC1, rate developed from the external pricing partner claims database. • (MRC2)-For plans that elect MRC2, Cigna uses a client-elected percentage of the CMS Medicare Resources

Benefit Classification/ Sub-classification	Factors	Sources for Each Factor
		Based Relative Value Scale ("RBRVS") system. 4. Fair Health Medicare Gap Fill Plus, and Internal MRC Policy Review Board

In establishing the factors used to determine Out-of-Network Reimbursement, Cigna considers the following **sources and evidentiary standards**:

Benefit Classification/ Sub-classification	Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
Out of Network Outpatient- All Other	1. Federal and state Law, as applicable 2. Out of Network Protection Program 3. Maximum Reimbursable Charge (MRC) applied to both M/S or MH/SUD 4. Medicare Gap Fill for procedures that are not covered by Medicare or do not have a CMS Medicare Resources Based Relative Value Scale ("RBRVS")	1. No Surprises Act (NSA) (45 CFR 149.420; Section 104 of the No Surprises Act; PHSA 2799B-2) 2. Out of Network Protection Program provided by an external pricing partner that utilizes one of three methods to establish reimbursement levels for covered charges with out-of-network providers. These include the following: • Pricing partner has standing agreements with providers that establish discounted rates which Cigna can access through its pricing partner agreement. The provider remains out-of-network but agrees not to balance bill the member. • Pricing partner reviews out-of-network claims and pricing partner negotiates with the provider on the Cigna's behalf for a claim-specific discount. The provider remains out-of-network but agrees not to balance bill the member. • Cigna initiates a direct negotiated amount with the provider. 3. When the Out of Network Protection Program does not apply Provider Reimbursement will be based on the lesser of the covered billed charges or the client-elected Maximum Reimbursable Charge (MRC).	1. No Surprises Act (NSA) Reimbursement is based on an amount negotiated with the provider or if an amount cannot be negotiated, the service is reimbursed on the Qualifying Payment Amount (QPA). 2. Out of Network Protection Programs • Savings through Claritev (formerly Multiplan) and Zelis. This service provides discounted rates accompanied by a signed agreement with the health care professional or facility. • Savings through Claritev (formerly Multiplan) and Zelis. This service negotiates charge reductions accompanied by a signed agreement with the health care professional or facility. • Cigna uses in-network rates as a basis for negotiation. 3. Maximum Reimbursable Charge (MRC) • (MRC1) – For plans that elect MRC1, Cigna uses FAIR Health data for professional services.

		• MRC1: Based on a percentile of charges made by physicians and outpatient facilities in a given geographical area where the service is received. These charges are compiled in a national charges database selected by Cigna, and subject to change. Clients select an MRC1 percentile between 50 and 95. • MRC2: Based on a percentage of a fee schedule developed by Cigna based on methodology similar to that used by Medicare to determine the allowable fee for services within a geographical area. Clients may select an MRC2 percentage between 100 and 300 4. In the absence of a Medicare Fee Schedule rate for a service, provider reimbursement will be based on the Medicare Gap Fill process: • FairHealth - The external vendor pricing we currently use is the FAIR Health product called Medicare GapFill PLUS™. FAIR Health pulls values from all Medicare non-facility fee schedules, zip codes are mapped to the geographic areas and values are updated twice a year. Where Medicare and FairHealth do not have a published rate the following is utilized: • Internal MRC Policy Review Board Where Medicare may not have a published rate for certain codes, we have an MRC policy review board that reviews clinical guidelines and procedure codes. The review board consists of clinicians and SME's who review comparable services and determine the appropriate	• (MRC2) – For plans that elect MRC2, Cigna uses a client-elected percentage of the CMS Medicare Resources Based Relative Value Scale (“RBRVS”) system for professional services. Cigna leverages the Optum Medicare database for facility services 4. Fair Health Medicare Gap Fill Plus, and Internal MRC Policy Review Board
--	--	--	--

		rate and code, if available.	
Out of Network Outpatient- Office	1. Federal and State Law, as applicable 2. Out of Network Protection Program 3. Maximum Reimbursable Charge (MRC) applied to both M/S or MH/SUD 4. Medicare Gap Fill for procedures that are not covered by Medicare or do not have a CMS Medicare Resources Based Relative Value Scale ("RBRVS")	1. Federal and State Law, as applicable 2. Out of Network Protection Program provided by an external pricing partner that utilizes one of three methods to establish reimbursement levels for covered charges with out-of-network providers. These include the following: • Pricing partner has standing agreements with providers that establish discounted rates which Cigna can access through its pricing partner agreement. The provider remains out-of-network but agrees not to balance bill the member. • Pricing partner reviews out-of-network claims and pricing partner negotiates with the provider on Cigna's behalf for a claim-specific discount. The provider remains out-of-network but agrees not to balance bill the member. • Pricing partner offers a market rate reimbursement, as determined by the pricing partner company. • Cigna: Cigna attempts negotiation with the provider at a claim-specific rate. The provider remains out-of-network but agrees not to balance bill the member. 3. When the Out of Network Protection Program does not apply, Provider Reimbursement will be based on the lesser of the covered billed charges or the client-elected Maximum Reimbursable Charge (MRC). • MRC1: Based on a percentile of charges made by physicians and outpatient facilities in a given geographical area where the service is received. These charges are compiled in a	1. Federal and State Law, as applicable 2. Out of Network Protection Programs • Savings through Claritev (formerly Multiplan) and Zelis. This service provides discounted rates accompanied by a signed agreement with the health care professional or facility. • Savings through Claritev (formerly Multiplan) and Zelis. This service negotiates charge reductions accompanied by a signed agreement with the health care professional or facility. • Savings through Claritev (formerly Multiplan) and Zelis. • Commercial benchmarks, CMS data, Contractual allowables, Historical claims, Provider insights, Geographic adjustments. Offer, not accompanied by a signed agreement. If the provider agrees to the rate, they agree not to balance bill the member. 3. Maximum Reimbursable Charge (MRC) • (MRC1) - Cigna uses FAIR Health data for professional services. • (MRC2)-For plans that elect MRC2, Cigna uses a client-elected percentage of the CMS Medicare Resources Based Relative Value Scale ("RBRVS") system for professional services. Cigna leverages the Optum Medicare database for facility services.

		national charges database selected by Cigna, and subject to change. Clients select an MRC1 percentile between 50 and 95. • MRC2: Based on a percentage of a fee schedule developed by Cigna based on methodology similar to that used by Medicare to determine the allowable fee for services within a geographical area. Clients may select an MRC2 percentage between 100 and 300. 4. In the absence of a Medicare Fee Schedule rate for a service, provider reimbursement will be based on the Medicare Gap Fill process: • FairHealth - The external vendor pricing we currently use is the FAIR Health product called Medicare GapFill PLUS™. FAIR Health pulls values from all Medicare non-facility fee schedules, zip codes are mapped to the geographic areas and values are updated twice a year. Where Medicare and FairHealth do not have a published rate the following is utilized: • Internal MRC Policy Review Board Where Medicare may not have a published rate for certain codes, we have an MRC policy review board that reviews clinical guidelines and procedure codes. The review board consists of clinicians and SME's who review comparable services and determine the appropriate rate and code, if available.	4. Fair Health Medicare Gap Fill Plus, and Internal MRC Policy Review Board
--	--	--	--

Step 3: Description of how factors are used in the design and application of the NQTL.

See [45 CFR 146.137\(c\)\(3\)](#). Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

- (1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;
- (2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;
- (3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;
- (4) If more than one factor is identified and defined in Step 2, an explanation of:
 - (A) How all of the factors relate to each other;
 - (B) The order in which all of the factors are applied, including when they are applied;
 - (C) Whether and how any factors are given more weight than others; and
 - (D) The reasons for the ordering or weighting of the factors.
- (5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also [FAQ 45](#) guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [\[Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee\]](#).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Design and Application:

Base Rates:

The personnel responsible for the design and application of the Provider Reimbursement (and Facility) Reimbursement NQTL includes:

- Provider Contracting Managing Director: Master's Degree preferred (MBA, Healthcare Administration, or health-related field preferred). 6+ years of healthcare experience
- Provider Contracting Senior Director: Bachelor's Degree preferred. 5+ years of healthcare experience
- Provider Contracting Director: Bachelor's Degree preferred or 5-10+ years of healthcare experience.

Cigna's reimbursement methodology for out-of-network services, incorporated by clients into their benefit plans, is predicated on achieving two fundamental objectives:

- reducing costs for enrollees/plan sponsors while, wherever possible,
- protecting the enrollees in Cigna-administered plans from excessive balance bills from out-of-network providers.

In pursuing this objective, Cigna's out-of-network reimbursement methodology ultimately rests on ensuring that the Maximum Reimbursable Charge (or "MRC") for a service, commonly referred to in the industry as a usual/customary charge, reflects a reasonable reimbursement amount consistent with the particular MRC methodology adopted by the client.

Claims are priced using the following methods:

- Maximum Reimbursable Charge (MRC): Claim processing based on applicable benefit plan elections (MRC) or billed charges.

The application of the MRC reimbursement methodology does not vary between M/S and MH/SUD.

Clients can elect to bypass the Out-of-Network Protection Program and have claims processed according to their MRC election.

Cigna determines the reimbursement amount for an out-of-network inpatient claim in the following order:

1. Determine whether federal or state law establishes or governs the applicable payment process.
2. If no controlling legal payment methodology applies, determine whether an accessible external pricing-partner network rate or other standing provider arrangement is available.

3. If no acceptable standing arrangement is available, determine whether a claim-specific vendor negotiation or Cigna-initiated direct negotiation produces an accepted rate.
4. If no negotiated arrangement applies, determine the allowable amount under the plan sponsor's elected MRC methodology, subject to the lesser of covered billed charges or MRC.
5. For an MRC2 professional service without an applicable Medicare amount, apply the Medicare Gap Fill methodology and, if necessary, the MRC Policy Review Board process.
6. Apply the member's benefit terms, including applicable cost sharing and any approved benefit enhancement or network-gap exception.

The same sequence is used for M/S and MH/SUD claims. Differences in the benchmark applied at a particular step are based on provider type, service type, coding, place of service, and the applicable external payment methodology, not MH/SUD status.

Maximum Reimbursable Charge (MRC)

To calculate appropriate reimbursement levels for covered charges with out-of-network providers, each of which is often referred to as the "allowed amount" for a covered service, Cigna first calculates on behalf of the plan sponsor the MRC for a covered service in one of several ways, which varies based on the plan sponsor's plan election. The MRC is calculated using one of two methodologies: MRC1 or MRC2. Cigna makes available to client plans both MRC1 and MRC2, which serve as the foundation for Cigna's out-of-network reimbursement program. The methodologies, including their evidentiary standards and sources, are set forth immediately below. The MRC for any and all inpatient, outpatient, or emergency services is calculated consistently across MH/SUD and M/S benefits aligned to a classification, as reflected by the written methodology described in the benefit plans, which sets forth a broadly applicable methodology for MRC under the plan that does not distinguish between MH/SUD and M/S benefits rendered on an out-of-network basis.

Maximum Reimbursable Charge – MRC1

In calculating the MRC for a service under the MRC1 methodology, Cigna applies to a covered inpatient service a plan-sponsor-elected percentile to a charge (often referred to as a "U&C" charge) as compiled in a national charges database. The charges in the database are specific to the service in question and are derived from charges submitted by providers located in the claimant provider's geographic area, specifically zip codes, if a charge for the zip code is available, in which the claimant provider resides. That is, the evidentiary standard for the out-of-network allowable amount is the charge set forth in a national charges database for the service in the geographic area of the claimant provider that aligns with the percentile elected by the client. Plan sponsors may select one of several possible MRC1 percentiles to apply to the applicable charge; these percentiles, which vary by plan, include as follows: 50th percentile, 60th percentile, 70th percentile, 80th percentile, 90th percentile, and 95th percentile. More specifically, to calculate the MRC for professional (i.e., non-facility) claims Cigna utilizes the FAIR Health database, which is a database maintained by a third-party vendor. FAIR Health collects actual charge data through a data contribution program available to its payer clients. FAIR Health clients (including Cigna) submit an extensive data layout, including the non-discounted fee-for-service billed charges that are submitted to them by providers. Once FAIR Health receives the submission, the data is ran through a validation process to validate zip code, procedure code, date of service, and other fields. FAIR Health GeoZips (geographical areas) are based on the first three digits of US ZIP codes. GeoZips may contain one three-digit ZIP code or a grouping of three-digit ZIP codes. GeoZip groupings are based on an analysis of submitted claims data. In addition, geographic proximity, local billing patterns and the quantity of available data are also taken into consideration. State boundaries are not crossed. FAIR Health currently has 494

GeoZips throughout the nation. Charges collected for a given period of time are sorted into appropriate GeoZips based on the provider zip codes. Once the charges are sorted by GeoZip, they are then sorted by CPT, ASA, ADA, or HCPCS procedure code. For each code, the charges are sorted in ascending order (lowest to highest). After the charges are sorted a total count of the charges is obtained. Each charge is assigned a number based on rank within the total count. To determine the benchmark for a given percentile, the total number of charges is multiplied by that percentage.

For example, if there are 200 charges for a Procedure Code, the lowest charge is assigned #1 and the highest charge is assigned #200. For the 80th percentile, the total number of charges is multiplied by 80% (.80). The charge on line 160 is the 80th percentile. $200 \times .80 = 160$. Any other percentile can be found the same way: $200 \times .70 = 140$ (The charge on line 140 is the 70th percentile); $200 \times .90 = 180$ (The charge on line 180 is the 90th percentile). If there are at least 9 charges for a Procedure Code/GeoZip combination, then that is considered to be statistically valid. If there are fewer than 9 charges for a Procedure Code, then data that is derived from charges for other services may be used.

Maximum Reimbursable Charge – MRC2

Under MRC2, the plan applies to a covered inpatient service a percentage of a charge based on a methodology similar to that used by CMS to pay Medicare claims, in which a charge is derived similarly to CMS' fee schedule methodology in that factors like service type, place of service, and geographic location impact the charge used to calculate the MRC, which are defined generally by reference to CMS' fee schedule methodology. Most of CMS' methodologies adjust payments based on regional costs and whether the claimant is a practitioner or a facility. Specifically, physician fees are adjusted based on the geographic practice cost index (GPCI) in about 100 localities, and institutional payments are adjusted for wage variations in about 200 core-based statistical areas (CBSA). Additionally, durable medical equipment (DME) and lab fees are adjusted by state, and ambulance fees are adjusted by GPCI and by the degree of urbanization.

MRC2 rate updates occur in response to instances when CMS changes reimbursement methodologies or releases new fee schedules; Cigna updates its MRC2 fee schedule used to administer plan benefits as soon as practicable following release of CMS changes.

Plan sponsor clients can select the percentage of MRC2 paid to out-of-network health care providers for non-emergency services. The standard percentages, subject to plan sponsor client election, applied to the MRC for a service are: 110 percent, 150 percent, 200 percent, and 300 percent.

The following terms apply to both MH/SUD and M/S services.

FAIR Health Relative Value Methodology (Derived Data)

FAIR Health employs a relative value methodology to calculate benchmarks in its FH Benchmarks modules when the actual data for a procedure code/geozip combination are insufficient to produce a benchmark. This methodology uses the relationships between procedure codes to determine the benchmark rates. Relative value methodologies are standard industry methods that use data for more frequently performed services in a specific geographic area and specific time period to derive values for less frequently performed services for the same geographic area and time period.

Derivation Process

Derived Charge Data is based on the charges for comparable procedures, multiplied by a factor that

takes into account the relative complexity of the procedure that was performed, to get the relative value for the procedure code. The relative value is then multiplied by the Geozip area Conversion Factor to get the derived charge.

Code Range

FAIR Health groups related procedure codes into a series of ranges. Using a range of codes, FAIR Health can model less frequently performed services using the billing patterns of frequently performed similar services in the same geographic area and time period. All charge data for the codes within a range are used to derive the percentile values for each of the codes under this methodology.

Relative Value

Each code has a relative value, a number designed to represent the resources used to provide the service represented by the code. FAIR Health uses a third-party relative value scale that is commonly used in the industry.

Geozip

FAIR Health defines geographic areas for its data generally on the basis of the first three digits of a ZIP code. Referred to as a geozip, an area may contain one three-digit ZIP code or a grouping of three-digit ZIP codes. Geozip groupings are based on an analysis of submitted claims data. In addition, geographic proximity, similarities in billing patterns and the quantity of available data are also taken into consideration. In most cases, geozips do not cross state boundaries. FAIR Health currently divides the United States into 493 geozips.

Conversion Factor

The conversion factor is determined by dividing each of the billed charges for every code in a range by its associated relative value. A code must have a relative value in order for FAIR Health to develop a derived rate. Examples of codes with no relative value are unlisted CPT codes and unlisted HCPCS codes. For any client plan that has adopted the MRC1 methodology, FAIR Health's charges database is used to calculate the MRC for either MH/SUD or M/S services rendered by health care professionals (i.e., non-facility).

The evidentiary standards for the aforementioned factors informing the MRC are reflected in the Medicare fee schedule or, where no Medicare fee exists for a service (e.g. a service not covered by Medicare), a charge generally developed by reference to the Medicare methodology. Specifically, Cigna obtains Medicare fees for inpatient facility services from the CMS Inpatient Prospective Payment System (IPPS) schedule, and inpatient professional services from the CMS Physician Fee Schedule. For services without an available Medicare fee, Cigna generally utilizes a methodology similar to Medicare, whereby, along with the Geographic Practice Cost Indices and conversion factors, Cigna utilizes a derived Relative Value Unit (RVU) using the RVU for a similar service or calculating what the RVU should be based on an assessment of the factors informing the RVU figure. Under MRC2, plan sponsor clients can select the percentage of the MRC paid to out-of-network health care providers for non-emergency services. The standard percentages, subject to plan sponsor client election, applied to the MRC for a service are: 110 percent, 150 percent, 200 percent, and 300 percent. These percentages are applied uniformly to the MRC for MH/SUD and M/S inpatient and outpatient services.

Customers with claims processed according to the MRC reimbursement process may be liable for any

amount over the allowed amount, in addition to their copay/coinsurance and deductible.

Adjusted Rates:

The personnel responsible for the design and application of the Provider Reimbursement (and Facility) Reimbursement NQTL includes:

- Provider Contracting Managing Director: Master's Degree preferred (MBA, Healthcare Administration, or health-related field preferred). 6+ years of healthcare experience
- Provider Contracting Senior Director: Bachelor's Degree preferred. 5+ years of healthcare experience
- Provider Contracting Director: Bachelor's Degree preferred or 5-10+ years of healthcare experience.

Cigna's reimbursement methodology for out-of-network services, incorporated by clients into their benefit plans, is predicated on achieving two fundamental objectives:

- reducing costs for enrollees/plan sponsors while, wherever possible,
- protecting the enrollees in Cigna-administered plans from excessive balance bills from out-of-network providers.

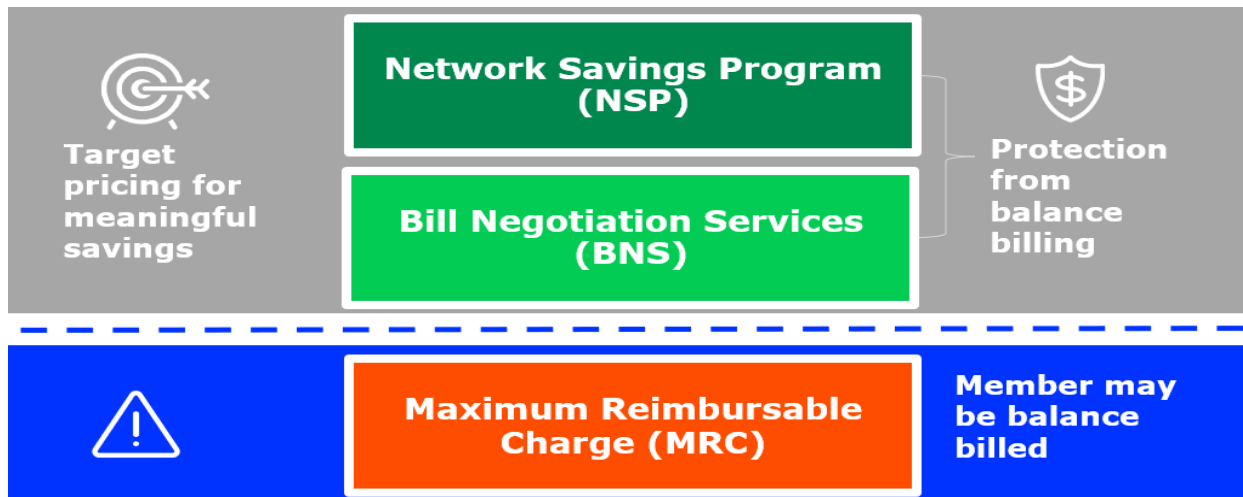
In pursuing this objective, Cigna's out-of-network reimbursement methodology ultimately rests on ensuring that the Maximum Reimbursable Charge (or "MRC") for a service, commonly referred to in the industry as a usual/customary charge, reflects a reasonable reimbursement amount consistent with the particular MRC methodology adopted by the client.

Cigna's Out of Network Reimbursement process first identifies out-of-network claims (OON) then sends the claim for external claim pricing.

Claims are priced using the following methods:

- Network Savings Program (NSP): Savings obtained through the Claritev (formerly Multiplan) network, as identified on the customer's medical ID card.
- Bill Negotiation Services (BNS): A suite of pricing techniques that attempt to achieve savings.
- Maximum Reimbursable Charge (MRC): Claim processing based on applicable benefit plan elections (MRC) or billed charges.

The application of the three reimbursement methods does not vary between M/S and MH/SUD. Cigna's Out of Network Reimbursement programs are designed to capture eligible out of network charges through:



Out-of-Network Protection Programs

Where Virginia state law or the No Surprises Act does not apply, Cigna reimburses providers either through its Out-of-Network Protection Programs, lesser of the covered billed charges, or the client-elected Maximum Reimbursable Charge (MRC). Cigna's Out of Network Protection Programs can supplement both the M/S and MH/SUD contracted networks. For clients that elect to use the Out-of-Network Protection Programs, M/S and MH/SUD claims may be priced using the vendor's network rates or direct negotiation with the provider. Cigna identifies whether it has access to an acceptable arrangement with an out-of-network health care provider whereby the out-of-network health care provider has agreed, or ultimately agrees, to accept the rate in question as payment in full for the services rendered to a plan enrollee and, consequently, not charge the enrollee any amount in excess of the plan cost-sharing for the out-of-network services. While the health care provider in this scenario remains out-of-network with the plan, in the event such an indirect rate arrangement is used to assess the allowable charges for the out-of-network service, the enrollee is protected by virtue of the contract between the provider and vendor from potential balance-billing of amounts in excess of the plan's allowable charges. The plan accesses these rate arrangements indirectly through Cigna's contracts with third party vendors, which in turn have contracts with, or enter into claim-specific rate arrangements with, a number of MH/SUD and M/S providers. Where available, these rates—which are derived from either proprietary databases that compile charges from that provider and/or similar providers performing similar services in similar geographies, or claim-specific pricing where such rates are not available—vary by provider type (i.e., facility v. physician practitioner v. non-physician practitioner), service type (i.e., CPT codes), and geography, as the costs of rendering services vary based on these factors. If such an indirect rate arrangement does not exist, cannot be obtained, or is unacceptable, as the case may be, then the reimbursement amount payable for services rendered by the out-of-network provider is, again, equal to the lesser of (i) the covered billed charges submitted by the provider or (ii) the percentile of the service's MRC set forth in the plan.

The Out-of-Network Protection Program reimbursement methodologies include:

- Fee Negotiation Service – Negotiates charge reductions ending in a signed agreement with the Provider/Facility;

- Supplemental Network – Additional regional networks of Provider/Facility's contracted with vendor partners, concluding with a signed agreement;
- Repricing – similar to bill negotiation where there is an offer and settlement and where the initial reimbursement on the claim is not a signed agreement but a part of the repricing process. The vendors apply a reasonable allowed amount based on the service and geographic location of the Provider/Facility. The Provider/Facility can decide not to accept the offer;
- Cigna-initiated direct negotiation -Cigna may initiate direct negotiations with a provider. This is a negotiated agreement where the provider remains non-contracted with Cigna but agrees not to balance bill the member.

Clients can elect to bypass the Out-of-Network Protection Program and have claims processed according to their MRC election.

In the absence of a Medicare Fee Schedule rate for a service (e.g. a service Medicare does not cover), Cigna utilizes a process known as Medicare Gap Fill to determine reimbursement. The Medicare Gap Fill process uses a third party/benchmarking source, Fair Health, to establish the rate. Fair Health is a national, independent, nonprofit organization whose mission is to bring transparency to healthcare costs and health insurance information through comprehensive data products, consumer resources and research tools, all powered by the nation's largest collection of privately billed medical and dental claims data.

Where Medicare and Fair Health do not have published rates for certain codes, the Cigna MRC Policy Review Board (comprised of clinicians and subject matter experts) reviews clinical guidelines and procedure codes for comparable services to determine an appropriate rate and code. As further discussed below Fair Health or the MRC Policy Review Board rate, where Fair Health rate is unavailable, provides the rate of reimbursement that is then multiplied by the client MRC election to determine the allowable fee.

The following terms apply to both MH/SUD and M/S services.

FAIR Health Relative Value Methodology (Derived Data)

FAIR Health employs a relative value methodology to calculate benchmarks in its FH Benchmarks modules when the actual data for a procedure code/geozip combination are insufficient to produce a benchmark. This methodology uses the relationships between procedure codes to determine the benchmark rates. Relative value methodologies are standard industry methods that use data for more frequently performed services in a specific geographic area and specific time period to derive values for less frequently performed services for the same geographic area and time period.

Derivation Process

Derived Charge Data is based on the charges for comparable procedures, multiplied by a factor that takes into account the relative complexity of the procedure that was performed, to get the relative value for the procedure code. The relative value is then multiplied by the Geozip area Conversion Factor to get the derived charge.

Code Range

FAIR Health groups related procedure codes into a series of ranges. Using a range of codes, FAIR Health can model less frequently performed services using the billing patterns of frequently performed similar services in the same geographic area and time period. All charge data for the

codes within a range are used to derive the percentile values for each of the codes under this methodology.

Relative Value

Each code has a relative value, a number designed to represent the resources used to provide the service represented by the code. FAIR Health uses a third-party relative value scale that is commonly used in the industry.

Geozip

FAIR Health defines geographic areas for its data generally on the basis of the first three digits of a ZIP code. Referred to as a geozip, an area may contain one three-digit ZIP code or a grouping of three-digit ZIP codes. Geozip groupings are based on an analysis of submitted claims data. In addition, geographic proximity, similarities in billing patterns and the quantity of available data are also taken into consideration. In most cases, geozips do not cross state boundaries. FAIR Health currently divides the United States into 493 geozips.

Conversion Factor

The conversion factor is determined by dividing each of the billed charges for every code in a range by its associated relative value. A code must have a relative value in order for FAIR Health to develop a derived rate. Examples of codes with no relative value are unlisted CPT codes and unlisted HCPCS codes. For any client plan that has adopted the MRC1 methodology, FAIR Health's charges database is used to calculate the MRC for either MH/SUD or M/S services rendered by health care professionals (i.e., non-facility).

The evidentiary standards for the aforementioned factors informing the MRC are reflected in the Medicare fee schedule or, where no Medicare fee exists for a service (e.g. a service not covered by Medicare), a charge generally developed by reference to the Medicare methodology. Specifically, Cigna obtains Medicare fees for inpatient facility services from the CMS Inpatient Prospective Payment System (IPPS) schedule, and inpatient professional services from the CMS Physician Fee Schedule. For services without an available Medicare fee, Cigna generally utilizes a methodology similar to Medicare, whereby, along with the Geographic Practice Cost Indices and conversion factors, Cigna utilizes a derived Relative Value Unit (RVU) using the RVU for a similar service or calculating what the RVU should be based on an assessment of the factors informing the RVU figure. Under MRC2, plan sponsor clients can select the percentage of the MRC paid to out-of-network health care providers for non-emergency services. The standard percentages, subject to plan sponsor client election, applied to the MRC for a service are: 110 percent, 150 percent, 200 percent, and 300 percent. These percentages are applied uniformly to the MRC for MH/SUD and M/S inpatient and outpatient services.

Whether the reimbursement for the services follows MRC or the Medicare Gap Fill process the customer may be liable for any amount over the allowed amount, in addition to their copay/coinsurance and deductible.

In-Network Benefit Level for Out-of-Network Services

In instances where emergent care is rendered by an out-of-network provider Cigna, in compliance with the Federal No Surprises Act, will reimburse those services at the in-network benefit level. Additionally, should an in-network provider not be available to provide specialized medically necessary care Cigna may approve those services at the in-network benefit level in accordance with

the guidelines described in the Network Adequacy Provision Policy (UM-20) and the Benefit Enhancement Policy. Cigna may enhance covered Out-of-Network services to the In-network benefit level. Some of these instances are (not all-inclusive):

- Emergency services (i.e., ground ambulance): Cigna may determine whether it is appropriate to process emergency services not covered under the No Surprises Act at the in-network benefit.
- Network Adequacy Provision Policy (UM-20): Cigna understands there may be instances where it may be necessary/prudent for a customer to seek care from an out-of-network practitioner/facility. Such instances may include:
 - The need for specialized care where an in-network practitioner/facility is not available.
 - Situations where a customer is unable to receive care at an in-network health care professional or facility within reasonable appointment availability timeframes or drive times from their home, for example.

When a network exception is approved, the claims may be processed according to the customers' in-network benefit if the criteria is met per this policy. Clients can elect an MRC Percentile of 200% for enhanced claims (emergency services and network exceptions).

Single Case Agreement

When a network exception is approved the nonparticipating provider or facility may initiate a request for a single case agreement negotiation. M/S and MH/SUD will negotiate with any willing provider.

For both M/S and MH/SUD services, Cigna conducts provider outreach by telephone or email and makes reasonable efforts to secure an agreement; MH/SUD outreach may also be conducted by fax. This additional communication method does not alter the substantive negotiation standard or impose a more restrictive process on MH/SUD benefits.

For both M/S and MH/SUD services, the negotiator reviews the approved NAP authorization, service type, provider or facility information, relevant billing and coding details, and any prior or existing reimbursement arrangements. If an established rate is not available, the Negotiator will initiate discussions with the provider/facility utilizing approved reimbursement methodologies and applicable Levels of Authority guidance. If an agreement is reached the agreed upon terms are documented in the system of record (i.e. Salesforce, SharePoint) along with a letter being sent to the provider/facility for signature of agreed terms. Upon receipt of a claim that is consistent with the authorization and agreement, Cigna reimburses the provider at the negotiated rate and adjudicates the claim under the member's applicable in-network plan benefits. If the provider does not accept the initial offer, Cigna continues reasonable negotiation efforts to reach an agreement, where possible. If the parties are unable to reach an agreement, the provider determines whether to furnish the authorized services. When the services are rendered pursuant to the approved NAP network gap exception, the claim is processed at the member's in-network benefit level and reimbursement is determined in accordance with the applicable maximum reimbursable charge provisions.

Member protections and notification practices are applied consistently to M/S and MH/SUD services. Once a single case agreement is established, the provider may not balance bill the member, and the member is responsible only for the applicable in-network cost-sharing amount. Cigna notifies the member of the approved services through an approval letter; consistent with

standard confidentiality and contracting practices, the letter does not disclose the negotiated reimbursement terms.

Finally, M/S and MH/SUD single case agreements are limited to the specific services and dates authorized by utilization management through the approved NAP network gap exception. To receive the negotiated rate, the submitted claim must correspond to the material terms of the authorization and agreement, including the provider, authorized services, and approved dates of service. Accordingly, each single case agreement applies only to the expressly authorized services and timeframe and does not extend to unrelated services, providers, or dates. Taken together, these standards demonstrate that Cigna applies a substantially comparable single case agreement framework to M/S and MH/SUD benefits.

Final Rates:

The personnel responsible for the design and application of the Provider Reimbursement (and Facility) Reimbursement NQTL includes:

- Provider Contracting Managing Director: Master's Degree preferred (MBA, Healthcare Administration, or health-related field preferred). 6+ years of healthcare experience
- Provider Contracting Senior Director: Bachelor's Degree preferred. 5+ years of healthcare experience
- Provider Contracting Director: Bachelor's Degree preferred or 5-10+ years of healthcare experience.

Cigna's reimbursement methodology for out-of-network services, incorporated by clients into their benefit plans, is predicated on achieving two fundamental objectives:

- reducing costs for enrollees/plan sponsors while, wherever possible,
- protecting the enrollees in Cigna-administered plans from excessive balance bills from out-of-network providers.

In pursuing this objective, Cigna's out-of-network reimbursement methodology ultimately rests on ensuring that the Maximum Reimbursable Charge (or "MRC") for a service, commonly referred to in the industry as a usual/customary charge, reflects a reasonable reimbursement amount consistent with the particular MRC methodology adopted by the client.

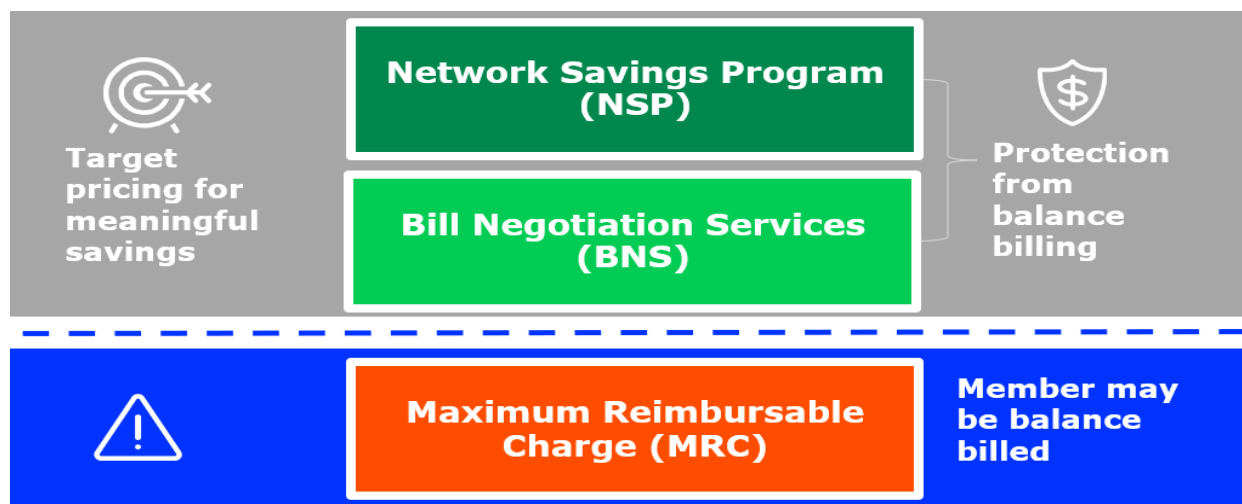
Cigna's Out of Network Reimbursement process first identifies out-of-network claims (OON) then sends the claim for external claim pricing.

Claims are priced using the following methods:

- Network Savings Program (NSP): Savings obtained through the Claritev (formerly Multiplan) network, as identified on the customer's medical ID card.
- Bill Negotiation Services (BNS): A suite of pricing techniques that attempt to achieve savings.
- Maximum Reimbursable Charge (MRC): Claim processing based on applicable benefit plan elections (MRC) or billed charges.

The application of the three reimbursement methods does not vary between M/S and MH/SUD.

Cigna's Out of Network Reimbursement programs are designed to capture eligible out of network charges through:



Out-of-Network Protection Programs

Where Virginia state law or the No Surprises Act does not apply, Cigna reimburses providers either through its Out-of-Network Protection Programs, lesser of the covered billed charges, or the client-elected Maximum Reimbursable Charge (MRC). Cigna's Out of Network Protection Programs can supplement both the M/S and MH/SUD contracted networks. For clients that elect to use the Out-of-Network Protection Programs, M/S and MH/SUD claims may be priced using the vendor's network rates or direct negotiation with the provider. Cigna identifies whether it has access to an acceptable arrangement with an out-of-network health care provider whereby the out-of-network health care provider has agreed, or ultimately agrees, to accept the rate in question as payment in full for the services rendered to a plan enrollee and, consequently, not charge the enrollee any amount in excess of the plan cost-sharing for the out-of-network services. While the health care provider in this scenario remains out-of-network with the plan, in the event such an indirect rate arrangement is used to assess the allowable charges for the out-of-network service, the enrollee is protected by virtue of the contract between the provider and vendor from potential balance-billing of amounts in excess of the plan's allowable charges. The plan accesses these rate arrangements indirectly through Cigna's contracts with third party vendors, which in turn have contracts with, or enter into claim-specific rate arrangements with, a number of MH/SUD and M/S providers. Where available, these rates—which are derived from either proprietary databases that compile charges from that provider and/or similar providers performing similar services in similar geographies, or claim-specific pricing where such rates are not available—vary by provider type (i.e., facility v. physician practitioner v. non-physician practitioner), service type (i.e., CPT codes), and geography, as the costs of rendering services vary based on these factors. If such an indirect rate arrangement does not exist, cannot be obtained, or is unacceptable, as the case may be, then the reimbursement amount payable for services rendered by the out-of-network provider is, again, equal to the lesser of (i) the covered billed charges submitted by the provider or (ii) the percentile of the service's MRC set forth in the plan.

The Out-of-Network Protection Program reimbursement methodologies include:

- Fee Negotiation Service – Negotiates charge reductions ending in a signed agreement with the Provider/Facility;
- Supplemental Network – Additional regional networks of Provider/Facility's contracted with vendor partners, concluding with a signed agreement;
- Repricing – similar to bill negotiation where there is an offer and settlement and where the initial reimbursement on the claim is not a signed agreement but a part of the repricing process. The vendors apply a reasonable allowed amount based on the service and geographic location of the Provider/Facility. The Provider/Facility can decide not to accept the offer;
- Cigna-initiated direct negotiation -Cigna may initiate direct negotiations with a provider. This is a negotiated agreement where the provider remains non-contracted with Cigna but agrees not to balance bill the member.

In the event, the customer pays the out-of-network provider prior to submitting the claim to Cigna, the Out-of-Network Protection Program is forfeited due to Cigna's inability to negotiate a rate on a claim that has already been paid in full. In those instances the claims are processed according to the client-elected MRC.

Clients can elect to bypass the Out-of-Network Protection Program and have claims processed according to their MRC election.

Maximum Reimbursable Charge (MRC)

To calculate appropriate reimbursement levels for covered charges with out-of-network providers, each of which is often referred to as the "allowed amount" for a covered service, Cigna first calculates on behalf of the plan sponsor the MRC for a covered service in one of several ways, which varies based on the plan sponsor's plan election. The MRC is calculated using one of two methodologies: MRC1 or MRC2. Cigna makes available to client plans both MRC1 and MRC2, which serve as the foundation for Cigna's out-of-network reimbursement program. The methodologies, including their evidentiary standards and sources, are set forth immediately below. The MRC for any and all inpatient, outpatient, or emergency services is calculated consistently across MH/SUD and M/S benefits aligned to a classification, as reflected by the written methodology described in the benefit plans, which sets forth a broadly applicable methodology for MRC under the plan that does not distinguish between MH/SUD and M/S benefits rendered on an out-of-network basis.

Maximum Reimbursable Charge – MRC1

In calculating the MRC for a service under the MRC1 methodology, Cigna applies to a covered inpatient service a plan-sponsor-elected percentile to a charge (often referred to as a "U&C" charge) as compiled in a national charges database. The charges in the database are specific to the service in question and are derived from charges submitted by providers located in the claimant provider's geographic area, specifically zip codes, if a charge for the zip code is available, in which the claimant provider resides. That is, the evidentiary standard for the out-of-network allowable amount is the charge set forth in a national charges database for the service in the geographic area of the claimant provider that aligns with the percentile elected by the client. Plan sponsors may select one of several possible MRC1 percentiles to apply to the applicable charge; these percentiles, which vary by plan, include as follows: 50th percentile, 60th percentile, 70th percentile, 80th percentile, 90th percentile, and 95th percentile. More specifically, to calculate the MRC for professional (i.e., non-facility) claims Cigna utilizes the FAIR Health database, which is a database maintained by a third-party vendor. FAIR Health collects actual charge data through a data

contribution program available to its payer clients. FAIR Health clients (including Cigna) submit an extensive data layout, including the non-discounted fee-for-service billed charges that are submitted to them by providers. Once FAIR Health receives the submission, the data is ran through a validation process to validate zip code, procedure code, date of service, and other fields. FAIR Health GeoZips (geographical areas) are based on the first three digits of US ZIP codes. GeoZips may contain one three-digit ZIP code or a grouping of three-digit ZIP codes. GeoZip groupings are based on an analysis of submitted claims data. In addition, geographic proximity, local billing patterns and the quantity of available data are also taken into consideration. State boundaries are not crossed. FAIR Health currently has 494 GeoZips throughout the nation. Charges collected for a given period of time are sorted into appropriate GeoZips based on the provider zip codes. Once the charges are sorted by GeoZip, they are then sorted by CPT, ASA, ADA, or HCPCS procedure code. For each code, the charges are sorted in ascending order (lowest to highest). After the charges are sorted a total count of the charges is obtained. Each charge is assigned a number based on rank within the total count. To determine the benchmark for a given percentile, the total number of charges is multiplied by that percentage.

For example, if there are 200 charges for a Procedure Code, the lowest charge is assigned #1 and the highest charge is assigned #200. For the 80th percentile, the total number of charges is multiplied by 80% (.80). The charge on line 160 is the 80th percentile. $200 \times .80 = 160$. Any other percentile can be found the same way: $200 \times .70 = 140$ (The charge on line 140 is the 70th percentile); $200 \times .90 = 180$ (The charge on line 180 is the 90th percentile). If there are at least 9 charges for a Procedure Code/GeoZip combination, then that is considered to be statistically valid. If there are fewer than 9 charges for a Procedure Code, then data that is derived from charges for other services may be used.

Maximum Reimbursable Charge – MRC2

Under MRC2, the plan applies to a covered inpatient service a percentage of a charge based on a methodology similar to that used by CMS to pay Medicare claims, in which a charge is derived similarly to CMS' fee schedule methodology in that factors like service type, place of service, and geographic location impact the charge used to calculate the MRC, which are defined generally by reference to CMS' fee schedule methodology. Most of CMS' methodologies adjust payments based on regional costs and whether the claimant is a practitioner or a facility. Specifically, physician fees are adjusted based on the geographic practice cost index (GPCI) in about 100 localities, and institutional payments are adjusted for wage variations in about 200 core-based statistical areas (CBSA). Additionally, durable medical equipment (DME) and lab fees are adjusted by state, and ambulance fees are adjusted by GPCI and by the degree of urbanization.

MRC2 rate updates occur in response to instances when CMS changes reimbursement methodologies or releases new fee schedules; Cigna updates its MRC2 fee schedule used to administer plan benefits as soon as practicable following release of CMS changes.

Plan sponsor clients can select the percentage of MRC2 paid to out-of-network health care providers for non-emergency services. The standard percentages, subject to plan sponsor client election, applied to the MRC for a service are: 110 percent, 150 percent, 200 percent, and 300 percent.

In the absence of a Medicare Fee Schedule rate for a service (e.g. a service Medicare does not cover), Cigna utilizes a process known as Medicare Gap Fill to determine reimbursement. The Medicare Gap Fill process uses a third party/benchmarking source, Fair Health, to establish the

rate. Fair Health is a national, independent, nonprofit organization whose mission is to bring transparency to healthcare costs and health insurance information through comprehensive data products, consumer resources and research tools, all powered by the nation's largest collection of privately billed medical and dental claims data.

Where Medicare and Fair Health do not have published rates for certain codes, the Cigna MRC Policy Review Board (comprised of clinicians and subject matter experts) reviews clinical guidelines and procedure codes for comparable services to determine an appropriate rate and code. As further discussed below Fair Health or the MRC Policy Review Board rate, where Fair Health rate is unavailable, provides the rate of reimbursement that is then multiplied by the client MRC election to determine the allowable fee.

The following terms apply to both MH/SUD and M/S services.

FAIR Health Relative Value Methodology (Derived Data)

FAIR Health employs a relative value methodology to calculate benchmarks in its FH Benchmarks modules when the actual data for a procedure code/geozip combination are insufficient to produce a benchmark. This methodology uses the relationships between procedure codes to determine the benchmark rates. Relative value methodologies are standard industry methods that use data for more frequently performed services in a specific geographic area and specific time period to derive values for less frequently performed services for the same geographic area and time period.

Derivation Process

Derived Charge Data is based on the charges for comparable procedures, multiplied by a factor that takes into account the relative complexity of the procedure that was performed, to get the relative value for the procedure code. The relative value is then multiplied by the Geozip area Conversion Factor to get the derived charge.

Code Range

FAIR Health groups related procedure codes into a series of ranges. Using a range of codes, FAIR Health can model less frequently performed services using the billing patterns of frequently performed similar services in the same geographic area and time period. All charge data for the codes within a range are used to derive the percentile values for each of the codes under this methodology.

Relative Value

Each code has a relative value, a number designed to represent the resources used to provide the service represented by the code. FAIR Health uses a third-party relative value scale that is commonly used in the industry.

Geozip

FAIR Health defines geographic areas for its data generally on the basis of the first three digits of a ZIP code. Referred to as a geozip, an area may contain one three-digit ZIP code or a grouping of three-digit ZIP codes. Geozip groupings are based on an analysis of submitted claims data. In addition, geographic proximity, similarities in billing patterns and the quantity of available data are also taken into consideration. In most cases, geozips do not cross state boundaries. FAIR Health currently divides the United States into 493 geozips.

Conversion Factor

The conversion factor is determined by dividing each of the billed charges for every code in a range by its associated relative value. A code must have a relative value in order for FAIR Health to develop a derived rate. Examples of codes with no relative value are unlisted CPT codes and unlisted HCPCS codes. For any client plan that has adopted the MRC1 methodology, FAIR Health's charges database is used to calculate the MRC for either MH/SUD or M/S services rendered by health care professionals (i.e., non-facility).

The evidentiary standards for the aforementioned factors informing the MRC are reflected in the Medicare fee schedule or, where no Medicare fee exists for a service (e.g. a service not covered by Medicare), a charge generally developed by reference to the Medicare methodology. Specifically, Cigna obtains Medicare fees for inpatient facility services from the CMS Inpatient Prospective Payment System (IPPS) schedule, and inpatient professional services from the CMS Physician Fee Schedule. For services without an available Medicare fee, Cigna generally utilizes a methodology similar to Medicare, whereby, along with the Geographic Practice Cost Indices and conversion factors, Cigna utilizes a derived Relative Value Unit (RVU) using the RVU for a similar service or calculating what the RVU should be based on an assessment of the factors informing the RVU figure. Under MRC2, plan sponsor clients can select the percentage of the MRC paid to out-of-network health care providers for non-emergency services. The standard percentages, subject to plan sponsor client election, applied to the MRC for a service are: 110 percent, 150 percent, 200 percent, and 300 percent. These percentages are applied uniformly to the MRC for MH/SUD and M/S inpatient and outpatient services.

Whether the reimbursement for the services follows MRC or the Medicare Gap Fill process the customer may be liable for any amount over the allowed amount, in addition to their copay/coinsurance and deductible.

In-Network Benefit Level for Out-of-Network Services

In instances where emergent care is rendered by an out-of-network provider Cigna, in compliance with the Federal No Surprises Act, will reimburse those services at the in-network benefit level. Additionally, should an in-network provider not be available to provide specialized medically necessary care Cigna may approve those services at the in-network benefit level in accordance with the guidelines described in the Network Adequacy Provision Policy (UM-20) and the Benefit Enhancement Policy. Cigna may enhance covered Out-of-Network services to the In-network benefit level. Some of these instances are (not all-inclusive):

- Emergency services (i.e., ground ambulance): Cigna may determine whether it is appropriate to process emergency services not covered under the No Surprises Act at the in-network benefit.
- Network Adequacy Provision Policy (UM-20): Cigna understands there may be instances where it may be necessary/prudent for a customer to seek care from an out-of-network practitioner/facility. Such instances may include:
 - The need for specialized care where an in-network practitioner/facility is not available.
 - Situations where a customer is unable to receive care at an in-network health care professional or facility within reasonable appointment availability timeframes or drive times from their home, for example.

When a network exception is approved, the claims may be processed according to the customers' in-network benefit if the criteria is met per this policy. Clients can elect an MRC Percentile of 200% for enhanced claims (emergency services and network exceptions).

Single Case Agreement

When a network exception is approved the nonparticipating provider or facility may initiate a request for a single case agreement negotiation. M/S and MH/SUD will negotiate with any willing provider.

For both M/S and MH/SUD services, Cigna conducts provider outreach by telephone or email and makes reasonable efforts to secure an agreement; MH/SUD outreach may also be conducted by fax. This additional communication method does not alter the substantive negotiation standard or impose a more restrictive process on MH/SUD benefits.

For both M/S and MH/SUD services, the negotiator reviews the approved NAP authorization, service type, provider or facility information, relevant billing and coding details, and any prior or existing reimbursement arrangements. If an established rate is not available, the Negotiator will initiate discussions with the provider/facility utilizing approved reimbursement methodologies and applicable Levels of Authority guidance. If an agreement is reached the agreed upon terms are documented in the system of record (i.e. Salesforce, SharePoint) along with a letter being sent to the provider/facility for signature of agreed terms. Upon receipt of a claim that is consistent with the authorization and agreement, Cigna reimburses the provider at the negotiated rate and adjudicates the claim under the member's applicable in-network plan benefits. If the provider does not accept the initial offer, Cigna continues reasonable negotiation efforts to reach an agreement, where possible. If the parties are unable to reach an agreement, the provider determines whether to furnish the authorized services. When the services are rendered pursuant to the approved NAP network gap exception, the claim is processed at the member's in-network benefit level and reimbursement is determined in accordance with the applicable maximum reimbursable charge provisions.

Member protections and notification practices are applied consistently to M/S and MH/SUD services. Once a single case agreement is established, the provider may not balance bill the member, and the member is responsible only for the applicable in-network cost-sharing amount. Cigna notifies the member of the approved services through an approval letter; consistent with standard confidentiality and contracting practices, the letter does not disclose the negotiated reimbursement terms.

Finally, M/S and MH/SUD single case agreements are limited to the specific services and dates authorized by utilization management through the approved NAP network gap exception. To receive the negotiated rate, the submitted claim must correspond to the material terms of the authorization and agreement, including the provider, authorized services, and approved dates of service. Accordingly, each single case agreement applies only to the expressly authorized services and timeframe and does not extend to unrelated services, providers, or dates. Taken together, these standards demonstrate that Cigna applies a substantially comparable single case agreement framework to M/S and MH/SUD benefits.

Step 4: Demonstration of comparability and stringency as written.

See [45 CFR 146.137\(c\)\(4\)](#). The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

- (1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;
 - (A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and
 - (B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;
- (2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;
- (3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and
- (4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [\[Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits\]](#):
 - (A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;
 - (B) In the design of the factors or evidentiary standards; or
 - (C) In the application or design of the NQTL.

See also [FAQ 45](#) guidance that states that the following is necessary for a sufficient

response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.

- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Base Rates:

To ensure that Cigna's policies are consistently applied, Cigna conducts a thorough review of policies and procedures at least annually. The annual review includes an analysis of applicable M/S and MH/SUD policies and procedures to identify potential gaps or inconsistencies. Cigna is providing the below Provider Reimbursement policies used in the application of the Provider Reimbursement NQTL to demonstrate comparability and consistency. As described in policy *OPS-18 Policy and Procedure Maintenance, Review and Approval Process*, these Cigna policies were developed and reviewed according to URAC and NCQA standards, and regulatory requirements.

As described in the Maximum Reimbursable Charge Policy that establishes the governing operational standards for determining allowable reimbursement when covered services are furnished by non-participating providers. The policy applies to claims administration for both medical/surgical ("M/S") and mental health/substance use disorder ("MH/SUD") services and requires reimbursement to be determined in accordance with the applicable plan terms, the client-selected out-of-network benefit methodology, and controlling federal and state law.

Depending on the plan election, the allowable amount may be established under MRC1, using a selected percentile of geographically relevant provider-charge data, or MRC2, using a selected percentage of a fee schedule developed through a methodology similar to Medicare; where an applicable Medicare equivalent is unavailable, the policy permits use of the MRC1 methodology. The policy also addresses the potential application of authorized cost-containment, offer-and-settlement, and benefit-enhancement processes, together with the member's responsibility for applicable cost sharing and any permissible billed amount above the plan's allowable

reimbursement. These standards operate within a common enterprise framework for M/S and MH/SUD benefits and do not establish a separate or more restrictive reimbursement standard for MH/SUD services.

Additionally, the Non-Par Reimbursement Rate Methodology guidelines outlines how Cigna utilizes external entities/vendors to determine out-of-network reimbursement rates. This process ensures industry standard fair market processes and methodologies are utilized for all M/S and MH/SUD out-of-network reimbursement. In the event an entity or vendor does not have an assigned reimbursement rate Cigna will attempt to negotiate directly with the provider/facility. If those negotiations are not successful Cigna will reimburse according to the members benefit plan based on the provider/facility amount billed.

Each entity or vendor used are assigned by the reimbursement methodology chosen by the plan and is used for both M/S and MH/SUD.

All reimbursement methodologies are used for both M/S and MH/SUD.

Out-of-Network Protection Program:

- Claritev (formerly Multiplan)
- Zelis
- Cigna direct negotiation
- MRC1: FAIRHealth
- MRC2: Medicare CMS

Determining Total Amount Due to Provider - "Out of Network Rate"

Under Federal law, the total amount due from both the issuer and the covered individual combined to an out-of-network provider or facility for furnishing a covered item or service is the "out-of-network rate," which can differ from the "recognized amount".

The recognized amount, per federal law is determined by the following:

- Emergency and non-emergency services:
 - All-Payer Model Agreement
 - If no, All-Payer Model Agreement exists: Amount determined by specified state law
 - If no, All-Payer Model Agreement or specified state law exists, the lesser of:
 - the amount billed by the provider/facility or
 - the qualifying payment amount for the item or service

Professional Services Reimbursement

In order to determine the out-of-network rate Cigna annually sets the Resource Based Relative Value Scale (RBRVS). The RBRVS is a CMS created reimbursement methodology to reimburse providers for members covered under the Medicare program and as a baseline for commercial reimbursement rates. The RBRVS rate for each applicable out of network service is then multiplied by the client elected MRC to determine the service allowed amount.

RBRVS utilizes three components in calculating an out-of-network allowed amount for a service. These components are the following:

- **RVU** = Relative Value Unit
- **GPCI** = Geographic Practice Cost Index

- **CF** = Conversion Factor (a dollar amount set annually by CMS)

RVU:

The Relative Value Units (RVUs) measure the value of M/S and MH/SUD services based on three components:

1. Work RVU shows the Medicare PFS services' relative time and intensity
2. Practice Expense RVU shows the costs of supporting a practice (like renting office space, buying supplies and equipment, and staff cost)
3. Malpractice RVU shows the cost of malpractice insurance.

GPCI:

The Geographic Practice Cost Index (GPCIs) is a geographic variation measure used for M/S and MH/SUD services that adjusts the different types of RVU based on the costs of practicing medicine based on where the service is being rendered.

CF:

The Conversion Factor (CF) is set annually by CMS based on federal statute and applicable to both M/S and MH/SUD services.

Professional Services Reimbursement Calculation:

Cigna RBRVS is set annually:

$$[(\text{Work RVU} \times \text{Work GPCI}) + (\text{Practice RVU} \times \text{Practice GPCI}) + (\text{Malpractice RVU} \times \text{Malpractice GPCI})] \times \text{Conversion Factor} = \text{Medicare Rate}$$

 (X multiplied by) the client MRC election
 (X multiplied by) any additional units performed for each service
 (= equals) the allowed amount for each service

Absent a Medicare rate, Cigna utilizes the following reimbursement calculations:

Fair Health rate for the service being rendered (or MRC Policy Review Board rate when Fair Health rate is unavailable)

(X multiplied by) the client MRC election
 (X multiplied by) any additional units performed for each service
 (= equals) the allowed amount for each service

As noted, the lesser of the provider's billed charges or MRC is used to determine the out-of-network reimbursement amount unless Cigna has access to an indirect discount arrangement, whether maintained pursuant to a standing agreement between a third-party vendor and provider or negotiated on a case-by-case basis with the provider, that are within Cigna's established target pricing for a service. To be clear, the established target pricing for a service is derived identically for an MH/SUD or M/S benefit. Specifically, under the MRC2 methodology—which is based on a Medicare pricing methodology—any negotiations resulting in indirect discount arrangements maintained by a third-party vendor and a provider, whether rendering MH/SUD or M/S services, are subject to the same MRC2 target price for both MH/SUD and M/S services. Similar to the calculation of reimbursement under the MRC1 methodology, where the indirect discount arrangement amount meets or is lower than the target price—which target price is, again, the same percentage of the applicable Medicare rate whether it is an MH/SUD or M/S service—then the amount resulting from the indirect discount arrangement is the allowable reimbursement

amount, and where the indirect discount arrangement amount exceeds the target price the MRC is the allowable reimbursement amount.

Moreover, for any claim whose reimbursement is determined under an indirect discount arrangement, Cigna monitors for any attempt by a provider to inappropriately balance-bill participants by informing participants that they should notify Cigna in the event the provider issues the participant a bill in excess of the otherwise applicable cost-sharing for the out-of-network service.

This approach is employed identically across MH/SUD and M/S benefits irrespective of out-of-network benefit classification—balances the management of claims expenses with the other objective of the out-of-network reimbursement program, protecting enrollees from balance-billing wherever possible. In the absence of such an acceptable rate arrangement, and as previously noted, the plan agrees to pay a benefit equal to the lesser of the billed charges or the client-elected Maximum Reimbursable Charge for the covered services, which, as described, above, is calculated based on the Maximum Reimbursable Charge methodology selected by the plan.

Adjusted and Final Rates:

To ensure that Cigna's policies are consistently applied, Cigna conducts a thorough review of policies and procedures at least annually. The annual review includes an analysis of applicable M/S and MH/SUD policies and procedures to identify potential gaps or inconsistencies. Cigna is providing the below Provider Reimbursement policies used in the application of the Provider Reimbursement NQTL to demonstrate comparability and consistency. As described in policy *OPS-18 Policy and Procedure Maintenance, Review and Approval Process*, these Cigna policies were developed and reviewed according to URAC and NCQA standards, and regulatory requirements.

As described in the Maximum Reimbursable Charge Policy that establishes the governing operational standards for determining allowable reimbursement when covered services are furnished by non-participating providers. The policy applies to claims administration for both medical/surgical ("M/S") and mental health/substance use disorder ("MH/SUD") services and requires reimbursement to be determined in accordance with the applicable plan terms, the client-selected out-of-network benefit methodology, and controlling federal and state law.

Depending on the plan election, the allowable amount may be established under MRC1, using a selected percentile of geographically relevant provider-charge data, or MRC2, using a selected percentage of a fee schedule developed through a methodology similar to Medicare; where an applicable Medicare equivalent is unavailable, the policy permits use of the MRC1 methodology. The policy also addresses the potential application of authorized cost-containment, offer-and-settlement, and benefit-enhancement processes, together with the member's responsibility for applicable cost sharing and any permissible billed amount above the plan's allowable reimbursement. These standards operate within a common enterprise framework for M/S and MH/SUD benefits and do not establish a separate or more restrictive reimbursement standard for MH/SUD services.

Additionally, the Non-Par Reimbursement Rate Methodology guidelines outlines how Cigna utilizes external entities/vendors to determine out-of-network reimbursement rates. This process ensures industry standard fair market processes and methodologies are utilized for all M/S and MH/SUD out-of-network reimbursement. In the event an entity or vendor does not have an assigned

reimbursement rate Cigna will attempt to negotiate directly with the provider/facility. If those negotiations are not successful Cigna will reimburse according to the members benefit plan based on the provider/facility amount billed.

Each entity or vendor used are assigned by the reimbursement methodology chosen by the plan and is used for both M/S and MH/SUD.

All reimbursement methodologies are used for both M/S and MH/SUD.

Out-of-Network Protection Program:

- Claritev (formerly Multiplan)
- Zelis
- Cigna direct negotiation
- MRC1: FAIRHealth
- MRC2: Medicare CMS

Determining Total Amount Due to Provider - "Out of Network Rate"

Under Federal law, the total amount due from both the issuer and the covered individual combined to an out-of-network provider or facility for furnishing a covered item or service is the "out-of-network rate," which can differ from the "recognized amount".

The recognized amount, per federal law is determined by the following:

- Emergency and non-emergency services:
 - All-Payer Model Agreement
 - If no, All-Payer Model Agreement exists: Amount determined by specified state law
 - If no, All-Payer Model Agreement or specified state law exists, the lesser of:
 - the amount billed by the provider/facility or
 - the qualifying payment amount for the item or service

Professional Services Reimbursement

In order to determine the out-of-network rate Cigna annually sets the Resource Based Relative Value Scale (RBRVS). The RBRVS is a CMS created reimbursement methodology to reimburse providers for members covered under the Medicare program and as a baseline for commercial reimbursement rates. The RBRVS rate for each applicable out of network service is then multiplied by the client elected MRC to determine the service allowed amount.

RBRVS utilizes three components in calculating an out-of-network allowed amount for a service. These components are the following:

- **RVU** = Relative Value Unit
- **GPCI** = Geographic Practice Cost Index
- **CF** = Conversion Factor (a dollar amount set annually by CMS)

RVU:

The Relative Value Units (RVUs) measure the value of M/S and MH/SUD services based on three components:

1. Work RVU shows the Medicare PFS services' relative time and intensity

2. Practice Expense RVU shows the costs of supporting a practice (like renting office space, buying supplies and equipment, and staff cost)
3. Malpractice RVU shows the cost of malpractice insurance.

GPCI:

The Geographic Practice Cost Index (GPCIs) is a geographic variation measure used for M/S and MH/SUD services that adjusts the different types of RVU based on the costs of practicing medicine based on where the service is being rendered.

CF:

The Conversion Factor (CF) is set annually by CMS based on federal statute and applicable to both M/S and MH/SUD services.

Professional Services Reimbursement Calculation:

Cigna RBRVS is set annually:

$$[(\text{Work RVU} \times \text{Work GPCI}) + (\text{Practice RVU} \times \text{Practice GPCI}) + (\text{Malpractice RVU} \times \text{Malpractice GPCI})] \times \text{Conversion Factor} = \text{Medicare Rate}$$

 (X multiplied by) the client MRC election
 (X multiplied by) any additional units performed for each service
 (= equals) the allowed amount for each service

Absent a Medicare rate, Cigna utilizes the following reimbursement calculations:

Fair Health rate for the service being rendered (or MRC Policy Review Board rate when Fair Health rate is unavailable)
 (X multiplied by) the client MRC election
 (X multiplied by) any additional units performed for each service
 (= equals) the allowed amount for each service

As noted, the lesser of the provider's billed charges or MRC is used to determine the out-of-network reimbursement amount unless Cigna has access to an indirect discount arrangement, whether maintained pursuant to a standing agreement between a third-party vendor and provider or negotiated on a case-by-case basis with the provider, that are within Cigna's established target pricing for a service. To be clear, the established target pricing for a service is derived identically for an MH/SUD or M/S benefit. Specifically, under the MRC2 methodology—which is based on a Medicare pricing methodology—any negotiations resulting in indirect discount arrangements maintained by a third-party vendor and a provider, whether rendering MH/SUD or M/S services, are subject to the same MRC2 target price for both MH/SUD and M/S services. Similar to the calculation of reimbursement under the MRC1 methodology, where the indirect discount arrangement amount meets or is lower than the target price—which target price is, again, the same percentage of the applicable Medicare rate whether it is an MH/SUD or M/S service—then the amount resulting from the indirect discount arrangement is the allowable reimbursement amount, and where the indirect discount arrangement amount exceeds the target price the MRC is the allowable reimbursement amount.

Moreover, for any claim whose reimbursement is determined under an indirect discount arrangement, Cigna monitors for any attempt by a provider to inappropriately balance-bill participants by informing participants that they should notify Cigna in the event the provider issues the participant a bill in excess of the otherwise applicable cost-sharing for the out-of-network

service.

This approach is employed identically across MH/SUD and M/S benefits irrespective of out-of-network benefit classification—balances the management of claims expenses with the other objective of the out-of-network reimbursement program, protecting enrollees from balance-billing wherever possible. In the absence of such an acceptable rate arrangement, and as previously noted, the plan agrees to pay a benefit equal to the lesser of the billed charges or the client-elected Maximum Reimbursable Charge for the covered services, which, as described, above, is calculated based on the Maximum Reimbursable Charge methodology selected by the plan.

In-Network Benefit Level for Out-of-Network Services

Cigna conducted a side-by-side review of UM-20 Network Adequacy Provision Policy to evaluate eligibility criteria, approval requirements, reimbursement methodologies, documentation standards, governance controls, and operational workflows. No differences were identified thus the determination was made that the policy does not impose a more restrictive standard on MH/SUD benefits.

M/S	MH/SUD
UM 20 Network Adequacy Provision Policy	UM 20 Network Adequacy Provision Policy
The policy outlines the criteria and process for network exception requests from a non-participating health care professional/facility requesting the services be considered at the in-network benefit level. The purpose of this policy is: Establish a consistent process for evaluating and responding to network adequacy authorization requests when it is perceived that a qualified, participating healthcare professional or provider is not available to provide medically necessary services within a reasonable distance from the customer's home or within reasonable appointment availability timeframes.	

Single Case Agreements:

Through its comparative analysis, Cigna identified a documentation gap related to the formalization of operational policies governing Single Case Agreements for M/S and MH/SUD. As detailed below, the policies establish the applicable processes, controls, approval requirements, and documentation standards and provide a basis for assessing comparable application across M/S and MH/SUD benefits.

Policy Element	MH/SUD SCA Standard Operating Procedure	Medical/Surgical SCA Standard Operating Procedure
Purpose	Describes the process for receiving, evaluating, negotiating, documenting, approving, and executing SCAs for approved out-of-network MH/SUD services.	Describes the process for receiving, evaluating, negotiating, documenting, approving, and executing SCAs for approved out-of-network medical services.
Authorization and Referral	Clinical Operations approves services and refers cases requiring reimbursement arrangements to the negotiation team.	Clinical Operations approves services and refers cases requiring reimbursement arrangements to the negotiation team.
Intake Channels	Requests received through operational reports, task assignments, and email.	Requests received through system-generated referrals, task assignments, operational reports, and email.
Case Assignment	Cases are assigned and documented within internal systems.	Cases are assigned to a Provider Network Manager or designated negotiator and

		documented within systems of record.
Negotiation Review Requirements	Negotiator reviews request, service type, provider information, and prior reimbursement arrangements.	Negotiator reviews authorization information, service type, provider/facility details, billing/coding information, and prior reimbursement arrangements.
Pricing Methodology	Existing rates are reviewed for potential reuse. If unavailable, request is evaluated using approved reimbursement methodologies, internal pricing resources, market information, historical reimbursement data and other applicable pricing tools.	Existing arrangements are reviewed. If unavailable, pricing is evaluated using approved reimbursement methodologies, internal pricing resources, market information, historical reimbursement data, and pricing tools.
Negotiation Standards	Negotiations are conducted using approved reimbursement methodologies and applicable Levels of Authority guidance.	Negotiations are conducted in accordance with approved reimbursement methodologies, operational procedures, and established Levels of Authority.
Documentation Requirements	Negotiation activity, communications, approvals, agreement documentation, and outcome determinations are maintained within systems of record.	Negotiation activity, communications, approvals, agreement documentation, and outcomes are maintained within systems of record.
Levels of Authority and Governance	References applicable Levels of Authority guidance and required approvals.	Contains a dedicated Levels of Authority section establishing approval authority, pricing ownership, countersignature requirements, and local market collaboration requirements.
Countersignature Requirements	Requires Sr. Director countersignature for all SCAs.	Requires AVP countersignature for all SCAs and specifies Director authority when the AVP is unavailable.
Local Market Validation	No comparable provision identified.	Requires collaboration with local markets and validation of existing contracted rates prior to use in negotiations.
Unsuccessful Negotiations	Systems updated and claims processed using applicable default reimbursement methodologies when appropriate.	Systems updated, final disposition documented, and claims processed using applicable reimbursement methodologies and benefit provisions when appropriate.
Successful Negotiations	Terms documented, agreement sent for signature, countersigned by Evernorth, systems updated, and reimbursement information documented and communicated to downstream operational areas.	Terms documented, internal review and approval completed, executed agreement retained, systems updated, and reimbursement information communicated to downstream operational areas.

Cigna reviewed the identified procedural differences between the MH/SUD and M/S Single Case Agreement SOPs. The review determined that these differences primarily involve administrative workflow, referral intake, communication channels, and organizational approval structures rather than substantive eligibility requirements, reimbursement methodologies, or approval criteria. Although the procedures reference different job titles, Cigna reviewed the applicable Levels of Authority framework and determined that the respective approval roles perform comparable review and approval functions for purposes of Single Case Agreement execution. MH/SUD negotiations are performed through a centralized national process that utilizes approved reimbursement methodologies and Levels of Authority requirements. Accordingly, local market

validation is not required because local contracting arrangements are not used as a prerequisite to negotiation or approval.

The policies use the same underlying trigger (approved Network Exception), the same reimbursement framework, the same requirement for negotiation and documentation, and the same authorization-based limitation on covered services. Accordingly, Cigna concluded that the identified procedural differences do not impose additional substantive requirements or more restrictive standards on MH/SUD benefits.

Step 5: Demonstration of comparability and stringency in operation.

See [45 CFR 146.137\(c\)\(5\)](#). The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

- (1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:
 - (A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;
 - (B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;
 - (C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and
 - (D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was

- considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);
- (2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);
 - (3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:
 - (A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A);
 - (B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);
 - (4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:
 - (A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and
 - (B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH and SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and
 - (5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:
 - (A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and
 - (B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD

benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also [FAQ 45](#) guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Relevant Data Review:

At least annually, Cigna reviews applicable operational data in consultation with qualified Subject Matter Experts to validate the data's continued relevance, reliability, completeness, and suitability for evaluating the Out-of-Network Outpatient Reimbursement NQTL. The review requires Cigna to identify and evaluate newly available or emerging data relevant to the NQTL's operational impact and to determine, based on the totality of the available evidence, whether the NQTL is applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. Cigna documents the review, its conclusions, and any identified limitations or disparities and implements timely corrective actions, including updates to data sources, methodologies, policies, procedures, or operational practices, when warranted by the findings.

Outcome Data:

Reimbursement Table A – Physician and Non-Physician:

Data Methodology: Reimbursement Table A evaluates separately billed Physician and Non-Physician services. The same claims-selection and average-reimbursement calculation methodology is applied to M/S and MH/SUD services.

For both M/S and MH/SUD, the analysis uses Virginia fully insured claims experience for calendar year 2025 and includes only claims identified as out-of-network based on the network-status field.

MH/SUD Claims Population

- Virginia fully insured claims incurred during calendar year 2025;
- claims identified as out-of-network; and
- professional claims reported for the following Physician and Non-Physicians:
 - Psychiatrist;
 - Addiction Medicine Physician;
 - Psychologist; and
 - Social Worker

M/S Claims Population

- Virginia fully insured claims incurred during calendar year 2025;
- claims identified as out-of-network; and
- professional claims reported for the following Physician and Non-Physicians:
 - Cardiologist;
 - Dermatologist;
 - Chiropractor; and

- Physical Therapist

Average Reimbursement Calculation:

For each benefit category, average reimbursement is calculated using the same formula: **Average Reimbursement per Service Unit = Total Reimbursement Amount ÷ Total Service Units**. “Total Reimbursement Amount” means the sum of the reimbursement amount used for the included professional claim lines, and “Total Service Units” means the sum of the service units reported on those claim lines. The calculation therefore differs between M/S and MH/SUD only because of the physician and non-physician types required in the population; the formula and calculation steps are otherwise the same.

For each applicable table, average reimbursement per service unit was calculated by dividing the total allowed amount for the included claim lines by the total service units reported on those claim lines. The same calculation was applied to the M/S and MH/SUD claims populations. Any differences in the resulting average reimbursement reflect the claims included in each population, including the applicable physician types, and not a difference in the calculation methodology.

The reimbursement outcome data reflect Virginia fully insured claims experience for calendar year 2025 and use the same calculation for both benefit categories: total allowable amount divided by total service units.

The table reports the 10 highest-volume combinations separately for each included provider. Because the selection was performed within provider categories, less than 10 total rows may appear in each benefit group.

Accordingly, the data provided an operational comparison of observed reimbursement outcomes but does not constitute a matched cohort of identical services, providers, utilization volumes, contractual terms, or case mix.

MH/SUD:

CLASSIFICATION	PROVIDER TYPE	PROCEDURE CODE	AVERAGE BILLED AMOUNT PER UNIT	AVERAGE ALLOWED AMOUNT PER UNIT
Out-of-Network Outpatient	Addiction Medicine Physician	99213	\$111.24	\$77.87
Out-of-Network Outpatient	Addiction Medicine Physician	80305	\$14.96	\$11.34
Out-of-Network Outpatient	Psychiatrist	J1944	\$6.53	\$5.23
Out-of-Network Outpatient	Psychiatrist	99214	\$220.40	\$146.23
Out-of-Network Outpatient	Psychiatrist	99213	\$174.91	\$107.13
Out-of-Network Outpatient	Psychiatrist	90836	\$147.25	\$120.69
Out-of-Network Outpatient	Psychiatrist	90833	\$108.05	\$78.11
Out-of-Network Outpatient	Psychiatrist	99215	\$243.48	\$174.70
Out-of-Network Outpatient	Psychiatrist	90868	\$2,933.33	\$310.41
Out-of-Network Outpatient	Psychiatrist	90834	\$201.35	\$107.81
Out-of-Network Outpatient	Psychiatrist	90792	\$579.90	\$298.26
Out-of-Network Outpatient	Psychiatrist	90846	\$296.42	\$136.08
Out-of-Network Outpatient	Psychologist	90834	\$224.51	\$142.09
Out-of-Network Outpatient	Psychologist	90837	\$221.09	\$187.64
Out-of-Network Outpatient	Psychologist	90853	\$85.41	\$41.15
Out-of-Network Outpatient	Psychologist	90847	\$230.64	\$127.23

Out-of-Network Outpatient	Psychologist	90846	\$220.77	\$143.89
Out-of-Network Outpatient	Psychologist	96137	\$202.70	\$59.36
Out-of-Network Outpatient	Psychologist	90832	\$114.83	\$101.19
Out-of-Network Outpatient	Psychologist	90791	\$320.39	\$220.59
Out-of-Network Outpatient	Psychologist	96131	\$361.23	\$143.60
Out-of-Network Outpatient	Psychologist	99213	\$298.00	\$140.40
Out-of-Network Outpatient	Social Worker	97153	\$67.34	\$18.37
Out-of-Network Outpatient	Social Worker	90837	\$188.95	\$159.78
Out-of-Network Outpatient	Social Worker	90834	\$193.78	\$131.86
Out-of-Network Outpatient	Social Worker	97155	\$103.78	\$28.75
Out-of-Network Outpatient	Social Worker	97156	\$83.77	\$28.42
Out-of-Network Outpatient	Social Worker	90853	\$113.00	\$52.91
Out-of-Network Outpatient	Social Worker	97151	\$133.00	\$36.53
Out-of-Network Outpatient	Social Worker	90847	\$209.27	\$141.10
Out-of-Network Outpatient	Social Worker	90832	\$102.05	\$78.20
Out-of-Network Outpatient	Social Worker	90791	\$242.58	\$178.29

M/S:

CLASSIFICATION	PROVIDER TYPE	PROCEDURE CODE	AVERAGE BILLED AMOUNT PER UNIT	AVERAGE ALLOWED AMOUNT PER UNIT
In-Network Outpatient	Cardiologists	93010	\$34.51	\$18.02
In-Network Outpatient	Cardiologists	99214	\$273.77	\$180.89
In-Network Outpatient	Cardiologists	93000	\$56.24	\$34.86
In-Network Outpatient	Cardiologists	93306	\$486.66	\$304.08
In-Network Outpatient	Cardiologists	99204	\$408.35	\$279.96
In-Network Outpatient	Cardiologists	93015	\$248.20	\$165.42
In-Network Outpatient	Cardiologists	99213	\$187.18	\$116.18
In-Network Outpatient	Cardiologists	Q9967	\$1.00	\$0.15
In-Network Outpatient	Cardiologists	78452	\$1,068.02	\$514.54
In-Network Outpatient	Cardiologists	A9502	\$276.27	\$86.98
In-Network Outpatient	Chiropractor	98941	\$60.81	\$29.91
In-Network Outpatient	Chiropractor	97110	\$47.02	\$20.80
In-Network Outpatient	Chiropractor	97530	\$55.44	\$26.89
In-Network Outpatient	Chiropractor	98943	\$45.16	\$19.49
In-Network Outpatient	Chiropractor	97014	\$25.57	\$9.88
In-Network Outpatient	Chiropractor	97140	\$43.29	\$19.49
In-Network Outpatient	Chiropractor	97012	\$27.32	\$10.92
In-Network Outpatient	Chiropractor	97112	\$58.45	\$24.87
In-Network Outpatient	Chiropractor	98940	\$48.23	\$24.74
In-Network Outpatient	Chiropractor	86003	\$8.55	\$0.06
In-Network Outpatient	Dermatologists	99213	\$186.23	\$84.70
In-Network Outpatient	Dermatologists	99214	\$268.16	\$122.82
In-Network Outpatient	Dermatologists	17003	\$25.08	\$7.65
In-Network Outpatient	Dermatologists	17110	\$256.45	\$119.26
In-Network Outpatient	Dermatologists	99203	\$238.11	\$111.33
In-Network Outpatient	Dermatologists	99204	\$369.53	\$169.39
In-Network Outpatient	Dermatologists	11102	\$224.39	\$102.73
In-Network Outpatient	Dermatologists	17000	\$159.06	\$59.99

In-Network Outpatient	Dermatologists	99212	\$119.10	\$52.60
In-Network Outpatient	Dermatologists	J3301	\$10.18	\$1.29
In-Network Outpatient	Physical Therapists	97110	\$84.38	\$36.94
In-Network Outpatient	Physical Therapists	97530	\$74.35	\$44.86
In-Network Outpatient	Physical Therapists	97112	\$74.48	\$39.85
In-Network Outpatient	Physical Therapists	97140	\$99.57	\$31.00
In-Network Outpatient	Physical Therapists	97164	\$291.74	\$172.79
In-Network Outpatient	Physical Therapists	97161	\$190.56	\$106.56
In-Network Outpatient	Physical Therapists	97535	\$82.87	\$41.38
In-Network Outpatient	Physical Therapists	97162	\$175.80	\$93.28
In-Network Outpatient	Physical Therapists	97014	\$51.48	\$17.68
In-Network Outpatient	Physical Therapists	92507	\$132.87	\$71.47

Reimbursement Table A evaluates average reimbursement outcomes for separately billed physician and non-physician professional services using Virginia fully insured claims incurred during calendar year 2025. The stated methodology applies the same claims-selection framework and average-reimbursement calculation to Medical/Surgical (“M/S”) and Mental Health/Substance Use Disorder (“MH/SUD”) services.

The MH/SUD results demonstrate average allowed amounts range from \$5.23 per unit for psychiatrist-administered J1944 to \$310.41 per unit for psychiatrist-administered 90868.

Addiction Medicine Physicians

The two reported addiction medicine physician services show the following outcomes:
99213: \$77.87 allowed compared with \$111.24 billed, or approximately 70.0% of billed charges.
80305: \$11.34 allowed compared with \$14.96 billed, or approximately 75.8%.

Psychiatrists

Psychiatrist average allowed amounts range from \$5.23 for J1944 to \$310.41 for 90868. The allowed-to-billed relationships vary materially:

J1944: approximately 80.1%.
99214: approximately 66.3%.
99213: approximately 61.2%.
90836: approximately 82.0%.
90833: approximately 72.3%.
99215: approximately 71.8%.
90868: approximately 10.6%.
90834: approximately 53.5%.
90792: approximately 51.4%.
90846: approximately 45.9%.

Psychologists

Psychologist average allowed amounts range from \$41.15 for 90853 to \$220.59 for 90791. The allowed-to-billed relationships range from approximately 29.3% for 96137 to approximately 88.1% for 90832. Examples include:
90834: approximately 63.3%.
90837: approximately 84.9%.

90847: approximately 55.2%.
90846: approximately 65.2%.
90791: approximately 68.9%.
99213: approximately 47.1%.

Social Workers

Social worker average allowed amounts range from \$18.37 for 97153 to \$178.29 for 90791. The allowed-to-billed relationships likewise vary:

97153: approximately 27.3%.
90837: approximately 84.6%.
90834: approximately 68.0%.
97155: approximately 27.7%.
97156: approximately 33.9%.
90853: approximately 46.8%.
97151: approximately 27.5%.
90847: approximately 67.4%.
90832: approximately 76.6%.
90791: approximately 73.5%.

The variation within each MH/SUD provider category demonstrates that reimbursement outcomes are service-specific and do not reflect a uniform reduction applied to MH/SUD claims.

The M/S results also demonstrate average allowed amounts ranging from \$0.06 per unit for chiropractor-reported 86003 to \$514.54 per unit for cardiologist-reported 78452.

Cardiologists

Cardiologist average allowed amounts range from \$0.15 for Q9967 to \$514.54 for 78452. The allowed-to-billed relationships range from 15.0% for Q9967 to approximately 68.6% for 99204.

Examples include:

93010: approximately 52.2%.
99214: approximately 66.1%.
93000: approximately 62.0%.
93306: approximately 62.5%.
93015: approximately 66.6%.
99213: approximately 62.1%.
78452: approximately 48.2%.

Chiropractors

Chiropractor average allowed amounts range from \$0.06 for 86003 to \$29.91 for 98941. Excluding 86003, the reported allowed-to-billed relationships generally range from approximately 38.6% to 51.3%:

98941: approximately 49.2%.
97110: approximately 44.2%.
97530: approximately 48.5%.
98943: approximately 43.2%.
97014: approximately 38.6%.
97140: approximately 45.0%.
98940: approximately 51.3%.

Dermatologists

Dermatologist average allowed amounts range from \$1.29 for J3301 to \$169.39 for 99204. The allowed-to-billed relationships range from approximately 12.7% for J3301 to approximately 46.7% for 17110. The evaluation and management codes are comparatively consistent:

99213: approximately 45.5%.

99214: approximately 45.8%.

99203: approximately 46.8%.

99204: approximately 45.8%.

99212: approximately 44.2%.

Physical Therapists

Physical therapist average allowed amounts range from \$17.68 for 97014 to \$172.79 for 97164. The allowed-to-billed relationships range from approximately 31.1% for 97140 to approximately 60.3% for 97530:

97110: approximately 43.8%.

97530: approximately 60.3%.

97112: approximately 53.5%.

97164: approximately 59.2%.

97161: approximately 55.9%.

97535: approximately 49.9%.

97162: approximately 53.1%.

92507: approximately 53.8%.

As in the MH/SUD population, the M/S results demonstrate that reimbursement varies by provider type and procedure code rather than through a uniform allowed-to-billed percentage.

Same-Code Comparisons

Procedure codes 99213 and 99214 appear in both benefit categories and provide the most direct available comparisons. These comparisons remain subject to differences in practitioner specialty, utilization, provider charges, network status, and claim mix.

Procedure Code 99213

Reported average allowed amounts were:

Addiction Medicine Physician: \$77.87.

Psychiatrist: \$107.13.

Psychologist: \$140.40.

Cardiologist: \$116.18.

Dermatologist: \$84.70.

The MH/SUD results span the M/S results. The psychiatrist allowed amount exceeds the dermatologist amount but is below the cardiologist amount, while the psychologist amount exceeds both M/S amounts. The addiction medicine physician amount is modestly below the reported M/S values. This distribution does not demonstrate a uniform MH/SUD reimbursement disadvantage.

Allowed-to-billed relationships for 99213 also overlap:

MH/SUD: approximately 47.1% to 70.0%.

M/S: approximately 45.5% to 62.1%.

Procedure Code 99214

Reported average allowed amounts were:

Psychiatrist: \$146.23.

Cardiologist: \$180.89.

Dermatologist: \$122.82.

The psychiatrist result falls between the two M/S provider results. Its allowed-to-billed relationship of approximately 66.3% is comparable to the cardiologist result of approximately 66.1% and exceeds the dermatologist result of approximately 45.8%.

The operational findings support the conclusion that the reimbursement calculation methodology was comparable and was not applied more stringently to MH/SUD benefits than to M/S benefits.

Reimbursement Table C – Professional Services Rendered in Facility Setting:

Data Methodology: Reimbursement Table C evaluates separately billed professional services rendered in an outpatient facility setting. The same claims-selection and average-reimbursement calculation methodology is applied to M/S and MH/SUD services. The only difference is the set of place-of-service (“POS”) codes and claims service type specific to Intensive Outpatient Facility used to identify the outpatient settings applicable to each benefit category.

For both M/S and MH/SUD, the analysis uses Virginia fully insured claims experience for calendar year 2025 and includes only claims identified as out-of-network based on the network-status field. Professional claims are assigned to the out-of-network outpatient classification using the POS code and claims service type specific to Intensive Outpatient Facility reported on the claim. The applicable POS codes and claims service type specific to Intensive Outpatient Facility are identified below.

MH/SUD Claims Population

- Virginia fully insured claims incurred during calendar year 2025;
- claims identified as out-of-network; and
- professional claims reported with one of the following POS codes:
 - Psych Fac – Partial Hosp (POS 52);
 - Non-Residential SA Fac (POS 57);
 - On-Campus OP Hospital (POS 22);
 - Intensive Outpatient Facility (Partial Hospitalization and Intensive Outpatient Programs)

M/S Claims Population

- Virginia fully insured claims incurred during calendar year 2025;
- claims identified as out-of-network; and
- professional claims reported with one of the following POS codes:
 - Ambulatory Surgical Center (POS 24);
 - ESRD Treatment Facility (POS 65);
 - On-Campus OP Hospital (POS 22).

Average Reimbursement Calculation:

For each benefit category, average reimbursement is calculated using the same formula: **Average Reimbursement per Service Unit = Total Reimbursement Amount ÷ Total Service Units.** “Total Reimbursement Amount” means the sum of the reimbursement amount used for the included

professional claim lines, and “Total Service Units” means the sum of the service units reported on those claim lines. The calculation therefore differs between M/S and MH/SUD only because each category includes the POS codes applicable to its outpatient professional services population; the formula and calculation steps are otherwise the same.

For each applicable table, average reimbursement per service unit was calculated by dividing the total [allowed amount/paid amount—confirm the actual field used] for the included claim lines by the total service units reported on those claim lines. The same calculation was applied to the M/S and MH/SUD claims populations. Any differences in the resulting average reimbursement reflect the claims included in each population, including the applicable place-of-service codes, and not a difference in the calculation methodology.

The reimbursement outcome data reflect Virginia fully insured claims experience for calendar year 2025 and use the same calculation for both benefit categories: total billed or allowable amount divided by total service units.

The table reports the 10 highest-volume combinations separately for each included provider. Because the selection was performed within provider categories, less than 10 total rows may appear in each benefit group.

Accordingly, the data provided an operational comparison of observed reimbursement outcomes but does not constitute a matched cohort of identical services, providers, utilization volumes, contractual terms, or case mix.

MH/SUD:

CLASSIFICATION	PROVIDER TYPE	TYPE	PROCEDURE CODE	AVERAGE BILLED AMOUNT PER UNIT	AVERAGE ALLOWED AMOUNT PER UNIT
Out-of-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	H0035	\$2,284.00	\$224.07
Out-of-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	H0015	\$2,728.63	\$1,275.34
Out-of-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	S0201	\$3,912.28	\$727.21
Out-of-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	S9480	\$2,053.75	\$799.69
Out-of-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	90853	\$928.30	\$480.28
Out-of-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	H2012	\$550.00	\$152.81
Out-of-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	H0001	\$725.00	\$124.17
Out-of-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	90792	\$423.00	\$401.85
Out-of-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	99214	\$650.00	\$565.50
Out-of-Network Outpatient	On-Campus OP Hospital (POS 22)	Facility	H0002	\$1,000.00	\$115.51
CLASSIFICATION	PROVIDER TYPE	TYPE	PROCEDURE CODE	AVERAGE BILLED AMOUNT PER UNIT	AVERAGE ALLOWED AMOUNT PER UNIT
Out-of-Network Outpatient	Intensive Outpatient Facility	Professional	S0201	\$4,650.00	\$299.90
Out-of-Network Outpatient	On-Campus OP Hospital (POS 22)	Professional	90834	\$165.00	\$99.55

M/S:

CLASSIFICATION	PROVIDER TYPE	TYPE	PROCEDURE CODE	AVERAGE BILLED AMOUNT PER UNIT	AVERAGE ALLOWED AMOUNT PER UNIT
----------------	---------------	------	----------------	--------------------------------	---------------------------------

Out-of-Network Outpatient	Ambulatory Surgical Center	Facility	490	\$7,009.14	\$1,203.04
Out-of-Network Outpatient	Ambulatory Surgical Center	Facility	307	\$34.00	\$4.04
Out-of-Network Outpatient	Ambulatory Surgical Center	Facility	632	\$1,604.83	\$329.86
Out-of-Network Outpatient	Ambulatory Surgical Center	Facility	320	\$623.00	\$164.82
Out-of-Network Outpatient	Ambulatory Surgical Center	Facility	636	\$1,040.00	\$2,163.83
Out-of-Network Outpatient	On-Campus OP Hospital	Facility	97110	\$74.88	\$56.46
Out-of-Network Outpatient	On-Campus OP Hospital	Facility	80053	\$58.02	\$20.74
Out-of-Network Outpatient	On-Campus OP Hospital	Facility	97140	\$84.23	\$54.48
Out-of-Network Outpatient	On-Campus OP Hospital	Facility	80061	\$45.70	\$19.01
Out-of-Network Outpatient	On-Campus OP Hospital	Facility	83036	\$17.05	\$11.57
Out-of-Network Outpatient	On-Campus OP Hospital	Facility	85025	\$40.82	\$15.05
Out-of-Network Outpatient	On-Campus OP Hospital	Facility	85027	\$18.12	\$8.25
Out-of-Network Outpatient	On-Campus OP Hospital	Facility	36415	\$53.98	\$6.73
Out-of-Network Outpatient	On-Campus OP Hospital	Facility	80048	\$9.41	\$8.22
Out-of-Network Outpatient	On-Campus OP Hospital	Facility	84443	\$72.62	\$29.76
CLASSIFICATION	PROVIDER TYPE	TYPE	PROCEDURE CODE	AVERAGE BILLED AMOUNT PER UNIT	AVERAGE ALLOWED AMOUNT PER UNIT
Out-of-Network Outpatient	On-Campus OP Hospital	Professional	99223	\$674.00	\$454.08
Out-of-Network Outpatient	On-Campus OP Hospital	Professional	10005	\$426.00	\$109.73
Out-of-Network Outpatient	On-Campus OP Hospital	Professional	58662	\$12,349.78	\$136.74
Out-of-Network Outpatient	On-Campus OP Hospital	Professional	99395	\$237.95	\$237.95
Out-of-Network Outpatient	Ambulatory Surgical Center	Professional	142	\$1,134.68	\$89.87
Out-of-Network Outpatient	Ambulatory Surgical Center	Professional	64416	\$3,094.00	\$76.67
Out-of-Network Outpatient	Ambulatory Surgical Center	Professional	64447	\$10,167.94	\$90.56

Reimbursement Table C results reflect substantial variation in average billed and allowed amounts within both the M/S and MH/SUD populations. This variation is attributable to differences in procedure codes, provider settings, service intensity, utilization, billing practices, case mix, and applicable reimbursement benchmarks. Because the populations do not represent matched cohorts of identical services, providers, utilization volumes, or contractual terms, direct comparison of reimbursement dollar amounts or allowed-to-billed percentages does not provide a valid measure of relative stringency.

For the MH/SUD facility claims shown, average allowed amounts range from \$115.51 per unit for H0002 to \$1,275.34 per unit for H0015. The corresponding allowed-to-billed relationships also vary substantially by service. For example:

- H0035 reflects an average allowed amount of \$224.07, or approximately 9.8% of the average billed amount of \$2,284.00.
- H0015 reflects an average allowed amount of \$1,275.34, or approximately 46.7% of the

average billed amount of \$2,728.63.

- S9480 reflects an average allowed amount of \$799.69, or approximately 38.9% of the average billed amount of \$2,053.75.
- 90792 reflects an average allowed amount of \$401.85, or approximately 95.0% of the average billed amount of \$423.00.
- 99214 reflects an average allowed amount of \$565.50, or approximately 87.0% of the average billed amount of \$650.00.

For the MH/SUD professional claims shown, S0201 has an average billed amount of \$4,650.00 and an average allowed amount of \$299.90, representing approximately 6.4% of billed charges. Procedure code 90834 has an average billed amount of \$165.00 and an average allowed amount of \$99.55, representing approximately 60.3% of billed charges.

The M/S facility results likewise reflect substantial variation. Average allowed amounts range from \$4.04 per unit for procedure code 307 to \$2,163.83 per unit for procedure code 636. Examples include:

- Revenue code 490 reflects an average allowed amount of \$1,203.04, or approximately 17.2% of the average billed amount of \$7,009.14.
- Revenue code 632 reflects an average allowed amount of \$329.86, or approximately 20.6% of the average billed amount of \$1,604.83.
- Procedure code 97110 reflects an average allowed amount of \$56.46, or approximately 75.4% of the average billed amount of \$74.88.
- Procedure code 80048 reflects an average allowed amount of \$8.22, or approximately 87.4% of the average billed amount of \$9.41.
- Procedure code 84443 reflects an average allowed amount of \$29.76, or approximately 41.0% of the average billed amount of \$72.62.

For the M/S professional claims shown, average allowed amounts range from \$76.67 for procedure code 64416 to \$454.08 for procedure code 99223. The allowed-to-billed relationships vary from approximately 0.9% for procedure code 64447 to 100% for procedure code 99395. This range further demonstrates that reimbursement outcomes are service-specific and cannot appropriately be interpreted without accounting for differences in procedure type, billing level, provider setting, utilization, and the reimbursement methodology applicable to each claim.

Single Case Agreement:

Data Methodology:

SCA Table evaluates services rendered in an outpatient setting that had an successfully negotiated SCA. The same claims-selection and average-reimbursement calculation methodology is applied to M/S and MH/SUD services.

For both M/S and MH/SUD, the analysis uses Virginia fully insured claims experience for calendar year 2025 and includes only claims identified as out-of-network based on the network-status field.

MH/SUD Claims Population

MH/SUD

- Virginia fully insured claims incurred during calendar year 2025;

- claims identified as Out-of-Network; and
- with a successfully negotiated SCA

M/S Claims Population

- Virginia fully insured claims incurred during calendar year 2025;
- claims identified as out-of-network; and
- with a successfully negotiated SCA

Average Reimbursement Calculation:

For each benefit category, average reimbursement is calculated using the same formula: **Average Reimbursement per Service Unit = Total Reimbursement Amount ÷ Total Service Units**. “Total Reimbursement Amount” means the sum of the reimbursement amount used for the included professional claim lines, and “Total Service Units” means the sum of the service units reported on those claim lines. The calculation therefore differs between M/S and MH/SUD only because each category includes the POS codes applicable to its outpatient professional services population; the formula and calculation steps are otherwise the same.

For each applicable table, average reimbursement per service unit was calculated by dividing the total [allowed amount/paid amount—confirm the actual field used] for the included claim lines by the total service units reported on those claim lines. The same calculation was applied to the M/S and MH/SUD claims populations. Any differences in the resulting average reimbursement reflect the claims included in each population, including the applicable place-of-service codes, and not a difference in the calculation methodology.

MH/SUD:

MH/SUD			
TYPE	PROCEDURE CODE	AVERAGE BILLED AMOUNT	AVERAGE ALLOWED AMOUNT
Practitioner	90837	\$357	\$298
Practitioner	90834	\$486	\$315
Practitioner	99214	\$297	\$171
Practitioner	G0480	\$471	\$91
Practitioner	97153	\$4,101	\$911
Practitioner	99213	\$200	\$112
Practitioner	90791	\$269	\$190
Practitioner	90853	\$302	\$115
Practitioner	90847	\$479	\$293
Practitioner	90833	\$122	\$72

M/S:

M/S			
TYPE	PROCEDURE CODE	AVERAGE BILLED AMOUNT	AVERAGE ALLOWED AMOUNT
Practitioner	A0425	\$199	\$125
Practitioner	A0427	\$1,070	\$709
Practitioner	97110	\$113	\$53
Practitioner	S9083	\$284	\$218
Practitioner	A0429	\$819	\$603
Practitioner	97140	\$115	\$53
Practitioner	99213	\$210	\$106
Practitioner	99214	\$263	\$145
Practitioner	98941	\$81	\$37
Practitioner	97112	\$98	\$57

The Single Case Agreement (“SCA”) table evaluates reimbursement outcomes for outpatient

practitioner services furnished by out-of-network providers under successfully negotiated SCAs.

The MH/SUD results demonstrate service-specific variation in both average billed and average allowed amounts. Average billed amounts range from \$122 per unit for procedure code 90833 to \$4,101 per unit for procedure code 97153, while average allowed amounts range from \$72 per unit for 90833 to \$911 per unit for 97153.

The relationship between average allowed and billed amounts also varies by procedure code:

- 90837: \$298 allowed compared with \$357 billed, or approximately 83.5% of billed charges.
- 90834: \$315 allowed compared with \$486 billed, or approximately 64.8%.
- 99214: \$171 allowed compared with \$297 billed, or approximately 57.6%.
- G0480: \$91 allowed compared with \$471 billed, or approximately 19.3%.
- 97153: \$911 allowed compared with \$4,101 billed, or approximately 22.2%.
- 99213: \$112 allowed compared with \$200 billed, or 56.0%.
- 90791: \$190 allowed compared with \$269 billed, or approximately 70.6%.
- 90853: \$115 allowed compared with \$302 billed, or approximately 38.1%.
- 90847: \$293 allowed compared with \$479 billed, or approximately 61.2%.
- 90833: \$72 allowed compared with \$122 billed, or approximately 59.0%.

The range of outcomes confirms that successfully negotiated MH/SUD SCA reimbursement is not based on a uniform percentage of billed charges. Rather, the negotiated amounts vary by procedure code and the circumstances of the applicable agreement.

The M/S results similarly demonstrate material variation by service. Average billed amounts range from \$81 per unit for procedure code 98941 to \$1,070 per unit for A0427, while average allowed amounts range from \$37 per unit for 98941 to \$709 per unit for A0427.

The allowed-to-billed relationships are as follows:

- A0425: \$125 allowed compared with \$199 billed, or approximately 62.8% of billed charges.
- A0427: \$709 allowed compared with \$1,070 billed, or approximately 66.3%.
- 97110: \$53 allowed compared with \$113 billed, or approximately 46.9%.
- S9083: \$218 allowed compared with \$284 billed, or approximately 76.8%.
- A0429: \$603 allowed compared with \$819 billed, or approximately 73.6%.
- 97140: \$53 allowed compared with \$115 billed, or approximately 46.1%.
- 99213: \$106 allowed compared with \$210 billed, or approximately 50.5%.
- 99214: \$145 allowed compared with \$263 billed, or approximately 55.1%.
- 98941: \$37 allowed compared with \$81 billed, or approximately 45.7%.
- 97112: \$57 allowed compared with \$98 billed, or approximately 58.2%.

As with MH/SUD services, the M/S outcomes do not reflect a single allowed-to-billed percentage. The variation demonstrates that reimbursement under a successfully negotiated SCA is determined at the service or agreement level rather than through a uniform benefit-category reduction.

Procedure codes 99213 and 99214 appear in both the MH/SUD and M/S populations and provide the closest available same-code comparisons.

For 99213:

- MH/SUD average billed amount: \$200.
- MH/SUD average allowed amount: \$112.

- M/S average billed amount: \$210.
- M/S average allowed amount: \$106.

The MH/SUD average allowed amount is \$6 higher than the M/S average allowed amount. The allowed amount represents 56.0% of billed charges for MH/SUD and approximately 50.5% for M/S.

For 99214:

- MH/SUD average billed amount: \$297.
- MH/SUD average allowed amount: \$171.
- M/S average billed amount: \$263.
- M/S average allowed amount: \$145.

The MH/SUD average allowed amount is \$26 higher than the M/S average allowed amount. The allowed amount represents approximately 57.6% of billed charges for MH/SUD and approximately 55.1% for M/S.

Accordingly, the available operational results demonstrate that the processes, strategies, evidentiary standards, and factors used to evaluate reimbursement under successfully negotiated SCAs were comparable and were not applied more stringently to MH/SUD benefits than to M/S benefits. Differences in observed reimbursement amounts reflect the underlying services, billed charges, providers, utilization, and negotiated agreement terms represented in each claims population—not a different calculation methodology or a more restrictive standard applicable to MH/SUD services.

Reimbursement Rates; outpatient Office:

Cigna evaluated the application of its out-of-network reimbursement methodologies using selected professional reimbursement results and claims-platform data. The operational results were reviewed as supplemental indicators of how the reimbursement pathways operated for MH/SUD and M/S claims and were not treated as standalone evidence of compliance.

In its evaluation, Cigna compiled mean reimbursement rates from claims data submitted by providers servicing locations in Virginia that included: primary care level MD and non-MD mid-level providers (i.e., Physician Assistants, Advanced Practice Registered Nurses) claims and behavioral health MD level psychiatrists and non-MD level psychologist and Licensed Clinical Social Workers (LCSWs) claims. The mean reimbursement was compared to Medicare rates to calculate the percent of Medicare ratio.

For purposes of the operational comparison, Cigna selects procedure codes that are consistent with the DOL Self-Compliance Tool's MHPAEA comparative analysis framework and that are representative of outpatient professional services routinely subject to the reimbursement methodology evaluated in this analysis. The selected codes are intended to provide a reasonable and administrable basis for comparing how the reimbursement NQTL operates across M/S and MH/SUD services, including whether comparable reimbursement methodologies, contracting factors, evidentiary standards, negotiation processes, and approval controls are applied.

The selected codes are representative outpatient professional services that are consistent with the DOL Self-Compliance Tool framework and routinely subject to the reimbursement

methodology evaluated in this analysis.

- CPT codes 99213 and 99203 are commonly used outpatient evaluation and management codes billed by physicians across both M/S and MH/SUD specialties, and therefore provide a direct and administrable basis for comparing physician-level professional reimbursement.
- For non-physician providers, there are not similarly shared CPT codes used across both M/S and MH/SUD specialties. Accordingly, CPT codes 90791 and 90832 are used for MH/SUD non-physician and psychiatric diagnostic evaluation services because they represent the best available comparison from a services-provided perspective. These codes reflect core outpatient professional diagnostic evaluation services and allow Cigna to assess whether the reimbursement methodology, contracting factors, and approval processes are applied comparably across M/S and MH/SUD services, even where the specific CPT codes differ due to differences in clinical discipline and billing structure.

Cigna compared M/S primary care physicians to MH/SUD psychiatrists as the physician-level comparison group. For the non-physician comparison, Cigna compared M/S mid-level practitioners to MH/SUD non-physician practitioners, including psychologists and licensed clinical social workers (“LCSWs”). For the non-physician comparison, Cigna compared M/S mid-level to MH/SUD non-physician practitioners, including psychologists and LCSWs. After identifying the comparable provider groups, Cigna selected representative service codes within each benefit category to assess the application of the reimbursement related NQTL. For M/S services Cigna selected chose CPT codes 99213 and 99203, which are commonly used outpatient office evaluation and management services. For MH/SUD services, Cigna selected and CPT codes 90791 and 90832, which are commonly used psychiatric diagnostic evaluation services. These codes were selected because they are frequently rendered by the relevant provider types, are specific to the respective M/S and MH/SUD billing frameworks and provide an appropriate basis for comparing how reimbursement methodologies are design and applied across benefit classifications.

The purpose of the selecting these codes was not to establish clinical equivalency between particular MH/SUD and M/S services. Rather, the codes were used as representative examples, to evaluate whether Cigna applied comparable reimbursement methodologies, contracting processes, negotiation standards, approval requirements, and governance controls to outpatient professional services within the benefit classification.

CPT codes 90791 and 90832 were selected because they are among the most commonly utilized MH/SUD diagnostic evaluation services and represent core professional behavioral health services routinely subject to outpatient practitioner reimbursement methodologies.

CPT codes 99213 and 99203 were selected because they are among the most commonly utilized M/S outpatient office evaluation and management services and similarly represent core professional practitioner services subject to the same reimbursement methodology review.

Accordingly, the selected service codes serve as illustrative and operationally relevant examples for evaluating the comparability and stringency of the reimbursement NQTL as applied to representative outpatient professional services. They are not intended to function as direct clinical matches but they support a legally meaningful comparison of whether the same reimbursement-related standards and controls were applied consistently across MH/SUD and M/S services.

Cigna has provided the specific CPT reimbursement information requested in the table set forth below:

Virginia 2025 Book of Business M/S Non-Facility Out-of-Network Professional Services					
Provider Type	Provider Type Code	CPT Code	Mean Reimbursement	Medicare (or Cigna RBRVS) Reimbursement	% of Medicare
Internists MD	IM	99203*	\$117.71	\$107.01	110.00%
		99213**	\$112.27	\$87.55	128.24%
General Practice MD	GP	99203	No claims	No claims	No claims
		99213*	\$61.33	\$87.55	70.05%
Family Practice MD	FP	99203*	\$92.00	\$107.01	85.98%
		99213	\$81.69	\$87.55	93.30%
Mid-Levels	FA, NF, NG, NH, NS	99203*	\$101.92	\$107.01	95.24%
		99213	\$78.30	\$87.55	89.43%
Virginia 2025 Book of Business MH/SUD Non-Facility Out-of-Network Professional Services					
Psychiatrists		99203*	\$174.56	\$107.01	163.13%
		99213	\$110.14	\$87.55	125.80%
Child Psychiatrists	No code; manual derivation	99203	No claims	No claims	No claims
		99213**	\$99.10	\$87.55	113.19%
Psychologists		90832**	\$101.19	\$78.45	128.99%
		90791**	\$217.52	\$165.73	131.25%
LCSW		90832	\$77.86	\$78.45	99.24%
		90791	\$175.79	\$165.73	106.07%

*<10 visits

**<50 visits

Operational Testing Results

Based on the above tables, the reimbursement comparison does not indicate that Cigna applies its out-of-network reimbursement methodology more stringently in operation to MH/SUD professional services than to M/S professional services. The tables compare mean reimbursement with the applicable Medicare or Cigna RBRVS benchmark for selected Virginia 2025 Book of Business non-facility, out-of-network professional services.

Within the M/S comparison set, reported reimbursement for CPT codes 99203 and 99213 ranged from 70.05% to 128.24% of the applicable benchmark, depending on provider type and service code. Internists were reimbursed at 110.00% of benchmark for CPT 99203 and 128.24% for CPT 99213. General practice physicians had no reported claims for CPT 99203 and were reimbursed at 70.05% of benchmark for CPT 99213. Family practice physicians were reimbursed at 85.98% for CPT 99203 and 93.30% for CPT 99213. Mid-level practitioners were reimbursed at 95.24% for CPT 99203 and 89.43% for CPT 99213.

The MH/SUD comparison set reflects reimbursement results for psychiatrists, child psychiatrists, psychologists, and licensed clinical social workers (LCSWs). For psychiatrists and child psychiatrists billing E/M codes comparable to those included in the M/S comparison, reported reimbursement exceeded the applicable benchmark for every code with claims. Psychiatrists were reimbursed at 163.13% of benchmark for CPT 99203 and 125.80% for CPT 99213. No child psychiatrist claims were

reported for CPT 99203; child psychiatrists were reimbursed at 113.19% of benchmark for CPT 99213. These results fall within or above the range of the reported M/S E/M reimbursement outcomes and do not indicate that MH/SUD professional E/M services were systematically reimbursed less favorably than comparable M/S professional services.

Psychologists were reimbursed at 128.99% of benchmark for CPT 90832 and 131.25% for CPT 90791. LCSWs were reimbursed at 99.24% of benchmark for CPT 90832 and 106.07% for CPT 90791. Because directly equivalent M/S provider types and service codes were not identified for these services, the psychologist and LCSW results are presented as supplemental operational indicators rather than direct comparisons of reimbursement for equivalent M/S and MH/SUD services.

These results support the conclusion that the out-of-network reimbursement NQTL was applied comparably and no more stringently to MH/SUD professional services than to M/S professional services. The data reflects MH/SUD reported claims were reimbursed above the applicable Medicare benchmark, while the M/S results include claims reimbursed both above and below benchmark. Reimbursement above or below the applicable Medicare or Cigna RBRVS benchmark is not treated as a standalone MHPAEA compliance threshold. The benchmark comparison provides supplemental outcome information and must be evaluated together with the applicable MRC election, billed-charge limitation, vendor-routing process, negotiation pathway, gap-fill methodology, and claims-system configuration. Variation among individual provider types and CPT codes does not, standing alone, establish disparate application of the NQTL because reimbursement outcomes may reflect provider type, service code, billed charges, negotiated amounts, client-elected reimbursement parameters, geography, and claims volume.

Cigna has provided the specific CPT reimbursement information requested in the table set forth below:

Cigna 2025 Book of Business M/S Non-Facility Out-of-Network Professional Services					
Provider Type	Provider Type Code	CPT Code	Mean Reimbursement	Medicare (or Cigna RBRVS) Reimbursement	% of Medicare
Internists MD	IM	99203	\$157.86	\$109.01	144.82%
		99213	\$119.58	\$88.95	134.43%
General Practice MD	GP	99203	\$148.86	\$109.01	136.56%
		99213	\$105.23	\$88.95	118.31%
Family Practice MD	FP	99203	\$127.44	\$109.01	116.91%
		99213	\$99.08	\$88.95	111.39%
Mid-Levels	FA, NF, NG, NH, NS	99203	\$128.00	\$109.01	117.42%
		99213	\$90.17	\$88.95	101.37%
Cigna 2025 Book of Business MH/SUD Non-Facility Out-of-Network Professional Services					
Psychiatrists		99203	\$180.97	\$109.01	166.01%
		99213	\$159.71	\$88.95	179.55%
Child Psychiatrists	No code; manual derivation	99203	\$152.97	\$109.01	140.33%
		99213	\$150.65	\$88.95	169.37%
Psychologists		90832	\$132.60	\$78.93	167.99%
		90791	\$242.11	\$166.91	145.05%

LCSW		90832	\$91.35	\$78.93	115.73%
		90791	\$197.05	\$166.91	118.06%

Operational Testing Results

Based on the defined 2025 claims populations and representative outpatient professional-service measures described above, the observed reimbursement outcomes do not indicate that the processes, standards, or methodologies comprising the out-of-network reimbursement NQTL were applied more stringent to MH/SUD benefits than to M/S benefits. For physician services billed under the same E/M codes, the MH/SUD results were within or above the range observed for the identified M/S comparison groups. Results for psychologists and LCSWs are supplemental because those practitioners bill discipline-specific services for which no directly equivalent M/S codes or provider types were identified. Those results nevertheless show that the selected MH/SUD services were reimbursed at or above the applicable benchmark and do not evidence systematic disadvantage attributable to the NQTL. These findings are limited to the populations, codes, provider types, reimbursement pathways, geographic scope, and measurement period tested and should be considered together with the process-level evidence demonstrating that common claim-routing, pricing, negotiation, MRC, governance, and exception standards apply to MH/SUD and M/S benefits.

The tables compare mean out-of-network reimbursement with the applicable Medicare benchmark for selected 2025 book-of-business professional services. Within the M/S comparison set, reimbursement for CPT codes 99203 and 99213 ranged from 101.37% to 144.82% of the applicable benchmark, depending on provider type and service code. Internists were reimbursed at 144.82% of benchmark for CPT 99203 and 134.43% for CPT 99213; general practice physicians at 136.56% and 118.31%; family practice physicians at 116.91% and 111.39%; and mid-level practitioners at 117.42% and 101.37%, respectively.

The MH/SUD comparison set reflects reimbursement results for psychiatrists, child psychiatrists, psychologists, and LCSWs. For psychiatrists and child psychiatrists billing the same E/M codes used in the M/S comparison, reimbursement was favorable to the applicable benchmark and within or above the range of M/S E/M outcomes. Psychiatrists were reimbursed at 166.01% of benchmark for CPT 99203 and 179.55% for CPT 99213. Child psychiatrists were reimbursed at 140.33% of benchmark for CPT 99203 and 169.37% for CPT 99213. Thus, all reported psychiatrist and child psychiatrist results exceeded both the applicable benchmark and the corresponding percentages for each M/S provider type shown for the same CPT codes. These results support the conclusion that Cigna does not uniformly reimburse MH/SUD professional E/M services below comparable M/S professional E/M services.

For MH/SUD non-physician services, psychologists were reimbursed at 167.99% of benchmark for CPT 90832 and 145.05% for CPT 90791, while LCSWs were reimbursed at 115.73% and 118.06%, respectively. Each MH/SUD non-physician result exceeded the applicable benchmark. The LCSW percentages were comparable to the M/S mid-level results of 117.42% for CPT 99203 and 101.37% for CPT 99213, while the psychologist percentages were substantially higher. Because the MH/SUD and M/S non-physician practitioners bill different service codes, these results are not presented as direct code-for-code clinical comparisons; rather, they provide operational evidence that the reimbursement methodology did not systematically disadvantage MH/SUD non-physician services.

The results support the conclusion that the out-of-network reimbursement NQTL was applied

comparably and no more stringently to MH/SUD professional services than to M/S professional services. The data reflects MH/SUD and M/S reported claims were reimbursed the applicable Medicare benchmark, and MH/SUD physician-level E/M results exceeded the corresponding M/S results for the same codes. Reimbursement above or below the applicable Medicare or Cigna RBRVS benchmark is not treated as a standalone MHPAEA compliance threshold. The benchmark comparison provides supplemental outcome information and must be evaluated together with the applicable MRC election, billed-charge limitation, vendor-routing process, negotiation pathway, gap-fill methodology, and claims-system configuration.

It must be noted that these CPT codes are not rendered or billed with equal frequency across M/S and MH/SUD provider types. For example, codes 90791 and 90832 are diagnostic and therapeutic services predominantly billed by MH/SUD providers and much less likely by M/S. While 99213 and 99203 are evaluation and management services are much more likely to be billed by M/S rather than MH/SUD, although the billing distribution is less uneven for some E/M services. It should also be noted that CMS reimburses LCSWs at 75% of Medicare Allowable (Less than 100% paid to MDs and Psychologists and 85% paid to Mid-Levels). LCSWs are masters-level, non-prescribing providers, for which there is not a truly similar M/S provider type.

Cigna utilizes service codes 99213 (M/S) and 90791 (MH/SUD) based on guidance provided in the Department of Labor (DOL) Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) comparison framework, alongside review of internal claims data suggesting these codes were highly utilized. In addition to these codes, 99203 (M/S) and 90832 (MH/SUD) were also considered for inclusion due to the similarities in services offered compared to 99213/90791 and the review of internal claims data suggesting that these codes were also highly utilized. Per the self-compliance tool, service code 99213 was suggested for use amongst most M/S provider types and with MH/SUD Psychiatrists. Service code 90791 was recommended for inclusion in the self-compliance tool for Psychologists and LCSWs, as they are unable to bill E/M codes (99213) per their licensure.

Reimbursement rates; Outpatient facilities:

In establishing reimbursement rates for outpatient facilities, Cigna utilizes various techniques based on the client elected MRC including:

MRC1:

- Vendor Pricing (Rate Negotiation)
- Cigna Rate Negotiation
- Billed Charges

MRC2:

- Optum Medicare database

This report provides inspection of non-participating MH/SUD and M/S claims processed on Cigna's internal claims system including:

- Proclaim is the claims system for Commercial Medical and Behavioral claims
- Facets is the claims system for Commercial and Individual and Family Plans (IFP) Medical and Behavioral claims
- PowerMHS is the claims system for HMO Medical claims

2025 (incurred and paid in 2025)												
Outpatient	PROCLAIM				FACETS				POWER			
	Covered \$	TOTAL Capture		No Discount	Covered \$	TOTAL Capture		No Discount	Covered \$	TOTAL Capture		No Discount
	% of Total	Capture	Discount	Capture	% of Total	Capture	Discount	Capture	% of Total	Capture	Discount	Capture
MH/SUD		91.6%	65.7%	8.4%		96.6%	61.2%	3.4%				
MRC1	100.0%	87.7%	64.1%	12.3%	100.0%	75.0%	47.5%	25.0%				
Facility-Outpatient	26.0%	98.1%	72.2%	1.9%	30.2%	91.5%	56.9%	8.5%				
Professional	50.8%	77.6%	65.3%	22.4%	66.5%	66.3%	41.7%	33.7%				
MRC2	100.0%	93.5%	66.5%	6.5%	100.0%	98.4%	62.6%	1.6%				
Facility-Outpatient	31.3%	99.7%	83.6%	0.3%	60.4%	99.5%	70.5%	0.5%				
Professional	27.9%	79.1%	58.5%	20.9%	31.2%	96.1%	46.6%	3.9%				
Medical/Surgical		96.2%	70.4%	3.8%		98.0%	71.4%	2.0%		92.5%	71.2%	7.5%
MRC1	100.0%	94.4%	71.1%	5.6%	100.0%	92.2%	70.2%	7.8%	100.0%	84.8%	73.4%	15.2%
Facility-Outpatient	16.7%	97.1%	75.3%	2.9%	14.2%	91.2%	68.4%	8.8%	37.4%	86.5%	70.1%	13.5%
Professional	80.7%	94.0%	70.7%	6.0%	82.6%	93.0%	71.1%	7.0%	52.6%	89.6%	66.6%	10.4%
MRC2	100.0%	96.7%	70.1%	3.3%	100.0%	98.1%	70.9%	1.9%	100.0%	88.5%	75.2%	11.5%
Facility-Outpatient	19.4%	97.1%	69.9%	2.9%	20.0%	98.4%	70.6%	1.6%	48.8%	90.2%	76.4%	9.8%
Professional	73.4%	97.1%	71.6%	2.9%	75.5%	98.3%	72.2%	1.7%	42.9%	89.0%	68.3%	11.0%

Each of the claim platforms have slight differences in the Out of Network reimbursement programs. Furthermore, some clients cross platforms between where their MH/SUD claims are processed and where their M/S claims are processed, requiring the systems to be disaggregated in the report to enable a comparative analysis.

Given that the Out of Network reimbursement programs are a series of pricing techniques subject to a plan's out of network benefit design, the report demonstrates holistic program capture and discounts based on the client elected MRC and whether the claim is facility-outpatient, or professional claim.

- The red column represents the percentage of charge dollars captured in the Out of Network reimbursement programs.
- The orange column represents the percentage of discount achieved by leveraging the Out of Network reimbursement programs.
- The blue column represents the percentage of claims allowed at the billed charge.

This report indicates the average discount applied to MH/SUD claims is lower than the average discount applied to M/S based on the client elected MRC and whether the claim is for facility-outpatient or professional services. A lower aggregate discount may result in recognition of a greater percentage of covered billed charges, but the result does not independently establish comparable application of the NQTL. The observed differences may reflect billed-charge patterns, service mix, provider type, plan election, vendor arrangement, negotiation outcome, platform configuration, or other variables. Accordingly, discount outcomes were treated as supplemental indicators and evaluated together with the underlying routing and pricing processes.

Step 6: Findings and conclusions.

See [45 CFR 146.137\(c\)\(6\)](#). The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

- (1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;
- (2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;
- (3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;
- (4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and
- (5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the [FAQ 45](#) guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Base Rates, Adjusted Rates, and Final Rates:

Based on the analyses described in Steps One through Five, Cigna concludes that the processes,

strategies, evidentiary standards, factors, reimbursement methodologies, and administrative controls used to determine allowable amounts for out-of-network outpatient MH/SUD benefits are comparable to, and applied no more stringently than, those used for M/S benefits within the same outpatient classifications and sub-classifications.

Comparability as written. The applicable plan terms establish a common reimbursement framework for covered out-of-network outpatient services and do not prescribe a separate or more restrictive methodology for MH/SUD benefits. Subject to applicable federal and state law and the terms of the plan, claims may be priced through an applicable out-of-network protection arrangement or negotiated rate. If no applicable or acceptable arrangement is available, reimbursement is determined under the plan's elected methodology, generally based on the lesser of the covered billed charge or the applicable Maximum Reimbursable Charge. Under MRC1, the plan-selected percentile and the applicable geographic charge benchmark are used for both MH/SUD and M/S services. Under MRC2, the plan-selected percentage and the applicable Medicare-based methodology are used for both MH/SUD and M/S services. When a Medicare fee-schedule amount is unavailable, the Medicare GapFill Plus methodology, or the MRC Policy Review Board process when the external source does not yield a rate, applies without regard to whether the covered service is classified as MH/SUD or M/S. Differences in the resulting amounts may arise from neutral claim and service characteristics, including provider type, professional or facility status, procedure or service code, place of service, geographic area, applicable Medicare payment system, units of service, billed charges, and the plan sponsor's reimbursement election. Those distinctions are not based on the MH/SUD or M/S classification of the benefit.

Out-of-Network Protection Program. Claritev and Zelis support standing provider arrangements, supplemental-network pricing, claim-specific negotiations, and other repricing services described in the preceding steps. Cigna may also conduct direct claim-specific negotiations. The analysis did not identify separate MH/SUD-specific referral criteria, negotiation standards, pricing factors, approval requirements, or fallback methodologies. Rather, MH/SUD and M/S claims are evaluated using the applicable vendor or direct-negotiation pathway based on the same categories of information, including provider type, service type, geography, available contractual arrangements, historical or commercial benchmarks, and the plan's reimbursement methodology. If an acceptable rate arrangement is not available, the claim proceeds to the applicable plan-based reimbursement methodology under the same decision framework for MH/SUD and M/S benefits.

Comparability in operation. Cigna evaluated 2025 operational data in two complementary ways. First, Cigna compared mean reimbursement for selected **Virginia** and broader book-of-business out-of-network professional services with the applicable Medicare or Cigna RBRVS benchmark. For physician services billed under the same E/M codes, the reported MH/SUD psychiatrist results were within or above the range of the identified M/S comparison results. The psychologist and LCSW results were above the applicable benchmark in the reported data. Because psychologists and LCSWs bill discipline-specific services for which the analysis did not identify directly equivalent M/S provider types and service codes, those results are treated as supplemental operational evidence rather than direct clinical or code-for-code comparisons.

Second, Cigna evaluated outpatient claims by claims platform, MRC methodology, and professional or facility status using program-capture, discount, and no-discount measures. The reported data show variation across Proclaim, Facets, and PowerMHS, reflecting differences in plan design, claims-system configuration, service composition, reimbursement election, and professional or

facility claim status. After disaggregating the claims by platform and relevant reimbursement pathway, the analysis did not identify a pattern showing that MH/SUD claims were routed into the out-of-network reimbursement programs under more restrictive criteria or subjected to systematically greater discounts than M/S claims. Within the tested populations, MH/SUD claims generally reflected a lower average discount from covered billed charges than M/S claims. This indicates that a greater proportion of covered billed charges was allowed for the tested MH/SUD claims, although it does not establish that MH/SUD providers received higher nominal payments for clinically equivalent services.

The operational results are not treated as independently dispositive of MHPAEA compliance. Reimbursement outcomes may vary based on provider type, service code, professional or facility status, billed charges, negotiated amounts, plan-elected reimbursement parameters, geography, units of service, claims-system configuration, and claim volume. In addition, certain service-code cells had limited or no claims, and certain non-physician MH/SUD services did not have directly equivalent M/S comparators. Cigna therefore considered the operational results together with the written plan terms, claims-routing hierarchy, benchmark selection rules, MRC1 and MRC2 methodologies, Medicare GapFill Plus process, vendor practices and controls, direct-negotiation standards, and fallback reimbursement procedures.

Findings and conclusion. Taken together, the written and operational evidence supports the following findings:

1. The same overall reimbursement pathways and sequencing rules apply to MH/SUD and M/S outpatient benefits.
2. The applicable plan-elected MRC methodology is not selected or modified based on whether a service is classified as MH/SUD or M/S.
3. The factors used to determine the applicable reimbursement amount are service-neutral and include provider type, service code, place of service, geography, applicable external benchmark, billed charge, negotiated amount, and plan election.
4. The Medicare GapFill Plus and MRC Policy Review Board processes apply when an applicable published rate is unavailable, without a separate or more restrictive standard for MH/SUD services.
5. The analysis did not identify MH/SUD-specific vendor referral criteria, negotiation requirements, approval standards, or fallback processes.
6. The tested professional reimbursement and claims-platform outcomes do not indicate systematic disadvantage to MH/SUD benefits attributable to the NQTL.

Accordingly, based on the plan terms, written policies and procedures, reimbursement methodologies, vendor and direct-negotiation processes, claims-routing rules, governance controls, and 2025 operational testing described in this analysis, Cigna concludes that the out-of-network outpatient provider reimbursement NQTL is designed and applied comparably, and no more stringently, to MH/SUD benefits than to M/S benefits within the affected outpatient classifications and sub-classifications.

This conclusion is limited to the plans, benefit classifications, reimbursement methodologies, claims populations, measurement period, service categories, and operational data evaluated in this comparative analysis. Cigna will continue to review relevant reimbursement and claims-processing data. If future monitoring identifies a material difference, anomalous pattern, or data limitation suggesting that the NQTL may contribute to more restrictive treatment of MH/SUD benefits, Cigna

will investigate the identified difference, assess whether it is attributable to the design or application of the NQTL, and take appropriate corrective action.

This version of the analysis was drafted and performed in 2026 based Cigna's and Virginia 2025 book-of-business data, by members of the legal, compliance, and various business teams, including the following individuals:

Mental Health Parity Legal Team including:

Managing Counsel;
Associate Senior Counsel; and
Legal Compliance Senior Advisor

Mental Health Parity Compliance team including:

Legal Compliance Senior Manager;
Legal Compliance Senior Advisor

M/S and MH/SUD subject matter experts including:

Program Management Senior Manager;
Product Management Senior Advisor
Provider Contracting Director
Provider Contracting Senior Director;
Provider Contracting Senior Advisor;