

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.

Network Access and Adequacy

Applies to M/S and MH/SUD benefits in the In-Network Inpatient classification and the In-Network Outpatient Office Visit and In-Network Outpatient - All Other subclassifications.

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 Network Access and Adequacy parameters applied to mental health/substance use disorder (“MH/SUD”) and/or medical/surgical (“M/S”) services for the Inpatient and Outpatient benefit classifications and is incorporated in plans insured by Cigna Health and Life Insurance Company ("CHLIC")

Evernorth Behavioral Health (“Evernorth,” “EBH”) an affiliate of CHLIC maintains the network for MH/SUD benefits, while Cigna Health Life Insurance Company Inc. maintains the network for most M/S benefits. 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 multiple business segments including Cigna Healthcare (M/S) and Behavioral Health (MH/SUD), and policies applicable to specific business segments only.

The plan language or coverage terms governing Network Access and Adequacy NQTL is excerpted from the M.C. Dean, Inc. plan document and states as follows:

M.C. Dean, Inc. Plan Language
Notice of Provider Directory/Networks Notice Regarding Provider Directories and Provider Networks A list of network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, affiliated or contracted with Cigna or an organization contracting on its behalf. Notice Regarding Pharmacy Directories and Pharmacy Networks A list of network pharmacies is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of pharmacies affiliated or contracted with Cigna or an organization contracting on its behalf.¹ Opportunity to Select a Primary Care Physician Choice of Primary Care Physician: This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents. Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician.

Standing referrals to Specialists

After consulting with your Primary Care Physician, you may receive a referral for an ongoing special condition. Your participating specialist will be permitted to treat this condition without a further referral from your Primary Care Physician, within the treatment period authorized by the standing referral, and may authorize referrals, procedures, tests, and other medical service needs. A participating board certified Physician in pain management or oncologist will be permitted to treat you if diagnosed with cancer under a standing referral.²

Selection of a Primary Care Provider

This plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.³

The Schedule

Open Access Plus Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Open Access Plus Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible or Coinsurance. If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.⁴

Definitions

Participating Provider 01-20 The term Participating Provider means a person or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services and/or supplies, the Charges for which are Covered Expenses. It includes an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies, the Charges for which are Covered Expenses.⁵

Description of the NQTL:

The Network Access and Adequacy NQTL consists of the processes, strategies, evidentiary standards, and methodologies Cigna uses to establish, maintain, evaluate, and remediate the accessibility and availability of its participating provider and facility networks. The NQTL governs how Cigna evaluates network composition and determines whether participating provider and facility networks contain a sufficient number, type, specialty, and geographic distribution of appropriately licensed and credentialed providers and facilities to furnish covered services to members within applicable access parameters. In applying this NQTL, Cigna evaluates network accessibility and availability using access metrics and performance indicators that may include provider-to-member ratios, geographic travel distance standards, appointment wait-time standards, provider and facility type and specialty, member location and population density, provider supply and member demand, applicable federal and state requirements, and accreditation standards. Cigna monitors network performance through periodic and

² M.C. Dean, Inc. Plan Booklet pg. 13 of 90

³ M.C. Dean, Inc. Plan Booklet pg. 8 of 90

⁴ M.C. Dean, Inc. Plan Booklet pg. 14 of 90

⁵ M.C. Dean, Inc. Plan Booklet pg. 83 of 90

annual analyses, which may include geographic access assessments, provider and customer surveys, claims and utilization data, complaints, appeals, and other network performance information. The NQTL applies to the evaluation and management of participating providers and facilities furnishing M/S and MH/SUD benefits in the In-Network Inpatient classification and the In-Network Outpatient Office Visit and In-Network Outpatient All Other subclassifications.

Glossary:

1. Credentialing: The process of verifying that a Health Care Provider/Practitioner and/or facility are qualified to practice medicine. Many health care institutions and provider networks conduct their own credentialing, generally through a credentialing specialist or electronic service, with review by its own credentialing committee.
2. Inpatient Benefit Classification: is defined as care provided in a hospital or other type of inpatient facility, where you are admitted, and spend at least one night.
 - Services that are provided by a hospital while Confined in a Hospital, Inpatient Rehab, Skilled Nursing facility or MH/SUD Residential facility.
3. Outpatient Benefit Classification: Outpatient is defined as care that does not require a hospital stay.
 - Outpatient services are provided in an Outpatient setting such as a physician's office, free standing surgical or behavioral health outpatient facility.
4. Demand for provider type: The number of members requiring a particular service/level of care in a particular geographic area. Factors applicable to provider demand include:
 - internal claims experience, the evidentiary source of which is Cigna's historical claims data and
 - external GeoAccess reports the evidentiary source of which is network access assessments that measure the distance between members and providers. These assessments can be leveraged to determine how to adequately support its existing membership and the potential market if a strategic growth/network fortification plan is undertaken, as required to meet any applicable regulatory access standards.
5. Lack of access: The lack of an appropriately qualified, participating health care professional is not available to provide medically necessary services within a reasonable travel distance from the customer's home or within a reasonable appointment availability timeframe.
6. Mental Health or Substance Use Disorder (MH/SUD): Behavioral Health defines MH/SUD conditions as those included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the current edition of the International Classification of Diseases
7. Medical/Surgical: Cigna defines the Medical/Surgical benefit as 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 International Classification of Diseases (ICD) or State guidelines).
8. National Committee for Quality Assurance (NCQA): Accreditation Body that is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality.
9. Network Adequacy: The standards and monitoring processes used to ensure a network has sufficient number, distribution, availability and accessibility of practitioners and facilities to meet customers' availability, cultural, ethnic, racial, and linguistic needs, preferences, and expectations.

10. Participating Provider/In-Network Provider: means a Hospital, Physician, and Other Health Care Facility or Professional which are: (i) licensed in accordance with any applicable federal and state laws, (ii) accredited by the Joint Commission on the Accreditation of Healthcare Organizations or by another organization, if approved by Cigna, and (iii) acting within the scope of the practitioner's license and accreditation, and have contracted with Cigna to provide services to Members; or For the purposes of reimbursement for Covered Expenses, an entity that has contracted with Cigna to arrange, through contracts with Providers for the provision of any services and/or supplies, the charges for which are Covered Expenses. Provider agreement in effect with Cigna for this EOC at the time services are rendered.
11. 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
12. Subclassification: Cigna subclassifies "Office Visit" and "Outpatient All Other" within the Outpatients classification. For purposes of this analysis, the term subclassification is limited to Outpatient Services.
13. Supply of providers: The number of available providers of a particular type/license in a particular geographic area. Factors in determining the supply of providers include (1) the evaluation of Cigna's existing network, the evidentiary source of which is Cigna's internal provider contracting and credentialing data sources; and (2) the evaluation of other payers' networks the evidentiary source of which is third party data comprising of competitor intel, i.e., directories, licensing, and NPI registry.

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.
Appendix A: Network Accessibility and Availability Evidentiary Standards	Document that houses the Network Accessibility and Availability standards for CMS and NCQA.
HM-NET-029 Behavioral Provider Recruitment	Establishes MH/SUD requirements for solicited recruitment of providers and facilities.
HM-NET-031 Measuring Accessibility of Behavioral Services	Establishes methodology used for measuring accessibility of MH/SUD services to ensure customers can obtain services in a timely manner.
HM-NET-032 Measuring Availability of Behavioral Practitioners and Providers	Describes availability standards and the processes used to assure that the MH/SUD network has a sufficient number and distribution of practitioners and Providers to meet customers availability, cultural, ethnic, racial, and linguistic needs, preferences, and expectations.
PS-6 Measuring Accessibility of Medical Services	Establishes methodology used for measuring accessibility of M/S services to ensure customers can obtain services in a timely manner.
PS-10 Medical Provider Recruitment	Establishes M/S requirements for solicited recruitment of providers and facilities.
PS-8 Measuring Availability of Practitioners and Providers	Describes availability standards and the processes used to assure that the M/S network has a sufficient number and distribution of practitioners and Providers to meet customers availability, cultural, ethnic, racial, and linguistic needs,

	preferences, and expectations.
OPS 18 Policy and Procedure Maintenance, Review and Approval Process	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 manner.

Benefit Classification

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. Within the Outpatient Classification, 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.

The classification or subclassification assigned to a service reflects the setting and nature of the covered service. As described below, the Network Access and Adequacy NQTL applies to in-network providers and facilities furnishing MH/SUD or M/S services in the Inpatient, Outpatient Office Visits, and Outpatient - All Other classifications; it does not apply to Emergency Care. All M/S and MH/SUD benefits provided in-network are subject to network access and adequacy standards. Applicable benefit classifications include, In-Network Inpatient, In-Network Outpatient - All other, and In-Network Office Visit.

Services Subject to the NQTL

Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to In Network Outpatient-	Is NQTL applied to In Network Outpatient-All Other sub- classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?
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	Office sub-classification?			
YES-Acute Services: Inpatient (Medical) Hospice - IP Other HC Facility Inpatient Hospital Inpatient Hospital Physician's Visit/Consultation Inpatient Preventive Inpatient Professional Services Inpatient Surgery Inpatient Services at Other Health Care Facilities (Long Term Acute Care – Medical) Inpatient (MH/SUD) Acute Inpatient (Mental Health and Substance Use) Acute Inpatient Detoxification Sub-acute Services: Inpatient Services at Other Health Care Facilities (Skilled Nursing Facility and Rehab – Medical) MHSUD Residential Treatment	YES-Outpatient Office Visits (Medical) Primary Care Physician (PCP) Services/Office visit Specialty Care Physician Services/Office Visit Telehealth Outpatient Office (MH/SUD) Visits Office Visits, including Individual, Family and Group Psychotherapy and Medication Management Telehealth	YES-Outpatient All Other Services (Medical) 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 Outpatient All Other Services (MH/SUD) Partial Hospitalization Program Intensive Outpatient Services Applied Behavior Analysis Transcranial Magnetic Stimulation	No- for both M/S and MH/SUD	No-for both M/S and MH/SUD

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 has identified and defined the **factors** used in the design, implementation and ongoing administration of the M/S and MH/SUD Network Adequacy and Access NQTL. The factors identified below are representative of those currently used in the design and application of the NQTL. No additional independent factors were identified that materially influence the establishment or administration of network adequacy standards and no additional factors were considered and

rejected.

These factors are applied comparable to M/S and MH/SUD benefits and are supported by objective evidentiary standards, including applicable legal requirements, accreditation standards, provider accessibility metrics, provider availability analyses, and network monitoring tools.

The same categories of factors and evidentiary standards are applied to both M/S and MH/SUD benefits. Differences in the resulting standards or metrics reflect differences in applicable legal, regulatory, accreditation, or clinical requirements rather than differences in the factors considered.

When multiple applicable requirements exist, Cigna applies the most stringent applicable legal, regulatory, accreditation, or network adequacy standard. This approach is applied consistently regardless of whether the benefit is classified as M/S or MH/SUD.

Differences in appointment-access metrics between M/S and MH/SUD services reflect specialty-specific standards established by NCQA and the clinical nature of the services being measured. These differences do not represent separate factors, evidentiary standards or decision-making criteria. Rather, the same factor, provider accessibility, is evaluated for both MH/SUD and M/S benefits using the applicable NCQA standards for the relevant provider specialty and service type.

Factors	Sources for Each Factor
1. Federal or State Law, as applicable	1. Federal or State Law, as applicable; 12 VAC 5-408-260. Network adequacy; 12 VAC 5-408-270. Travel and appointment waiting times
2. Provider Availability	2. Provider Availability • Provider to Enrollee Ratio Standards by Provider Type and/or specialty monitoring • Travel Distance Standards by Provider Type (i.e., hospital and practitioner) and/or specialty monitoring using Quest Analytics reporting
3. Provider Accessibility to meet Appointment Wait Time Standards	3. M/S and MH/SUD specific requirements: M/S: • NCQA Network Management Standard 2 Accessibility of services Element A: Access to Primary Care • Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against its standards for access to: ○ Regular and routine care appointments. ○ Urgent care appointments. ○ After-hours care. MH/SUD: • NCQA Network Management Standard 2 Accessibility of Services Element B: Access to Behavioral Healthcare • Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for: ○ Care for a non-life-threatening emergency within 6 hours. ○ Urgent care within 48 hours.

	○ Initial visit for routine care within 10 business days ○ Follow-up routine care.
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In establishing the factors used to determine what services are subject to Network Adequacy and Access NQTL, Cigna considers the following **sources and evidentiary standards**:

Inpatient, in-network M/S:

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
1. Federal or State Law, as applicable	1. Federal or State Law, as applicable; 12 VAC 5-408-260. Network adequacy; 12 VAC 5-408-270. Travel and appointment waiting times	1. Federal or State Law, as applicable; 12 VAC 5-408-260. Network adequacy; 12 VAC 5-408-270. Travel and appointment waiting times
2. Provider Availability	2. Provider Availability • Provider to Enrollee Ratios – Calculation of the number of providers compared to the number of customers. • Travel Distance Standards – Calculation of the distance between a customer and provider, in miles and/or minutes. Quest Analytics is used to conduct this reporting/analysis. ⁶	2. Provider Availability • Provider to Enrollee Ratio Standards by Provider Type and/or specialty monitoring, using internal Cigna data regarding number of available providers and impacted enrollees. • Travel Distance Standards by Provider Type (i.e., hospital and practitioner) and/or specialty monitoring using is measured using Quest Analytics reporting.
3. Provider Accessibility to meet Appointment Wait Time Standards	3. Provider Accessibility Appointment Wait Time Standards – Time from request of an appointment to appointment, as determined through provider and customer surveys. ⁷	3. Provider Accessibility is measured through provider and customer surveys. • Appointment Wait Time Standards by Provider Type (i.e., hospital and practitioner) and/or specialty monitoring. • NCQA Guidelines

Inpatient, in-network MH/SUD:

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
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⁶ Appendix A: Network Accessibility and Availability Evidentiary Standards

⁷ Appendix A: Network Accessibility and Availability Evidentiary Standards

1. Federal or State Law, as applicable	1. Federal or State Law, as applicable; 12 VAC 5-408-260. Network adequacy; 12 VAC 5-408-270. Travel and appointment waiting times	1. Federal or State Law, as applicable; 12 VAC 5-408-260. Network adequacy; 12 VAC 5-408-270. Travel and appointment waiting times
2. Provider Availability	2. Provider Availability • Provider to Enrollee Ratios – Calculation of the number of providers compared to the number of customers. • Travel Distance Standards – Calculation of the distance between a customer and provider, in miles and/or minutes. Quest Analytics is used to conduct this reporting/analysis.	2. Provider Availability • Provider to Enrollee Ratio Standards by Provider Type and/or specialty monitoring, using internal Cigna data regarding number of available providers and impacted enrollees. • Travel Distance Standards by Provider Type (i.e., hospital and practitioner) and/or specialty monitoring using Quest Analytics reporting.
3. Provider Accessibility to meet Appointment Wait Time Standards	3. Provider Accessibility Appointment Wait Time Standards – Time from request of an appointment to appointment, as determined through annual provider and customer survey. ⁸	3. Provider Accessibility is measured through provider and customer survey. • Appointment Wait Time Standards by Provider Type (i.e., hospital and practitioner) and/or specialty monitoring. • NCQA Guidelines

Office visit M/S:

1. Federal or State Law, as applicable	1. Federal or State Law, as applicable; 12 VAC 5-408-260. Network adequacy; 12 VAC 5-408-270. Travel and appointment waiting times	1. Federal or State Law, as applicable; 12 VAC 5-408-260. Network adequacy; 12 VAC 5-408-270. Travel and appointment waiting times
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2. Provider Availability	2. Provider Availability ⁹ • Provider to Enrollee Ratios – Calculation of the number of providers compared to the number of customers. • Travel Distance Standards – Calculation of the distance between a customer and provider, in miles and/or minutes. Quest Analytics is used to conduct this reporting/analysis.	2. Provider Availability • Provider to Enrollee Ratio Standards by Provider Type and/or specialty monitoring, using internal Cigna data regarding number of available providers and impacted enrollees. • Travel Distance Standards by Provider Type (i.e., hospital and practitioner) and/or specialty monitoring using Quest Analytics reporting.
3. Provider Accessibility to meet Appointment Wait Time Standard	3. Provider Accessibility • Appointment Wait Time Standards – Time from request of an appointment to appointment, as determined through provider and customer surveys.¹⁰	3. Provider Accessibility is measured through provider and customer surveys, as applicable. • Appointment Wait Time Standards by Provider Type (i.e., PCP and Specialist) and/or specialty monitoring. • NCQA guidelines

Office visit MH/SUD:

1. Federal or State Law, as applicable	1. Federal or State Law, as applicable; 12 VAC 5-408-260. Network adequacy; 12 VAC 5-408-270. Travel and appointment waiting times	1. Federal or State Law, as applicable; 12 VAC 5-408-260. Network adequacy; 12 VAC 5-408-270. Travel and appointment waiting times
2. Provider Availability	2. Provider Availability ¹¹ • Provider to Enrollee Ratios – Calculation of the number of providers compared to the number of customers. • Travel Distance Standards – Calculation of the distance between a customer and provider, in miles and/or minutes. Quest Analytics is used to conduct this reporting/analysis.	2. Provider Availability • Provider to Enrollee Ratio Standards by Provider Type and/or specialty monitoring, using internal Cigna data regarding number of available providers and impacted enrollees. • Travel Distance

⁹ Appendix A: Network Accessibility and Availability Evidentiary Standards

¹⁰ Appendix A: Network Accessibility and Availability Evidentiary Standards

¹¹ Appendix A: Network Accessibility and Availability Evidentiary Standards

		Standards by Provider Type (i.e., hospital and practitioner) and/or specialty monitoring using Quest Analytics reporting. NCQA guidelines.
3. Provider Accessibility to meet Appointment Wait Time Standards	3. Provider Accessibility Appointment Wait Time Standards – Time from request of an appointment to appointment, as determined through provider and customer surveys. ¹²	3. Provider Accessibility is measured through provider and customer surveys. - Appointment Wait Time Standards by Provider Type (i.e., hospital and practitioner) and/or specialty monitoring. - NCQA Guidelines

Outpatient – All Other M/S:

1. Federal or State Law, as applicable	1. Federal or State Law, as applicable; 12 VAC 5-408-260. Network adequacy; 12 VAC 5-408-270. Travel and appointment waiting times	1. Federal or State Law, as applicable; 12 VAC 5-408-260. Network adequacy; 12 VAC 5-408-270. Travel and appointment waiting times
2. Provider Availability	2. Provider Availability - Provider to Enrollee Ratios – Calculation of the number of providers compared to the number of customers. - Travel Distance Standards – Calculation of the distance between a customer and provider, in miles and/or minutes. Quest Analytics is used to conduct this reporting/analysis¹³	2. Provider Availability - Provider to Enrollee Ratio Standards by Provider Type and/or specialty monitoring, using internal Cigna data regarding number of available providers and impacted enrollees. - Travel Distance Standards by Provider Type (i.e., hospital and practitioner) and/or specialty monitoring using Quest Analytics reporting.
3. Provider	3. Provider Accessibility	3. Provider Accessibility is

¹² Appendix A: Network Accessibility and Availability Evidentiary Standards

¹³ Appendix A: Network Accessibility and Availability Evidentiary Standards

Accessibility to meet Appointment Wait Time Standards	Appointment Wait Time Standards – Time from request of an appointment to appointment, as determined through provider and customer surveys.¹⁴	measured through provider and customer surveys. - Appointment Wait Time Standards by Provider Type (i.e., hospital and practitioner) and/or specialty monitoring. - NCQA guidelines
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Outpatient - All other MH/SUD:

1. Federal or State Law, as applicable	1. Federal or State Law, as applicable; 12 VAC 5-408-260. Network adequacy; 12 VAC 5-408-270. Travel and appointment waiting times	1. Federal or State Law, as applicable; 12 VAC 5-408-260. Network adequacy; 12 VAC 5-408-270. Travel and appointment waiting times
2. Provider Availability	2. Provider Availability - Provider to Enrollee Ratios – Calculation of the number of providers compared to the number of customers. - Travel Distance Standards – Calculation of the distance between a customer and provider, in miles and/or minutes. Quest Analytics is used to conduct this reporting/analysis.¹⁵	2. Provider Availability - Provider to Enrollee Ratio Standards by Provider Type and/or specialty monitoring, using internal Cigna data regarding number of available providers and impacted enrollees. - Travel Distance Standards by Provider Type (i.e., hospital and practitioner) and/or specialty monitoring using Quest Analytics reporting.
3. Provider Accessibility to meet Appointment Wait Time Standards	3. Provider Accessibility Appointment Wait Time Standards – Time from request of an appointment to appointment, as determined through provider and customer surveys. ¹⁶	3. Provider Accessibility is measured through provider and customer surveys. - Appointment Wait Time Standards by Provider Type (i.e., hospital and practitioner) and/or specialty monitoring. - NCQA guidelines

¹⁴ Appendix A: Network Accessibility and Availability Evidentiary Standards

¹⁵ Appendix A: Network Accessibility and Availability Evidentiary Standards

¹⁶ Appendix A: Network Accessibility and Availability Evidentiary Standards

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:

Cigna maintains broad network participation opportunities for both M/S and MH/SUD providers. M/S and MH/SUD providers and facilities must agree to contract language and terms, including reimbursement rates and meet Cigna's Network Provider admission criteria ("Credentialing Criteria"), which may vary depending on provider/facility type, but generally include:

- Credentialing Application
- Signed Contract/Agreement
- License
- DEA or CDS Certification (when applicable)
- Hospital Affiliation
- Education
- Work History
- Acceptable History of Malpractice
- Proof of Adequacy Professional Liability Coverage
- Medicare & Medicaid Sanction History
- Other Sanction Information

Network participation requires execution of a participation agreement; however, reimbursement levels are not used as a factor in determining whether a provider is eligible for participation. Eligibility is determined by satisfaction of credentialing, licensure, quality, and contracting requirements. Network adequacy standards are established and monitored independently of provider reimbursement levels.

Provider admissions standards for entrance to the network are triggered by either a provider request or Cigna's recruitment of the provider to join the network. For example, depending on licensure level: the appropriate degree, state licensure, DEA (if applicable), State Controlled Substance Registration Certificate (where applicable), professional liability insurance, and other criteria related to professional training and work history. Additionally, providers are required to enter into a contract with Cigna/Evernorth that includes negotiated reimbursement rates.

Recruitment activities for M/S and MH/SUD networks are initiated using substantially similar processes and may result from network adequacy monitoring, member access concerns, out-of-

network utilization, provider availability analyses, regulatory requirements, customer demand, or network needs.

CHLIC also maintains NCQA accreditation, which requires a comprehensive and rigorous audit of the Quality Program documents, policies, and other materials regarding Quality Management, Utilization Management, Case Management, Care Coordination, Credentialing, and Members' Rights & Responsibilities (approximately 250 documents). This evidence spans a period of 2 years and the majority of the evidence has to be reviewed and approved by our Medical Management Quality Committee ("MMQC"), Integrated Health Management Quality Committee ("IHMQC"), and Clinical Advisory Committee ("CAC"). Additionally, NCQA performs an audit of a random sample of denials, appeals, case management, and credentialing cases (approximately 350 records).

Evernorth maintains NCQA Managed Behavioral Healthcare Organization ("MBHO") Accreditation and conducts an annual directory audit which includes a valid random sample to ensure the network and directory meet all NCQA MBHO accreditation requirements. MBHO Accreditation includes standards for Behavioral Health Care, Credentialing/Re-credentialing, Provider Accessibility and Availability Monitoring, and Provider Contracting and Satisfaction. Cigna conducts quality management activities for both medical and behavioral healthcare products. Additionally, NCQA performs an audit of a random sample of denials, appeals, case management, and credentialing cases (approximately 350 records).

NCQA Requirements for access and availability dictate that Cigna monitors MH/SUD and M/S provider availability and accessibility utilizing various elements including:

- The use of ratios such as the number of each type of practitioners to number of members or the number of primary care practices accepting new patients to number of members.
- The geographic distribution of practitioners that are within an acceptable distance to a practitioner's office or within an acceptable drive time.
- A quantitative and qualitative analysis that includes initial measurements to analyze data, then subsequent remeasurements if quantitative analysis demonstrates that stated goals were not met.
- In the event state-specific requirements differ from NCQA, Cigna and Evernorth will maintain compliance with the most stringent requirements.

These external standards are applied to both M/S and MH/SUD networks and serve as objective evidentiary standards for monitoring provider availability and accessibility.

Wait Time Standards:

M/S		MH/SUD	
Waiting Time Standards		Waiting Time Standards	
Urgent care for medical services	24 Hours	Life-Threatening Emergency	Immediately
Routine primary care	14 days	Non-Life-Threatening Emergency	6 hours
Preventive visit/well visit	14 days	Urgent	48 hours
Non-urgent specialty care	14 days	Routine Initial Visit	10 working days
		Routine follow-up care	30 days

VA Specific Standards

M/S		MH/SUD	
Waiting Time Standards		Waiting Time Standards	
Emergency care	Immediately	Emergency care	Immediately
Urgent care	Within 24 hours	Urgent care	Within 24 hours
Routine appointments	Within 2 weeks	Routine appointments	Within 2 weeks for nonemergency or nonurgent care
Routine physicals	Within 60 days		

MH/SUD:

Network Adequacy Ratio Requirements

Practitioner Type	Performance Goal
Prescriber	1:1,500
Psychologist	1:1,500
Masters Level Clinician	1:800
Inpatient Facility	1:10,000
Residential Facility	1:20,000
Ambulatory Program	1:10,000

Network Adequacy Radius Requirements

Practitioner Type	Urban Standard	Suburban Standard	Rural Standard	Performance Goal
Prescriber	1 in 15 miles	1 in 15 miles	1 in 25 miles	90%
Psychologist	1 in 15 miles	1 in 15 miles	1 in 25 miles	90%
Masters Level Clinician	1 in 15 miles	1 in 15 miles	1 in 25 miles	90%
Inpatient Facility	1 in 25 miles	1 in 30 miles	1 in 40 miles	90%
Residential Facility	1 in 25 miles	1 in 30 miles	1 in 40 miles	90%
Ambulatory Program	1 in 25 miles	1 in 30 miles	1 in 40 miles	90%

M/S:

Network Adequacy Ratio Requirements

Provider Type	Performance Goal
Adult PCP	1 per 300 customers
Pediatrics	1 per 300 customers
Each specialty except OB/GYN & Allergy/Immunology	1 per 10,000 customers
OB/GYN & Allergy/Immunology	1 per 2,000 customers

Network Adequacy Radius Requirements

Provider Type	Urban	Suburban	Rural	Performance Goal
Adult PCP	1 Adult PCP in 10 miles	1 Adult PCP in 15 miles	1 Adult PCP in 30 miles	90%
Pediatrics	1 Pediatrician in 15 miles	1 Pediatrician in 60 miles	1 Pediatrician in 75 miles	90%
High volume specialists – Cardiology, Dermatology, OB/GYN, Allergy & Immunology, Orthopedic	1 Separate Specialist Category in 20 miles	1 Separate Specialist Category in 35 miles	1 Separate Specialist Category in 60 miles	90%
High impact specialists - Hematology/Oncology	1 Separate Specialist Category in 30 miles	1 Separate Specialist Category in 45 miles	1 Separate Specialist Category in 60 miles	90%
High impact specialists - All others (Infectious Disease, Nephrology, Neurology, Pulmonary Medicine)	1 Separate Specialist Category in 40 miles	1 Separate Specialist Category in 75 miles	1 Separate Specialist Category in 90 miles	90%
Hospitals	1 Hospital in 25 miles	1 Hospital in 30 miles	1 Hospital in 35 miles	90%
High Volume Specialists: M/S Specialists below are identified by researching claim data for a 12-month period and the number of transactions of the top five specialties, excluding hospital-based specialists (i.e., radiologists).				
Specialists Code(s)	Category	Specialists Descriptions		
CD, CI, SC, AY, BD, GJ	Cardiology	Cardiovascular Disease; Cardiology, Interventional; Surgery/Cardiovascular		
DR, BM	Dermatology	Dermatology		
GY, MF, MI, MW, NO, OB, OG, CK, DX, ER, ES	OB/GYN	Gynecology (No OB); Maternal and Fetal; Midwifery; Midwifery; Women's Health Nurse Practitioner; Obstetrics (No GYN); Obstetrics/Gynecology		
AI, AL, AG	Allergy & Immunology	Allergy/Immunology, Allergy		
OA, OR, OU, EQ, EY, EW	Orthopedic	Orthopedic Sports Medicine; Surgery/Orthopedic; Orthopedic Trauma		
High Impact Specialists: M/S Specialists below are identified as specialists that treat conditions that have a high mortality morbidity rate or if the specialty treats conditions that require significant resources.				
Specialists code(s)	Category	Specialists descriptions		
GO, HC, HE, ON, RO, BZ, CQ, CU, EU, GG	Hematology/ Oncology	Gynecologic Oncology; Hospice and Palliative Medicine; Hematology; Oncology; Radiation Oncology		
HV, ID, DK, DL	Infectious Disease	HIV/AIDS Specialist, Infectious Disease		
NE, EG	Nephrology	Nephrology		
BI, NC, NU, SN, AV, EE, EL, GV	Neurology	Brain Injury Medicine; Clinical Neurophysiology; Neurology;		

		Surgery/Neurological
PL, TS, FJ, HG	Pulmonary medicine	Pulmonary Disease; Surgery/Thoracic

Virginia Wait Time requirements establish minimum standards applicable to network providers. When multiple standards apply, Cigna applies the most stringent applicable standard regardless of whether the benefit is classified as M/S or MH/SUD.

These state-specific standards apply based on provider type and service category without regard to whether the service is MH/SUD or M/S. Differences in internal requirements reflect differences in provider specialty type, utilization patterns, provider supply, service setting, and applicable accreditation or regulatory requirements. Such differences are not based on whether the service is classified as M/S or MH/SUD.

The factors identified in Step 2 are used in the same manner for both M/S and MH/SUD benefits. Differences in the resulting quantitative standards reflect provider specialty type, provider supply, utilization patterns, service setting, and applicable legal or accreditation requirements rather than whether a benefit is classified as MH/SUD or M/S.

In the event, any internal and/or state-specific metric is not met, a variety of resources are used to identify potential providers for network adequacy recruitment purposes including internet licensure searches, out-of-network utilization, and review of publicly available provider information, licensure databases and provider directories. In the unlikely event of an inability to remediate that deficiency caused by the unavailability of a provider/facility in the appropriate location with the appropriate degree/specialty this would be considered a lack of access. The same remediation framework is applied to both M/S and MH/SUD provider types when network adequacy monitoring identifies a deficiency.

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:

As Written:

To ensure network adequacy for both MH/SUD and M/S networks Cigna monitors Network Adequacy at least annually and regularly produces Network Adequacy Plans for both MH/SUD and M/S. A Network Adequacy Plan is a data report that measures in-network providers/facilities access and availability compared to plan membership data for a specific geographic region to ensure network adequacy standards are being met. Requirements for Network Adequacy Plan submissions include requirements for both Provider Availability and Provider Access, which are reflected in the following policies:

- M/S:
 - PS-8 Measuring Availability of Practitioners and Providers
 - PS-6 Measuring Accessibility of Medical Services
- MH/SUD:
 - HM-NET-032 Measuring Availability of Behavioral Practitioners and Providers
 - HM-NET-031 Measuring Accessibility of Behavioral Services

Cigna reviewed these policies to ensure specific - Provider Availability and Accessibility standards were reflected in writing comparably between M/S and MH/SUD as shown in the tables below.

Because MH/SUD services are generally delivered through specialty practitioners and specialty facilities rather than primary care providers, MH/SUD provider categories are compared primarily to M/S specialty practitioner and facility categories that perform analogous access and treatment functions.

Any variation between MH/SUD and M/S network adequacy metrics reflects differences in provider specialty availability, service delivery models, and applicable regulatory requirements rather than the application of different decision-making standards or evidentiary thresholds. Comparable processes are used across both classifications to assess member access and determine network sufficiency.

M/S Policy PS-6 Measuring Accessibility of Medical Services		MH/SUD Policy HM-NET-031 Measuring Accessibility of Behavioral Services	
Waiting Time Standards		Waiting Time Standards	
Urgent care for medical services	24 Hours	Life-Threatening Emergency	Immediately

Routine primary care	14 days	Non-Life-Threatening Emergency	6 hours
Preventive visit/well visit	14 days	Urgent	48 hours
Non-urgent specialty care	14 days	Routine Initial Visit	10 working days
		Routine follow-up care	30 days

VA Specific Standards

M/S Policy PS-6 Measuring Accessibility of Medical Services		MH/SUD Policy HM-NET-031 Measuring Accessibility of Behavioral Services	
Waiting Time Standards		Waiting Time Standards	
Emergency care	Immediately	Emergency care	Immediately
Urgent care	Within 24 hours	Urgent care	Within 24 hours
Routine appointments	Within 2 weeks	Routine appointments	Within 2 weeks for nonemergency or nonurgent care
Routine physicals	Within 60 days		

M/S Policy		
PS-8 Measuring Availability of Practitioners and Providers		
Travel Distance Standards		
Adult Primary Care Provider	Urban/Suburban/Rural	10/15/30 miles
Pediatric Primary Care Provider	Urban/Suburban/Rural	15/60/75 miles
Cardiology	Urban/Suburban/Rural	20/35/60 miles
Dermatology	Urban/Suburban/Rural	20/35/60 miles
OB/Gyn	Urban/Suburban/Rural	20/35/60 miles
Allergy & Immunology	Urban/Suburban/Rural	20/35/60 miles
Orthopedics	Urban/Suburban/Rural	20/35/60 miles
Hematology/Oncology	Urban/Suburban/Rural	30/45/60 miles
Infectious Disease	Urban/Suburban/Rural	40/75/90 miles
Nephrology	Urban/Suburban/Rural	40/75/90 miles
Neurology	Urban/Suburban/Rural	40/75/90 miles
Pulmonary Medicine	Urban/Suburban/Rural	40/75/90 miles
General Acute Care Hospital	Urban/Suburban/Rural	25/30/35 miles

MH/SUD Policy		
HM-NET-032 Measuring Availability of Behavioral Practitioners and Providers		
Travel Distance Standards		
Masters Level Clinician	Urban/Suburban/Rural	15/15/25 miles
Psychologist	Urban/Suburban/Rural	15/15/25 miles
Prescriber	Urban/Suburban/Rural	15/15/25 miles
Inpatient Facility	Urban/Suburban/Rural	25/30/40 miles
Residential Facility	Urban/Suburban/Rural	25/30/40 miles
Ambulatory Facility	Urban/Suburban/Rural	25/30/40 miles

Virginia specific standards for both MH/SUD and M/S benefits are based upon applicable Virginia law. Where multiple standards apply, Cigna applies the most stringent applicable standard regardless of whether the benefit is classified as M/S or MH/SUD.

Cigna's review of PS-10 Medical Provider Recruitment and HM-NET-029 Behavioral Provider Recruitment demonstrates that the provider recruitment standards for M/S and MH/SUD networks are comparable as written and are not more stringently applied to MH/SUD. Both policies establish structured recruitment processes designed to support network access, availability, adequacy, and compliance with applicable state and federal requirements. The policies rely on similar recruitment methods, including regional initiatives, sales or client requests, performance guarantees, customer nominations, network adequacy concerns, legal or regulatory requirements, Quality Management survey findings, and complaints or appeals related to access and availability. Both policies also require recruitment planning, Salesforce tracking, standard onboarding, and satisfaction of credentialing and contracting requirements before providers may participate in the network.

Recruitment activities may be initiated based upon network adequacy monitoring results, access complaints, out-of-network utilization, customer demand, provider availability, or applicable regulatory requirements for both MH/SUD and M/S networks. When deficiencies are identified, the same remediation framework applies to both MH/SUD and M/S provider types, including provider identification efforts, recruitment outreach, contracting activities, and ongoing monitoring.

The evidentiary standards used to establish MH/SUD and M/S network adequacy requirements are the same, including applicable state law, accreditation requirements, provider availability analyses, time-and-distance measurements, appointment availability standards, member demand, and access monitoring activities. Although the numerical standards vary by provider type and service category, those differences reflect provider market characteristics and clinical delivery models rather than whether a service is classified as MH/SUD or M/S.

Requirements	M/S Policy PS-10 Medical Provider Recruitment	MH/SUD Policy HM-NET-029 Behavioral Provider Recruitment
Recruitment request sources	Recruitment requests may originate from regional recruitment initiatives, Regional Sales requests, National Account Sales requests, performance guarantees, customer nominations, network adequacy corrective action, Cigna Legal, Quality Management survey analysis, Quality Management complaints/provider appeals, and annual Essential Community Provider analysis.	Recruitment requests may originate from regional recruitment initiatives, Sales requests, performance guarantees, customer nominations, network adequacy corrective action, Legal, Quality Management survey analysis, Quality Management complaints/provider appeals, Network Exception Requests, and out-of-network utilization.
Tracking tool	Recruitment projects are tracked in Salesforce, where reports are created at least monthly to track progress and support reporting.	Recruitment projects are tracked in Salesforce for progress and reporting purposes.

Completion timeframe	Standard timeframe for recruitment projects is 3–6 months.	Standard timeframe for solicited recruitment projects is 3–6 months.
Annual recruitment planning	Annual recruitment plans are developed by Regional Contracting Network Development and Competitive Insights leads and local contracting teams and modified throughout the year as needed.	Annual recruitment plans are developed and modified as needed throughout the year to accommodate projects.
Escalated/ad hoc request timing	Escalated requests from Sales, Cigna Legal, or Compliance are submitted to MRT upon receipt and initiated within 30 days of review.	Ad hoc requests from Sales, Legal, Compliance, and Customers are submitted by email; initial outreach to provider leads is made within 20 business days of receipt.
Recruitment plan monitoring	Recruitment projects are tracked through Salesforce reports, with status updates provided to requestors as needed.	Recruitment plans are developed and monitored in support of network adequacy remediation or out-of-network utilization mitigation.
Provider eligibility after recruitment	Successfully recruited providers follow standard onboarding and must meet credentialing and contracting requirements to become participating providers.	Successfully recruited providers follow the standard onboarding process and must meet all credentialing and contracting requirements to become participating providers.
Recruitment outreach procedure	MRT makes outreach by phone or email to viable providers. A minimum of three outreach attempts are made. Interested providers receive electronic or paper materials. Completed contract materials are returned to MRT, reviewed for completeness, and sent to Onboarding.	Behavioral Market Managers and Network Compliance coordinate with contracting teams to facilitate recruitment and that provider appeals and recruitment projects are tracked through defined channels.
Onboarding process	Onboarding completes the application/review process, sends practitioners to Credentialing Committee, and approved providers are loaded into Health Care Provider Manager. A welcome letter and executed contract are sent.	Successfully recruited providers follow the standard onboarding process and must meet credentialing and contracting requirements.
Reporting	Salesforce recruitment reports are pulled monthly by the Contracting Network Development and Competitive Insights team, with status updates provided to the requestor as needed.	Recruitment projects are tracked in Salesforce for progress and other reporting purposes.

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.

Although administrative procedures may differ in wording, both policies require prompt initiation of recruitment activities and ongoing recruitment planning and monitoring, although organization responsibilities differ based on network structure, and neither establishes more restrictive requirements for MH/SUD recruitment.

Based upon this review, Cigna concludes the Network Access and Adequacy NQTL is comparable and is not applied more stringently to MH/SUD benefits than to M/S benefits, as written. The same factors, evidentiary standards, recruitment processes, credentialing requirements, monitoring activities, and remediation processes are applied across both classifications. Differences in numerical standards reflect provider specialty characteristics, service delivery models, provider availability, and applicable regulatory requirements rather than whether a service is classified as MH/SUD or M/S.

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:

In Operation:

On an annual basis, Cigna reviews applicable operational data for both MH/SUD and M/S provider networks to assess whether the Network Access and Adequacy NQTL is applied comparably and no more stringently to MH/SUD benefits. The review is performed using the same factors and evidentiary standards identified in Steps 2 through 4. Operational results are reviewed in conjunction with Subject Matter Experts and network management personnel to determine whether network adequacy standards are being met and whether remediation activities are necessary.

For both MH/SUD and M/S networks, Cigna measures provider availability and accessibility using established provider-to-customer ratio requirements, time-and-distance standards, appointment access requirements, and other applicable network adequacy metrics. The same monitoring framework is used for both classifications. Operational differences in results may occur due to provider market conditions, provider supply, specialty-specific workforce availability, geographic distribution of providers, service delivery models, and population density. Such differences do not reflect the use of different factors, evidentiary standards, or decision-making processes for MH/SUD versus M/S benefits.

In Cigna’s review of provider availability ratios as between M/S and MH/SUD providers use the applicable ratio of 1 provider per 2,000 customers and 1 provider per 10,000 customers for a M/S NON-PCP’s and 1 provider per 800 customers and 1 provider per 1,500 customers for a MH/SUD offers more availability to MH/SUD care which in turn is more favorable when comparing MH/SUD to M/S. In the event Virginia Standards requirements differ from NCQA, Cigna and Evernorth will maintain compliance with the most stringent requirements. Further, the in-operation results reflected in the tables below show that Cigna is meeting these availability standards.

Virginia 2025 Data is based on Virginia practitioners and facilities
MH/SUD Availability Results (EBH Network):

Provider Availability		
Provider/Facility Type	Required Ratio	Standard Met
Prescriber	1:1,500 members	Yes
Psychologist	1:1,500 members	Yes
Master’s Level Clinician	1:800 members	Yes
Inpatient Acute	1:10,000 members	Yes
Residential Treatment	1:20,000 members	Yes
Ambulatory Program	1:10,000 members	Yes

M/S Availability Results:

Provider Availability		Standard Met	
Provider/Facility Type	Required Ratio	OAP	PPO
Adult Primary Care Provider	1:300 members	Yes	Yes
Pediatric Primary Care Provider	1:300 members	Yes	Yes
Cardiology	1:10,000 members	Yes	Yes
Dermatology	1:10,000 members	Yes	Yes
OB/Gyn	1:2,000 members	Yes	Yes
Allergy & Immunology	1:2,000 members	Yes	Yes
Orthopedics	1:10,000 members	Yes	Yes
Hematology/Oncology	1:10,000 members	Yes	Yes
Infectious Disease	1:10,000 members	Yes	Yes

Nephrology	1:10,000 members	Yes	Yes
Neurology	1:10,000 members	Yes	Yes
Pulmonary Medicine	1:10,000 members	Yes	Yes
Hospital	1:10,000 members	Yes	Yes

Virginia 2025 Data is based on Virginia practitioners and facilities

Provider Accessibility:

MH/SUD EBH Network Access Results (must meet 90%):

Provider Accessibility — 90% Standard		
Provider/Facility Type	Standard Urban/Suburban/Rural	Standard Met
Masters Level Clinician	15/15/25 miles	Yes
Psychologist	15/15/25 miles	Yes
Prescriber	15/15/25 miles	Yes
Inpatient Facility	25/30/40 miles	Yes
Residential Facility	25/30/40 miles	Yes
Ambulatory Facility	25/30/40 miles	Yes

M/S Access Results (All Networks shown in tables below) (must meet 90%):

Provider Accessibility — 90% Standard		Standard Met	
Provider/Facility Type	Standard Urban/Suburban/Rural	OAP	PPO
Adult Primary Care Provider	10/15/30 miles	Yes	Yes
Pediatric Primary Care Provider	15/60/75 miles	Yes	Yes
Cardiology	20/35/60 miles	Yes	Yes
Dermatology	20/35/60 miles	Yes	Yes
OB/Gyn	20/35/60 miles	Yes	Yes
Allergy & Immunology	20/35/60 miles	Yes	Yes
Orthopedics	20/35/60 miles	Yes	Yes
Hematology/Oncology	30/45/60 miles	Yes	Yes
Infectious Disease	40/75/90 miles	Yes	Yes
Nephrology	40/75/90 miles	Yes	Yes
Neurology	40/75/90 miles	Yes	Yes
Pulmonary Medicine	40/75/90 miles	Yes	Yes
General Acute Care Hospital	25/30/35 miles	Yes	Yes

As demonstrated by the results above, Cigna met M/S and MH/SUD provider adequacy requirements. Certain MH/SUD provider categories utilize time and distance standards that are equal to or more stringent than selected M/S specialty categories. The analysis evaluates comparability of the processes, factors, evidentiary standards, monitoring activities, and remediation requirements rather than relying solely on comparison of individual distance metrics. In the event a deficiency is identified both MH/SUD and M/S networks will review data for recruitment/contracting opportunities via a corrective action plan. Additional monitoring will occur to ensure deficiency is remediated.

Wait time Audit Results:

These national customer experience survey results are provided as a proxy measure of access and availability during the period under review and are not intended to represent Virginia specific compliance results during the 2025 reporting period. Cigna is providing results from its 2025 national customer experience surveys, which include multiple questions addressing members' ability to obtain timely access to care. Virginia state-specific plan data is forthcoming and will be provided in a follow-up submission once the analysis is complete.

Cigna Healthcare and Evernorth Behavioral Health assess customer satisfaction as part of their respective NCQA surveys. NCQA requires all Health Plans to use the CAHPS® survey question set and methodology so they can draw comparisons across plans as part of their Health Plan ratings. No modifications are allowed.

NCQA does not have the same requirement with the BH Customer Experience Survey so modifications can be made to the question set to accommodate regulatory requirements and support quality improvement activities.

Both CAHPS® and the BH Customer Experience Surveys were developed by a Consortium of medical and behavioral experts to assess various clinical and service facets of patient care.

Behavioral National Customer Satisfaction Survey 2025 results

Prescriber:

Question	Outcome	Goal
Seen when you needed care within 6 hours (Emergency)	74%	90%
Seen when you needed care withing 48 hours	58%	63%
Seen when you needed initial routine care within 10 days	78%	70%
Seen when you needed follow-up routine care within 30 days	89%	90%

Non-Prescriber:

Question	Outcome	Goal
Seen when you needed care within 6 hours (Emergency)	57%	90%
Seen when you needed care withing 48 hours	59%	63%
Seen when you needed initial routine care within 10 days	85%	70%
Seen when you needed follow-up routine care within 30 days	93%	90%

Medical/Surgical National Customer Satisfaction Survey 2025 results

Question	Outcome	Goal
In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed? (never, sometimes, usually, always)	80%	90%
In the last 12 months, how often was it easy to get the care, tests or treatment you needed? (never, sometimes, usually, always)	80%	90%
In the last 12 months, when you needed care right away,	80%	90%

how often did you get care as soon as you needed? (never, sometimes, usually, always)		
In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed? (never, sometimes, usually, always)	80%	90%
In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed? (never, sometimes, usually, always)	80%	90%

Although certain survey measures fell below internal goal thresholds, these national survey results are proxy access indicators and are not Virginia specific compliance results. The results do not, by themselves, establish that Cigna applied access standards or network adequacy processes more stringently to MH/SUD benefits than to M/S benefits. Cigna uses these results as part of ongoing access monitoring and has implemented processes to measure appointment availability.

Based upon the operational review described above, Cigna concludes that the Network Access and Adequacy NQTL is applied comparably and no more stringently to MH/SUD benefits than to M/S benefits in operation. The same factors, evidentiary standards, monitoring activities, network adequacy methodologies, recruitment processes, and remediation protocols are used across both classifications. Although operational results may vary due to provider specialty characteristics, workforce availability, geographic distribution, population density, and market conditions, those differences do not result from the application of different standards to MH/SUD benefits. Operational testing demonstrates that both MH/SUD and M/S provider networks are subject to the same network adequacy framework, ongoing monitoring activities, and remediation requirements. Accordingly, Cigna concludes that the Network Access and Adequacy NQTL is comparable to and not applied more stringently to MH/SUD benefits than to M/S benefits in operation.

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:

Provider availability and accessibility (Network Adequacy) monitoring is conducted on an ongoing basis and an analysis is performed annually to ensure that established accreditation, state, and federal standards for reasonable geographical location, number of providers, appointment availability, and provision for emergency care are measured. Monitoring activities may include evaluation of satisfaction surveys, evaluation of complaint and appeal reports, and evaluation of provider to customer ratios. An assessment of the provider network is also performed to ensure that the network meets the cultural, ethnic, racial, and linguistic needs and preferences of customers. Specific deficiencies are addressed with a corrective action plan and follow up activities are conducted to reassess compliance.

Cigna assesses supply and demand of both M/S and MH/SUD provider types and/or specialties based upon the same indicators including NCQA and NAIC, and federal/state, network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; customer satisfaction surveys; customer complaint data. The conclusion of such assessments may result in network recruitment, outreach, contracting, provider education, or other network development activities intended to improve member access and availability. Network adequacy monitoring is separate from provider reimbursement methodologies.

With respect to Virginia's appointment wait-time requirements, Cigna will submit a supplemental analysis upon completion of the Virginia Wait Time Survey and validation and compilation of the resulting data.

Cigna continues to invest in the breadth of the behavioral network, which has more than doubled since 2021 to approximately 454,000 MH/SUD providers and facilities nationwide. Additionally, the virtual care network (telehealth) has grown over 500% since 2021 to include over 309,000 providers. Over the past several years Cigna has conducted a comprehensive review of its MH/SUD network admission standards, including network access standards, contracting processes and reimbursement rates applicable to Network Providers.

In connection with its ongoing NQTL compliance efforts, Cigna has taken proactive, additional steps to continually ensure the comparability of standards for provider admissions into the MH/SUD provider network to ensure the processes, strategies and evidentiary standards implemented are not more stringent for MH/SUD services than M/S services. Consistent with the NQTL requirement for comparability/stringency, Cigna has confirmed that standards for provider admission into the MH/SUD provider network, including credentialing and adequacy for inpatient and outpatient services are comparable to, and applied no more stringently than, that of the M/S provider network as written and in operation. The 2025 Virginia network adequacy monitoring demonstrated that the applicable MH/SUD and M/S availability and accessibility standards identified in this analysis were satisfied. The operational results did not identify evidence that MH/SUD provider admission, recruitment, availability monitoring, accessibility monitoring, or corrective-action processes were applied more stringently than corresponding M/S processes.

This version of the analysis was drafted and performed in 2026 based upon 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

Medical/Surgical and Behavioral Health subject matter experts including:

MH/SUD Program Management Senior Manager;
M/S, Provider Contracting Director;
MH/SUD, Provider Contracting Senior Advisor;
M/S, Provider Contracting Director