

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 In-patient Provider Reimbursement NQTL

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) Inpatient Provider Reimbursement parameters applied to mental health/substance use disorder (“MH/SUD”) and/or medical/surgical (“M/S”) services for the inpatient 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 Inpatient Provider Reimbursement NQTL, Cigna reviewed policies applicable to Cigna and Evernorth Behavioral Health (EBH) and 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 inpatient 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 Inpatient Provider Reimbursement is excerpted from 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

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

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 Inpatient Provider Reimbursement NQTL consists of the standards, processes, and methodologies Cigna uses to determine the allowable reimbursement amount for covered inpatient facility and practitioner services furnished by out-of-network providers. Subject to the terms of the plan and applicable federal and state law, reimbursement is determined through the applicable pricing techniques, which may include an amount required under the No Surprises Act or other governing law; an external pricing-partner network rate, claim-specific negotiation, or Cigna-initiated direct negotiation; or, when no acceptable negotiated arrangement applies, the lesser of the provider's covered billed charge or the plan sponsor's elected Maximum Reimbursable Charge methodology. MRC1 is based on a plan-selected percentile of geographically relevant charge data, while MRC2 is based on a plan-selected percentage of a fee schedule developed using a methodology similar to Medicare. When an applicable Medicare fee-schedule amount is unavailable, Cigna applies the Medicare Gap Fill process using FAIR Health Medicare GapFill PLUS™ or, if no published benchmark is available, a rate determined through the MRC Policy Review Board. These methodologies determine the amount payable by the plan for covered out-of-network services. The NQTL applies to both MH/SUD and M/S benefits within the inpatient classification, including facility and practitioner services.

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

Provider Types and Payment Structures:

The Out-of-Network Inpatient M/S and MH/SUD facilities and practitioners as shown in the List of Services Subject to the NQTL are reimbursed based on Cigna's Out of Network Reimbursement Programs as expounded on in steps 2-5, which include:

- Base and Final rates:
 - Maximum Reimbursable Charge (MRC) out-of-network benefit elections
- Adjusted and Final Rates:
 - Non-Participating/Out-of-Network Cost Containment Programs
 - Rate Negotiation (Cigna utilizes vendors, Clartiv and Zelis for these negotiations)
 - Medicare Gap Fill for procedures that are not covered by Medicare or do not have a CMS Medicare Resources Based Relative Value Scale ("RBRVS") (Cigna Utilizes vendor, Fair Health)
 - In addition to the reimbursement methodologies shown above Cigna offers Single Case Agreements (SCA) when a Network Exception has been approved. Cigna does not utilize any vendors for SCA's.

Other Payment Models:

Cigna does not utilize any other payment models in its reimbursement of M/S or MH/SUD OON Inpatient facilities or practitioners.

Glossary:

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 GPCIs 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 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.

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.

List of Services Subject to the NQTL

The Out-of-Network (OON) Inpatient Provider Reimbursement NQTL applies to the following benefit classifications:

	<i>Medical/Surgical</i>	<i>Mental Health & Substance Use</i>
Is NQTL applied to Out-of-Network Inpatient classification?	Yes 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, Skilled Nursing Facility and Rehab – Medical)	Yes Acute Inpatient (Mental Health and Substance Use) Acute Inpatient Detoxification MH/SUD Residential Treatment

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) Inpatient Provider Reimbursement NQTL. In making and determination of the Out-of-Network Inpatient Provider Reimbursement NQTL there were no additional factors considered and rejected.

Base Rates:

Benefit Classification/ Sub-classification	Factors	Sources for Each Factor
Out-of-Network Inpatient-Facility	1. Maximum Reimbursable Charge (MRC) applied to both M/S or MH/SUD	1. Maximum Reimbursable Charge (MRC) • For plans that elect MRC1, Cigna uses FAIR Health data for professional services. • 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.
Out of Network Inpatient-Practitioner	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

Benefit Classification/ Sub-classification	Factors	Sources for Each Factor
		CMS Medicare Resources Based Relative Value Scale ("RBRVS") system for professional services. For facility services, Cigna leverages the Optum Medicare database.

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 Inpatient-Facility	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). The client may elect one of two Maximum Reimbursable Charge (MRC) options to determine the allowable amount. - 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	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.

		MRC2 percentage between 100 and 300.	
Out of Network Inpatient- Practitioner	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) – 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

Adjusted Rates:

Benefit Classification/ Sub-classification	Factors	Sources for Each Factor
Out-of-Network Inpatient-Facility	1. Federal and State Law as applicable, No Surprises Act (NSA) - Federal law prescribes how plans must reimburse out-of-network providers for emergency services or when the member did not voluntarily use out-of-network benefits. 2. Out of Network Protection Program	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. Emergency inpatient admissions will be subject to the No Surprises Act (NSA). 2. Out-of-Network Protection Program • External pricing partner network rate • External pricing partner direct negotiation • Cigna-initiated direct negotiation
Out of Network Inpatient-Practitioner	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: For services subject to the No Surprises Act, member cost sharing is calculated using the applicable recognized amount. The total out-of-network rate is determined in accordance with the applicable All-Payer Model Agreement, specified state law, or federal process, including an agreed-upon amount or an amount determined through the federal independent dispute resolution process, as applicable. The QPA is used as required by federal law but is not automatically treated as the final provider reimbursement amount. 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

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 Inpatient-Facility	1. Federal and State law, as applicable. • No Surprises Act (NSA) - federal laws prescribe how plans must reimburse out-of-network providers for emergency services or when the member did not voluntarily use out-of-network benefits. 2. Out of Network Protection Program	1. No Surprises Act (NSA) (45 CFR 149.420; Section 104 of the No Surprises Act; PHSA 2799B-2) Federal laws prescribe how plans must reimburse Out of Network providers for emergency services or when the member did not voluntarily use out-of-network benefits. 2. Out of Network Protection Program provided by external pricing partners that utilize 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. • Cigna: Cigna attempts negotiation with the provider at a claim-specific rate. The provider remains out-	1. Inpatient emergency admission facility claims are subject to the 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 Program • 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.

		of-network but agrees not to balance bill the member.	
Out of Network Inpatient-Practitioner	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. 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. 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	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. Fair Health Medicare Gap Fill Plus, and Internal MRC Policy Review Board

		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.	
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Final Rates:

Benefit Classification/ Sub-classification	Factors	Sources for Each Factor
Out-of-Network Inpatient-Facility	1. Federal and State Law as applicable, No Surprises Act (NSA) - Federal law prescribes how plans must reimburse out-of-network providers for emergency services or when the member did not voluntarily use out-of-network benefits. 2. Out of Network Protection Program 3. Maximum Reimbursable Charge (MRC) applied to both M/S or MH/SUD	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. Emergency inpatient admissions will be subject to the No Surprises Act (NSA). 2. Out-of-Network Protection Program • External pricing partner network rate • External pricing partner direct negotiation • Cigna-initiated direct negotiation 3. Maximum Reimbursable Charge (MRC) • For plans that elect MRC1, Cigna uses FAIR Health data for professional services. • 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.
Out of Network Inpatient-Practitioner	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 For services subject to the No Surprises Act, member cost sharing is calculated using the applicable recognized amount. The total out-of-network rate is determined in accordance with the applicable All-Payer Model Agreement, specified state law, or federal process, including an agreed-upon amount or an amount determined through the federal independent dispute resolution process, as applicable. The QPA is used as required by federal law but is not automatically treated as the final provider reimbursement amount. 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. Maximum Reimbursable Charge (MRC): • (MRC1) - For plans that elect MRC1, Cigna uses a rate developed from the external pricing partner claims database.

Benefit Classification/ Sub-classification	Factors	Sources for Each Factor
		(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

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 Inpatient-Facility	- Federal and State law, as applicable. - No Surprises Act (NSA) - federal laws prescribe how plans must reimburse out-of-network providers for emergency services or when the member did not voluntarily use out-of-network benefits. - Out of Network Protection Program - Maximum Reimbursable Charge (MRC) applied to both M/S or MH/SUD	- No Surprises Act (NSA) (45 CFR 149.420; Section 104 of the No Surprises Act; PHSA 2799B-2) Federal laws prescribe how plans must reimburse Out of Network providers for emergency services or when the member did not voluntarily use out-of-network benefits. - Out of Network Protection Program provided by external pricing partners that utilize 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	- Inpatient emergency admission facility claims are subject to the 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). - Out of Network Protection Program - 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.

		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. • 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). The client may elect one of two Maximum Reimbursable Charge (MRC) options to determine the allowable amount. • 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	3. 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.
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		Medicare to determine the allowable fee for services within a geographical area. Clients may select an MRC2 percentage between 100 and 300.	
Out of Network Inpatient-Practitioner	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	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. • (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

		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 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.	services. Cigna leverages the Optum Medicare database for facility services 4. Fair Health Medicare Gap Fill Plus, and Internal MRC Policy Review Board
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		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.	
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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

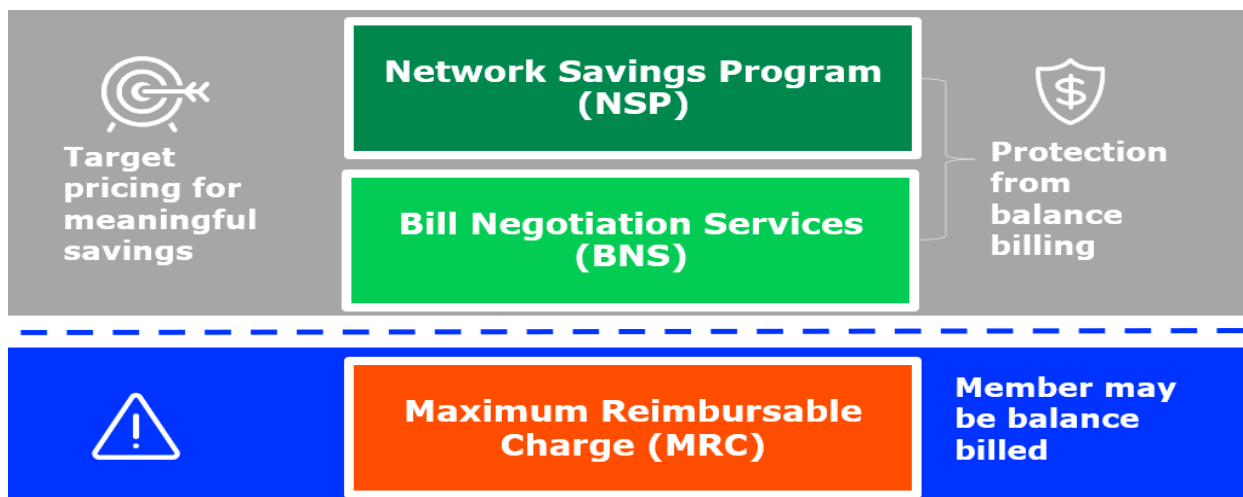
the industry as a usual/customary charge, reflects a reasonable reimbursement amount consistent with the particular MRC methodology adopted by the client.

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.

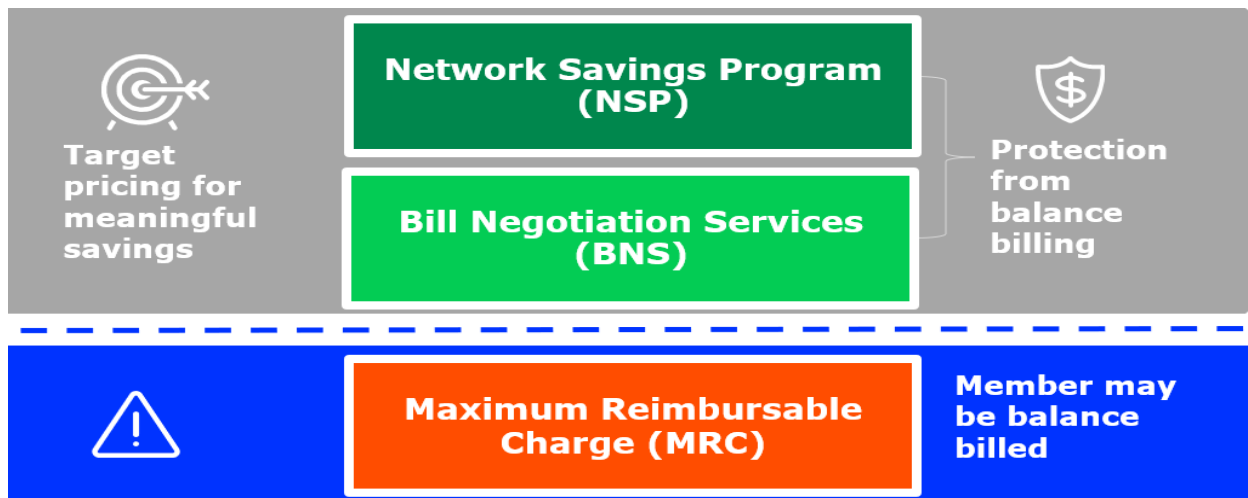
In pursuing this objective, Cigna's out-of-network reimbursement methodology ultimately rests on ensuring that the Maximum Reimbursable Charge (or "MRC") for a service, commonly referred to in the industry as a usual/customary charge, reflects a reasonable reimbursement amount consistent with the particular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

Reimbursement Table B – Inpatient Facility:

Data Methodology: Reimbursement Table B evaluates separately billed facility services rendered in an inpatient 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 used to identify the inpatient settings applicable to each benefit category. The analysis does not include institutional facility reimbursement under DRG, per diem, percent-of-charge, or other facility payment arrangements.

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. Facility claims are assigned to the Out-of-Network Inpatient classification using the POS code reported on the claim. The applicable POS codes are identified below.

MH/SUD Claims Population

MH/SUD

- Virginia fully insured claims incurred during calendar year 2025;
- claims identified as Out-of-Network; and
- facility claims reported with one of the following POS codes:
 - Inpatient Hospital (POS 21);
 - Inpatient Psychiatric Facility (POS 51); or
 - Residential Substance Abuse Treatment Facility (POS 55).

M/S Claims Population

- Virginia fully insured claims incurred during calendar year 2025;
- claims identified as out-of-network; and
- facility claims reported with one of the following POS codes:
 - Inpatient Hospital (POS 21);
 - Skilled Nursing Facility (POS 31); or
 - Comprehensive Inpatient Rehabilitation Facility (POS 61).

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

facility 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 inpatient 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:

CLASSIFICATION	PROVIDER TYPE	TYPE	PROCEDURE CODE	AVERAGE BILLED AMOUNT PER UNIT	AVERAGE ALLOWED AMOUNT PER UNIT
Out-of-Network Inpatient	Inpatient Hospital (POS 21)	Facility	H0010	\$5,906.29	\$2,060.13

M/S:

CLASSIFICATION	PROVIDER_TYPE	PROCEDURE_CODE	AVG_BILLED_AMT_PER_UNIT	AVG_ALLOWABLE_AMT_PER_UNIT
Out-of-Network Inpatient	Skilled Nursing Facility	430	\$101.69	\$49.46
Out-of-Network Inpatient	Skilled Nursing Facility	420	\$101.19	\$51.08
Out-of-Network Inpatient	Skilled Nursing Facility	120	\$513.10	\$313.83
Out-of-Network Inpatient	Skilled Nursing Facility	300	\$41.68	\$20.28
Out-of-Network Inpatient	Skilled Nursing Facility	250	\$80.32	\$47.17

The MH/SUD analysis contains only one inpatient hospital procedure codes, while the M/S data include a skilled nursing facility records. The Virginia fully insured out-of-network inpatient claims population produced a limited number of MH/SUD claim lines during the measurement period. Because the limited volume restricts reliable service-level outcome comparisons, Cigna did not treat the observed reimbursement percentages as independently dispositive of comparative stringency.

Single Case Agreement (SCA):

Data Methodology:

SCA Table evaluates services rendered in an inpatient 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 inpatient 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			
TYPE	PROCEDURE CODE	AVERAGE BILLED AMOUNT	AVERAGE ALLOWED AMOUNT
Inpatient	H0018	\$7,403	\$3,333
Inpatient	S9480	\$2,574	\$843
Inpatient	1001	\$1,404	\$694
Inpatient	1002	\$666	\$259
Inpatient	H0015	\$7,798	\$2,072
Inpatient	S0201	\$6,001	\$1,055
Inpatient	H0035	\$9,572	\$2,356
Inpatient	H2018	\$3,305	\$790
Inpatient	H0017	\$9,939	\$5,739
Inpatient	H0010	\$8,853	\$2,974

M/S			
TYPE	PROCEDURE CODE	AVERAGE BILLED AMOUNT	AVERAGE ALLOWED AMOUNT
Inpatient	80053	\$244	\$108
Inpatient	85025	\$145	\$66
Inpatient	unlisted code	\$47,571	\$24,685
Inpatient	83735	\$120	\$64
Inpatient	36415	\$19	\$5
Inpatient	84100	\$83	\$45
Inpatient	87497	\$495	\$309
Inpatient	80197	\$223	\$122
Inpatient	86833	\$1,274	\$655
Inpatient	82570	\$99	\$50

The Single Case Agreement (“SCA”) analysis evaluates Virginia fully insured inpatient services incurred during calendar year 2025 that were identified as out-of-network and for which an SCA was successfully negotiated. The claims-selection criteria, population parameters, and

reimbursement calculations were applied consistently to Medical/Surgical (“M/S”) and Mental Health/Substance Use Disorder (“MH/SUD”) services.

For both benefit categories, the claims populations were limited to: (1) Virginia fully insured claims incurred during calendar year 2025; (2) claims identified as out-of-network based on the network-status field; and (3) claims associated with a successfully negotiated SCA. Accordingly, neither claims population was subject to a unique eligibility criterion, exclusion, or analytical threshold based on whether the service was classified as M/S or MH/SUD.

Within the MH/SUD claims population, average billed amounts ranged from \$666 to \$9,939, and average allowed amounts ranged from \$259 to \$5,739. The highest average allowed amount was reported for procedure code H0017, at \$5,739, followed by H0018, at \$3,333, and H0010, at \$2,974. The remaining MH/SUD procedure codes had average allowed amounts ranging from \$259 to \$2,356.

Within the M/S claims population, average billed amounts ranged from \$19 to \$47,571, and average allowed amounts ranged from \$5 to \$24,685. The highest average allowed amount was associated with the unlisted code, at \$24,685. Excluding that unlisted code, the M/S average allowed amounts ranged from \$5 to \$655. The M/S results therefore demonstrate substantial variation by procedure code, particularly where an unlisted service is included.

The dollar amounts should not be interpreted as a direct measure of comparative stringency because the MH/SUD and M/S tables contain different procedure codes and materially different types of inpatient professional services. The tables do not present matched or clinically comparable services, and the data provided do not include claim counts, service-unit volumes, provider types, negotiated discounts, or measures of distribution. As a result, a higher or lower average allowed amount for one category does not, by itself, establish that the SCA process was applied more or less favorably to that category.

The results instead demonstrate that the same claims-selection standards and average-allowed-amount calculation were used for both M/S and MH/SUD services. The observed variation is attributable to the composition and characteristics of the respective claims populations—not to a difference in the methodology used to identify claims, negotiate an SCA, or calculate average reimbursement. Nothing in the reported data indicates that a different reimbursement formula, claims-selection rule, or analytical threshold was applied to MH/SUD services.

Accordingly, based on the methodology and data presented, Cigna applied the SCA reimbursement analysis comparably to M/S and MH/SUD inpatient services. The processes, strategies, evidentiary inputs, and calculation methodology were no more restrictive or more stringently applied to MH/SUD benefits than to M/S benefits. The quantitative results support the conclusion that differences in average billed and allowed amounts arise from underlying service and claims-population differences and do not evidence a disparity in the design or application of the SCA reimbursement NQTL.

Reimbursement rates; Inpatient:

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

MRC1:

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

MRC2:

- Vendor Pricing (Rate Negotiation)
- Cigna Rate Negotiation
- Medicare CMS
 - Facility rates are grouped at a DRG level and priced according to Medicare.
 - M/S Inpatient Prospective Payment System (IPPS)
 - MH/SUD Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS)
 - Per CMS a Prospective Payment System (PPS) is 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.

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 Cigna's commercial book of business

2025 (incurred and paid in 2025)												
Inpatient	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-Inpatient	23.2%	98.2%	52.8%	1.8%	3.3%	99.6%	47.0%	0.4%				
MRC2	100.0%	93.5%	66.5%	6.5%	100.0%	98.4%	62.6%	1.6%				
Facility-Inpatient	40.8%	98.5%	57.5%	1.5%	8.4%	98.6%	63.5%	1.4%				
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-Inpatient	2.7%	89.9%	52.5%	10.1%	3.2%	76.3%	51.8%	23.7%	10.0%	53.1%	78.1%	46.9%
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-	7.2%	91.3%	55.2%	8.7%	4.5%	92.9%	50.0%	7.1%	8.3%	76.1%	59.9%	23.9%

- (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, Adjusted, and Final Rates:

Cigna has evaluated the design and operation of the out-of-network reimbursement NQTL, including each process, strategy, evidentiary standard, sources, threshold and factor to determine reimbursement for MHSUD and M/S benefits within the applicable inpatient out of network classification. Based on that review, Cigna concludes the NQTL is designed and applied using processes, strategies and evidentiary standards and factors that are comparable to, and applied no more stringently, as-written and in-operation to MH/SUD than to M/S benefits.

The same reimbursement framework applies without regard to whether a claim is for an MH/SUD or M/S benefit. The applicable reimbursement methodology is determined by the plan sponsor's benefit election, the nature of the service, provider or facility type, geographic location, the availability of an applicable external rate or negotiated arrangement, and governing federal or state law. These factors are neutral as to MH/SUD status. Cigna does not apply different thresholds, approval standards, negotiation procedures, vendor-routing criteria, MRC percentages, or fallback methodologies to MH/SUD claims.

Where reimbursement differs among claims, those differences result from neutral and independently established considerations, including differences in procedure codes, provider type, place of service, geography, billed charges, available market data, plan-specific MRC elections, and applicable Medicare payment methodologies. For example, inpatient M/S facilities and inpatient psychiatric facilities are reimbursed under distinct Medicare prospective payment systems because CMS has established service-specific payment methodologies for those facility types. Reliance on the applicable Medicare methodology does not impose a more stringent standard on MH/SUD benefits; rather, Cigna applies the relevant externally established methodology consistently to the corresponding service category.

Cigna also reviewed 2025 operational data by claims platform, benefit type, MRC methodology, and inpatient facility status. Although the claims platforms contain operational differences and certain clients process MH/SUD and M/S claims on different platforms, the data were disaggregated to permit an appropriate comparison and did not identify evidence that MH/SUD claims were routed, priced, negotiated, or reimbursed under a more restrictive process. Observed differences may reflect claim mix, service type, provider charges, platform configuration, plan benefit elections, vendor participation, or negotiation outcomes. The aggregate analysis was not designed to quantify the extent to which any individual variable caused the observed differences. Cigna therefore did not treat those differences, standing alone, as establishing compliance or noncompliance.

The operational results further show that, on average, MH/SUD providers received a greater percentage of billed charges than M/S providers. Cigna does not rely on that outcome alone to establish compliance because differences in reimbursement outcomes are not dispositive of whether an NQTL is comparable and no more stringently applied. Rather, the outcome corroborates the underlying process analysis and provides no indication that the reimbursement methodology disadvantages MH/SUD benefits or creates a greater restriction on access to MH/SUD services.

Cigna therefore concludes that the Out of Network Inpatient Provider Reimbursement NQTL complies with MHPAEA because (1) the same neutral factors and evidentiary standards that govern MH/SUD and M/S reimbursement; (2) those factors and standards are applied through the same reimbursement sequence and decision criteria; (2) any service-specific distinctions are attributable to legitimate clinical, coding, provider-type, geographic, market, legal or payment differences and not to MH/SUD status; and (4) the operational data do not demonstrate that the NQTL is applied more stringently to MH/SUD benefits. Cigna will continue to review relevant policies, vendor practices, claims-system operations, and outcome data at least annually and will investigate and take appropriate corrective action if future information indicates a material disparity attributable to the design or application of this NQTL.

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